UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS, FORT WORTH DIVISION

FEDERAL TRADE COMMISSION,

STATE OF ALASKA,

STATE OF IOWA,

STATE OF NEBRASKA, *ex rel.* Michael T. Hilgers, Attorney General,

and

STATE OF TEXAS, *ex rel.* Ken Paxton, Attorney General,

Plaintiffs,

v.

WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH, INC., a Texas corporation,

WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH, INC., an Illinois corporation,

and

UNITED STATES PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH,

Defendants

Case No. 4:26-cv-00748-O

FIRST AMENDED COMPLAINT FOR PERMANENT INJUNCTION AND OTHER RELIEF

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Plaintiffs the Federal Trade Commission ("FTC" or "Commission"), the State of Alaska, the State of Iowa, the State of Nebraska *ex rel*. Michael T. Hilgers, Attorney General ("Nebraska"), and the State of Texas, ex rel. Ken Paxton, Attorney General ("Texas"), for their Amended Complaint allege:

1. Plaintiff the FTC brings this action for Defendants' violations of Sections 5(a) and 12 of the FTC Act, 15 U.S.C. §§ 45(a), 52. For these violations, the FTC seeks relief, including a permanent injunction pursuant to Section 13(b) of the FTC Act, 15 U.S.C. § 53(b).

2. Plaintiff Alaska brings this action for Defendants' violations of the Alaska Consumer Protection Act, AS §§ 45.50.471, 45.50.501, and 45.50.551. For these violations, Alaska seeks relief, including a permanent injunction, civil penalties, restitution, attorneys' fees and costs, and other appropriate relief as authorized by AS §§ 45.50.501, 45.50.551(b), and 45.50.537.

3. Plaintiff Iowa brings this action for Defendants' violations of the Iowa Consumer Fraud Act. Iowa Code § 714.16. For these violations, Iowa seeks relief including: a permanent injunction, civil penalties, disgorgement, attorney's fees, costs, and other appropriate relief as authorized by Iowa Code.

4. Plaintiff Nebraska brings this action for Defendants' violations of the Nebraska Uniform Deceptive Trade Practices Act ("NE UDTPA"), Neb. Rev. Stat. § 87-301 *et seq*. For these violations, Nebraska seeks relief, including a permanent injunction, civil penalties, attorneys' fees, costs and other appropriate relief as authorized by Neb. Rev. Stat. §§ 87-303(b), 87-303.05, and 87-303.11.

5. Plaintiff Texas brings this action for Defendants' violations of the Texas Deceptive Trade Practices Act, Tex. Bus. & Com. Code §§ 17.41-17.63. For these violations,

Texas seeks relief, including a permanent injunction, civil penalties, restitution, attorneys' fees, costs, and all other appropriate relief provided by Texas law.

I. SUMMARY OF THE CASE

6. The World Professional Association for Transgender Health ("WPATH") is an organization founded and incorporated in Texas that operates for the profit of its members by promoting the medical transition services that its members provide to children.[1] These services—drugs, surgeries, and other interventions—are sold to consumers whose children express dissatisfaction with, or report distress about, their sex-linked biological and anatomical characteristics (their "sex traits"). WPATH's membership predominantly consists of clinicians who profit from these services, including surgeons, endocrinologists, psychiatrists, and pediatricians.

7. To maintain and expand the market for transition services, WPATH provides its members and other clinicians with the means to promote the purchase of medical transition services in a variety of ways. Chief among them is the self-publication, distribution, and promotion of what it calls the "Standards of Care" ("SOC"). WPATH represents that the SOC—the latest version, SOC-8, published in 2022—are evidence- and consensus-based clinical guidelines for providing medical transition services, including for children who express

[1] This Amended Complaint uses the common definition of "children" throughout. See Child, Black's Law Dictionary (12th ed. 2024) (defining a child as "1. An unemancipated person under the age of majority" or "3. A boy or girl; a young person"). WPATH often uses a different definition of "children," and refers to a child as an "adolescent" when he or she "reach[es] Tanner stage 2 of puberty," which may occur as early as 8 or 9 years old. Eli Coleman, *et al.*, Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 S44, S64 (2022) (hereinafter "SOC-8").

dissatisfaction with or report distress about their sex traits.[2]

8. The SOC recommends life-altering surgeries for children such as penis removal, facial surgery, and breast amputation. One woman who—at age 14—resided in the Dallas-Fort Worth area and underwent breast amputation elsewhere in Texas is now an adult, and provided the FTC with written consent to disclose an image taken of her scarred chest following the surgery. *See* Image A. The photograph clearly demonstrates the life-altering nature of these procedures.

9. In addition to representing that the SOC itself, and the life-altering surgeries it recommends, reflect expert consensus and high-quality evidence, WPATH represents in the SOC that these and other transition services are medically necessary and effective at preventing suicide in children, that puberty blockers are fully reversible, that cross-sex hormones improve mental health, and that breast amputations are safe, effective, and consistently and directly increase children's health-related quality of life.

10. WPATH's representations have further deceived many consumers into believing that its treatment guidelines are based on strong evidence derived from scientific methods. Numerous parents and patients, responding to an FTC Request for Information ("RFI") in 2025 about the medical transitioning of children, have expressed complete confidence that WPATH and its SOC are reliable and trustworthy sources. For example, one person stated that "[t]he guidelines of major professional organizations such as . . . WPATH . . . have been clear and

[2] This Amended Complaint may refer to diagnoses and treatments that occurred before 2022 and were undertaken by clinicians following SOC-7's provisions which were in effect at that time, and which are identical or materially similar to WPATH's current guidance in SOC-8. Because the injuries and harm due to those diagnoses and treatments were caused by clinicians following SOC-7 provisions that were identical or materially similar to that in SOC-8, those injuries and harm illustrate the injuries and harm that result from clinicians' use of SOC-8. Where clinicians before 2022 were conducting themselves in line with what SOC-8's guidance would become, the resulting harms and injuries can similarly exemplify the consequences of clinicians following SOC-8.

follow evidence-based care for these youth for optimal best outcomes." Another wrote, "[g]ender-affirming care for minors already has a number of medical standards and best-practices based on the . . . WPATH Standards of Care which have a substantial and proven research basis." Another commenter stated that "[s]cience shows that transitioning per WPATH . . . lowers the rate of suicide among individuals with in-congruence of gender with their assigned sex at birth."

11. Medical professionals have also been duped. One clinician responded to the RFI by stating that "[t]he WPATH standards of care does an excellent job providing recommendations and guidelines for practices that are evidence based and expert reviewed." Another said, "[a]s a mental health professional . . . affirming and coordinated healthcare, informed by recognized standards of care (including WPATH), provides young people and their families with stability, safety." Unfortunately, this is not the case.

12. WPATH recommends that medical transition services be provided to children as young as 8 or 9 years old. One form of genital surgery that WPATH approves for minors is "vaginoplasty," in which the surgeon cuts off the bulk of a child's testicles and penis. The surgeon restructures the patient's scrotum to mimic a "clitoris" and "labia." Finally, to simulate a vagina, the surgeon carves a wound next to the patient's anus, severs and discards the penile shaft and testicles while saving the penile skin, and lines the wound with the patient's emptied penile skin.

13. The significant number of children being medically transitioned in recent years is driven at least in part by WPATH's removal of age limits for most interventions. WPATH removed any age limitations for breast amputation, penis removal, or any other procedure except one specific type of genital surgery for girls in the final version of SOC-8. WPATH's removal of

these age limitations was not based on a change in the medical consensus or evidence. Indeed, one WPATH leader admitted to "struggl[ing] to find any sound evidence-based argument(s) underpinning" the removal of the age limitations. WPATH nonetheless removed the age limits, expanding the customer base of its members and exposing children to significant mental and physical harm.

14. The success of WPATH's systematic efforts to expand eligibility for transition services to children in order to profit its members is difficult to overstate. Through the SOC and its other efforts, WPATH has created and currently sustains a lucrative industry of pediatric medical transition services. Over roughly the past two decades, the number of pediatric medical transition providers has multiplied rapidly. The first pediatric medical transition clinic in the United States opened in 2007. By 2015, there were at least forty-one pediatric medical transition clinics across the United States, many embedded within major children's hospitals and academic medical centers. Between 2017 and 2021, the number of children who were diagnosed yearly with distress about their sex traits in the U.S. nearly tripled from around 15,000 in 2017 to about 42,000 in 2021.

15. Clinicians rely on WPATH's representations when diagnosing children, exactly as WPATH intends. Also as WPATH intends, in clinical encounters, clinicians repeat WPATH's assertions in the SOC and elsewhere about the necessity, safety, and purported benefits of medical transition when persuading children and their parents to purchase it. Clinicians also direct parents to WPATH's publications, website, and the SOC as authoritative sources of medical information. Many, if not most, sales of pediatric medical transition services would not happen without WPATH.

16. Major health insurance companies likewise rely on the SOC's determination of

medical necessity. That is no accident. In fact, WPATH crafted the SOC with the explicit goal of guaranteeing that insurers would classify medical transition services as medically necessary and therefore covered by their insurance plans. Indeed, SOC-8's drafters repeatedly emphasized in internal communications that SOC-8 should be written to guarantee insurance coverage—including by replacing objective criteria with provider discretion, removing age minimums, and issuing broad "medical necessity" declarations for nearly every medical-transition intervention. As a result, most major insurance companies now foot the bill for pediatric medical transition services, including services that parents would otherwise be unable or unwilling to purchase without insurance.

17. Through these and other efforts, WPATH's professional members have profited immensely from the organization's work. But this profit has come at the expense of children and their parents. To advance its members' financial interests, WPATH has made false, misleading, or unsubstantiated statements—both in the SOC and other public-facing materials—regarding medical consensus and medical necessity, as well as the safety and efficacy of medical transition.

18. WPATH falsely asserts that its recommendations are the result of rigorous scientific procedures and expert consensus, even though WPATH, in producing SOC-8, disregarded established guideline-development standards, ignored the results of its own evidence reviews, and removed age limits in response to external pressure rather than scientific evidence. WPATH further represents that puberty blockers are fully reversible despite internal admissions from SOC-8's authors that this claim required an "asterisk," and it repeatedly asserts that cross-sex hormones and breast amputations improve children's mental health even though WPATH's own leaders privately acknowledged "gaps in research," lack of "research basis," and very low quality evidence. WPATH also misleadingly characterizes pediatric medical transition as

"lifesaving" or "medically necessary," despite the absence of evidence that these interventions reduce the incidence of suicide or have significant health benefits.

19. As WPATH intends, its statements provide the means for medical providers to repeat misleading, false, incomplete, or unsubstantiated information when persuading parents to purchase medical transition services for their children. WPATH informs its members—expressly or by implication—that children who express dissatisfaction with or distress about their sex traits face a higher risk of suicide unless they undergo medical transition, and it repeatedly characterizes transition as "lifesaving" or "medically necessary" despite the absence of evidence that these interventions reduce the risk of suicide. Also as WPATH intends, clinicians recite these claims to parents, often presenting transition as the only alternative to a child's death. In many cases, including those discussed below, providers explicitly ask parents whether they "would rather have a live daughter or a dead son," or vice-versa. These statements echo WPATH's messaging, rely on WPATH's false and unsubstantiated assertions, and induce the purchase of pediatric transition services from WPATH members.

20. If that were not enough, WPATH has also failed to disclose material information about the significant risks and life-long side effects associated with medical transition drugs, surgeries, and other interventions. For example, although puberty blockers can cause hot flashes, lethargy, psychosocial harms, and long-term cognitive deficits, WPATH omits or minimizes these risks in the SOC. Likewise, WPATH fails to adequately disclose that cross-sex hormones carry significant harms for minors, including mood disturbances, vocal pain, pelvic pain, pelvic floor dysfunction, clitoral discomfort, vaginal pain, persistent sexual dysfunction continuing after cessation of use, and erectile pain—effects that can be permanent. And regarding breast amputations, WPATH does not meaningfully disclose the inability to breastfeed, nerve damage

that frequently follow these procedures, nor the serious risk of necrosis. By failing to disclose these material risks, WPATH provides the means by which clinicians can unequivocally recommend the purchase of medical transition services to parents and children. WPATH's misrepresentations and deceptive omissions are thus the means by which providers mislead parents and children to their detriment about the necessity, efficacy, safety, and scientific basis of pediatric medical transition. These misrepresentations and deceptive omissions have caused unspeakable physical and psychological harm to countless children, as reflected in the sworn statements attached hereto and described below. For example, parents and children have reported being told by clinicians that puberty would resume as normal if puberty-blocking drugs stopped being administered.[3] Others were not informed of the various side effects of puberty blockers,[4] such as brain fog and an inability to concentrate,[5] hot flashes,[6] anxiety or depression,[7] urinary incontinence or bloody urine,[8] and genital pain.[9] Serious side effects of cross-sex hormones also were frequently undisclosed or not adequately disclosed,[10] such as experiencing psychotic episodes and other mental-health problems,[11] genital pain,[12] leaking from the nipples,[13] and inability to orgasm.[14] Complications from breast amputation were similarly undisclosed or

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[3] *E.g.*, Ex. 4, Decl. of Caroline Miller at ¶¶ 14, 17.
[4] *E.g.*, Ex. 5, Decl. of Elisabeth Bourne at ¶ 16.
[5] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 16.
[6] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶¶ 32, 35.
[7] *E.g.*, Ex. 4, Decl. of Caroline Miller at ¶¶ 20–21.
[8] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶¶ 35, 36–39, 44, 46; Ex. 8, Decl. of Melissa Skinner at ¶ 37.
[9] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 35.
[10] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 26; Ex. 9, Decl. of [redacted] at ¶ 14; Ex. 5, Decl. of Elisabeth Bourne at ¶ 16.
[11] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶¶ 43, 45, 49, 56; Ex. 10, Decl. of [redacted] at ¶¶ 33, 45; Ex. 1, Decl. of Soren Aldaco at ¶ 26.
[12] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶¶ 24–25; Ex. 7, Decl. of Jonathon Skinner at ¶¶ 49–50, 53; Ex. 1, Decl. of Soren Aldaco at ¶ 25.
[13] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 48.
[14] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 76.

insufficiently disclosed, such as extreme pain,[15] bruising, and internal bleeding.[16]

21. One Texas girl was admitted to a psychiatric facility in Fort Worth after a stressful family-related incident. There, a doctor repeatedly questioned her about whether she identified as a male—she liked stereotypically masculine hobbies like playing video games and was self-conscious about how her body was changing in puberty. The psychiatrist did not meaningfully address her complex family situation or existing mental health issues, but instead "affirmed" her as a male. She subsequently attended a support group in the Dallas-Fort Worth area where they discussed medical transition and where she learned about WPATH and its "standards of care" for the first time. This girl then underwent pediatric medical transition by injecting testosterone, blocking her estrogen, and undergoing breast amputation. Throughout the process of attending the Dallas-Fort Worth area support group and undergoing medical transition, she learned more about WPATH and the standards of care. She has since accepted that she is a woman and stopped taking testosterone, but she "continue[s] to experience ongoing health problems including fatigue, joint pain, clitoral cysts, and a lot of pain and physical discomfort in [her] upper chest and shoulders" from her medical transition treatments.[17]

22. Through this lawsuit, the FTC is taking action to stop the unconscionable harm inflicted by WPATH's ongoing furnishing of the means necessary for its members and other clinicians to make deceptive claims about the necessity, safety and efficacy of pediatric medical transition drugs, surgeries, and other treatments on children and their parents. The FTC has received hundreds of reports from consumers of medical transition services, including patients and parents, as well as healthcare professionals. In particular, numerous parent and patient

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[15] *E.g.*, Ex. 10, Decl. of [redacted] at ¶¶ 39, 55.
[16] *E.g.*, Ex. 1, Decl. of Soren Aldaco at ¶¶ 34–37.
[17] Ex. 1, Decl. of Soren Aldaco at ¶ 41.

declarants have complained to the FTC about serious medical complications arising from medical transition services—and that the risks and side effects that they incurred were often not, or not adequately, disclosed to them. For example, one consumer complained that nobody disclosed "that taking cross-sex hormones and undergoing major surgery at 14 years old could leave me with pelvic floor dysfunction and urinary incontinence, problems I have to manage now as a young adult. I'm only 20 years old. They didn't tell me that these complications are common enough to be known risks, and yet they were hidden from me at an age where I didn't even understand what these terms meant, let alone the impact they would have on my daily life."

23. Additionally, consumers report serious harms that continue after they stop taking cross-sex hormones and identifying as the opposite sex:

- "Today, my chest area is still weak and strange-feeling, and I have limited range of motion in my arms. My voice is deep. I have been told I might not be able to bear a child because of the puberty blocker and five years of testosterone use."[18]
- "I still suffer from urinary incontinence if I sneeze, cry, laugh, or lift something heavy. Just bending over can cause a trickle. I am like a faucet that does not turn off. It is just a constant drip, even though I have been to physical therapy and tried medications. I often wear multiple pairs of underwear or change my underwear throughout the day. I typically wear black pants in public to disguise the leaks. I have never experienced an orgasm."[19]
- "I lost the ability to scream normally when I started taking testosterone. I still cannot scream, and I have recurrent nightmares of not being able to scream when I need to."[20]
- "I experienced nerve pain and electrical sensations from the mastectomy, which continues to this day. I now wear prosthetic breasts, and the mild compression helps with my nerve pain while I am wearing them. I wear those or a sports bra when I am intimate with my girlfriend to modulate or buffer the raw nerves. With only a shirt on, or when my girlfriend lays on my bare chest, the pain is

[18] Ex. 6, Decl. of Clementine Breen at ¶ 60.
[19] Ex. 7, Decl. of Jonathon Skinner at ¶¶ 75–76.
[20] Ex. 10, Decl. of [redacted] at ¶ 53.

excruciating."[21]

- "I continue to experience ongoing health issues, including fatigue, joint pain, clitoral cysts, and a lot of pain and physical discomfort in my upper chest and shoulders. I also have nerve issues around my mastectomy scars. I get strong, weird sensations at the bottom of the scars."[22]

24. The FTC's receipt of these consumer complaints coincides with mounting scientific and international criticism and rejection of WPATH's approach, including by the English National Health Service's Cass Review and by countries such as Sweden and Finland, all of which have examined the same body of evidence that WPATH claims to have analyzed, yet reached starkly different conclusions. The Cass Review found that several existing guidelines (including WPATH's) lack methodological rigor, and that no reliable data supports strong recommendations for puberty blockers and cross-sex hormones. Similarly, Sweden and Finland, after conducting their own systematic reviews, now classify pediatric medical transition as experimental, prohibit or severely restrict the use of puberty blockers and cross-sex hormones in children outside of research settings, or prohibit transition surgeries for children entirely.

25. In November 2025, the U.S. Department of Health and Human Services published a 400-page report titled "Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices" ("The HHS Report"), which assessed the evidence base for the medical interventions on children that WPATH recommends and concluded that it is exceptionally weak. The HHS Report also highlighted potential risks and side effects of medical transition services—and ultimately recommended psychological therapy as the generally appropriate treatment for children who express dissatisfaction with, or report distress about, their sex traits. The HHS Report's authors commented that their "[r]eview is published against the backdrop of growing

[21] Ex. 10, Decl. of [redacted] at ¶ 55.
[22] Ex. 1, Decl. of Soren Aldaco at ¶ 41.

international concern about pediatric medical transition. Having recognized the experimental nature of these medical interventions and their potential for harm . . . health authorities in a number of countries have imposed restrictions. For example, the U.K. has banned the routine use of puberty blockers as an intervention for pediatric gender dysphoria."

26. The FTC therefore has reason to believe that WPATH is violating or is about to violate laws enforced by the Commission. Specifically, WPATH's ongoing and intentional furnishing of the means and instrumentalities by which its members and other clinicians deceive consumers into purchasing pediatric medical transition services violates the FTC Act and must be enjoined. Alaska, Iowa, Nebraska and Texas similarly have reason to believe that the laws of their respective states have been violated and must be redressed.

II. JURISDICTION AND VENUE

27. This Court has subject matter jurisdiction pursuant to 28 U.S.C. §§ 1331, 1337(a), and 1345 and supplemental jurisdiction over the related claims asserted by the States of Alaska, Iowa, Nebraska, and Texas pursuant to 28 U.S.C. § 1367(a).

28. Venue is proper in this District under 28 U.S.C. §§ 1391(b)(1), (c)(2), and (d); and 15 U.S.C. § 53(b).

III. PLAINTIFFS

29. The FTC is an agency of the United States Government created by the FTC Act, which authorizes the FTC to commence this district court civil action by its own attorneys. 15 U.S.C. §§ 41–58. The FTC enforces Section 5(a) of the FTC Act, 15 U.S.C. § 45(a), which prohibits unfair or deceptive acts or practices in or affecting commerce. The FTC also enforces Section 12 of the FTC Act, 15 U.S.C. § 52, which prohibits false advertisements for food, drugs, devices, services, or cosmetics in or affecting commerce.

30. The State of Alaska is one of fifty sovereign states of the United States. Cori M. Mills is the duly appointed Attorney General of the State of Alaska and is empowered by the Alaska Consumer Protection Act, AS §§ 45.50.471, 45.50.501, and 45.50.551 to bring an action in the name of Alaska to restrain unfair or deceptive acts or practices, and to seek restitution and civil penalties therefor.

31. The State of Iowa is one of fifty sovereign states. Brenna Bird is the duly elected Attorney General of the State of Iowa and is empowered to bring an action in the name of the State of Iowa. *See* Iowa Code § 13.2. The Iowa Consumer Fraud Act provides a cause of action for deceptive practices. *See* Iowa Code § 714.16.

32. The State of Nebraska is one of fifty sovereign states of the United States. Michael T. Hilgers is the duly elected Attorney General of the State of Nebraska and is empowered by the Nebraska Uniform Deceptive Trade Practices Act, Neb. Rev. Stat. §§ 87-303.05, 303.11 to bring an action in the name of Nebraska to protect the public from deceptive or unconscionable trade practices.

33. The State of Texas is one of fifty sovereign states of the United States. Ken Paxton is the duly elected Attorney General of the State of Texas and is empowered by the Texas Deceptive Trade Practices Act to bring an action in the name of the State of Texas, and in the public interest, to protect the public from false, misleading, and deceptive acts and practices in the conduct of any trade or commerce. *See* Tex. Bus. & Com. Code § 17.47.

IV. DEFENDANTS

34. Defendant the World Professional Association for Transgender Health, Inc., ("WPATH-TX") was incorporated in Texas in 1980. WPATH-TX remains an active Texas domestic corporation, with Northwest Registered Agent LLC serving as its registered agent in

Texas and with a registered office in Texas. WPATH-TX's current bylaws state that it is a Texas corporation.

35. Thirty-seven years after WPATH-TX was organized, Defendant World Professional Association for Transgender Health, Inc., was incorporated in Illinois ("WPATH-IL") in 2017.

36. The United States Professional Association for Transgender Health ("USPATH") is an unincorporated affiliate of WPATH that WPATH controls.

37. At all times relevant to this Amended Complaint, WPATH-TX, USPATH, and WPATH-IL (collectively, "WPATH"), operated for the profit of their members.

V. COMMON ENTERPRISE

38. At all times relevant to this Amended Complaint, WPATH-TX, WPATH-IL, and USPATH have operated as a common enterprise.

39. The operations of WPATH-TX, USPATH, and WPATH-IL are managed by the same management company: Veritas Association Management, Inc.

40. Veritas Association Management, Inc. (which operated as Veritas Meetings Solutions, Inc. until 2020) ("Veritas") was co-founded by Sue O'Sullivan, who serves as Veritas' president. Veritas provides management services for "more than 44 . . . healthcare associations and professional meetings" and lists over 50 clients including WPATH and USPATH.

41. Veritas's president and co-founder incorporated WPATH-IL and serves as one of its directors.

42. Blaine Vella signed WPATH-TX's most recent filing with the Texas Secretary of State, which listed her title as "Executive Director." The filing also lists Veritas's address as WPATH-TX's principal place of business. Indeed, at least at the time of that submission, Veritas

employed Vella as its "Vice President for Client Leadership" while she simultaneously served as "Executive Director, World Professional Association for Transgender Health." WPATH-TX lists its principal place of business as Veritas's address, 1061 E Main St. STE 300, East Dundee IL 60118.

43. WPATH-TX and WPATH-IL have overlapping officers and directors

44. WPATH's website does not distinguish between the two WPATH entities and simply brands itself as "WPATH." WPATH's current website lists its Executive Committee and Board of Directors as: Asa Radix as President; Marci Bowers as Immediate Past-President; Loren Schechter as President-Elect; Chris McLachlan as Secretary; Stephen Rosenthal as Treasurer; Javier Belinky, Kamilla Kamaruddin, Scott Leibowitz, Beth McElrea, Tonia Poteat, Sari Reisner, and Josua Safer as Board members; and Annelou L.C. de Vries, Johanna Olson-Kennedy, Erika Castellanos, and Soufiane Benaouda as Board members and representatives of affiliate organizations.

45. In 2024, the website listed a single set of officers for "WPATH": President as Marci Bowers, Immediate Past President as Walter Pierre Bouman, President Elect as Asa Radix, Secretary as Jamie Veale, Treasurer as Loren Schechter, Board members: Christina Richards, Stephen Rosenthal, Sanjay Sharma, Scott Leibowitz, Chris McLachlan, Sari Reisner, and Joshua Safer. As filed with the Texas Secretary of State in 2024, WPATH-TX identifies its officers and directors as the identical set of twelve people: Marci Bowers (President), Pierre Bouman (Immediate Past President), Asa Radix (President Elect), Jamie Veale (Secretary), Loren Schechter (Treasurer). It listed its directors as: Christina Richards, Stephen Rosenthal, Sanjay Sharma, Scott Leibowitz, Chris McLachlan, Sari Reisner, and Joshua Safer.

46. In its 2023 annual report, WPATH-IL listed its corporate officers and directors as

four of the same people, plus Veritas' president: Marci Bowers (President), Jaimie Veale (Secretary), Loren Schechter (Treasurer), Sue O'Sullivan (Director), Marci Bowers (Director), Jaimie Veale (Director). In its 2026 annual report, WPATH-IL lists its officers and directors as five of the same people, plus Veritas's president: Asa Radix (President), Chris McLachlan (Secretary), Stephen Rosenthal (Treasurer), Marci Bowers (Director), Loren Schechter (Director), Sue O'Sullivan (Director). The WPATH website currently lists three of the same people as officers: Asa Radix as President, Chris McLachlan as Secretary, and Loren Schechter as President-Elect.

47. WPATH-TX and WPATH-IL intermingle their finances. For tax year 2022, 2023, and 2024 (the most recent year for which tax records are available), WPATH filed its tax returns with the Internal Revenue Service as a Texas corporation. For tax years 2020 and 2021, WPATH filed its tax returns as an Illinois corporation. WPATH used the same Employer Identification Number for all filings.

48. WPATH formed USPATH pursuant to WPATH-TX's bylaws, which permit the formation of "Regional Affiliate Organizations." Pursuant to WPATH-TX's bylaws, USPATH's representative (currently, USPATH president Johanna Olson-Kennedy) sits on WPATH's board as a "representative Director." USPATH members automatically become WPATH members, and WPATH members who reside in the United States are automatically USPATH members.

49. The WPATH entities operate the website domain "wpath.org" as the enterprise's main internet presence. USPATH's main internet presence is located on the WPATH website, at "wpath.org/USPATH/", where USPATH lists its Board of Directors, publishes press releases and newsletters, and provides membership information.

VI. COMMERCE

50. At all times relevant to this Amended Complaint, Defendants have maintained a substantial course of trade in or affecting commerce, as Section 4 of the FTC Act defines "commerce." 15 U.S.C. § 44.

VII. BACKGROUND

A. Transition doctors founded WPATH to promote the transition service industry's financial interests after losing academic support and insurance coverage for medical transition services.

51. America's first "Gender Identity Clinic" opened at Johns Hopkins University in 1966 under the leadership of a plastic surgeon. It aimed to "reassign" patients' sexes using surgery.

52. Clinicians struggled to define the precise contours of the condition they were treating and many expressed concern that not everyone seeking such significant interventions was an appropriate candidate for them.

53. In 1974, psychiatrist Norman Fisk proposed "liberalizing the indications" for medical transition through "employing the diagnostic term gender dysphoria syndrome." Under this model, doctors initiated transition treatment based on the expressed desire to do so, which broadened the number of patients that would be referred to surgery.

54. Meanwhile, some mental health professionals criticized transition doctors for operating without evidence of long-term benefit. After one Johns Hopkins psychiatrist published a paper showing no objective patient benefit to transition, the university shut down its clinic in 1979. Other universities followed.

55. The loss of academic support for transition services posed an existential threat to the burgeoning medical transition services industry. After a decade of growth, transition doctors

were losing the support of insurance providers whose coverage decisions had facilitated that initial growth. In 1979, against this backdrop, transition doctors formed the organization that would become WPATH.

56. To address the growing problem that the loss of insurance coverage presented, WPATH published its "Standards of Care," which purported to establish clinical guidelines for the diagnosis and treatment of persons experiencing dissatisfaction with or distress about their sex traits.

B. WPATH fully embraces the medical transition of children.

57. Since 1981, WPATH has revised its "Standards of Care" seven times, culminating in SOC-8 in 2022. In the initial 1981 version of the Standards of Care, WPATH acknowledged that "[h]ormonal and surgical sex reassignment is extensive in its effects, is invasive to the integrity of the human body, has effects and consequences which are not, or are not readily, reversible, and may be requested by persons experiencing short-termed delusions or beliefs which may later be changed and reversed." WPATH emphasized that prospective patients often underestimated those risks, and that "published and unpublished case histories" revealed patients who ultimately "regretted" these treatments and found the final results "to be psychologically dehabilitating [*sic*]."

58. Recognizing these serious and often irreversible medical risks, WPATH concluded that "[h]ormonal and surgical sex reassignment may be conducted or administered only to persons obtaining their legal majority" or who had been legally emancipated.

59. But this guidance would quickly change. In 1987, Dr. Peggy Cohen-Kettenis, a psychologist who would later become a WPATH board member and leading voice within the organization, founded a medical transition clinic for minors in Utrecht, Holland. At the time, no

transition clinics worldwide were known to medically transition children before age 16, and surgical procedures were performed only on adults.

60. Dr. Cohen-Kettenis published articles about administering puberty blockers, pharmaceuticals which prevent natural pubertal development, in children beginning at age 12. Her co-author was a "professor of transsexuality," Dr. Louis Gooren, who believed that humans could possess a "brain sex" which was different from their "genetic, gonadal and genital sex."

61. Despite not having performed any studies on children who had been puberty-blocked at that age, they claimed that puberty blockers were "fully reversible; in other words, no lasting undesired effects are to be expected." Ferring Pharmaceuticals, a manufacturer of puberty blocking drugs, sponsored their work.

62. Dr. Cohen-Kettenis presented her research on cross-sex identified youth at international WPATH conferences beginning in the 1980s. She then served on WPATH's board for four-year terms beginning in 1995 and 2003; Dr. Gooren served on WPATH's board for the intervening term. By the 2000s, WPATH regularly hosted their presentations on pediatric medical transition.

63. In SOC 6, published in 2001, WPATH endorsed administering puberty blockers to children as soon as puberty begins. Dr. Cohen-Kettenis and Dr. Gooren served on SOC-6's drafting committee. At this time, only one published article purported to show evidence that puberty blockers are a safe and effective medical transition procedure: a case report on a single patient of Dr. Cohen-Kettenis. In that report, a young girl whose depression was improved by therapy but who continued to display tomboyish traits and express a desire to be a boy was administered puberty blockers, followed eventually (after the patient reached age 18) by hormone therapy, a mastectomy, an ovariectomy, and a metoidioplasty (a procedure to surgically

separate the clitoris from surrounding tissue to create the appearance of a "micropenis"). Dr. Cohen-Kettenis reported no physical side effects from any of the procedures, "slightly improved" results on most psychological questionnaires, and that the patient was subjectively satisfied with the procedures. Dr. Cohen-Kettenis reported this case to be "the first we know of to show that pubertal delay and subsequent hormonal and surgical intervention . . . has resulted in a positive outcome."

64. Despite only having a single report regarding a single person, WPATH issued a full-throated endorsement of administering puberty blockers at the onset of puberty. WPATH's recommendation for "fully reversible" puberty blockers remained in SOC-7, released in 2012, and remains in the current version, SOC-8, published in 2022.

65. Most children who begin taking puberty blockers proceed to cross-sex hormones. From 2017 to 2021, almost 15 thousand children were started on cross-sex hormone treatment. As explained in more detail below, cross-sex hormones attempt to induce physical changes to make a child more closely resemble the opposite sex. SOC-8 contains a chapter titled "Children," discussing diagnosis and treatment recommendations for pre-pubescent children, and an "Adolescent" chapter discussing diagnosis and treatment recommendations for children who have reached the onset of puberty. SOC-8 endorses cross-sex hormones for children who have "[r]eached Tanner stage 2," which is the onset of puberty—a threshold that many girls cross at age 8 and many boys at age 9.

66. WPATH also recommends various surgeries as a part of pediatric medical transition, including breast amputation and penis removal. WPATH removed any age limitations for breast amputation, penis removal, or any other procedure except one type of genital surgery for girls in the final version of SOC-8. SOC-7 similarly endorsed breast amputations before the

age of majority.

67. Over the past twenty years, the ranks of pediatric medical transition doctors have grown. The first pediatric medical transition services clinic in the United States opened in 2007, but by 2015, there were at least 41 pediatric medical transition clinics across the United States. From 2017 to 2021 the number of children who were diagnosed yearly with distress about their sex traits in the U.S. nearly tripled from about 15,000 in 2017 to about 42,000 in 2021. And in 2025, a single hospital in Colorado administered puberty blockers to 257 children for the purpose of medical transition. As the HHS report notes, "[r]eports from individual clinics suggest that medicalization is the norm, rather than the exception."

VIII. WPATH'S DECEPTIVE PRACTICES

A. WPATH developed SOC-8 without regard for scientific protocols

68. Typically, the medical profession develops what are called "trustworthy guidelines" to optimize medical care. According to the National Academy of Medicine ("NAM"), a competent and reliable guideline for medical care bears several "characteristics."

69. The methodology WPATH used to create SOC-8 does not satisfy accepted medical standards of evidence. Consequently, WPATH's assertions about the necessity, safety, and efficacy of pediatric medical transition drugs, surgeries, and other interventions are not supported by competent and reliable scientific evidence. Nor do they bear the hallmarks of a trustworthy guideline.

70. To begin with, the NAM explains that a trustworthy guideline is "based on a systematic review of existing evidence" and "on an explicit and transparent process that minimizes distortions, biases, and conflicts of interest." Conflicts of interests are "circumstances that create a risk that professional judgments or actions . . . will be unduly influenced by a

secondary interest" such as "financial interests" and non-financial interests including "the pursuit of professional advancement and recognition." The "potential for conflicts of interest are great when funding for [clinical practice guideline] development . . . comes from . . . specialty societies, which might benefit or whose members might gain from guideline recommendations." "Potential sources of bias in the development of clinical practice guidelines include professional affiliations and practice specialization, reimbursement incentives, intellectual preconceptions and previously stated positions, and the desire for recognition and career advancement." Particular concern exists when those creating the guidelines are practicing physicians. Their "secondary interest (*i.e.,* increased income from increased services) has the potential to bias physicians' primary interest in their patients' welfare" resulting in "harm [to] patients who receive unnecessary services." Thus, groups developing practice guidelines should severely restrict the influence of biased professionals including by "exclud[ing] panel members with conflicts from deliberating, drafting, or voting on specific recommendations."

71. According to the NAM, a trustworthy guideline should further "provide a clear explanation of the logical relationships between alternative care options and health outcomes." And it should "provide ratings of both the quality [certainty] of evidence and the strength of the recommendations."

72. WPATH's SOC-8 fails to meet these criteria for multiple reasons: WPATH selected authors who had conflicts of interest; WPATH ignored the consensus protocol that SOC-8 purports to follow; WPATH failed to adhere to proper protocols both in evaluating scientific and medical evidence and in making recommendations based on that evidence; and WPATH made material changes to its recommendations in response to external pressure rather than scientific evidence.

73. SOC-8 claims, just as SOC-7 did, to be based on "the best available science and expert professional consensus." As WPATH knows, its members and others use the SOC to make claims to parents and children. Thus, WPATH's assertions that its recommendations represent evidence-based and "consensus-based expert opinion" give members and other clinicians the means to misrepresent to consumers that the SOC reflects expert scientific consensus and to repeat the unsubstantiated statements therein when persuading parents and children to purchase pediatric medical transition services in accordance with WPATH's recommendations.

74. For example, one parent visited an endocrinologist to discuss purchasing pediatric medical transition services for her child. That doctor sent the parent a link to WPATH's then-current SOC-7 after she asked for information supporting cross-sex hormones.[23] And another parent visited a transition clinic but was reluctant to purchase pediatric medical transition services. A clinic worker responded by informing this parent that WPATH's guidelines were the standard of care.[24]

i. WPATH failed to disclose biases and conflicts of interest in the development of SOC-8.

75. WPATH provides to members and other clinicians the means to falsely convey to parents and patients that WPATH's guidelines are based on a reliable methodology which follows established scientific procedures, including by minimizing biases and conflicts of interest amongst its drafters. That false representation about process is crucial to WPATH's claims regarding the necessity, safety, and efficacy of pediatric medical transition and specific transition services—claims that clinicians also convey to parents.

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[23] Ex. 5, Decl. of Elisabeth Bourne at ¶ 19.
[24] Ex. 11, Decl. of Gwen Turecki at ¶ 7.

76. For example, SOC-8 claims that it followed the NAM and World Health Organization ("WHO") standards on managing conflicts of interest. Yet WPATH ignored WHO standards requiring that those "who have major conflicts of interest, be they financial or nonfinancial, cannot be appointed to the [guideline development group]." And it likewise ignored the NAM standards, which provide that subject matter experts with conflicts of interest "can share their expertise with the [guideline development group] as consultants and as reviewers . . . but generally should not serve as members of the [guideline development group]." And even where it is necessary for a guideline development group to have members with conflicts of interest, the NAM cautions that "[m]embers with [conflicts of interest] should represent not more than a minority of the [guideline development group]" and that "[t]he chair or cochairs should not be a person(s) with [conflicts of interest]."

77. Far from attempting to manage or minimize conflicts of interest, WPATH's author selection process ensured that SOC-8's drafters would harbor biases and conflicts of interest. Thus, SOC-8 is a product of bias and financial conflicts of interest, and therefore not based on a reliable methodology that follows established scientific procedures.

78. The WHO warns against allowing "intellectual conflicts of interest" to taint the development of guidelines, and the NAM warns that individuals with "intellectual relationship[s] that may impact [their] ability to approach a scientific question with an open mind," and whose "community standing" might be impacted by voicing dissent have conflicts of interest. Nevertheless, WPATH exclusively selected authors for SOC-8 who already supported medical transition services. For example, the selection criteria for SOC-8 Revision Committee co-chairs and Chapter Leads required that each be a "[l]ongstanding WPATH Full Member in good standing" and a "[w]ell recognized advocate for WPATH and the SOC."

79. These conflicts of interest were not merely intellectual—SOC-8 authors often stood to benefit personally and financially from guideline recommendations. WPATH's former president and current board member Dr. Marci Bowers is a prime example of the conflicts of interest that affected SOC-8's development. Dr. Bowers, who has advocated for performing genital surgeries on children, made more than a million dollars in a single year from transition surgeries but declared it "absurd" to disclose that conflict or attempt to account for it in SOC-8.

80. Those conflicts were not limited to Dr. Bowers. Dr. Eli Coleman, a leader of the SOC-8 drafting effort, testified in a deposition that "most participants in the SOC-8 process had financial and/or nonfinancial conflicts of interest." Dr. Coleman himself was the director of the University of Minnesota's Institute for Sexual and Gender Health—which provides puberty blockers and cross-sex hormones to children—for over three decades. In May 2023, after SOC-8 was published, the Institute renamed itself the Eli Coleman Institute for Sexual and Gender Health.

81. The leader of an external review team lamented that "[d]isclosure, and any necessary management of potential conflicts, should take place *prior* to the selection of guideline members" but "this was not done here."

82. Notwithstanding these conflicts of interest, WPATH falsely represents that SOC-8 complied with WHO and NAM standards in reviewing "[c]onflicts of interests . . . as part of the selection process" and determining that "[n]o conflicts of interest were . . . significant or consequential."

83. But WPATH's selection process, as a leading SOC-8 author admitted, resulted in most—if not all—SOC-8 authors having conflicts of interest that were significant and consequential.

ii. Contrary to its claims, WPATH failed to obtain consensus on consequential changes to recommendations in SOC-8 regarding the provision of transition services to children

84. WPATH knowingly provides members and other clinicians the means to convey to parents and children that medical consensus supports the provision of transition services to children. WPATH represents in SOC-8 that it developed its recommendations through a specific process that yielded expert consensus. But WPATH failed to follow that process and failed to obtain consensus among SOC-8 drafters for key recommendations regarding pediatric medical transition services. It published its recommendations and represented them as the product of medical consensus nevertheless.

85. WPATH claims that SOC-8 used the "Delphi process," which is a formal method of developing recommendations based on expert consensus.

86. The Delphi process ensures a level of consensus by posing a question to experts who answer anonymously. Those answers are collated, ranked, and voted upon. That process continues until a consensus statement is reached based on the highest ranked choice.

87. WPATH failed to follow Delphi when developing SOC-8. The most glaring example of SOC-8's departure from this framework is the removal of age minimums for pediatric medical transition drugs, surgeries, and services including cross-sex hormones, breast amputations, surgical penis removal, and facial surgery. The initial draft of SOC-8 included age minimums ranging from 14 to 17 years old for cross-sex hormones, chest surgeries, facial surgeries, genital surgeries,[25] and other surgeries. These age limits were the product of WPATH's "expert consensus" but were removed at the last minute because of external pressure,

[25] As in the final draft, an age limit of 18 was set for phalloplasty.

as discussed in more detail below.[26]

88. The removal of age minimums did not itself go through Delphi. At least one WPATH member could not "see how we can simply remove something that important from the document—without going through a Delphi—at this final stage of the game."

89. WPATH failed to disclose that it disregarded the results of the Delphi process with respect to age limits and thus its statement that "[c]onsensus on the final recommendations was attained using the Delphi process" is false.

iii. WPATH misrepresented the quality of evidence underlying its guidelines for pediatric medical transition services

90. Publicly, WPATH provides members and other clinicians the means to convey to parents and children that its recommended transition services reflect quality medical evidence and established scientific methodology. Privately, SOC-8 drafters knew that they did not have sufficient medical evidence to support their recommendations. Moreover, WPATH did not follow its stated methodology for grading the quality of evidence and exaggerated the quality of evidentiary support for medical transition services.

91. Dr. Coleman acknowledged in a 2023 strategy memo to his fellow drafters that "[a]ll of us are painfully aware that there are many gaps in research to back up our recommendations."

92. In 2024, Dr. Amy Tishelman, the lead drafter of SOC-8's Children chapter, admitted in an NPR interview that she and her peers had no "research basis" for making decisions or a sufficient "evidence base to know what the best treatments are":

> TISHELMAN: [W]e're talking about assessments [prior to transitioning a child], but we really don't have research on what assessments are effective.

[26] See *infra,* ¶¶ 107–116.

> Right now, we don't have a research basis for making those decisions, but at least we could bring together a diversity of sophisticated clinicians who do believe that transgender youth exist, to come up with some guidelines about what we mean by assessment.
>
> NPR: That is so remarkable. We don't even know yet what the best assessments are, let alone we don't have an evidence base to know what the best treatments are.
>
> TISHELMAN: No.

93. But that lack of evidence did not deter the SOC-8 authors, who knew "what we should end up with" in SOC-8 despite the lack of evidence. In other words, WPATH's SOC-8 authors had prejudged that SOC-8 would ultimately make strong recommendations in favor of pediatric medical transition regardless of whether the quality of the evidence supported such recommendations.

94. In February 2026, Dr. Tishelman justified transitioning children despite not understanding "the etiology [of desiring transition], or why," by comparing pediatric medical transition to knowing "that the sun and the moon existed before we understood anything about why. Lots of things we observe in life, we know to be true, and we don't understand them."

95. Although WPATH had recommended prescribing puberty blockers to children as early as SOC-6, in connection with the preparations for SOC-8 members of WPATH's guideline development group acknowledged that "there is no agreement on [the use of puberty blockers] within pediatric endocrinologists," that "a global consensus on 'puberty blockers' does not exist," that various European countries had begun restricting puberty blockers and expressing skepticism about their use, and that they did not believe that SOC-8's recommendation "is supported by the data."

96. Moreover, as former WPATH board member Dr. Erica Anderson explained in 2025, there is not "a lot of long term research on the use of puberty blockers," so experts "don't

know" whether they "affect not just the advance of physical development but also . . . cognitive development . . . and emotional development" amongst other side effects. Thus, SOC-8 lacked sufficient medical and scientific basis for its strong recommendation that puberty blockers be administered to children because WPATH could not support the claim that "there are few downsides of" doing so.[27]

97. Despite the acknowledged lack of evidence, SOC-8 purported to use a version of the "GRADE" system. That system asks a clinical question that is then answered by a systematic literature review of available evidence. Reviewers then assess the evidence and assign it a value of "very low, low, moderate, or high." Next, the reviewers weigh the evidence and make a recommendation for or against a particular medical intervention. Finally, the reviewers classify that recommendation as "strong" or "weak."

98. The quality of evidence reflects the certainty of that evidence. High quality evidence means that a reviewer is "very confident that the true effect" of a treatment "lies close to that of the estimate of the effect." Very low quality evidence means that a reviewer has "very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect."

99. Evidence quality can suffer for several reasons, including risk of bias, unexplained variations in results, evidence that is not directly applicable to the research question, precision flaws like small sample sizes or wide confidence intervals, publication bias, selective reporting, and other problems.

100. Low-quality and very-low-quality evidence often contain serious flaws, including

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[27] See *infra,* ¶ 103 (noting SOC-8's representations regarding the requisite level of evidentiary support for its recommendations).

failure to account for comorbidities, failure to control for the placebo effect, selective inclusion of respondents, unrepresentative respondents, lack of comparison groups, lack of controls for differences with comparison groups if any were present, and short follow-up intervals.

101. According to the NAM, a trustworthy guideline should "provide ratings of both the quality [certainty] of evidence and the strength of the recommendations."

102. But WPATH decided not to include the results of its GRADE review of evidence in SOC-8. This was a deliberate decision to obfuscate the strength of the evidence supporting WPATH's recommendations and allow WPATH to overstate the strength of its evidence.

103. SOC-8's misleading methodology purports to rely on GRADE despite not following the GRADE system. SOC-8 states that the phrase "we recommend" is a "strong recommendation" which indicates that: "the evidence is of high quality," that "there is a high degree of certainty [that the intervention's] effects will be achieved in practice," that "there are few downsides of [the] therapy/intervention/strategy," and that "there is a high degree of acceptance among providers and patients or those for whom the recommendation applies." Conversely, the term "we suggest" is a "weak recommendation."

104. With respect to children, SOC-8 "recommend[s] . . . surgical interventions for eligible*" children, referring the reader to the summary criteria for eligibility contained in SOC-8 Appendix D and the Adolescents chapter generally for eligibility criteria. Appendix D lists surgeries including "breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery." By using "we recommend," SOC-8 represents that its recommendations for these surgeries are "[s]trong recommendations" because the "evidence is of high quality" with few accompanying downsides.

105. WPATH's recommendations are false and misleading because they represent that

they are supported by high-quality evidence and that the treatments in question have few downsides. In reality, WPATH's recommendations are unsupported by high-quality evidence, and the recommended procedures often have severe and permanent negative physical and psychological side effects. Indeed, at least some of WPATH's recommendations are contrary to the results of WPATH's consensus process. Thus, WPATH provides the means by which clinicians deceive parents when claiming that strong evidence and scientific consensus support pediatric medical transition.

106. For example, in initial drafts of SOC-8, WPATH included a strong recommendation in favor of administering puberty blockers "after [children] first exhibit physical changes of puberty," despite WPATH grading the supporting evidence as "moderate." In the published final version of SOC-8, WPATH decided to omit its "moderate" grade. Thus, because SOC-8 claims that a "strong recommendation" reflects that "the evidence is of high quality," the omission of WPATH's "moderate" grade misrepresents that the evidence supporting administering puberty blockers is of high quality. Clinicians rely on SOC-8's representations about the strength of the evidence when assuring parents that purchasing puberty blocker treatment is medically necessary to treat their children.

iv. Improper external pressure, not scientific or medical evidence, also led to WPATH's recommendations in SOC-8 pertaining to pediatric medical transition services

107. Finally, WPATH's claim that its guidelines are the product of scientific evidence and medical consensus is also untrue as to key portions of SOC-8, including the lack of age minimums for nearly all aspects of pediatric medical transition other than phalloplasty for girls, because those recommendations are the result of external pressure, not scientific or medical evidence. Specifically, WPATH provides the means that enable clinicians to deceive parents and

children by representing or implying that that SOC-8 reflects evidence-based scientific consensus.

108. For example, Admiral Rachel Levine, then serving as the Assistant Secretary for Health at the United States Department of Health and Human Services, was "extremely supportive of the SOC 8" and "very eager for its release—so to ensure integration in the US health policies of the Biden government." As shown below, Admiral Levine's office pressured WPATH to lift age limitations on medical transition services and that pressure contributed to WPATH's decision to lift all age limitations.

109. SOC-8's drafters initially included recommended minimum ages for various pediatric medical transition services. These recommendations had gone through SOC-8's Delphi process. But these age limits would have reduced the pool of potential customers for pediatric medical transition services by restricting provision of those services to those above the specified ages.

110. In July 2022, Admiral Levine's Chief of Staff spoke with a SOC-8 author and expressed concern that WPATH's then-proposed minimum ages for a variety of pediatric medical transition services (which underscore that patients are children) would "result in devastating legislation" limiting those services. Such legislation would also have damaged the careers and livelihood of many of WPATH's members, who profit from the legality of pediatric medical transition service. Accordingly, Admiral Levine's Chief of Staff asked "if the specific ages can be taken out."

111. WPATH members discussed this request in light of their shared financial objective of "help[ing] in the fight against" what they termed "the conservative anti trans agenda." A co-lead of SOC-8's Adolescent chapter explained that if age minimums were in

SOC-8, "[t]he conservatives will only hone in on the ages and say that WPATH is supporting 'cutting off healthy girl breasts at 15 years old.'" If SOC-8 stayed silent on ages, the reasoning went, "[i]t doesn't give them the headline."

112. Some WPATH members expressed concerns that acquiescing to external pressure would harm the "messaging and marketing" of SOC-8. For example, then-WPATH president Dr. Walter Pierre Bouman stated that it would not be "appropriate to take any feedback from a nonmedical professional seriously." But those concerns were ignored. Indeed, one SOC-8 author wrote that, in a meeting, Admiral Levine "asked us to remove" references to minimum ages. Another WPATH member wrote, after suggesting a "compromise" solution, that "it is frustrating to have politics in our brains as we make these decisions. But it is what it is!"

113. The outside pressure continued. According to a WPATH leader, the American Academy of Pediatrics threatened to "actively publicly oppose" SOC-8 if WPATH did not remove the age minimums. Dr. Bouman expressed "surprise[] that a 'reputable' association" like "the AAP [wa]s so thin on scientific evidence" for its demands. Dr. Bouman likewise "struggle[d] to find any sound evidence-based argument(s) underpinning" the AAP's demanded changes.

114. But WPATH made the change anyway. Specifically, WPATH caved to this external pressure and removed the age minimums, which, relative to the initial SOC-8 draft, broadened the class of potential patients to whom its members could sell transition services to include children of even younger ages. And WPATH did this to further the profits of its members, despite the acknowledged absence of high-quality evidence supporting the change and in violation of its own stated procedures, including by disregarding the Delphi process that it purported to follow.

115. One WPATH committee member acknowledged that it was "the most strange experience" to see WPATH eliminate minimum age recommendations at the "last minute" after internal discussion made clear that "nobody [on the committee] wanted to [eliminate] them, and personally not agreeing with the change."

116. Ultimately, the removal of age limits at the behest of interested third parties was intended to—and did—increase the profits generated by WPATH's members by expanding the pool of potential patients to include more and younger children.

B. WPATH knows that its recommendations are not supported by scientific evidence or a medical consensus

i. WPATH commissioned an evidence review, then blocked the results from being published

117. SOC-8's authors commissioned systematic reviews of evidence regarding pediatric medical transition from Johns Hopkins University. A team led by Dr. Karen Robinson was to conduct those reviews, grade the evidence, and present the results to the SOC-8 drafters to inform their work.

118. Dr. Robinson told a government official in 2020 that she and her team had "completed and submitted reports of reviews (dozens!) to WPATH."

119. In commissioning these reviews, WPATH secured significant control over the creation and use of any of the Johns Hopkins reports, including whether they would ultimately be published. Among other things, WPATH required that the Johns Hopkins team "use the Data[28] for the benefit of advancing transgender health in a positive manner" and "involve[] at least one

[28] WPATH's policy defines "Data" to include essentially any work done by Dr. Robinson's team in connection with SOC-8, to include "raw data, research data, records, reports, notes, tables, writing, sound recordings, pictorial reproduction, drawings or other graphical representations, and works of any similar nature (whether or not copyrighted) which are generated or specified to be delivered by Dr. Robinson and her team in connection with the update and development of the SOC8."

member of the transgender community in the design, drafting of the article, and the final approval of the article." Only after meeting these criteria could Johns Hopkins seek final approval from the WPATH Board of Directors for publication.

120. Johns Hopkins attempted to gather scientific studies concerning "multiple types of interventions (surgical, hormone, voice therapy . . .)," but "found little to no evidence about children and adolescents."

121. WPATH obstructed the distribution of multiple Johns Hopkins manuscripts, causing Dr. Robinson to express frustration that WPATH was "trying to restrict our ability to publish."

122. This was not the only notable evidentiary exclusion from SOC-8. For example, two preliminary articles regarding a study by later USPATH president Dr. Johanna Olson-Kennedy and others formed the evidence base of SOC-8. Two subjects of that study committed suicide during the period of observation. Yet SOC-8 did not disclose or discuss those deaths and how they might undermine SOC-8's conclusion that pediatric medical transition improved psychological well-being.

123. Because WPATH fears that open scientific debate will result in less profit and business for its members, WPATH routinely suppresses opposing scientific viewpoints by intentionally concealing information. For example, one WPATH member complained on a "WPATH Member Forum" in 2021 that when WPATH members publicly disagree with each other, "[i]t doesn't help me with my corporate, HR, and DEI clientele." This WPATH member feared that open discussion of detransitioners, or those who undergo medical transition but later return to living as their sex, potentially jeopardized his or her income. Indeed, the WPATH member complained that public debates "reduce[] the inclusion/exclusion battle to mutually

opposing academics with paychecks at stake, which means companies are less likely to invest in trans and gender expansive infrastructure."

124. A WPATH member forwarded this post to WPATH leaders, commenting that "it is very well articulated feedback for WPATH."

125. Thus, WPATH works to protect its members' revenues by quashing internal debate, including the type of debate that is necessary to the scientific process and development of medical guidelines. Relatedly, those associated with WPATH have worked to keep crucial details concerning patient encounters, patient outcomes, and their efforts to expand the market for medical transition services hidden to reduce potential criticism. Dr. Kellan Baker, whose doctorate is in health policy and management, lectured WPATH conference attendees in 2023 to "[k]eep it simple" because "[i]t is really, really, really detrimental right now for us to provide, unfortunately, a lot of detail about who we are, who our patients are, what our work looks like."

126. WPATH also suppresses debate and dissension by engaging in personal attacks and invective. As the Cass Review, an independent review commissioned by England's National Health Service, noted, "the toxicity of the debate" around transition services "is exceptional," and "[t]here are few other areas of healthcare where professionals are so afraid to openly discuss their views, where people are vilified on social media, and where name-calling echoes the worst bullying behaviour."

127. WPATH contributes to that toxicity. For example, the American Medical Association privately declined to "endorse" SOC-8 because it generally does not back "standards of care" as they "fall outside of [the AMA's] expertise." WPATH's then-president, Dr. Walter Pierre Bouman, forwarded the AMA's email to other WPATH leaders, speculating that "the AMA and its current custodians" were "probably some white heterosexual cisgender hillbillies

from nowhere."

ii. WPATH has falsely represented in SOC-8 that pediatric medical transition is the standard of care for children experiencing dissatisfaction with or distress about their sex traits

128. Despite the low-quality evidence supporting pediatric medical transition, WPATH represents that pediatric medical transition is the "Standard of Care" for children who express dissatisfaction with or distress about their sex traits.

129. A "standard of care" typically reflects the collective judgment of the medical community and best available research evidence regarding the diagnosis of specific conditions and safe and effective treatment. A "standard of care" informs medical malpractice law, where the standard of care sets the bar that physicians must meet based on the norms of a given practice area.

130. By titling its publication "Standards of Care," WPATH purposely represents that the SOC has the hallmarks of traditional standards of care used by the medical community and courts of law. But as WPATH's president-elect Dr. Loren Schechter conceded under oath, despite bearing the name, the SOC "is not considered" by courts to be "the standard of care" for treating sex-trait-related dissatisfaction or distress. When asked why WPATH nonetheless titles its marquee publication "Standards of Care," Dr. Schechter quipped, "I didn't come up with that in 1979. I was 17 years old." Yet WPATH continues to represent that its recommendations are in fact the "standard of care" for children's medical care.

131. As the HHS report notes, SOC-8's recommendations do not represent medical consensus as to the appropriate manner of care for pediatric medical transition services. To the contrary, "[t]here is currently no international consensus about best practices for the care of children and adolescents with gender dysphoria." WPATH's use of the term "standards of care"

with respect to medical transition (including cross-sex hormones, puberty blockers, and surgical interventions), and WPATH's recommendations for those treatments, additionally implies that such treatments are standard, appropriate, and universally and widely accepted. In fact, those procedures are not and never were standard and are, in fact, prohibited or discouraged in many states and countries. The procedures are the subject of significant medical debate as to their appropriateness and effectiveness and evidence supporting performing them on children is weak or nonexistent.

iii. WPATH is aware of myriad factors that lead children to experience distress about their sex traits, but still directs clinicians to medically transition children notwithstanding potential alternative diagnoses and treatments

132. There are numerous potential root causes of a child's distress about or discomfort with their sex traits. For example, some minors who seek to transition are girls who want to escape being girls because they were sexually assaulted,[29] or gay teenagers who are uncomfortable with or confused about their sexual orientation.[30] At first glance, WPATH appears to acknowledge this fact—at least as to mental illness and trauma. In practice, however, WPATH leads clinicians to disregard it, directing children to medical transition procedures instead of the care they need.

133. WPATH acknowledges that patients who express discomfort with or distress about their sex traits have "a higher prevalence of depression," "anxiety," and "suicidality" and have often experienced "complex trauma," "discrimination," and "violence." SOC-8 notes that "it is critical to differentiate gender incongruence from specific mental health presentations" including "trauma," "parent/child interaction difficulties," "obsessions and compulsions,"

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[29] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 57.
[30] *See* Ex. 10, Decl. of [redacted] at ¶¶ 5–9; Ex. 7, Decl. of Jonathon Skinner at ¶¶ 3–11.

"broader identity problems," and even "psychotic thoughts."

134. This is a frequent problem due to the prevalence of mental health morbidities for children who express discomfort with or distress about their sex traits. A Finnish study covering all Finnish adolescents referred for medical transition services between 1996 and 2019—over 2,000 children and over 16,000 control-group individuals—found that 45.7% of the adolescents referred to medical transition services had psychiatric morbidity, while only 15.0% of the control group presented psychiatric morbidities.

135. Despite the awareness of these potential alternative causes of distress, SOC-8 discourages "gatekeeping practices" which WPATH decries as a "barrier to the provision of" what it deems necessary medical transition procedures. "Gatekeeping," however, simply refers to a clinicians' diligent application of eligibility criteria to determine whether to administer medical transition procedures.

136. Even if WPATH legitimately encouraged clinicians to investigate whether medical transition treatment is appropriate for a given child, SOC-8 offers no genuine method for making such a determination. Indeed, WPATH defines "gender incongruence" as a subjective "experience" that is "deeply felt" by the child. It offers no objective diagnosis criteria for clinicians. SOC-8 asserts that some distress about sex traits stems from biological factors that exist "from birth," while other distress is "a developmental process," and that "it is not possible to distinguish between those" causes in individual cases. It is likewise "impossible to delineate the contribution of various factors contributing" to a child's dissatisfaction or distress with their sex traits. As the HHS Report notes, "the diagnosis of gender dysphoria is based entirely on subjective self-reports and behavioral observations, without any objective physical, imaging, or laboratory markers." Instead, it "centers on attitudes, feelings, and behaviors that are known to

fluctuate during adolescence."

137. Thus, at face value, SOC-8 purports to require rigorous diagnostic procedures, namely that clinicians "undertake a comprehensive biopsychological assessment of adolescents who present with gender identity-related concerns and seek medical/surgical transition-related care." In practice, however, this is an empty requirement that lacks any concrete, objective criteria. The assessments are framed only in broad, indeterminate terms, telling clinicians they "should aim to understand the adolescent's strengths, vulnerabilities, diagnostic profile, and unique needs to individualize their care." WPATH's procedures do not specify what these factors mean, how they should be evaluated, or how they should influence clinical decisions. Instead, what these factors mean, and how they should be determined or weighed, WPATH leaves entirely to individual clinicians.

138. That indeterminate and desultory guidance is unsurprising since, as the lead drafter of SOC-8's Children chapter conceded, "we don't have a research basis for making those decisions." Indeed, that is why WPATH effectively discourages clinicians from seeking to understand and address the source of a child's distress. Presenting at a WPATH conference, psychologist Dr. Laura Kuper of the University of Texas Southwestern Medical Center mocked a clinician who tried to "understand" a child patient's "sexuality" before beginning medical transition, stating: "Well, wait a minute, I'm a grown woman and I don't even quite know exactly which box I'd want to tick, so I—Are you asking [the child] to pigeonhole?"

139. A responsible clinician faced with a child who expresses distress about their sex traits might wish to engage in therapy or treatment to encourage a child to become comfortable with their sex traits. SOC-8 emphatically forecloses this option. It dismisses such approaches as "reparative" and "conversion therapy" and provides a strong recommendation against attempting

them. Indeed, it states that such "efforts may be viewed as a form of violence."

140. Despite providing no tools to determine the source of a child's distress, SOC-8 tells clinicians that, when faced with a child who expresses that they are the opposite sex, clinicians need not—indeed, should not—seek to resolve a child's issues regarding mental health and trauma before administering cross-sex hormones and performing medical transition surgeries. SOC-8 makes clear that "not all mental health challenges can or should be resolved completely" before administering transition procedures and tells clinicians not to allow "addressing mental illness and substance use disorders" to be "a barrier to" medical transition. They are advised only to ensure that "any mental health concerns are treated sufficiently" so that medical transition treatments "can be provided optimally," meaning that the child will take their transition medications consistently, "attend follow up medical appointments," and exercise "self-care, particularly in a postoperative course," that is, after a mastectomy or genital surgery has been performed.

141. The practical—and intended—result is that SOC-8 permits disregarding and leads clinicians to disregard other causes of distress and encourages proceeding to medical transition as soon as possible. As a result, many medical transition clinics lack adequate mental health staff. If they do provide some form of talk therapy, it often focuses on the child's aesthetic preferences. For example, a WPATH member and the medical director of a public university's transition clinic, explained that the clinic's "psychology and social work" interactions with a 17-year-old boy uncovered that "Frank-N-Furter from Rocky Horror [Picture Show] really aligns with [the patient's] gender expression, and so began to explore what that would look like and we were able to access breast forms in a corset and [the patient] reported that this really feels affirming to them."

142. SOC-8 also fails to acknowledge that many children expressing distress about their sex traits as puberty approaches are simply gay or lesbian.

143. To the contrary, SOC-8 discourages clinicians from adequately pursuing this possibility, asserting that clinicians "must be sensitive to the history of (mis)use of sexual identity and orientation as a gatekeeping function to exclude transgender people from" receiving medical transition procedures. As a result, clinicians perform medical transition procedures on children instead of helping them to become comfortable with their sexuality.

144. For example, upon receiving an "immediate" diagnosis of gender dysphoria after only a cursory virtual examination of their son via Zoom, two parents questioned the clinician by suggesting that perhaps their son was merely gay. But the clinician "shut us down immediately and insisted that [the son] was transgender. She would not address any of our questions or explain why any alternative explanation was wrong."[31]

C. Independent reviews and guidelines reinforce that WPATH's recommendations and claims regarding pediatric medical transition are unsupported by competent and reliable scientific evidence

145. The independent reviews conducted by several European government entities reinforce that SOC-8's guidelines and recommendations for providing transition services to children are unsupported by competent and reliable scientific evidence.

146. For instance, the English National Health Service commissioned an Independent Review, known as the Cass Review after Dr. Hilary Cass, the Chair of the Independent Review. Dr. Cass published the review in 2024.

147. The Cass Review sought to definitively examine the current state of the medical

[31] Ex. Decl. of [redacted] at ¶¶ 11–12.

evidence regarding care for children who express discomfort with or distress about their sex traits. To that end, the Cass Review "commissioned systematic reviews on a range of issues from epidemiology through to treatment approaches, and international models of current practice."

148. As the Cass Review noted, systematic reviews provide "the highest form of evidence" by summarizing "the literature on a particular question" and "us[ing] explicitly defined and reproducible methods to systematically search, critically appraise, and synthesize primary research information." In doing so, systematic reviews are "designed to be reproducible, reliable and to eliminate bias." Using these standardized and reproducible methods "ensures that, as far as is possible, different people appraising a paper will come to similar conclusions."

149. For the Cass Review, the University of York conducted an "independent research programme" which provided "the best available collation of published evidence."

150. The Cass Review examined existing guidelines addressing pediatric medical transition and concluded that "[o]nly five" of the twenty-three such "guidelines published between 1998 and 2022" claimed to employ a "systematic approach to searching for and/or selecting evidence."

151. According to the Cass Review, most guidelines, including SOC-8, scored "poorly on the rigour of development, applicability and editorial independence domains."

152. The Cass Review noted that "it was difficult to detect what evidence had been reviewed and how this informed development of the recommendations. For example, most of the guidelines described insufficient evidence about the risks and benefits of medical treatment in adolescents, particularly in relation to long-term outcomes. Despite this, many," including SOC-8, "then went on to cite this same evidence to recommend medical treatments."

153. The Cass Review also noted that "[e]arly versions of two international guidelines

- the Endocrine Society 2009 and WPATH [SOC] 7 - influenced nearly all the other guidelines, except for the recent Nordic guidelines." And the Endocrine Society and WPATH guidelines were themselves "closely interlinked, with WPATH adopting Endocrine Society recommendations, and acting as a co-sponsor and providing input to drafts of the Endocrine Society guideline." SOC-8 is also a product of this incestuous cycle, as it "cited many of the other national and regional guidelines to support some of its recommendations, despite these guidelines having been considerably influenced by WPATH [SOC] 7."

154. The Cass Review concludes that "[t]he circularity of this approach may explain why there has been an apparent consensus on key areas of practice despite the evidence being poor." That circular approach, combined with other problems including the failure to "follow[] the international standards for guideline development" and "lack [of] developmental rigour," "raise[] serious questions about the reliability of current guidelines" like SOC-8. The Cass Review also found that SOC-8 "overstates the strength of the evidence in making [its] recommendations."

155. For example, there is "insufficient and/or inconsistent evidence about the effects of puberty suppression on psychological or psychosocial health," which is a conclusion "in line with the finding of . . . other systematic reviews, apart from the systematic review commissioned by WPATH." As for why WPATH reached a different conclusion, the Cass Review explained that "eight of the 12 studies" that WPATH considered "were rated as low quality."

156. Notably, the Cass Review reported that the two systemic guidelines which WPATH had not influenced, "the recent Nordic guidelines" from Sweden and Finland, had a far stronger evidentiary basis than WPATH's guidelines. Specifically, as part of the Cass Review, the University of York evaluated guidelines using "AGREE II [Appraisal of Guidelines,

Research, and Evaluation] . . . which is the most commonly applied and comprehensively validated appraisal tool" for clinical guidelines. Among other things, that tool evaluates "rigour of development," which "is an important bedrock of guideline development" that "includes systematically searching the evidence, being clear about the link between recommendations and supporting evidence, and ensuring that health benefits, side effects and risks have been considered in formulating the recommendations." The Cass Review found that SOC-8 scored 38% on "rigour of development."

157. Only the Swedish and Finnish guidelines "scored above 50% for rigour of development." In contrast to WPATH, the Swedish and Finnish guidelines concluded that there was a "lack of robust evidence about medical [transition] treatments," leading "to a recommendation that treatments should be provided under a research framework or within a research clinic." The Cass Review further observed that the Nordic guidelines were "the only guidelines that have been informed by an ethical review conducted as part of the guideline development." Accordingly, the Cass Review concludes that "only the Finnish (2020) and the Swedish (2022) guidelines could be recommended for use in practice."

158. Unsurprisingly, the Finnish and Swedish guidelines recommend a significantly different treatment approach to SOC-8. For example, rather than undertake a process where a doctor's role is simply to assist a child with accomplishing "embodiment goals," the Swedish guidelines restrict the use of puberty blockers and cross-sex hormones by children to narrowly defined exceptional cases in the context of clinical research, with surgeries likewise limited to exceptional circumstances. Even then, the Swedish guidelines still prohibit medical transition services without significant additional precautions, including that clinicians identify and successfully treat any other mental health conditions before proceeding with these experimental

treatments.

159. The Finnish guidelines impose similar restrictions. They categorize pediatric medical transition as an "experimental practice," prohibit pediatric medical transition surgery, and also prohibit administering puberty blockers and cross-sex hormones if the patient has any major untreated psychiatric comorbidities. Taken together, the Cass Review and guidelines from Sweden and Finland illustrate that there is no consensus concerning pediatric medical transition services.

160. Accordingly, the Cass Review and practices in Sweden and Finland underscore the absence of competent and reliable scientific evidence supporting WPATH's SOC-8. Nevertheless, WPATH disseminates SOC-8 to clinicians, knowing and expecting that they will convey these unsubstantiated recommendations to consumers and children, thereby providing the means and instrumentalities for others to make unsubstantiated claims about medical transition interventions.

D. WPATH falsely claims that pediatric medical transition is "lifesaving" or "medically necessary" and, in so doing, misrepresents the risks and benefits of pediatric medical transition

161. Medically transitioning children can involve blocking the onset of puberty with drugs, administering cross-sex hormones, and performing surgeries on the face, chest, and genitals. These medical interventions have serious, physically harmful, and irreversible effects.

162. Importantly, the overall quality of evidence purporting to show a benefit to pediatric medical transition is very low.

163. Despite the low-quality of evidence supporting pediatric medical transition, WPATH represents that its recommendations—which by and large recommend the medical transitioning of children—are the "Standard of Care" for treating children who express

dissatisfaction with or distress about their sex traits.

i. WPATH's representation that medical transition is necessary and effective to prevent suicide in children is false, misleading, or unsubstantiated

164. SOC-8 asserts that "chest dysphoria" can lead to anxiety, depression, and distress, all of which can be treated by mastectomy. SOC-8 additionally asserts that not providing medical transitioning can lead to depression and anxiety. SOC-8 further claims that "hormone therapy is considered a lifesaving intervention," and that medical transition "is associated with a substantial reduction in the risk of suicide attempt[s]."

165. To reach these and other conclusions, WPATH relies on spurious studies that frequently fail to control for the placebo effect or contain other serious defects. WPATH also ignores or dismisses evidence that suggests there are no benefits to pediatric medical transitioning, or that pediatric medical transition harms mental health. Despite arguing against legal restrictions that had been placed on pediatric medical transition services, counsel for the American Civil Liberties Union in *United States v. Skrmetti* conceded to the Supreme Court at oral argument in that case that "there is no evidence [] in the studies that [transition] treatment reduces completed suicide."

166. WPATH nevertheless asserts that medical transition is "lifesaving" or "medically necessary" despite the lack of evidence to substantiate the claim that medical transition is necessary and effective at preventing suicide.

167. Although WPATH does not explicitly claim in SOC-8 that medical transition reduces completed suicide, WPATH instead asserts that medical transition treatments reduce "suicidality" and "suicidal ideation." But a reasonable consumer, hearing that pediatric medical transition "reduces suicidality" would understand those claims to mean that medical consensus and scientific evidence establish that medical transition is necessary and effective to prevent

suicide. Thus, regardless of whether WPATH refers to "suicidality" or "suicide" in the materials (SOC-8) that it provides to its members and other clinicians, the net impression that consumers take away is the same.

168. Indeed, that medical transition is lifesaving—*i.e.*, necessary and effective to prevent suicide—is precisely the message that WPATH intends to convey. As Dr. Johanna Olson-Kennedy, the current president of USPATH, told ABC News, "[w]e often ask parents, [w]ould you rather have a dead son than a live daughter?"

169. WPATH has deceived consumers by claiming that "high quality evidence" supports its treatment recommendations and its assertion that medical transition is "lifesaving" or "medically necessary"—causing many parents and patients to reasonably, but incorrectly, believe that SOC-8 is grounded on reliable methods and solid evidence. Numerous consumers, responding to an FTC Request for Information ("RFI") in 2025 about the medical transitioning of children, expressed their reliance upon or confidence in WPATH's guidelines. For instance, one commentator stated, "for trans and gender diverse people, especially youth, access to gender affirming care is imperative and life-saving. The current recommendations provided by . . . WPATH for gender-affirming care [prevent an eight-fold increase in the risk of children] attempt[ing] suicide." Another wrote, "WPATH ha[s] stated that this care is safe, and necessary. The amount of harm that will be caused by restricting or banning gender affirming care will be life threatening to trans children."

170. WPATH's representations thus leverage parents' fear that their child might commit suicide to obtain parental consent for the purchase of medical transition services, despite the lack of evidence that such treatments will in fact alleviate the child's distress and reduce their risk of suicide.

ii. WPATH's representation that puberty blockers are fully reversible is false, misleading, or unsubstantiated

171. Puberty is the stage between childhood and adulthood during which a person becomes capable of reproduction. The onset of puberty typically occurs between ages 9 and 14 in boys and 8 and 13 in girls. SOC-8 recommends that clinicians begin medical transition when children reach puberty.

172. Puberty begins and proceeds through complex endocrine signaling. In the brain, the anterior pituitary gland secretes gonadotropin hormones, which act on the gonads (ovaries or testes) to stimulate the synthesis of sex steroids (testosterone in boys; estrogen and progesterone and in girls) and promote gametogenesis, the biological process of forming mature germ cells (sperm in boys and eggs in girls). During puberty, sex steroid hormones promote skeletal growth, muscle and nerve development, reproductive development, and cognitive development in both sexes.

173. Puberty blockers impede these developments and come in two forms. A doctor may inject the drug on a regular schedule (*e.g.*, monthly) or implant a device in the child's arm that lasts for a certain period (*e.g.*, twelve months) and then is typically removed.[32]

174. The Food and Drug Administration ("FDA") has approved various pharmaceuticals classified as gonadotropin-releasing hormone agonists—commonly called "puberty blockers" or GnRHas—for the treatment of "precocious puberty," which occurs when a child's pituitary gland activates prematurely. Puberty blockers act directly on the pituitary gland to significantly reduce the release of gonadotropins, which prevents the onset or further pubertal development. Once a child reaches a normal age at which to begin puberty, the use of puberty

[32] *See* Ex. 12, Decl. of [redacted] at ¶ 16 (describing process of implanting puberty blockers); *e.g.*, Ex. 4, Decl. of Caroline Miller at ¶¶ 18 (discussing implantation), 27 (discussing removal).

blockers is discontinued.

175. These drugs have other FDA-approved uses, such as in androgen deprivation therapy for adult males with prostate cancer and for estrogen deprivation in adult females with endometriosis.

176. The FDA has not approved puberty blockers for the treatment of patients who express dissatisfaction with or distress about their sex traits, or for healthy children of normal pubertal age. Their use in pediatric medical transition is thus "off-label," a term that refers to doctors prescribing FDA-approved medications for a purpose, dosage, or population not listed on the FDA-approved label.

a. WPATH asserts that puberty blockers are fully reversible

177. WPATH recommends that puberty blockers be prescribed to children despite serious side effects that can include bone issues and psychosocial harms (*i.e.*, mental, emotional, and social harms), while failing to adequately disclose, discuss, and warn against other side effects, which include hot flashes, long-term cognitive deficits, and lethargy.

178. Despite the side effects, SOC-8 recommends that clinicians begin medical transition as early as 8 or 9 years old and represents that puberty blockers are "fully reversible." WPATH repeats that representation elsewhere, too. For example, in a presentation that WPATH continues to publish on its website entitled "Applying and Understanding the WPATH Standards of Care (SOC) Through the Healthcare Providers Lens," WPATH asserts that puberty blockers are "fully reversible."

179. Consumers are deceived by these assertions. For example, a respondent to the FTC's 2025 RFI stated, "[t]here are multiple organizations that support providing gender affirming care to both adults and children … [including] WPATH. The care given to minors is

safe and completely reversible."

180. While SOC-8 purports to emphasize "the importance of addressing other risks and benefits of pubertal suppression," rather than proceeding to disclose and discuss the aforementioned risks and side effects, WPATH instead focuses on purported benefits by suggesting that puberty blockers will result in "improvement in romantic and sexual satisfaction for adolescents."

181. Despite these risks, WPATH claims that the use of puberty blockers "is generally safe with the development of hypertension being the only short-term adverse event" when used for medical transition of children. It further asserts that there are "no known long-term adverse events" when used for its FDA-approved purpose on children experiencing precocious puberty, and claims that puberty blockers are "medically necessary" for children being medically transitioned.[33]

182. As shown below, these recommendations wrongly state and imply that puberty blockers' off-label use to medically transition children is scientifically established as safe and effective.

b. WPATH's representation that puberty blockers are safe, effective, and reversible is false, misleading, or unsubstantiated

183. When clinicians administer puberty blockers as part of pediatric medical transition, they prevent naturally timed puberty in children. That causes a condition known as hypogonadotropic hypogonadism ("HH"). HH occurs because puberty blockers cause the pituitary gland's release of gonadotropins to stop, meaning the gonads cannot produce the sex

[33] SOC-8's predecessor was similarly deceptive; despite mentioning "concerns about negative physical side effects of [puberty blockers] (e.g., on bone development and height)" and admitting that "long-term effects can only be determined when the earliest treated patients reach the appropriate age," SOC-7 still labeled puberty blockers' effects "fully reversible."

steroids testosterone or estrogen and, consequentially, pubertal development halts, disrupting the progression of the child's physical, cognitive, and reproductive development.

184. Additionally, HH is associated with a range of increased health risks including anemia; headaches, fatigue, and hot flashes;[34] impaired brain development and functioning; diminished mental health and depression;[35] decreased bone mineral density, osteoporosis, and bone fractures; and sexual dysfunction.

185. Although these children remain stalled in a prepubertal or early pubertal stage, their classmates progress through puberty, impeding the puberty-blocked child's social development and undermining that child's psychological well-being.

186. During adolescence, the brain undergoes substantial reorganization that involves profound structural and functional changes aimed at increasing efficiency and maturity. At least one study has found that children who undergo puberty blockers for more than one year have decreased executive function compared to those who do not block puberty, prompting concerns that puberty blockers may temporarily or permanently disrupt brain maturation and cause significant neuropsychological consequences.

187. The accrual of peak bone mass typically occurs during puberty. Sex steroid hormones play an essential role in the mineralization of the skeleton.

188. Failure to reach peak bone density may lead to increased risk of osteoporosis and fractures later in life, including debilitating fractures of the spine and hip.

189. Studies on pediatric patients undergoing medical transition have consistently

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[34] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 35 (hot flashes, muscle spasms, "could not keep weight on"); Ex. 6, Decl. of Clementine Breen at ¶ 16 (hot flashes and "sluggish[ness]").

[35] *E.g.*, Ex. 12, Decl. of [redacted] at ¶¶ 60–62; Ex. 4, Decl. of Caroline Miller at ¶¶ 21, 25; Ex. 6, Decl. of Clementine Breen at ¶ 16 (brain fog).

demonstrated decreases in bone density with the use of puberty blockers.

190. No studies have considered the effects of medical transition on the bone health of pediatric patients into middle age or late adulthood.

191. When children receiving puberty blockers later receive cross-sex hormones, bone mineralization typically increases, but a critical period for bone-density accrual during adolescence may have been missed or shortened, because bone density accrual slows during the patient's twenties and then begins to decline. Children administered puberty blockers may therefore never reach their possible peak bone density. Although SOC-8 does disclose that "[a] prolonged hypogonadal state in adolescence," including due to "GnRHa monotherapy," "is often associated with an increased risk of poor bone health later in life," it immediately proceeds to minimize this risk, noting that "bone mass accrual is a multifactorial process that involves a complex interplay between endocrine, genetic, and lifestyle factors."

192. Puberty blockers also inhibit or prevent genital growth during a possibly critical period, with potential harms to future sexual function in both boys and girls. Research on sexual-function outcomes in children who undergo pediatric medical transitioner is also meager and lacking.

193. Transition drugs, including puberty blockers, are linked to erectile pain for boys and men. This is a common patient complaint. But when a teenage boy in Michigan tried to investigate why arousal created a sensation of broken glass scraping against his penis, doctors repeatedly assured him it was not caused by the transition drugs.[36]

194. Safety data for puberty blockers as used in children of normal pubertal age are

[36] Ex. 7, Decl. of Jonathon Skinner at ¶¶ 49–50, 52–53.

meager or absent. Despite the lack of research, SOC-8 provides a "strong recommendation" that clinicians administer puberty blockers to children, thereby asserting that "the evidence [for the intervention] is of high quality," "there are few downsides," and "there is a high degree of acceptance among providers" for the treatment.

195. WPATH knows that its representations about the reversibility of puberty blockers are deceptive. Dr. Scott Leibowitz, who co-authored the relevant chapter of SOC-8, acknowledged behind closed doors that the claim puberty blockers are "reversible" should have an "asterisk" next to it.

iii. WPATH's representation that cross-sex hormones are safe, effective, and improve mental health is false, misleading, or unsubstantiated

196. Transition doctors administer cross-sex hormones to help children reach their "embodiment goals," *i.e.*, to shape the way their sex characteristics develop to control their appearance. For example, transition doctors prescribe testosterone to girls to make them appear more like boys. Indeed, as the HHS report notes, these "embodiment goals" often "serve as the primary guide for treatment decisions." SOC-8 directs doctors to honor these goals as "medically necessary."[37]

197. Cross sex-hormones are FDA-approved for conditions like hypogonadism (when the gonads produce little or no sex steroids) or menopause. The use of cross-sex hormones for pediatric medical transition is off-label and not FDA approved.

198. In SOC-8, WPATH strongly recommends that clinicians administer cross-sex hormones to children who have "Reached Tanner stage 2," which is the onset of puberty—an extension from SOC-7's proclamation that adolescents are medically "eligible" for cross-sex

[37] SOC-7 similarly labels cross-sex hormones in the treatment of gender dysphoria as "medically necessary."

hormones with parental consent.[38] In other words, SOC-8 recommends that WPATH members and clinicians inject girls as young as 8 with testosterone, if that 8-year-old has begun puberty and expresses discomfort with her sex traits.[39]

a. WPATH represents that cross-sex hormones are safe, effective, and improve mental health

199. In SOC-8, WPATH represents that cross-sex hormones are medically necessary for children who express discomfort with or distress about their sex traits, and that cross-sex hormone use is an appropriate treatment as early as the onset of puberty.[40]

200. WPATH claims in public statements that the administration of cross-sex hormones is "safe" for children and asserts in SOC-8 that cross-sex hormone therapy "has been shown to improve quality of life and to decrease depression and anxiety."

201. WPATH asserts that hormone therapy "positively impact[s] the mental health and quality of life of [children]" and "is considered a lifesaving intervention."

202. WPATH therefore represents, expressly and by implication, that the administration of cross-sex hormones to children is lifesaving, medically necessary, safe, effective, and improves mental health.

203. WPATH makes these representations despite a panoply of side effects that it

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[38] See, *e.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 47 (describing being prescribed estrogen at 13); Ex. 6, Decl. of Clementine Breen at ¶ 18 (describing being prescribed testosterone at 13); Ex. 9, Decl. of [redacted] at ¶ 13 (describing clinical worker advocating for cross-sex hormone treatment for declarant's 14-year-old); Ex. 2, Decl. of Cassidy Andrews at ¶ 24 (girl prescribed testosterone at 14).

[39] Ex. 9, Decl. of [redacted] at ¶ 13 (describing clinical worker advocating for cross-sex hormone treatment for declarant's 14-year-old in 2024).

[40] SOC-7 similarly contemplates children's use of cross-sex hormones may be necessary, explaining that they "may be eligible to begin feminizing/ masculinizing hormone therapy" and explains the dangers of "withholding puberty suppression and subsequent feminizing and masculinizing hormone therapy" to include "prolong[ing] gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization [which] … is strongly associated with the degree of psychiatric distress during adolescence." "[W]ithholding" hormones "is [accordingly] not a neutral option for adolescents." And in subsequent discussion, SOC-7 describes "[f]eminizing/masculinizing hormone therapy … [a]s a medically necessary intervention."

acknowledges exist, along with additional side effects that it fails to disclose. Among the side effects that WPATH acknowledges are hyperkalemia, hypertriglyceridemia, weight gain, cardiovascular disease, cerebrovascular disease, meningioma, hypertension, erectile dysfunction, type 2 diabetes, low bone mass, hyperprolactinemia, polycythemia, infertility, acne, and androgenic alopecia.

204. WPATH notes other potential side effects of the administration of cross-sex include "problematic sexual health outcomes" including "impact [on] sexual function, pleasure and sexual self-expression," and the potential "to impact reproductive functions and fertility," while noting that the "consequences are heterogenous" (*i.e.*, varied). But WPATH presents such impacts as reversible once the administration of cross-sex hormones ceases: "If hormonal therapy is discontinued and gonads are retained, many physical changes will revert to pre-hormone therapy status . . . including . . . erectile dysfunction."

205. SOC-8 fails to adequately disclose the existence and severity of additional effects for children treated with cross-sex hormones,[41] which include mood disturbances, vocal pain, pelvic pain, pelvic floor dysfunction, clitoral discomfort, vaginal pain, persistent sexual dysfunction continuing after cessation of use, and erectile pain.

206. Cross-sex hormones halt a child's normal pubertal development. Cross-sex hormones do not induce opposite-sex pubertal development. The natural endpoint of puberty—sexual maturation and reproductive capacity—does not result so long as cross-sex hormones continue to be administered. In fact, continued use can suppress or eliminate entirely the child's potential for sexual maturity and fertility.

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[41] SOC-7 is similarly flawed: Despite providing a non-exhaustive list of health risks associated with hormone therapy *in adults*, SOC-7 omits that information in its chapter on children and adolescents.

207. For example, an endocrinologist, who has testified to following the WPATH Standards of Care when treating his patients, implanted a puberty blocker in a boy who had never experienced erections and prescribed cross-sex hormones. The boy, now a 23-year-old man, stopped using transition drugs several years ago. But he has still never experienced an orgasm.[42] Nonetheless, in SOC-8,[43] WPATH has failed to adequately disclose that sexual health dysfunction can persist even after a patient stops taking cross-sex hormones. Indeed, as noted above, WPATH represents that sexual function "will revert to pre-hormone therapy status."

208. SOC-8 recommends cross-sex hormones even where there are alternative medical explanations for the child's expressed discomfort. For example, it endorses "hormone treatment if a transgender and gender diverse individual requires admission to a psychiatric . . . unit." And it advises that "the presence of [psychosis] symptoms does not necessarily equate to an inability to give consent" for interventions.

209. Leveraging WPATH's guidance, transition doctors push hormonal interventions onto consumers—which can have detrimental psychoactive effects—even when children experience mental health crises.[44] For example, a Missouri doctor reacted to a girl's avoidance of school and hospitalization for mental health issues while on puberty blockers by prescribing her testosterone.[45]

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[42] Ex. 7, Decl. of Jonathon Skinner at ¶ 76; *see* Ex. 12, Decl. of [redacted] at ¶ 64 (describing this as a common side effect). That this 23-year-old man received treatment while SOC-7 was in effect makes no difference here; SOC-7 and SOC-8 contain materially similar content on this point, and therefore, SOC-8 will cause and is causing the same harms. *Supra* n.2; *infra* n.46.

[43] SOC-7 similarly described the effects of puberty blockers as "fully reversible" and, concerning the risks of cross-sex hormones as relevant to this declarant's side effects, mentioned only "variable impact on sexually stimulated erections[,]" which among other associated risks "may be considered minor or even desired, depending on the patient."

[44] *E.g.*, Ex. 12, Decl. of [redacted] at ¶¶ 54, 62, 68.Ex. 6, Decl. of Clementine Breen at ¶¶ 43–51; Ex. 10, Decl. of [redacted] at ¶ 33

[45] Ex. 12, Decl. of [redacted] at ¶ 62.

b. WPATH's representation that the administration of testosterone to girls is safe and effective and improves mental health is false, misleading, or unsubstantiated, including because of side effects that WPATH has failed to adequately disclose

210. Testosterone comes in multiple forms. Patients may inject it on a regular basis (*e.g.*, weekly) or apply a less potent gel.

211. In girls, high doses of testosterone may cause changes in musculature, thickening of vocal cords causing voice deepening, differences in fat distribution, increased facial and body hair, cystic acne, and male pattern hair distribution or loss. Serious health risks include high blood pressure, worsened cholesterol and lipid blood levels, insulin resistance, vaginal atrophy, persistent pelvic pain and discomfort, pelvic floor dysfunction, and cardiovascular problems. Emotional and mental instability may be additional consequences.[46]

212. Girls and young women have also reported vocal issues including pain when speaking, inability to sing, and inability to scream after starting testosterone. Thickened vocal cords are a permanent effect of testosterone; they do not return to original size when the patient stops using testosterone. Although SOC-8 does note that many patients "experience difficulties such as inadequate pitch lowering, compromised voice quality, vocal loudness, vocal endurance, pitch range, and flexibility," in SOC-8, like in SOC-7, WPATH does not disclose vocal pain as a side effect.

213. Clitoral enlargement is an effect of testosterone in girls.[47] This can cause chafing against underwear and tight pants.[48] Girls and young women have reported strange feelings or dulled sensation in their clitorises after using testosterone.

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[46] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶¶ 21, 42–51; Ex. 10, Decl. of [redacted] at ¶ 33; Ex. 1, Decl. of Soren Aldaco at ¶ 26.
[47] Ex. 12, Decl. of [redacted] at ¶ 53.
[48] Ex. 12, Decl. of [redacted] at ¶ 53.

214. A Texas woman reports that she began developing painful cysts on her clitoris after starting testosterone as a minor. The problem has not resolved since she stopped using testosterone years ago.[49] SOC-8, like SOC-7, contains no mention of painful clitoral cysts as a risk associated with masculinizing hormones.

215. Certain effects of testosterone in girls, such as thick vocal cords, changes to clitoral size and sensation, and hair growth, are irreversible.

216. Testosterone use in girls can cause reproductive organ atrophy, including thinning of vaginal epithelium; symptoms mimicking polycystic ovary syndrome; persistent pelvic pain and discomfort; and pelvic floor dysfunction leading to incontinence, constipation, and chronic pelvic pain. SOC-8 discloses "pelvic floor dysfunction" as a potential side effect only in connection with vaginoplasty, not the administration of testosterone or other cross-sex hormones.

217. To resolve the pelvic pain that testosterone use causes, transition doctors advise girls and young women to undergo hysterectomy. This operation renders the patient sterile.

218. Vaginal atrophy is painful and has significant consequences. It can make penetrative sex unbearable and even dangerous, as the thinned walls can rupture and hemorrhage. Such pain can impair other activities as well. For example, a 9th-grade girl undergoing medical transition had to quit cross country and track because she developed intense vaginal pain after starting testosterone.[50]

219. SOC-8 notes that cross-sex hormones "may affect mood." The reality is much worse. People using cross-sex hormones for medical transition have reported mood disturbances

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[49] Ex. 1, Decl. of Soren Aldaco at ¶¶ 25, 41. That this woman received treatment while SOC-7 was in effect makes no difference here; SOC-7 and SOC-8 contain materially similar content on this point, and therefore, SOC-8 will cause and is causing the same harms. *Supra* n.2.

[50] Ex. 6, Decl. of Clementine Breen at ¶ 24. That this woman received treatment while SOC-7 was in effect makes no difference here. *Supra* n.49.

including anxiety, depression, mood swings, suicidal ideation, and homicidal ideation. A California woman recalls transforming from being a "big reader and very polite" to "a horrible student" who "bull[ied] outcasts" after, at age 13, she took testosterone prescribed to her by Dr. Olson-Kennedy. After using testosterone for about 18 months, she began hallucinating that people were "stalking" her and that bugs were "crawling on [her] skin," having panic attacks, experiencing "intense delusions that [her] parents were demonic forces set against" her, and cutting herself because she "felt like there was something inside [her] that she could not get out."[51] SOC-8 fails to disclose these severe psychological side effects.

220. Testosterone causes weight gain, which in turn causes more health problems.[52] A St. Louis transition clinic saw so many of its young female patients develop sleep apnea after gaining weight on testosterone that it began routinely screening every girl for the condition.[53]

221. Girls and women using testosterone can become dependent on it.

c. WPATH's representation that the administration of estrogen and progesterone to boys is safe, effective, and improves mental health is false, misleading, or unsubstantiated, including because of side effects that WPATH has failed to adequately disclose

222. In boys, transition doctors frequently administer a cocktail of estrogen, progesterone, and finally—to block testosterone production or uptake—a puberty blocker or anti-androgen medication, such as Spironolactone (Aldactone). Spironolactone is a potassium-sparing diuretic that blocks androgen receptors and inhibits testosterone production. Its primary on-label

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[51] Ex. 6, Decl. of Clementine Breen at ¶¶ 21, 43–51. That this California woman underwent this treatment while SOC-7 was in effect does not matter here. SOC-7 similarly failed to disclose these severe psychological side effects to using testosterone for these purposes; SOC-7 warns only that "testosterone or other androgenic steroids may increase the risk of hypomanic, manic, or psychotic symptoms in patients with underlying psychiatric disorders that include such symptoms," which this young woman did not have before using testosterone. Because SOC-7, like SOC-8, is materially similar in that it omits relevant side effects, SOC-8 will cause and is causing the same harms. *Supra* n.2

[52] Ex. 12, Decl. of [redacted] at ¶ 51.

[53] Ex. 12, Decl. of [redacted] at ¶ 51.

uses include managing high blood pressure and treating fluid retention associated with heart failure, liver cirrhosis, or kidney disease. It is not an FDA-approved treatment for medical transition.

223. Side effects of estrogen use in boys include blood clots; high blood pressure; potential cardiovascular issues like a stroke, heart attack, or venous thromboembolism; decreased libido; erectile dysfunction; erectile pain; infertility; weight gain; mood swings; fluid leaking from nipples; and pain near the nipple.[54]

224. Transition drugs, including estrogen, can cause erectile pain for boys and men. A presentation at a WPATH conference in 2021 reported that over half of respondents in a survey "reported experiencing painful erections while on hormone therapy." Despite these common patient reports of erectile pain,[55] SOC-8, like SOC-7, does not disclose this risk.

225. Many effects of estrogen in boys, such as breast growth, shrunken testicles, and stunted or arrested fertility, are generally irreversible.

226. Many boys and young men on cross-sex hormone regimens complain of "brain fog," or inability to think clearly. Their parents report that these boys and young men seem unable to regulate emotions or cope with social interactions.[56]

iv. WPATH's representations that breast amputation for girls is safe, effective, and consistently results in better health and quality of life are false, misleading, or unsubstantiated

227. WPATH's assertions in SOC-8 concerning the purported safety, efficacy, and health and quality of life benefits of breast amputation for minors are not supported by reliable evidence and fail to disclose the known risks associated with the procedure. By characterizing

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[54] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶¶ 48, 73; Ex. 12, Decl. of [redacted] at ¶ 65.
[55] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶¶ 49–50; *see* Ex. 12, Decl. of [redacted] at ¶ 63.
[56] *E.g.*, Ex. 13, Decl. of [redacted] at ¶¶ 19–24; *see* Ex. 12, Decl. of [redacted] at ¶ 66.

breast amputation as a routine, medically necessary intervention that consistently improves health-related quality of life, WPATH provides the means by which clinicians deceive consumers into purchasing breast amputations for children. These representations, and the omissions accompanying them, operate to mislead consumers regarding both the evidentiary basis for the procedure and the scope and severity of its potential adverse outcomes.

a. WPATH represents that breast amputations are safe and effective, and consistently result in better health and quality of life

228. WPATH represents in SOC-8 that breast amputations are safe, effective, and consistently result in better health and quality of life for girls experiencing dissatisfaction with or distress about their sex traits. SOC-8 states that "[t]he efficacy of top surgery has been demonstrated in multiple domains, including a consistent and direct increase in health-related quality of life," and a "consistent increase in satisfaction with body and appearance." WPATH adds that "the evidence demonstrates top surgery to be a safe and effective intervention." In sum, SOC-8 presents breast amputations as routine, medically necessary procedures that result in better health and quality of life.

229. SOC-8 discloses minimal potential risks and side effects associated with breast amputations.[57] It says that "[c]hest surgeries" such as "mastectomy" "may adversely affect erogenous sensation." It recommends that patients should be "abstinent from tobacco/nicotine prior to gender-affirmation surgery" because "[t]obacco use has been associated with worse outcomes in plastic surgery, including overall complications, tissue necrosis, and the need for surgical revision." SOC-8 further recommends that "[i]ndividuals who undergo gender-affirming

[57] Its predecessor, SOC-7, similarly contained minimal disclosures of potential risks and side effects; it warned only, for example, that "[c]omplications of subcutaneous mastectomy can include nipple necrosis, contour irregularities, and unsightly scarring."

surgery of the chest should have ongoing breast cancer surveillance."

b. WPATH's representations that breast amputation for girls is safe, effective, and consistently results in better health and quality of life are false, misleading, or unsubstantiated

230. Breast amputation, or mastectomy, involves removal of the mammary glands together with the ducts that transfer milk from the glands to the nipple. Breast amputation typically results in an inability to breastfeed and loss of erogenous sensation.

231. Clinicians have referred girls for breast amputations at age 12.

232. The immediate aftermath of breast amputation can be incredibly painful, and patients typically require intimate care for weeks afterward. For example, a WPATH member performed a breast amputation on a 14-year-old girl in San Francisco. The teen woke up from the operation feeling like she "had been hit by a truck" and found herself "hardly" able to "move [her] arms"[58]—none of which are side effects disclosed by WPATH in SOC-8 or its predecessor SOC-7.

233. Breast amputation is associated with numerous surgical complications, such as necrosis, seroma or lymphedema (fluid buildup and swelling), hematoma (localized clotted or pooled blood outside blood vessels), scarring, and nerve damage resulting in chronic pain or loss of sensation.

234. Breast amputation can involve removing the nipples and then sewing them back on—what SOC-8 refers to as nipple grafts. Some women who began transition as minors report

[58] Ex. 6, Decl. of Clementine Breen at ¶¶ 40–41. That this woman received treatment while SOC-7 was in effect makes no difference here; SOC-7 and SOC-8 are materially similar on this point in that neither contain those side effects, and therefore, SOC-8 will cause and is causing the same harms. *Supra* n.2

experiencing "nipple necrosis" or that their nipples turned black and fell off afterward.[59] But SOC-8 describes "necrosis" as a potential risk only in connection with the use of tobacco. Some surgeons try to avoid this side-effect by advertising no-nipple breast amputations to girls and women who identify as nonbinary. Regardless, skin at the site of breast-amputation scars tends to droop in an effect known as "dog ears."

235. Though SOC-8 discloses that breast amputation "may adversely affect erogenous sensation," this brief, qualified disclaimer substantially downplays the potential adverse outcomes from breast amputation. Many girls and women report strange sensations in their chests years after breast amputation, including rawness around scars, numbness near nipples, pain, and electrical sensations. Some cannot locate exactly where sensations are coming from, which could be a result of nerve damage. A Washington woman who underwent the surgery at 16 must wear a sports bra during intimacy to modulate the electrical sensations.[60] A California woman whose breasts were amputated at age 13 now experiences "extreme slicing sensations" in the area. A Massachusetts woman who underwent breast amputation at age 14 now feels an electric sensation in her scars and a deep pain below the skin that is hard to place. When her boyfriend touches her chest, she senses pressure but cannot say exactly where it is.

236. USPATH president Dr. Olson-Kennedy, who referred a 14-year-old girl for breast amputation while she was recovering from sexual abuse,[61] dismisses concerns about breast amputation, declaring that "[i]f you want breasts at a later point in your life, you can go and get

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[59] *E.g.*, Ex. 2, Decl. of Cassidy Andrews at ¶¶ 41–42. While this cited treatment occurred while SOC-7, which did explicitly warn of nipple necrosis as a side effect of breast amputation, was in effect, SOC-8 notably removed mention of that as a side effect, thus contributing to WPATH's misleading representations that breast amputations breast amputation for girls is safe, effective, and consistently results in better health and quality of life.

[60] Ex. 10, Decl. of [redacted] at ¶ 55.

[61] Ex. 6, Decl. of Clementine Breen at ¶¶ 30, 35.

them." But the effects of breast amputations are irreversible. Implants will not function as a girl's natural breasts did—she will not regain erogenous sensation or the ability to breastfeed a baby. And even if the procedure avoids potential harms including failed reconstruction, the patient's reconstructed breasts will never look or feel normal.

237. In sum, WPATH's representation that breast amputation is safe, effective, and consistently results in better health and quality of life is false, misleading, or unsubstantiated, including because of significant side effects that SOC-8, like SOC-7, fails to adequately disclose.

v. WPATH recommends surgical amputation of a child's penis and testicles as treatment for dissatisfaction or distress regarding sex traits

238. One form of genital surgery performed on children is "vaginoplasty," in which the surgeon cuts off the bulk of a child's testicles and penis. The surgeon restructures the child's scrotum to mimic a "clitoris" and "labia." Finally, the surgeon carves a wound next to the child's anus, empties the penile skin, and lines the wound with the child's emptied penile skin.

239. It is inherently harmful and unsafe to surgically remove a child's healthy and functioning genitals. Nevertheless, WPATH deems it "medically necessary" for treating dissatisfaction with or distress about sex traits. WPATH represents that vaginoplasty is "associated with a low rate of complications." SOC-8 deems boys eligible for vaginoplasty after just twelve months of hormone therapy—though that requirement can be waived if the hormone therapy is not "required[] to achieve the desired surgical result." SOC-8 claims that "there may be a benefit" to performing vaginoplasty on children, and indeed "recommend[s] surgeons consider" performing them on children. This is despite acknowledging that "[l]imited data are available on the outcomes for youth undergoing vaginoplasty."

240. SOC-8 cites a 2017 article, "Age Is Just a Number: WPATH-Affiliated Surgeons' Experiences and Attitudes Toward Vaginoplasty in Transgender Females Under 18 years of Age

in the United States." This title reflects the views of Dr. Marci Bowers, a plastic surgeon who is WPATH's immediate past president and a current board member. Dr. Bowers "advocate[s] for 17 as the new norm" for vaginoplasty and "continue[s] to maintain that 17 may indeed be the ideal age for surgery."

241. This is in part due to the brutality of the procedure. Recovery from vaginoplasty requires the patient to "dilate" the new wound 3-4 times daily for months so that it does not heal. For this reason, some transition doctors, including Dr. Bowers, believe performing the surgery while the boy is a minor still living with his parents is preferable, rather than when the boy is living in a communal setting with limited privacy.

242. WPATH clinicians lead children to vaginoplasty in other ways, as well. The erectile pain that often results from administering transition drugs to children can be so severe that it drives boys to seek surgical penis removal. A research team at UCLA found that "a huge chunk of" male medical transition patients "were not planning to have bottom surgery, but then change[d] their mind[s] as a result of the erectile pain."

243. WPATH calls a common version of the vaginoplasty operation "penile inversion." This is misleading. While the procedure involves inverting the skin of the child's penile shaft, the shaft itself is removed and discarded along with the child's testicles.

244. Likewise, "vaginoplasty" is inapt, as is WPATH's advertisement of a "neovagina," because the surgically-created wound is not any sort of vagina. It is constructed of different material, it does not have the same stretch and elasticity, it does not keep itself clean, it does not self-lubricate, and it cannot deliver a baby.

245. Despite the risks and lack of benefits, this procedure is shockingly common. One pediatric medical transition clinic "routinely" referred minor boys seeking this surgery to

surgeons willing to perform it.[62] An academic study surveyed twenty WPATH-member surgeons, many of whom advertised their services on WPATH's public provider directory, and over half of the surgeons reported having performed a vaginoplasty on a child. These WPATH surgeons' "preferred method" was the "penile inversion" surgery, where the child's penile shaft was severed and discarded. One of the WPATH surgeons reported performing this operation on twenty different children.

IX. WPATH OPERATES FOR ITS MEMBERS' PROFIT

246. WPATH misrepresents scientific and medical consensus and makes false, deceptive, or unsubstantiated claims regarding pediatric medical transition and related services for a simple reason: WPATH's members generate significant profit because of the organization's representations and guidance.

247. WPATH's members predominantly work in fields related to the provision of transition services, including professionals who provide medical transition services to children. WPATH's members include doctors who prescribe drugs and perform surgery to modify patients' sex traits by, for example, amputating their breasts or instigating facial hair growth. Two of the five current members of WPATH's executive committee are surgeons who specialize in medical transition procedures, and a third member specializes in medical transition procedures for children. For example, Dr. Marci Bowers, WPATH's former president and current Executive Committee member, earned more than a million dollars in net income in 2023, mostly from performing transition surgeries. Each of these WPATH members, among many others, profits from WPATH's misrepresentations.

[62] Ex. 12, Decl. of [redacted] at ¶ 48.

248. Other members earn income in related work. For example, one "WPATH certified member/mentor" offers a $249 "Transgender & Intersex Cultural Competence Training" for healthcare "staff and contractors" covering interactions with transition patients. Others counsel patients who purchase transition services or conduct corporate trainings about how to accommodate such patients in the workplace. WPATH engages in a variety of acts and practices that increase these members' profits.

249. Notably, pediatric medical transition services present lucrative opportunities for clinicians. Children can be put on puberty blockers. And puberty blockers are the first of many expensive interventions that will continue for the rest of the child's life as that child undergoes genital, chest, and face surgeries, have their gonads removed, and rely on exogenous cross-sex hormones. A vast majority of children prescribed puberty blockers as transition medicine eventually proceed to cross-sex hormones. Many eventually return for surgery.

250. Critically, through its representations and guidelines, WPATH has successfully worked to expand public and private insurance payments to its members for transition services, including drugs and surgeries. As a result of WPATH's claimed status as the authority on medical transition, WPATH has secured substantial insurance coverage for its members' pediatric medical transition drugs, surgeries, and services.

251. The growing population of patients who have undergone medical transition also yields business for WPATH's non-physician members.

252. As the Supreme Court explained in *California Dental Association v. FTC*, when an organization acts to secure insurance coverage for its members and "engages in lobbying, litigation, marketing, and public relations for the benefit of its members' interests," there is "no

difficulty in concluding" that the organization acts for the profit of its members.[63] WPATH engages in those activities and therefore acts for the profit of its members.

A. WPATH has pushed—and continues to push—to expand insurance coverage to benefit its members

253. Since WPATH's members have sought to offer pediatric medical transitioning since 2007, a primary obstacle to their profitability has been whether insurance companies would cover transition services.

254. Generally, private insurance companies and Medicaid provide coverage to consumers only for services that are "medically necessary." The U.S. Centers for Medicare & Medicaid Services, an agency within the Department of Health and Human Services, defines the term as "[h]ealth care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine."

255. Insurance companies and State Medicaid offices maintain policies delineating what services are "medically necessary" to diagnose or treat particular conditions, and therefore what services their insurance policies will cover.

256. The majority of Americans receive their health insurance from private insurers. Additionally, Medicare, Medicaid, and various government health insurance programs cover people, including children, who meet specific age, income, or health criteria.

257. Health insurance typically does not cover all medical costs or services. Exclusions or limitations on coverage are listed in the policy contract, typically in a "Summary of Benefits Coverage" section. Typical exclusions include cosmetic surgery, alternative medicine (*e.g.*,

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[63] *California Dental Ass'n v. FTC*, 526 U.S. 756, 767–68 (1999); see *FTC v. National Comm'n on Egg Nutrition*, 517 F.2d 485, 487–88 (7th Cir. 1975) (holding that the FTC had jurisdiction over an organization which made health claims because the organization "promote[d] the general interests of the egg industry" and made statements "to encourage the consumption of eggs by allaying fears the public may have about" them).

acupuncture, herbal healing), weight-loss surgery (*e.g.*, gastric bypass and bariatric surgery), unapproved medical care (*e.g.*, procedures not pre-approved by the insurer), experimental procedures (*e.g.*, treatments that use new technology or methods lacking proven outcomes), and elective surgeries (*e.g.*, non-medically necessary procedures).

258. In the absence of insurance coverage, the market for transition services was severely constrained due to the exorbitant cost of these drugs, surgeries, and other interventions—some of which require a lifetime of care. For example, in 2012, pediatric medical transition providers lamented that without insurance coverage, the "incredibly high cost" of pediatric medical transition means that "[m]any, if not most" children "deemed appropriate candidates" were "unable to obtain the treatment."

259. Starting in 2008, WPATH recognized that tapping into insurance payments was crucial to WPATH members' profits. Accordingly, WPATH acted, and continues to act, to ensure that its members are able to secure insurance payments for their services.

i. WPATH developed its clinical guidelines to trigger maximum insurance coverage for pediatric medical transition services

260. In 2008, WPATH first declared that medical transition is "not 'cosmetic' or 'elective' or for the mere convenience of the patient," but instead was "understood to be medically necessary." It further "urge[d] insurance carriers and healthcare providers in the United States to eliminate transgender or trans-sex exclusions and to provide coverage for" what it deemed "the medically prescribed sex reassignment services necessary for their treatment and wellbeing." WPATH's statement of "medical necessity" was proposed and drafted by WPATH board member Jamison Green. Green did not have a medical degree, but rather a Master of Fine Arts in creative writing and was at the time engaged in what Green termed "lucrative" work "consulting with many corporations negotiating trans health with their insurance companies."

Green argued that WPATH "needed to be advocating for insurance coverage" more aggressively and that the declaration of "medical necessity" was "necessary to move forward on the insurance front, and it would also be helpful in some of the legal cases LGBT legal organizations were engaged in."

261. When WPATH released SOC-7 in 2011,[64] it added new language dubbing cross-sex hormones and transition surgery "medically necessary." And when WPATH published its latest medical transition guidelines, SOC-8, in September of 2022 it further urged "health care systems to provide these medically necessary treatments and eliminate any exclusions from their policy documents and medical guidelines that preclude coverage for any medically necessary procedures or treatments." The "medical necessity statement" spans several pages of SOC-8 and begins by recommending that "health care systems should provide medically necessary gender-affirming health care for transgender and gender diverse people." It quotes the American Medical Association's definition of "medical necessity" and then applies that label to roughly 30 medical transition interventions.

262. In fact, SOC-8 labels as "medically necessary" virtually every pediatric medical transition service that a transition doctor could perform for a fee, including administering puberty blockers, "voice surgery," "counseling,"[65] and "hair removal from . . . genital areas for gender affirmation," among many other transition services.

263. WPATH does not limit its declarations of medical necessity to attempts to treat distress or discomfort regarding sex traits. They also include the pursuit of "embodiment goals," *i.e.*, changing patients' sex characteristics not because they are in distress, but simply because

[64] Its official publication date by WPATH's journal is 2012.
[65] SOC-8 places limits on what the counselors may say, as discussed *infra* ¶ 139.

they want to look different. This pursuit of "embodiment goals" is not limited by age. Under SOC-8, a doctor can prescribe testosterone to a seventh-grade girl not because the girl identifies as male or is in distress about her female body, but because her goal is to become more muscular. And under SOC-8, such an intervention is considered "medically necessary."

264. The only pediatric medical transition service that SOC-8 does not deem "medically necessary" is one type of genital surgery, phalloplasty, on minor girls. WPATH may have conceded this point because such operations would likely violate statutes that criminalize female genital mutilation. In other words, performing such surgeries could hurt WPATH members rather than profit them.

265. WPATH's maximalist labeling of medical transition services as "medically necessary" is not rooted in medical or scientific evidence, as demonstrated above. Rather, WPATH makes unsubstantiated medical necessity claims to obtain maximum insurance coverage for its members' pediatric medical transition services, thereby helping its members profit. As SOC-8 itself explains, "[m]edical necessity is central to payment, subsidy, and/or reimbursement."

266. WPATH kept its objective—to obtain maximum insurance coverage for pediatric medical transition services—front-of-mind when drafting SOC-8. WPATH member and SOC-8 contributor Dr. Daniel Karasic wrote in August 2021 that SOC-8 "should allow for medical necessity to be determined by clinician assessment." WPATH adopted this approach because it would force "insurance regulatory bodies and independent medical reviewers" to wholly defer to transition service providers—generally WPATH members—rather than apply an objective standard when determining whether to cover transition services. Despite some WPATH members' concerns that clinicians were using WPATH's guidelines to medically transition too

many children, WPATH nevertheless pursued insurance coverage for these members. SOC-8 further exhorts "governments" to "ensure" that medical transition coverage is "established, extended or enhanced (as appropriate) as elements in any Universal Health Care, public health, government subsidized systems, or government-regulated private systems that may exist."

267. The lead drafter of SOC-8's mental health chapter, Dr. Karasic, wrote his colleagues that he "cannot overstate the importance of SOC 8 getting this right[,]" as "important lawsuits" were ongoing that concerned whether transition services are "medically necessary vs experimental or cosmetic." Dr. Karasic also prodded his co-drafters to "consider adding a medical necessity statement for care of minors."

268. In May 2022, Dr. Karasic argued that SOC-8 should include a general statement on medical necessity. He reminded his co-drafters that "[m]edical necessity is at the center of dozens of lawsuits in the US right now over state actions to make trans care inaccessible [to children], as well as being at the center of all reimbursement for trans care in the US." Another drafter responded, "I fully support what [Dr. Karasic] is saying."

269. One drafter thanked the team for drafting a "Medical Necessity Statement" because "we needed a tool for our attorneys to use in defending access to care here [in the United States]."

270. Given the importance of insurance coverage to members' profits, WPATH was not content to let SOC-8 speak for itself. Shortly after disseminating SOC-8 to its members, WPATH created, published, and disseminated a presentation titled "Insurance Coverage of Gender Affirming Healthcare: WPATH SOC-8 Updates" explaining that "Insurers Must Update Adolescent Surgery Eligibility Criteria to be in Alignment with SOC-8" to include no lower age limit for surgery so long as the child has sufficient "emotional and cognitive maturity" to consent

to the procedures.

ii. WPATH successfully secured insurance payments for the profit of its members

271. After WPATH's original 2008 "medical necessity" statement, WPATH leadership was "amazed" at the "powerful effect" it had and the changes in insurance coverage that resulted. By 2022, as an article in the New York Times Magazine reported, WPATH's Standards of Care had "influence[d] . . . the coverage offered by health insurers and national health services around the world." As the HHS Report notes, "[m]any U.S. public and private health insurers and regulatory bodies rely on SOC-8 when making coverage determinations."

272. SOC-8's recommendations are designed to allow almost any child who expresses a desire for medical transition treatments to receive them, and to have those procedures paid for by insurance providers. And where SOC-8 includes some prerequisite for treatment, like recommending that surgeons require letters of referral from mental health professionals, such requirements are a façade.

273. Today, many of the largest health insurance providers, both public and private, defer to WPATH's and SOC-8's declaration that medical transition drugs, surgeries, and services are medically necessary in determining whether to cover those interventions. For example:

A. Aetna invoked SOC-7 in denying coverage for specific "irreversible surgical interventions for minors," but updated its policy to cover such surgeries with no age restriction once WPATH published SOC-8. Throughout its policies, Aetna cites WPATH in covering pediatric medical transition drugs, surgeries, and services as medically necessary. For example, "Aetna considers gonadotropin-releasing hormone medically necessary to suppress puberty in trans identified adolescents if they meet World Professional Association for Transgender Health

(WPATH) criteria."

B. In covering medical treatments, Kaiser Foundation Health Plan "commits to following the World Professional Association for Transgender Health (WPATH) most up to date standards of care." In at least one region, relying on WPATH guidance and consistent with SOC-8, Kaiser has no age limitation on covered transition procedures, including genital surgery. Kaiser also provides "clinical practice recommendations" for pediatric medical transition providers which explicitly rely on WPATH's SOC-8.

C. Cigna applies WPATH's recommendations to cover transition services, including in its coverage of off-label use of puberty blockers. Its guidelines state that "GnRH agonists can also be used off-label for the treatment of gender-dysphoric/gender incongruent persons to suppress physical changes of puberty and gonadal function," citing SOC-8 in one of two footnotes.

D. Elevance's 2021 clinical guidelines stated that the company's "medical necessity criteria . . . [were] based upon the Standards of Care (SOC) . . . Seventh Version, published by the World Professional Association for Transgender Health (WPATH) (2013). This document is widely accepted as the definitive document in the area of gender dysphoria treatment." When SOC-8 was published, Elevance "[u]pdated" its guidelines to add "WPATH SOC-8 criteria and recommendations" with respect to a number of procedures.[66]

274. The net result of WPATH's efforts has been that, in the words of WPATH's then-

[66] Elevance expressly declined to follow SOC-8's recommendations that genital surgeries be performed on children.

president Dr. Bowers, "insurers look to the" SOC "to set criteria for their members to be covered."

iii. WPATH's efforts led to significant profits for its members

275. WPATH's successful efforts to obtain insurance coverage for pediatric medical transition services have unlocked enormous profits for WPATH's members.

276. In 2024, while president of WPATH, Dr. Bowers testified to personally receiving more than a million dollars in income over the previous year, the vast majority of which came from performing transition surgeries. Most of Dr. Bowers' patients had private insurance.

277. The Congressional Budget Office estimated in 2025 that Medicaid alone would pay transition providers $445 million over ten years, just for the medical transition of children.

278. Pediatric medical transition is a profitable market for transition doctors because most children will naturally desist, or cease experiencing discomfort with or distress about their sex traits, if clinicians delay medical transition procedures.

279. But by preventing the normal development of sex traits through puberty blockers, cross-sex hormones, and surgeries, clinicians instead reinforce the child's cross-sex identification creating a self-fulfilling prophecy. Clinicians profit from the procedures that otherwise would not have been performed, and they further profit from what is likely to be a lifetime of medical appointments, hormone prescriptions, and further procedures.

280. Data from 2015 estimated the fixed costs of surgery to range from $10,308 to $22,025, with annual costs of $2,175 thereafter. Another study showed a significant increase in total expenditures on cross-sex hormone therapy from 2015 to 2019, corresponding with a significant increase in the number of "newly identified transgender" children over that period, and estimated the mean costs for medical transition surgeries to be $41,236 per person, with up

to $3,792 in annual costs from hormones alone. Another source estimates the cost of medical transition procedures from childhood through adulthood for a single male patient, including puberty blockers, cross-sex hormones, and surgical interventions, as between $87,300 and $410,600 over one's lifetime. That cost for a female patient is estimated between $66,500 and $605,500. The Human Rights Campaign, which advocates for insurance coverage of medical transition services, estimates that the cost of medical transition for a single patient can be as high as $75,000. But, as just explained, this is likely a low estimate.

281. WPATH's members who work in hospital settings can become highly valued employees thanks to the revenue that pediatric medical transition attracts.

282. Researchers at an academic medical center reported that the surgical transition procedures were a significant source of profit for self-pay and privately insured patients (where insurance covered those procedures). Overall, especially as the proportion of privately insured and self-pay patients increased, researchers found that providing surgical transition procedures "is profitable for both the surgical department and the hospital system" and thus providing medical transition procedures "can be a favorable addition to academic medical centers in the US." This financial lifeline to academic medical centers comes at a time many are struggling to operate in the black.

283. Pediatric medical transition clinics find ways to squeeze as much money as possible from the insurance industry. For example, a St. Louis clinic augmented its revenue by booking surgical suites for the quick, simple procedure of implanting a puberty blocker in a child's arm since insurance companies may pay more for interventions provided in a surgical

suite.[67] That pediatric medical transition clinic's revenue put the hospital's entire endocrinology department "in the black" after operating at a loss for years, according to one of its physicians.[68]

284. One surgeon and WPATH member interviewed by an academic journal regarding transition surgeries on minors stated that "the biggest reason for why everyone is doing it now, is the money is flowing. Because now insurance is paying. And now all these institutions have to have a program yesterday."

285. According to the program manager at a major university's transition clinic, in its first two years of operation, 2019 to 2021, the clinic "really blew" its financial goals "out of the water."

286. Doctors at a large university medical center have noted behind closed doors that transition "surgeries bring in a lot of money" and that genital surgeries on women are "huge money makers."

287. One doctor at another prominent university medical center claims that transition doctors can enhance the profitability of "healthcare systems" by "training" other healthcare professionals on referring potential patients to transition clinics and "getting people to surgery," a "high money producing" intervention.

288. Hospitals and clinicians quickly realized the profitability of pediatric medical transition. By 2017, there were at least 41 pediatric medical transition clinics across the United States. Some prescribe transition drugs to hundreds of children each year. Pediatric medical transition clinics widely follow WPATH guidelines. The clinics typically administer puberty blockers and cross-sex hormones. They also promote surgery to minors and provide referrals to

[67] Ex. 12, Decl. of [redacted] at ¶ 16.
[68] Ex. 12, Decl. of [redacted] at ¶ 19.

surgeons, some of whom work within the same hospital system.[69] Where insurance companies require letters from mental health professionals, pediatric medical transition clinics supply templates to speed the process. For example, on a webpage advertising "breast augmentation" for 15-year-old boys (which has since been taken down), Boston Children's Hospital noted that "Sample letters are available on request from gendersurgery@childrens.harvard.edu."[70]

B. WPATH provides other economic benefits to members

289. WPATH membership provides other pecuniary benefits.

290. One perk of membership is business advice. WPATH has used a listserv to counsel its members on securing payment from insurance companies for transitioning minors.[71] Its private conferences (discounted for members) train attendees on founding their own pediatric medical transition clinics and promoting their pediatric practice in the media.

291. WPATH's recommendations also provide legal cover to WPATH members. For example, at WPATH's annual conference following the release of SOC-8, Dr. Amy Tishelman, one of the Guidelines Development Group members, stated that minimum ages for medical transition procedures were removed from SOC-8 to protect clinicians from lawsuits, should the clinician decide to provide a treatment to someone younger than WPATH's previously specified age minimums.

C. WPATH promotes the purchase of its members' pediatric medical transition services

292. WPATH directly promotes its members' services to the public. Until it became aware of the FTC's investigation earlier this year, WPATH operated a public provider directory

[69] Ex. 12, Decl. of [redacted] at ¶¶ 48–50; Ex. 3, Decl. of Vanessa Sivadge at ¶ 14.
[70] *See also* Ex. 12, Decl. of [redacted] at ¶ 27.
[71] Ex. 12, Decl. of [redacted] at ¶¶ 44–45.

that allowed users to view "Certified Members" only. And it advertised "[i]nclusion in the online WPATH 'Find a Provider' search tool" as a perk of WPATH membership.

293. WPATH also promotes pediatric medical transition by employing a large public relations firm and undertaking "education" campaigns which advertise pediatric medical transition. The clear goal of these public "education" campaigns is to encourage the purchase of pediatric medical transition services, including by allaying concerns that children and parents may have about pediatric medical transition.

294. As more American doctors opened pediatric medical transition practices, WPATH and its members repeatedly called for children to be "educated" about transition. This amounted to a marketing campaign advancing WPATH members' financial interests.

295. In SOC-7, WPATH called for mental health professionals to "educate and advocate on behalf of clients within their community" at "schools," adding that "[t]his role may involve consultation with school counselors, teachers, and administrators."

296. As WPATH's public relations firm, BerlinRosen, has explained, "[h]ealth care providers are widely trusted to speak with authority and educate broad audiences."

297. In a seminal 2012 article on transitioning children, Dr. Spack and Dr. Edwards-Leeper—who would soon become a leader within WPATH—announced themselves as committed to "educating the public through organized discussions and appropriate media outlets." They had already achieved deferential coverage in Time (2007), NPR (2008), The Atlantic Monthly (2008), and the Boston Globe (2008).

298. Dr. Johanna Olson-Kennedy, another future WPATH board member then practicing at Children's Hospital Los Angeles, received coverage of her pediatric medical transition practice on ABC (2007). Her CHLA colleague Dr. Melvin Belzer promoted child

transition on CNN (2007) and MSNBC (2007).

299. BerlinRosen advises WPATH's members on how to speak with the media, including by suggesting that WPATH members claim that medical transition "is safe and effective and endorsed by all leading medical associations," among other similar claims.

300. WPATH also urges other doctors to carry WPATH's message to children.

301. For example, Dr. Scott Leibowitz, a SOC-8 drafter and WPATH member who has been affiliated with Nationwide Children's Hospital in Columbus, Ohio, argues that transition doctors should "ensure that gender is the fabric of all healthcare for all kids" by training pediatricians. According to Dr. Leibowitz, "[t]hat will help . . . pediatricians be able to ally with those parents who wouldn't even consider coming to a clinic that we provide." Such training includes directing pediatricians to ask children about their gender identities.[72]

302. A St. Louis transition clinic saw rapid results from such trainings. After transition doctors trained their colleagues in the cystic fibrosis ward, the clinic received a referral for a child within three months.[73] And after training colleagues who treated sickle cell anemia, a child with that condition asked to see a transition doctor.[74]

303. In 2015, Dr. Edwards-Leeper and other WPATH leaders drafted guidance for the American Psychological Association about the care of "transgender and gender-nonconforming" ("TGNC") people. Under the banner of the APA, they advised psychologists to direct their gay patients toward a cross-sex identity, asserting that some people who "assume that they must be gay, lesbian, bisexual, or queer" may simply lack "awareness of a TGNC identity." Thus, "[p]sychologists may need to provide" these supposedly unaware "TGNC people with

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[72] Ex. 12, Decl. of [redacted] at ¶ 9.
[73] Ex. 12, Decl. of [redacted] at ¶ 11.
[74] Ex. 12, Decl. of [redacted] at ¶ 11.

information about TGNC identities."

304. In 2016, Dr. Edwards-Leeper co-authored "Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents" with 19 other clinicians, many of whom have been active in WPATH. They advised mental health professionals to screen autistic children for cross-sex identity by asking questions which could reveal "gender concerns," and trigger "a referral . . . to an appropriate gender specialist."

305. These training-and-referral systems financially benefit WPATH's members and the institutions at which they work. One doctor at a major public university explained that "[h]ealth care systems rely heavily on high money producing medical interventions to fund themselves, particularly surgeries." Thus, an "institution [that] has a surgical program for" medical transition will profit from a "training" that "will improve getting people to surgery somehow." This doctor encouraged clinicians to "[l]ink the two" concepts and understand that that conducting WPATH trainings will increase the number of people having transition surgeries, which increases the revenue of the institution.

306. WPATH's advertising efforts have been effective at increasing demand for its members' services. According to the Centers for Disease Control, 2% of high school students identified as "transgender" by 2017. Few had done so before WPATH began promoting that identity to children. In the 2010s, the rate of "adolescent gender dysphoria" increased by over 1,000%.

307. These are far from WPATH's only efforts to promote pediatric medical transition. Even SOC-8 is a tool to promote pediatric medical transition to children and parents directly. SOC-8 encourages "individuals, their families, and social institutions" to "use the SOC-8 to understand how it can assist with promoting optimal health for" people, including children, who

express dissatisfaction with or distress about their sex traits.

308. WPATH also posts statements on its website deceptively claiming that transition is "safe," "lifesaving," backed by "rigorous research" and "expert consensus," "evidence-based," and "medically necessary." Past WPATH president Jamison Green explains that such statements are "good strong documents that can be used by . . . members of the public to assist in the securing of transgender health and services."

309. However they first become exposed to cross-sex identity, many children soon find themselves at a pediatric medical transition clinic staffed by WPATH members. The clinics' practice, in accordance with WPATH guidelines, is never to challenge what children say about their sex or suggest talk therapy to reconcile with their physical characteristics. When children say they want to modify their sex traits, the clinics' general practice—consistent with SOC-8's instructions—is to express support for that desire and carry it out.[75] And as discussed below, once a child enters a transition clinic, a clinician quickly diagnoses that child as being dissatisfied with or having distress about sex traits and pressures parents to immediately consent to pediatric medical transition.

D. WPATH also profits itself by leveraging its position as the *de facto* authority on transition medicine in the United States

310. WPATH also profits itself by claiming to be the authority on transition medicine, then leveraging that authority to sell trainings and otherwise conduct profitable business.

311. Self-publishing the so-called "Standards of Care" is one component of this business strategy. Those unaware of SOC-8's shortcomings and disinclined to closely examine its underlying evidence are deceived by WPATH's claims that it arrived at its recommendations

[75] *See* Ex. 12, Decl. of [redacted] ¶¶ 12–13, 15.

via robust evidentiary review that comported with international standards of medical guidelines.

312. Another component of WPATH's business strategy is its Global Education Initiative. The Initiative is WPATH's curriculum for training medical professionals on medical transition, both in the United States and around the world. Official collaborators include the American Medical Student Association and the World Health Organization.

313. American hospitals, medical schools, and transition clinics rely on SOC-8 and the Initiative when setting standards, creating fellowships, and conducting other activities which touch on medical transition. For example, Mt. Sinai has established a "transgender psychiatry fellowship" in which fellows participate in WPATH's bi-annual conferences. Oregon Health and Sciences University provides a "gender surgery fellowship program" led by a WPATH member. Harvard Medical School provides continuing medical education led by senior WPATH leadership and SOC-8 drafters.

314. Some governmental authorities require a WPATH certification—obtained through the Initiative—for certain types of employment. For example, the Washington State Department of Corrections requires that doctors performing medical transition treatments must either already be WPATH-certified or obtain that certification within two years. The Oregon Health Authority has a similar requirement. And California requires insurance companies to enroll in training offered by WPATH. Regulators projected that the training would result in an annual cost to insurance companies—and revenue to WPATH—of $163,400.

315. WPATH's strategy has thus successfully rendered WPATH the self-appointed, *de facto* authority on transition medicine in the United States, bringing significant wealth to WPATH and its members.

X. WPATH HAS PROVIDED TO CLINICIANS THE MEANS BY WHICH THEY DECEIVE CHILDREN AND THEIR PARENTS INTO PURCHASING PEDIATRIC MEDICAL TRANSITION SERVICES

316. WPATH's false, misleading, or unsubstantiated representations have caused substantial consumer injury, including grievous bodily and psychological harm, to children experiencing dissatisfaction with or distress about their sex traits. WPATH also has injured these children's parents who paid for harmful medical transition treatments either out-of-pocket or in co-pays or insurance premiums. These injuries have occurred primarily through the means that WPATH supplies to clinicians.

317. Clinicians base their diagnoses on WPATH's false, misleading, or unsubstantiated statements and guidance, repeat WPATH's false, misleading, or unsubstantiated statements to consumers—children and their parents—and recommend specific drugs, surgeries, and other interventions based on WPATH's false, misleading, or unsubstantiated representations, all while failing to disclose to children and parents the significant harmful side effects because WPATH fails to disclose them or downplays them in SOC-8. Although the experience of every child and parent is unique, sworn testimony, affidavits, and other evidence that the FTC has gathered demonstrate a consistent pattern: clinicians follow WPATH's script, and children and parents rely on those representations in deciding to purchase transition services, leading to significant physical, mental, financial, and psychological harm.[76]

318. Historically, children identified by clinicians as candidates for pediatric medical transition were typically those who did not conform to stereotypical social roles associated with their sex. Prior to widely available medical transition, most of these children desisted—*i.e.*, they

[76] That some of the events described in testimony, affidavits, and other evidence relied on in this Amended Complaint to establish this consistent pattern may have occurred before 2022 does not undermine their support for these allegations against WPATH and SOC-8. *Supra* n.2.

ceased feeling dissatisfaction with or distress about their sex traits—and ultimately identified as gay.

319. Children identified by clinicians as candidates for pediatric medical conditions often present with serious mental health conditions such as anxiety, depression, and suicidality;[77] distress from a traumatic event or situation;[78] or neurodevelopmental difficulties like autism spectrum disorder.[79] These mental health and developmental challenges often correspond to or coexist with social problems which make these children feel like they do not fit in.[80]

320. These children experience social pressure to consider their sex as the cause of their challenges. That pressure can manifest in various ways, including online and media influence,[81] homophobia,[82] peer influence,[83] and influence from adult figures in a child's life.[84] Many girls going through puberty feel like they are not feminine enough to fit in as girls.[85] Many

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[77] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 11 (panic attacks, intrusive thoughts, and obsessive thoughts); Ex. 10, Decl. of [redacted] at ¶ 10; Ex. 14, Decl. of [redacted] at ¶ 8; Ex. 1, Decl. of Soren Aldaco at ¶¶ 4, 6; Ex. 15, Decl. of Evelyn Neel at ¶ 2; Ex. 12, Decl. of [redacted] at ¶ 14.

[78] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶¶ 3, 13, 31–32, 57 (sexual assault, difficult home situation, and abusive relationship); Ex. 5, Decl. of Elisabeth Bourne at ¶ 3 (friend was sexually assaulted and went to the ER); Ex. 14, Decl. of [redacted] at ¶ 2 (fled with mother from domestic violence); Ex. 1, Decl. of Soren Aldaco at ¶ 6; Ex. 2, Decl. of Cassidy Andrews at ¶ 4; Ex. 15, Decl. of Evelyn Neel at ¶ 2 (sexual abuse); Ex. 12, Decl. of [redacted] at ¶ 14.

[79] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 7 (diagnosed with autism at age 4); Ex. 9, Decl. of [redacted] at ¶ 2 (child diagnosed with autism and a rare genetic developmental disorder); Ex. 8, Decl. of Melissa Skinner at ¶ 5; Ex. 1, Decl. of Soren Aldaco at ¶ 12; Ex. 12, Decl. of [redacted] at ¶ 14.

[80] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 2; Ex. 7, Decl. of Jonathon Skinner at 4–11; Ex. 13, Decl. of [redacted] at 2; Ex. 8, Decl. of Melissa Skinner at ¶¶ 5, 8; Ex. 1, Decl. of Soren Aldaco at ¶ 4.

[81] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 4; Ex. 7, Decl. of Jonathon Skinner at ¶ 15; Ex. 13, Decl. of [redacted] at ¶ 6; Ex. 9, Decl. of [redacted] at ¶ 5; Ex. 10, Decl. of [redacted] at ¶ 11; Ex. 1, Decl. of Soren Aldaco at ¶ 3; Ex. 2, Decl. of Cassidy Andrews at ¶ 8.

[82] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶¶ 5–10; Ex. 10, Decl. of [redacted] at ¶¶ 5–9.

[83] *E.g.*, Ex. 13, Decl. of [redacted] at ¶ 5; Ex. 11, Decl. of Gwen Turecki at ¶ 2; Ex. 5, Decl. of Elisabeth Bourne at ¶ 5; Ex. 14, Decl. of [redacted] at ¶¶ 3, 8.

[84] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 16 (adult math tutor and family friend identified as opposite sex); Ex. 4, Decl. of Caroline Miller at ¶¶ 5, 7 (child's father took him to gender-related counseling despite the child identifying as bisexual and "affirmed" the child as transgender); Ex. 15, Decl. of Evelyn Neel at ¶ 3 (psychiatrist "planted a seed in my head").

[85] *E.g.*, Ex. 6, Decl. of Clementine Breen ¶ 2, Ex. 10, Decl. of [redacted] ¶¶ 4–5, Ex. 1, Decl. of Soren Aldaco ¶¶ 4–5.

of these children who feel that they do not fit in with members of their sex express dissatisfaction with or distress about sex traits to a parent,[86] or another authority figure, like a school counselor.[87]

321. Many parents ask a family doctor or mental health professional about their child's distress.[88] These individuals typically do not specialize in sex-trait modification and refer children to a specialized provider, like a transition clinic,[89] particularly if a local transition clinic has asked them to make such referrals.[90] Other parents schedule appointments with these clinics directly.[91] And some children are sent to transition clinics after being placed on psychiatric holds.[92]

322. Regardless of where they end up, children and parents are unlikely to avoid being influenced by WPATH's deceptive claims and omissions. Indeed, WPATH board member and former president Dr. Marci Bowers claims that "the vast majority of mental health providers in the country that [Dr. Bowers is] familiar with follow the WPATH standards of care."

323. Clinicians begin selling parents and children on medical transition procedures once they arrive at a medical transition provider's clinic. Sometimes, clinicians make the sale by directly invoking WPATH's name and providing parents with the SOC or other material containing WPATH's deceptive claims. Other times, clinicians repeat WPATH's deceptive

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[86] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 17; Ex. 13, Decl. of [redacted] at ¶ 8; Ex. 9, Decl. of [redacted] at ¶ 6; Ex. 8, Decl. of Melissa Skinner at ¶ 7; Ex. 10, Decl. of [redacted] at ¶ 12; Ex. 11, Decl. of Gwen Turecki at ¶ 3; Ex. 14, Decl. of [redacted] at ¶¶ 3, 5.
[87] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 4 (school counselor).
[88] *E.g.*, Ex. 13, Decl. of [redacted] at ¶ 8; Ex. 9, Decl. of [redacted] at ¶¶ 7–8; Ex. 11, Decl. of Gwen Turecki at ¶ 5; Ex. 14, Decl. of [redacted] at ¶ 11.
[89] *E.g.*, Ex. 13, Decl. of [redacted] at ¶ 8; Ex. 9, Decl. of [redacted] at ¶ 8; Ex. 11, Decl. of Gwen Turecki at ¶ 5; Ex. 14, Decl. of [redacted] at ¶ 11.
[90] *See* Ex. 12, Decl. of [redacted] at ¶ 9.
[91] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 5; Ex. 7, Decl. of Jonathon Skinner at ¶ 18.
[92] *E.g.*, Ex. 10, Decl. of [redacted] at ¶ 16; Ex. 1, Decl. of Soren Aldaco at ¶ 7; Ex. 15, Decl. of Evelyn Neel at ¶¶ 3, 6.

claims without attribution. And even without telling parents, clinicians often rely on WPATH's deceptive claims in making diagnoses and recommending treatment.

324. Parents sometimes expend considerable resources paying for pediatric medical transition treatments and managing their side effects. For example, parents have paid between $9,300 and $20,000 for breast-amputation surgery.[93] In many other cases, parents are able to pay for the procedure through insurance coverage[94]—coverage that would not exist but for WPATH's deceptive statements that the treatment is medically necessary and purportedly backed by expert consensus. The result is that, in numerous cases and for numerous reasons, WPATH's deceptive statements provide clinicians with the means and instrumentalities to mislead consumers into subjecting their children to unnecessary medical transition services.

A. Clinicians invoke WPATH and provide families with WPATH's deceptive material

325. Clinicians directly invoke WPATH's "Standard of Care" in encouraging their patients to purchase transition services.[95] Clinicians also cite or provide materials citing WPATH and the "Standards of Care" when discussing diagnoses and pediatric medical transition with parents.[96] Parents and children often consider and trust this information when they agree to medical transition procedures.

326. For example, a pediatric endocrinologist in California told a pediatric patient's mother that he follows the recommendations of WPATH. When the patient's mother asked for supporting studies and other evidence for medical transition, the doctor sent her a web link

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[93] *See* Ex. 6, Decl. of Clementine Breen at ¶ 37; Ex. 10, Decl. of [redacted] at ¶ 40.
[94] *E.g.*, Ex. 1, Decl. of Soren Aldaco at ¶ 18; Ex. 8, Decl. of Melissa Skinner at ¶ 40; Ex. 3, Decl. of Vanessa Sivadge at ¶ 16; Ex. 12, Decl. of [redacted] at ¶ 19.
[95] *E.g.*, Ex. 10, Decl. of [redacted] ¶ 24, Ex. 1, Decl. of Soren Aldaco at ¶¶ 10, 16; Ex. 2, Decl. of Cassidy Andrews at ¶ 18.
[96] *E.g.*, Ex. 11, Decl. of Gwen Turecki at ¶ 7; Ex. 5, Decl. of Elisabeth Bourne at ¶ 19.

directly to WPATH's SOC-7, which she then read.[97] Boston Children's Hospital Center for Gender Surgery cited "WPATH standards of care" on its page advertising breast implants for children. One online medical transition clinic asserts that it follows SOC-8 and promises to provide monthly prescriptions for transition services without an in-person visit, covered by major US insurers. It asserts that "puberty blockers are fully reversible" and that "children can begin their medical transition with puberty blockers." Stanford Medicine's Transgender Surgery team promises that it "follows the World Professional Association for Transgender Health (WPATH) guidelines to ensure patients are appropriate surgical candidates."

327. One 13-year-old girl visited a Dallas, Texas clinic with her parents. A psychologist who has presented at WPATH conferences told the girl's parents that their daughter needed to undergo medical transition, including cross-sex hormones and breast amputation. When these parents expressed skepticism and asked how the psychologist "knew that medical transition would help" their daughter's distress, the psychologist "answered that WPATH recommended it."[98]

328. One doctor at a large public university encouraged one 15-year-old patient to read the SOC. The girl, who was later prescribed testosterone and had her breasts amputated, believed based on her interaction with the doctor that WPATH was an official, authoritative medical organization.[99]

329. A nurse, who worked at Texas Children's Hospital, recalls that a pediatric endocrinologist at that hospital recorded in patient charts that he "told parents he was following

[97] Ex. 5, Decl. of Elisabeth Bourne at ¶¶ 18–19.
[98] Ex. 2, Decl. of Cassidy Andrews at ¶¶ 12–18.
[99] Ex. 10, Decl. of [redacted] ¶ 24.

WPATH's Standards of Care" and "explained WPATH's Standards of Care" to parents.[100] This doctor "frequently referenced WPATH" when communicating with parents.[101]

B. Clinicians repeat and rely on WPATH's claims without attribution to sell transition procedures

330. Even without directly referencing WPATH and the Standards of Care, clinicians often repeat deceptive phrases or concepts from SOC-8.

331. Clinicians emphasize the need for pediatric medical transition by stating or strongly implying that if parents do not consent to medical transition, their children will commit suicide.[102] Some clinicians tell parents that if their children die, the parents will be to blame.[103] Clinicians often ask parents if they would "rather have a dead son or a living daughter," or vice versa.[104]

332. Clinicians make these statements because WPATH represents that medical transition is "lifesaving" and SOC-8 expressly represents that medical transition is "medically necessary" and reduces suicidality, thereby providing clinicians with the rationale that they use

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[100] Ex. 3, Decl. of Vanessa Sivadge at ¶¶ 6–7.
[101] Ex. 3, Decl. of Vanessa Sivadge at ¶ 8.
[102] *E.g.*, Ex. 12, Decl. of [redacted] at ¶ 30(b). Like SOC-8, SOC-7 emphasized the need for medical transition and, for adolescents, even provides guidelines on the "Risks of Withholding" such treatments to include "abuse and stigmatization" and "psychiatric distress during adolescence" before warning that "withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents." On that basis, while SOC-7 was in place, clinicians similarly emphasized the need for pediatric medical transition by stating or strongly implying that if parents do not consent to medical transition, their children will experience "psychiatric distress" to include suicide. Ex. 7, Decl. of Jonathon Skinner at ¶ 28 (clinician claimed that "60% of transgender kids kill themselves if they are not medically transitioned"); Ex. 6, Decl. of Clementine Breen at ¶ 9 (recounting that her parents told her "that [the clinician] had told them that I was suicidal and firm in my male identity. Neither was true"); Ex. 13, Decl. of [redacted] at ¶¶ 14, 16; Ex. 4, Decl. of Caroline Miller at ¶¶ 13, 15; Ex. 9, Decl. of [redacted] at ¶ 15; Ex. 8, Decl. of Melissa Skinner at ¶ 10; Ex. 5, Decl. of Elisabeth Bourne at ¶ 16; Ex. 14, Decl. of [redacted] at ¶ 12; Ex. 2, Decl. of Cassidy Andrews at ¶¶ 11, 19; Ex. 15, Decl. of Evelyn Neel ¶ 8. Because SOC-7 and SOC-8 contain materially similar content on this point, SOC-8 will cause and is causing the same harms.
[103] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 37 (doctor told parents that their daughter might kill herself if her parents did not pay for a double mastectomy); Ex. 4, Decl. of Caroline Miller at ¶¶ 15, 18; Ex. 9, Decl. of [redacted] at ¶¶ 15, 19; Ex. 14, Decl. of [redacted] at ¶ 12.
[104] Ex. 8, Decl. of Melissa Skinner at ¶ 10; Ex. 13, Decl. of [redacted] at ¶ 14; Ex. 9, Decl. of [redacted] at ¶ 15; Ex. 2, Decl. of Cassidy Andrews at ¶ 11; Ex. 12, Decl. of [redacted] at ¶ 30(b).

to pressure parents into consenting. This approach aligns with that taken by USPATH president Dr. Johanna Olson-Kennedy, who has admitted to using such tactics to persuade parents to purchase transition services for their children.

333. For example, a Missouri clinician attempted to pressure a mother into consenting to puberty blockers for her son by rejecting her concerns and strongly implying that her son would commit suicide if she did not consent.[105] Dr. Olson-Kennedy told a girl's parents that the girl was suicidal and convinced that she was male, when neither was true. This caused the girl's mother to cry.[106] And an Arizona clinician addressing a boy and his parents asked if they would rather "have a live daughter or a dead son," telling the parents that if their son killed himself, it would be their fault.[107] A medical transition-supporting therapist repeated that these parents would be to blame if their son committed suicide.[108] And a Texas endocrinologist, who told parents that he was following WPATH's Standards of Care, warned them that there was a higher risk of a child harming themselves if the child is not "affirmed" in their desire to transition.[109]

334. Clinicians maintain that pediatric medical transition is the only effective option and reject any alternative treatment options for a child's distress.[110] They repeat WPATH's claims that pediatric medical transition is the "standard of care" and is "medically necessary."[111]

335. Dr. Johanna Olson-Kennedy told a twelve-year-old girl that people who express distress about their sex traits are born in the wrong body; the girl concluded that medical treatment was required to correct her body. Dr. Olson-Kennedy also told the girl's parents that

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[105] Ex. 4, Decl. of Caroline Miller at ¶¶ 13, 15.
[106] Ex. 6, Decl. of Clementine Breen at ¶¶ 9–10.
[107] Ex. 9, Decl. of [redacted] at ¶ 15.
[108] Ex. 9, Decl. of [redacted] at ¶ 19.
[109] Ex. 3, Decl. of Vanessa Sivadge ¶¶ 6, 10.
[110] *E.g.*, Ex. 9, Decl. of [redacted] at ¶ 15; Ex. 12, Decl. of [redacted] at ¶¶ 36–37.
[111] Ex. 12, Decl. of [redacted] at ¶ 30(c–d).

the only treatment for that distress was medical transition, which requires hormone therapy. When the parents asked whether talk therapy was an option, Dr. Olson-Kennedy claimed that it would not alleviate their daughter's distress.[112] And Dr. Olson-Kennedy explicitly referenced "standards of the World Professional Association for Transgender Health (WPATH)" as the basis for her "diagnoses and treatment."[113]

336. Clinicians' claims are effective because SOC-8, like its predecessor SOC-7, frames these interventions as medically necessary, emphasizes early initiation of medical transition at the onset of puberty, and asserts that delaying such interventions may have "harmful effects." Relying on the SOC, clinicians further create a sense of urgency by insisting that children immediately start taking drugs like puberty blockers regardless of the parents' uncertainty over the source of a child's distress.[114]

337. Under the guise that the treatments are necessary or lifesaving, clinicians sometimes take drastic measures to convince parents to consent to medical transition services. Some clinicians attempt to drive a wedge between parents and their children by sabotaging their relationship.[115] If parents disagree with one another about consenting to medical treatment, clinicians have encouraged the consenting parent to obtain an attorney.[116] A California transition doctor, speaking with both a young patient and his mother, told the son that if he felt unsafe at home, he should call the doctor.[117] One Georgia doctor recommended at a WPATH conference

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[112] Ex. 6, Decl. of Clementine Breen at ¶¶ 8, 11.
[113] Ex. 6, Decl. of Clementine Breen at ¶ 35.
[114] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 21, 25–28; Ex. 6, Decl. of Clementine Breen at ¶¶ 11–13; Ex. 13, Decl. of [redacted] at ¶¶ 16, 18; Ex. 4, Decl. of Caroline Miller at ¶¶ 12–13, 15, 17–18; Ex. 9, Decl. of [redacted] at ¶ 13; Ex. 11, Decl. of Gwen Turecki at ¶ 10.
[115] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶¶ 27–29; Ex. 13, Decl. of [redacted] at ¶¶ 13–14; Ex. 8, Decl. of Melissa Skinner at ¶ 24.
[116] Ex. 12, Decl. of [redacted] at ¶ 35.
[117] Ex. 13, Decl. of [redacted] at ¶ 14.

that doctors should threaten unsupportive parents by "letting parents know that" "[t]here are at least some child protective service workers who are willing to enforce the need for affirmation by parents."

C. Clinicians follow and rely on WPATH in failing to adequately disclose side effects

338. Clinicians also downplay, deny, or omit serious side effects of puberty blockers, cross-sex hormones, surgeries, and pediatric medical transition generally,[118] consistent with SOC-8's failure to adequately disclose or otherwise downplay those side effects,[119] which it carried over from SOC-7. For example, Kaiser Permanente provides a handout of frequently asked questions to parents and children who are considering puberty blockers. To the question "Are puberty blockers safe?" Kaiser Permanente responds: "The Endocrine Society and World Professional Associate [*sic*] for Transgender Health support the use of puberty blockers for youth who want to delay or prevent unwanted physical changes of puberty." Parents and children do not hear about how, for example, cross-sex hormones may cause fatal cardiovascular issues or how puberty blockers may lead to long-term cognitive deficits.

339. Clinicians suggest that the side effects that they do acknowledge are not permanent and can be remedied.[120] Clinicians similarly repeat SOC-8's claim that puberty blockers are "fully reversible,"[121] which was identical to that in SOC-7.

340. Collectively, WPATH's deceptive statements and material omissions cause

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[118] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶¶ 32–61; Ex. 6, Decl. of Clementine Breen at ¶¶ 12, 16, 22–25, 39–51; Ex. 13, Decl. of [redacted] at ¶¶ 19–24; Ex. 4, Decl. of Caroline Miller at ¶¶ 10, 21–28; Ex. 9, Decl. of [redacted] at ¶ 14; Ex. 8, Decl. of Melissa Skinner at ¶¶ 17–18, 37–39; Ex. 5, Declaration of Elisabeth Bourne at ¶ 16; Ex. 2, Decl. of Cassidy Andrews at ¶¶ 25, 27, 28, 35, 42, 49, 51, 52; Ex. 15, Decl. of Evelyn Neel at ¶¶ 15, 16, 19, 24, 34; Ex. 12, Decl. of [redacted] at ¶ 30(d–e).

[119] See *supra* ¶¶ 161–245.

[120] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 26; Ex. 4, Decl. of Caroline Miller at ¶ 11.

[121] Ex. 12, Decl. of [redacted] at ¶¶ 30(a), 33; *see* Ex. 4, Decl. of Caroline Miller at ¶¶ 14 (clinic worker "promised that puberty would resume as normal" upon stopping puberty blockers), 17 (same).

parents to worry that their children are in mortal peril and that the only effective solution is to consent to pediatric medical transition.[122] In many cases, the pressure created by WPATH's unlawful conduct—and the fear it creates—causes parents to purchase pediatric medical transition drugs, surgeries, or services.[123]

D. Clinicians use SOC-8's deceptive diagnosis and treatment guidelines to sell medical transition services

341. By proclaiming SOC-8 to represent expert consensus, and that pediatric medical transition is the standard of care, WPATH gives clinicians justification to follow SOC-8's diagnosis and treatment guidelines, deceiving parents and children into agreeing to unnecessary and harmful treatments.

342. In line with SOC-8's amorphous diagnosis guidelines (a characteristic shared by SOC-7), clinicians often diagnose children based on superficial and innocuous traits. The basis for these diagnoses often includes asking a child if they want to look different,[124] if they fear or dislike puberty,[125] if they are attracted to the same sex,[126] if they want to be referred to by cross-sex pronouns,[127] or if they enjoy hobbies or other activities commonly associated with the opposite sex,[128] without questioning whether the child's reported distress is truly caused by the child's sex traits.[129] One boy was told by an endocrinologist that being both feminine and attracted to boys indicated that he was female, which convinced the boy that he should have a

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[122] *E.g.*, Ex. 4, Decl. of Caroline Miller at ¶ 18; Ex. 9, Decl. of [redacted] at ¶ 15; Ex. 6, Decl. of Clementine Breen at ¶¶ 9–10; Ex. 13, Decl. of [redacted] at ¶ 16; Ex. 12, Decl. of [redacted] at ¶ 38.
[123] *E.g.*, Ex. 4, Decl. of Caroline Miller at ¶ 18.
[124] *E.g.*, Ex. 9, Decl. of [redacted] at ¶ 11.
[125] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 7.
[126] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶¶ 23–24.
[127] *E.g.*, Ex. 16, Decl. of [redacted] at ¶¶ 22–24 (psychologist diagnosed 8-year-old boy with "gender dysphoria," despite lack of distress, after he said he did not care what pronouns she used for him).
[128] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 7.
[129] *E.g.*, Ex. 12, Decl. of [redacted] at ¶ 25.

female body.[130]

343. Social workers, not doctors, often diagnose children with "gender dysphoria" and provide referrals to endocrinologists,[131] even after asking little more than how the child felt about his or her body.[132] A case worker at a transition clinic routinely saw pediatric patients who did not even moderately present as the opposite sex and who had only recently expressed distress about their sex traits.[133] Clinicians follow WPATH's "Standards of Care" in making such diagnoses[134] and represent that they follow WPATH's "Standards of Care" to their pediatric patients and their parents.[135]

344. Regardless of the screening performed, transition clinics routinely diagnose children as experiencing distress about their sex traits and recommend pediatric medical transition, often after one short and perfunctory examination which typically involves separating children from parents.[136]

345. Parents reasonably expect transition specialists to conduct a thorough examination of their children and exclude alternative causes of their children's distress, such as trauma, distress about sex-same attraction, autism, depression, or other mental-health issues, before recommending pediatric medical transition.[137] But following the SOC-8, clinicians instead

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[130] Ex. 7, Decl. of Jonathon Skinner at ¶¶ 23–25.

[131] *E.g.*, Ex. 11, Decl. of Gwen Turecki at ¶ 7.

[132] *E.g.*, Ex. 9, Decl. of [redacted] at ¶¶ 10–11.

[133] *E.g.*, Ex. 12, Decl. of [redacted] at ¶ 72.

[134] *E.g.*, Ex. 12, Decl. of [redacted] at ¶ 24; Ex. 3, Decl. of Vanessa Sivadge at ¶ 6; Ex. 7, Decl. of Jonathon Skinner at ¶¶ 22, 69.

[135] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 35.

[136] l. of Clementine Breen at ¶ 6–12; Ex. 13, Decl. of [redacted] at ¶¶ 8, 11–14; Ex. 9, Decl. of [redacted] at ¶16; Ex. 8, Decl. of Melissa Skinner at ¶¶ 9–10; Ex. 11, Decl. of Gwen Turecki at ¶¶ 6–7; Ex. 1, Decl. of Soren Aldaco at ¶¶ 7, 14–15; Ex. 2, Decl. of Cassidy Andrews at ¶¶ 15–16.

[137] *E.g.*, Ex. 12, Decl. of [redacted] at ¶ 12 (explaining that parents wanted a gender clinic "to determine if [their children] were transgender, or that they wanted to explore a non-medical pathway (like therapy) to address their children's gender dysphoria"); Ex. 9 Decl. of [redacted] [redacted] at ¶¶ 11–13.

proceed directly to medical transition.

346. A case manager at a transition clinic in St. Louis, Missouri, frequently encountered parents who wanted their children to be assessed by a mental-health professional to determine whether they were experiencing distress related to their sex traits—and to possibly pursue non-medical intervention as a treatment for that distress. Her clinic offered neither mental-health assessments nor non-medical therapies. The clinic's mantra—simply repeating the SOC—was that medical transition is medically necessary.[138]

347. When parents offer an alternative basis for a child's distress, clinicians routinely reject that explanation, no matter how plausible or grounded it is in a parents' direct observations of their own children.[139] This pattern is a direct consequence of SOC-8, which explicitly and implicitly instructs clinicians not to allow mental-health conditions, trauma histories, autism, internalized homophobia, or other alternative causes of distress to "delay" medical transition, thereby giving clinicians the means and justification to disregard these explanations.[140] Indeed, consistent with SOC-8's general directions, clinicians have rejected out of hand that a child's distress or discomfort could be caused by a diagnosed chromosome disorder,[141] autism,[142] body dysmorphia,[143] internalized homophobia or simply being gay,[144] or the normal search for identity that often accompanies puberty.[145]

348. For example, at the outset of a session conducted by a Michigan medical

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[138] Ex. 12, Decl. of [redacted] at ¶¶ 2, 12–13, 15, 30(d).
[139] *E.g.*, Ex. 9, Decl. of [redacted] at ¶ 12; Ex. 11, Decl. of Gwen Turecki at ¶ 8.
[140] See *supra* ¶¶ 132–344, 33.
[141] *E.g.*, Ex. 9, Decl. of [redacted] at ¶ 12.
[142] *E.g.*, Ex. 9, Decl. of [redacted] at ¶ 12.
[143] *E.g.*, Ex. 9, Decl. of [redacted] at ¶ 12.
[144] *E.g.*, Ex. 9, Decl. of [redacted] at ¶ 12.
[145] *E.g.*, Ex. 9, Decl. of [redacted] at ¶ 12.

transition clinic, a social worker told a family that the purpose of their meeting was to determine how to align their son's body with his self-image, citing WPATH as the standard of care, without first considering any of the child's many underlying emotional problems.[146]

349. An Arizona boy was diagnosed with autism and a rare genetic disorder, which required both private therapy and a special education program at his public school. When his parents brought him to a transition clinic at age 14, a social worker diagnosed the root of his distress as discomfort with his sex traits and recommended cross-sex hormones after just a few questions about his feelings over his physical appearance—and with an apparent disregard to his developmental and other mental-health issues.[147]

350. A Michigan clinician seemingly ignored a boy's psychological distress in quickly diagnosing him with "transsexualism" and recommending that he see an endocrinologist for cross-sex hormone therapy.[148] His mother rejected the recommendation and he stopped identifying as female within months.[149]

XI. WPATH CAUSES INJURY IN AND TO ALASKA

351. Plaintiff Alaska has sustained or will sustain injury because of Defendants' unlawful activities.

352. Defendants' "Standards of Care" framework has been consulted, referenced by, or otherwise relied-upon by health care providers and/or their associated clinics or hospitals in the State of Alaska.

353. Within the State of Alaska, multiple health care providers and/or their clinics or

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[146] Ex. 11, Decl. of Gwen Turecki at ¶¶ 5–8.
[147] Ex. 9, Decl. of [redacted] at ¶¶ 2–3, 9–13.
[148] Ex. 11, Decl. of Gwen Turecki at ¶ 7.
[149] Ex. 11, Decl. of Gwen Turecki at ¶¶ 13–14.

hospitals provide hormone therapy, medical transition surgical referrals, and other medical transition procedures, counseling, or services in reliance upon Defendants' activities or practices, such as their "Standards of Care" framework.

XII. WPATH CAUSES INJURY IN AND TO IOWA

354. Plaintiff Iowa has sustained or will sustain injury because of Defendants' unlawful activities.

355. Defendants' "Standards of Care" framework has been consulted, referenced by, or otherwise relied on by health care providers and their associated clinics or hospitals in the State of Iowa.

356. In the State of Iowa, multiple health care providers and their clinics or hospitals provided hormone therapy, medical transition, surgical referrals, and other medical transition procedures, counseling, or services in reliance on Defendants' activities or practices, such as their "Standards of Care" framework.

357. The proliferation of Defendants' deceptive practices into Iowa prompted the Iowa Legislature to enact Iowa Code § 147.164, which prohibits pediatric medical transition related procedures for children.

358. That law sadly came too late to protect many Iowa children from the harms caused by Defendants' deceptive practices.

XIII. WPATH CAUSES INJURY IN AND TO NEBRASKA

359. Plaintiff Nebraska has sustained or will sustain injury because of Defendants' unlawful activities.

360. The proliferation of Defendants' deceptive practices into Nebraska prompted the Nebraska Legislature to enact the "Let them Grow Act," Neb. Rev. Stat. § 71-7301 *et seq.*, in

2023, to protect children under the age of nineteen from pediatric medical transition.

361. Notwithstanding the "Let Them Grow Act," Defendants' deceptive conduct continues to impact Nebraska. Even with the enactment of the "Let Them Grow Act," the Act grandfathers in children who were receiving prohibited treatment, including puberty-blocking drugs, cross-sex hormones, or both, prior to October 1, 2023.

362. Further, groups that are aligned with Defendants' deceptive practices, such as the Trans Youth Emergency Project, operate to assist Nebraska children to leave the territorial jurisdiction of Nebraska to obtain procedures that are prohibited by Nebraska law, meaning Nebraska cannot effectively legislate away harm to its citizens while Defendants' deceptive practices continue.

363. The "Let Them Grow Act" also came too late to protect many Nebraska children from the harms caused by Defendants' deceptive practices. One such child was Luka Hein.

364. Luka has a pending lawsuit in state district court in Douglas County, Nebraska,[150] against her mental health counselor, physicians, and the hospital that performed a double mastectomy and prescribed testosterone when she was sixteen years old.

365. Luka's story has been widely publicized. Her publicly available complaint tells a tragic story of a 13-year-old girl who was grappling with her parents' divorce, victimization, and serious mental health issues, when she was misled into attributing her distress to her sex traits, consistent with Defendants' misrepresentations regarding children in Nebraska and elsewhere.

366. The facility where Luka underwent a double mastectomy and received testosterone, Nebraska Medicine at the University of Nebraska Medical Center (UNMC),

[150] *Luka Hein v. UNMC Physicians, et al.*, Case No. CI 23-7318.

advertised that it followed and implemented WPATH's "Standards of Care," then SOC-7, in the treatment of children who express dissatisfaction with or distress about their sex traits.

367. Luka's treatment providers at UNMC implemented WPATH's "gender affirming" model in her treatment and relied on WPATH's standards. Both her mental health counselor who recommended the double mastectomy and her physician prescribing testosterone were publicly identified "WPATH members."[151] Before the medical procedures, Luka's parents—who were required to consent to the procedure—were asked if they would rather have a live son or a dead daughter.

368. In 2023, after the harm caused by the removal of her breasts and years of testosterone, Luka detransitioned and questioned the legitimacy of her "treatments."

369. Luka is just one example of a child harmed by Defendants' misrepresentations in Nebraska.

XIV. WPATH CAUSES INJURY IN AND TO TEXAS

370. Plaintiff Texas has sustained or will sustain injury because of Defendants' unlawful activities.

371. Defendants' "Standards of Care" framework has been consulted, referenced by, or otherwise relied on by health care providers and their associated clinics or hospitals in the State of Texas.

372. In the State of Texas, multiple health care providers and their clinics or hospitals

[151] Although Luka alleges these self-identified "WPATH members" ignored WPATH's guidance in one aspect—that breast removal surgery should occur "preferably after . . . one year of testosterone treatment"—they otherwise relied on WPATH's standards in their treatment of Luka, including that such surgery could be carried out prior to Luka reaching the age of majority. See World Professional Association for Transgender Health, Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version 21 (2011), https://themeltzerclinic.com/wp-content/uploads/2025/04/Standards-of-Care-V7-2011-WPATH.pdf.

provided hormone therapy, medical transition, surgical referrals, and other medical transition procedures, treatment, counseling, or services in reliance on Defendants' activities or practices, such as their "Standards of Care" framework.

373. The proliferation of Defendants' deceptive trade practices into Texas prompted the Texas Legislature to pass Senate Bill 14, which prohibits physicians and healthcare providers from providing medical transition treatment to minors. *See* Tex. Health & Safety Code Ann. § 161.702 *et seq*.

374. Sadly, Senate Bill 14 came too late to protect many Texas children from the harms caused by Defendants' deceptive trade practices.

XV. CORE DECEPTIVE STATEMENTS

375. In conclusion, this Amended Complaint seeks relief for ten specific unlawful misrepresentations or omissions, including:

(1) WPATH misrepresents that pediatric medical transition is medically necessary to prevent suicide in children who express dissatisfaction with or report distress about their sex traits.

(2) WPATH misrepresents that pediatric medical transition is effective at preventing suicide in children who express dissatisfaction with or report distress about their sex traits.

(3) WPATH misrepresents that puberty blockers are fully reversible.

(4) WPATH misrepresents that cross-sex hormones improve mental health.

(5) WPATH misrepresents that performing breast amputations on children is safe, effective, and consistently results in better health and quality of life.

(6) WPATH misrepresents SOC-8 to be the result of unbiased, evidence-based expert consensus.

(7) WPATH misrepresents that pediatric medical transition is the "standard of

care" for children who express dissatisfaction with or report distress about their sex traits.

(8) WPATH fails in SOC-8 to adequately disclose certain side effects of puberty blockers including hot flashes, lethargy, and cognitive problems.

(9) WPATH fails in SOC-8 to adequately disclose certain side effects of cross-sex hormones including mood disturbances, vocal pain, pelvic pain, pelvic floor dysfunction, clitoral discomfort, vaginal pain, persistent sexual dysfunction continuing after cessation of use, and erectile pain.

(10) WPATH fails in SOC-8 to adequately disclose certain side effects of breast amputations including inability to breastfeed, nerve damage, and necrosis of the nipples.

376. WPATH made each of these ten misrepresentations or omissions expressly or by implication, WPATH knew they were false or misleading, and WPATH further knew—and intended—that they would provide WPATH members and other providers of medical transition services with the means to mislead consumers. Each of these ten misrepresentations was, and is, important to WPATH members and other providers of transition services. Each of these representations were, and are, important to the children, who receive, and parents, who pay for, those services. As a result of these ten central misrepresentations and omissions, and as pleaded herein, unlawful deception occurred and continues to occur.

377. Each of these ten misrepresentations or omissions occurred at least in certain specific instances detailed herein. In particular:

Misrepresentation (1): WPATH misrepresents that pediatric medical transition is medically necessary to prevent suicide in children who express dissatisfaction with or report distress about their sex traits.

378. WPATH asserts that medical transition is "lifesaving" or "medically necessary" despite the lack of evidence to substantiate the claim that medical transition is necessary and

effective at preventing suicide.[152]

379. In 2008, WPATH misleadingly asserted that medical transition is "not 'cosmetic' or 'elective' or for the mere convenience of the patient," but instead was "understood to be medically necessary."[153]

380. WPATH asserts in SOC-8 that not providing medical transitioning services can lead to depression and anxiety.[154]

381. When WPATH released SOC-7 it added new language dubbing cross-sex hormones and transition surgery "medically necessary."[155] And when WPATH published SOC-8 it further urged "health care systems to provide these medically necessary treatments and eliminate any exclusions from their policy documents and medical guidelines that preclude coverage for any medically necessary procedures or treatments"[156]

382. The "medical necessity statement" spans several pages of SOC-8 and begins by

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[152] See, *e.g.*, SOC-8 at S126 ("[I]n many cases, hormone therapy is considered a lifesaving intervention."); WPATH, Inc. & USPATH, WPATH and USPATH comment on the Cass Review at 2 (May 17, 2024), https://wpath.org/wp-content/uploads/2024/11/17.05.24-Response-Cass-Review-FINAL-with-ed-note.pdf (last visited June 16, 2026) (hereinafter "WPATH Cass Review Comment") (referring to administering puberty blockers to children as "widely recognized as medically necessary, and often reported as lifesaving"); WPATH, Inc. & USPATH, Statement of Opposition to Legislation Banning Access to Gender-Affirming Health Care in the US (Mar. 8, 2023), https://wpath.org/wp-content/uploads/2024/11/USPATH_WPATH-Statement-re_-GAHC-march-8-2023.pdf (last visited June 16, 2026) (characterizing medical transition as "lifesaving care") ; GLAAD *et al*., New York Times Sign On Letter at 1–3, https://glaad.org/nytimes (last visited June 16, 2026) (WPATH signing a letter characterizing medical transition as "lifesaving"); WPATH, Inc. & USPATH, USPATH and WPATH Respond to NY Times Article "They Paused Puberty, But Is There a Cost?" (Nov. 22, 2022) https://media.glaad.org/wp-content/uploads/2023/02/10142224/USPATHWPATH-Statement-re-Nov-14-2022-NYT-Article-Nov-22-2022.pdf (last visited June 16, 2026) (repeating claims that puberty blockers administered to children "can be a life-changing and lifesaving treatment").

[153] WPATH, Inc., WPATH Clarification on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A. at 3 (June 17, 2008).

[154] *See*, *e.g.*, SOC-8 at S66 (stating that "chest dysphoria" correlates to "anxiety, depression, and distress," which can be treated by mastectomy), S106 (claiming that those who experience distress about their sex traits not undergoing medical transition leads to "depression, anxiety, [and] suicidality"), S126 (claiming that cross-sex hormones "positively impact the mental health and quality of life of" patients).

[155] *See* Eli Coleman, *et al.*, Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People at 5, 8, 33, 54 (2012) (hereinafter "SOC-7").

[156] SOC-8 at S18.

recommending that "health care systems should provide medically necessary gender-affirming health care for transgender and gender diverse people."[157] It quotes the American Medical Association's definition of "medical necessity" and then declares that roughly 30 medical transition interventions are medically necessary.[158]

383. In SOC-8, WPATH labeled as "medically necessary" virtually every pediatric medical transition service that a transition doctor could perform for a fee, including administering puberty blockers, "voice surgery," "counseling,"[159] and "hair removal from . . . genital areas for gender affirmation," among many other transition services.[160]

384. WPATH also posts statements on its website falsely claiming that pediatric medical transition is "medically necessary."[161]

Misrepresentation (2): WPATH misrepresents that pediatric medical transition is effective at preventing suicide in children who express dissatisfaction with or report distress about their sex traits.

385. SOC-8 claims that "hormone therapy is considered a lifesaving intervention,"[162] and that medical transition "is associated with a substantial reduction in the risk of suicide attempt[s]."[163]

386. WPATH asserts in SOC-8 that medical transition treatments reduce "suicidality" and "suicidal ideation."[164]

387. WPATH also makes public statements falsely claiming that medical transition is

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[157] SOC 8 at S16.
[158] SOC-8 at S16–S18.
[159] So long as the counseling is not intended to encourage a child to feel comfortable with their natal sex traits. *See* SOC-8 at S53.
[160] SOC-8 at S18.
[161] WPATH Cass Review Comment at 1–2.
[162] SOC-8 at S126.
[163] SOC-8 at S174.
[164] *E.g.*, SOC-8 at S47, S106, S126.

"lifesaving."[165]

Misrepresentation (3): WPATH misrepresents that puberty blockers are fully reversible.

388. WPATH represents in SOC-8 that puberty blockers are "fully reversible."[166]

Misrepresentation (4): WPATH misrepresents that cross-sex hormones improve mental health.

389. WPATH claims in SOC-8 that the administration of cross-sex hormones "has been shown to improve quality of life and to decrease depression and anxiety."[167]

390. WPATH asserts in SOC-8 that hormone therapy "positively impact[s] the mental health and quality of life of [children]."[168]

Misrepresentation (5): WPATH misrepresents that performing breast amputations on children is safe, effective, and consistently results in better health-related quality of life.

391. WPATH represents in SOC-8 that breast amputations are safe, effective, and result in better health and quality of life for girls experiencing dissatisfaction with or distress about their sex traits.[169] SOC-8 claims that "[t]he efficacy of [breast amputation] has been demonstrated in multiple domains, including a consistent and direct increase in health-related quality of life."[170] Thus, WPATH concludes that "the evidence demonstrates [breast amputation] to be a safe and effective intervention."[171]

392. SOC-8 makes "strong recommendations" with respect to surgical interventions for children, thereby asserting that "the evidence [for the intervention] is of high quality," "there

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[165] See *supra* n.152.
[166] SOC-8 at S43, S112.
[167] SOC-8 at S174.
[168] SOC 8 at S126.
[169] SOC-8 at S18 (asserting that all "[g]ender-affirming interventions . . . are safe and effective"), S43 (noting that SOC-7 recommended breast amputation beginning at age 16), S128 (declaring breast amputations to be "a safe and effective intervention").
[170] SOC-8 at S128.
[171] SOC-8 at S128.

are few downsides," and "there is a high degree of acceptance among providers" for the treatment.[172]

Misrepresentation (6): WPATH misrepresents SOC-8 to be the result of unbiased, evidence-based expert consensus.

393. WPATH misrepresents that SOC-8 is "consensus-based expert opinion."[173]

394. WPATH makes public statements falsely claiming that medical transition is backed by "expert consensus[.]"[174]

395. WPATH falsely claims that SOC-8 follows WHO and NAM standards on managing conflicts of interest.[175]

396. WPATH falsely represents that it complied with these standards when it reviewed "[c]onflicts of interests . . . as part of the [SOC-8 committee member] selection process" and concluded that "[n]o conflicts of interest were . . . significant or consequential."[176]

397. WPATH falsely claims that SOC-8 used the "Delphi process," which is a formal method of developing recommendations based on expert consensus.[177]

398. WPATH falsely claims that SOC-8 followed the "GRADE" system.[178]

399. SOC-8 makes "strong recommendations" with respect to cross-sex hormones, puberty blockers, and surgical interventions for children, thereby asserting that "there is a high

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[172] SOC-8 at S111, S129, S250.
[173] SOC-8 at S247; WPATH, WPATH and USPATH response to the HHS report on gender dysphoria (May 2, 2025), https://wpath.org/wp-content/uploads/2025/05/WPATH-USPATH-Response-to-HHS-Report-02May2025-3.pdf (describing SOC-8's recommendations regarding hormone therapy and puberty blockers as "research and consensus-based").
[174] WPATH, WPATH and USPATH response to the HHS report on gender dysphoria (May 2, 2025), https://wpath.org/wp-content/uploads/2025/05/WPATH-USPATH-Response-to-HHS-Report-02May2025-3.pdf (last visited June 16, 2026); WPATH Cass Review Comment (claiming "professional consensus").
[175] SOC-8 at S8, S247; see *supra* ¶ 76.
[176] SOC-8 at S177.
[177] SOC-8 at S250.
[178] SOC-8 at S250.

degree of acceptance among providers" for the treatment.[179]

Misrepresentation (7): WPATH misrepresents that pediatric medical transition is the "standard of care" for children who express dissatisfaction with or report distress about their sex traits.

400. Despite the low-quality evidence supporting pediatric medical transition, WPATH represents that pediatric medical transition is the "standard[] of care" for children who express dissatisfaction with or distress about their sex traits.[180]

401. In SOC-8, WPATH represents that cross-sex hormones are medically necessary for children who express discomfort with or distress about their sex traits, and that cross-sex hormone use is an appropriate treatment as early as the onset of puberty.[181]

402. SOC-8 makes "strong recommendations" with respect to cross-sex hormones, puberty blockers, and surgical interventions for children, thereby asserting that "the evidence [for the intervention] is of high quality," "there are few downsides," and "there is a high degree of acceptance among providers" for the treatment.[182]

Omission (8): WPATH fails in SOC-8 to disclose or to adequately disclose certain side effects of puberty blockers.

403. SOC-8 provides a "strong recommendation" that clinicians administer puberty blockers to children, thereby asserting that "the evidence [for the intervention] is of high quality," "there are few downsides," and "there is a high degree of acceptance among providers" for the treatment.[183] But SOC-8 fails to disclose or to adequately disclose risks and side effects

[179] SOC-8 at S111, S129, S250.
[180] SOC-8 at S1.
[181] SOC-8 at S110–11, S114–15, S256–57.
[182] SOC-8 at S111, S129, S250.
[183] SOC-8 at S111, S250.

like hot flashes, lethargy, and cognitive issues when puberty blockers are used for pediatric medical transition.[184]

Omission (9): WPATH fails in SOC-8 to disclose or to adequately disclose certain side effects of cross-sex hormones.

404. SOC-8 makes "strong recommendations" with respect to administering cross-sex hormones to children, thereby asserting that "the evidence [for the intervention] is of high quality," "there are few downsides," and "there is a high degree of acceptance among providers" for the treatment.[185] But SOC-8 fails to disclose or to adequately disclose the existence and severity of risks and side effects associated with cross-sex hormones, including mood disturbances, vocal pain, pelvic pain, pelvic floor dysfunction, clitoral discomfort, vaginal pain, persistent sexual dysfunction continuing after cessation of use, and erectile pain.[186]

Omission (10): WPATH fails in SOC-8 to disclose or to adequately disclose certain side effects of breast amputations.

405. SOC-8 makes "strong recommendations" with respect to surgical interventions for children, including breast amputation, thereby asserting that "the evidence [for the intervention] is of high quality," "there are few downsides," and "there is a high degree of acceptance among providers" for the treatment.[187] But SOC-8 fails to disclose or to adequately disclose risks and side effects associated with breast amputations, like its effects on non-erogenous sensation, inability to breastfeed, nerve damage, and necrosis of the nipples.[188]

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[184] See generally SOC-8.
[185] SOC-8 at S111, S129 S250.
[186] SOC-8 at S254; see generally SOC-8.
[187] SOC-8 at S111, S129, S250.
[188] See generally SOC-8.

XVI. VIOLATIONS OF THE FTC ACT, AK CPA, IOWA CONSUMER PROTECTION ACT, NE UDTPA, AND TEXAS DTPA

406. Section 5(a) of the FTC Act, 15 U.S.C. § 45(a), prohibits "unfair or deceptive acts or practices in or affecting commerce."

407. Misrepresentations or deceptive omissions of material fact constitute deceptive acts or practices prohibited by Section 5(a) of the FTC Act.

408. Section 12 of the FTC Act, 15 U.S.C. § 52, prohibits the dissemination of any false advertisement in or affecting commerce for the purpose of inducing, or which is likely to induce, the purchase of food, drugs, devices, services, or cosmetics. For the purposes of Section 12 of the FTC Act, 15 U.S.C. § 52, puberty blockers and cross-sex hormones are a "drug" as defined in Section 15(c) of the FTC Act, 15 U.S.C. § 55(c).

Count I: Means and Instrumentalities to Engage in Deception—Deceptive Establishment and Efficacy Claims

409. Defendants have created, disseminated, and furnished to medical providers selling pediatric medical transition services false, misleading, or unsubstantiated representations, guidance, materials, training, and other content that represent, directly or indirectly,

A. Pediatric medical transition is medically necessary to prevent suicide in children who express dissatisfaction with or report distress about their sex traits.

B. Pediatric medical transition is effective at preventing suicide in such children who express dissatisfaction with or report distress about their sex traits.

C. Puberty blockers are fully reversible.

D. Cross-sex hormones improve mental health.

E. Performing breast amputations on children is safe, effective, and consistently results in better health and quality of life.

410. By furnishing this guidance, materials, and training containing false, misleading, or unsubstantiated representations describe in Paragraph 409, Defendants have provided the means and instrumentalities for the commission of deceptive acts and practices.

411. Therefore, Defendants' representations as described in Paragraph 409 constitute deceptive acts or practices and the making of false advertisements in violation of Sections 5(a) and 12 of the FTC Act, 15 U.S.C. §§ 45(a), 52.

Count II: Means and Instrumentalities to Engage in Deception—Misrepresentations Regarding the Standards of Care

412. Defendants have created and furnished medical providers who sell pediatric medical transition services with guidance, materials, and training containing false or misleading representations which claim, directly or indirectly, expressly or by implication, that:

A. Defendants' SOC-8 represents unbiased, evidence-based expert consensus.

B. Pediatric medical transition is the "standard of care" for children who express dissatisfaction with or report distress about their sex traits.

413. By furnishing the guidance, materials, and training containing the false or misleading representations described in Paragraph 412, Defendants have provided the means and instrumentalities for the commission of deceptive acts and practices.

414. Therefore, Defendants' representations as described in Paragraph 412 constitute deceptive acts or practices and the making of false advertisements in violation of Sections 5(a) and 12 of the FTC Act, 15 U.S.C. §§ 45(a), 52.

Count III: Means and Instrumentalities to Engage in Deception—Failure to Disclose Side Effects

415. Defendants have created and furnished medical providers who sell pediatric medical transition services with guidance, materials, and training that fails to disclose the

existence or extent of detrimental effects of drugs, surgeries, or other pediatric medical transition treatments, including that:

A. The side effects of puberty blockers include hot flashes, lethargy, and cognitive problems.

B. The side effects of cross-sex hormones include mood disturbances, vocal pain, pelvic pain, pelvic floor dysfunction, clitoral discomfort, vaginal pain, persistent sexual dysfunction continuing after cessation of use, and erectile pain.

C. The side effects of breast amputations include inability to breastfeed, nerve damage, and necrosis of the nipples.

416. In furnishing guidance, materials, and training that fail to disclose the material information described in Paragraph 415, Defendants have provided the means and instrumentalities for the commission of deceptive acts or practices.

417. Therefore, Defendants' practices as set forth in Paragraph 415 constitute deceptive acts or practices and the making of false advertisements in violation of Sections 5(a) and 12 of the FTC Act, 15 U.S.C. §§ 45(a), 52.

Count IV: Violations of the Alaska Consumer Protection Act (By Plaintiff State of Alaska)

418. Alaska repeats and realleges the facts above and incorporates them herein by reference.

419. Alaska brings this action for Defendants' violations of the Alaska Consumer Protection Act ("AK CPA"), AS § 45.50.471 *et. seq*. For these violations, Alaska seeks relief, including a permanent injunction, civil penalties, attorney's fees, costs and other appropriate relief as authorized by AS §§ 45.50.501, 45.50.551(b), and 45.50.537(d).

420. AK CPA specifies multiple acts or practices which, when conducted in the course

of business, constitute deceptive trade practices. AS § 45.50.471(b).

421. Defendants engaged in and continue to engage in deceptive trade practices in violation of AS § 45.50.471.

422. Defendants' false or misleading representations have affected the people of the State of Alaska causing harm.

423. Each deceptive act or practice as alleged herein constitutes a separate violation of AK CPA.

424. The Court should award injunctive relief and make all other orders or judgments necessary to prevent Defendants' deceptive trade practices or restore to any person any money or property acquired by means of such practices as authorized by AS § 45.50.501.

425. The Court should award civil penalties for each violation of AK CPA as authorized by AS 45.50.551(b).

426. The Court should award costs and attorneys fees as authorized by AS § 45.50.537.

Count V: Violations of the Iowa Consumer Fraud Act (By Plaintiff State of Iowa)

427. Iowa repeats and realleges the facts above and incorporates them by reference.

428. Iowa brings this action for Defendants' violations of the Iowa Consumer Fraud Act. Iowa Code § 714.16. For these violations, Iowa seeks relief including: a permanent injunction, civil penalties, disgorgement, attorney's fees, costs, and other appropriate relief as authorized by Iowa Code.

429. The Iowa Consumer Fraud Act specifies multiple acts or practices which, when conducted in the course of business, are deceptive trade practices.

430. Defendants engaged in and continue to engage in deceptive practices in violation of Iowa law.

431. Defendants' false or misleading representations have affected the people of Iowa, causing harm.

432. Each deceptive act or practice or course of conduct as alleged constitutes a separate violation of Iowa Code.

433. The Court should award injunctive relief and make all other orders or judgments necessary to prevent Defendants' deceptive trade practices and restore to any person any money or property acquired by means of such practices authorized by Iowa law.

434. The Court should award civil penalties for each violation and attorneys' fees as authorized by Iowa law.

Count VI: Violations of the Nebraska Uniform Deceptive Trade Practices Act (By Plaintiff State of Nebraska)

435. Nebraska repeats and realleges the facts above and incorporates them herein by reference.

436. Nebraska brings this action for Defendants' violations of the Nebraska Uniform Deceptive Trade Practices Act, Neb. Rev. Stat. § 87-301 *et. seq*. For these violations, Nebraska seeks relief, including a permanent injunction, civil penalties, attorney's fees, costs and other appropriate relief as authorized by Neb. Rev. Stat. §§ 87-303(b), 87-303.05, and 87-303.11.

437. The NE UDTPA specifies multiple acts or practices which, when conducted in the course of business, constitute deceptive trade practices. Neb. Rev. Stat. § 87-302.

438. Defendants engaged in and continue to engage in deceptive trade practices in violation of Neb. Rev. Stat. § 87-302(a).

439. Defendants' false or misleading representations have affected the people of the State of Nebraska, causing harm.

440. Each deceptive act or practice as alleged herein constitutes a separate violation of

the NE UDTPA.

441. The Court should award injunctive relief and make all other orders or judgments necessary to prevent Defendants' deceptive trade practices and restore to any person any money or property acquired by means of such practices as authorized by Neb. Rev. Stat. § 87-303.05(1).

442. The Court should award civil penalties for each violation of the NE UDTPA as authorized by Neb. Rev. Stat. § 87-303.11(1). The Court should award costs and attorney's fees as authorized by Neb. Rev. Stat. § 87-303(b).

Count VII: Violations of the Texas Deceptive Trade Practices Act (By Plaintiff State of Texas)

443. Texas repeats and realleges the facts above and incorporates them herein by reference.

444. Texas brings this action in the public interest for Defendants' violations of the Texas Deceptive Trade Practices Act, Tex. Bus. & Com. Code §§ 17.41-17.63. For these violations, Texas seeks relief, including a permanent injunction, civil penalties, restitution, attorneys' fees, costs, and all other appropriate relief provided by Texas law. *See e.g.* Tex. Bus. & Com. Code § 17.47.

445. The Texas Deceptive Trade Practices Act specifies multiple acts or practices which, when conducted in the conduct of any trade or commerce, are deceptive trade practices. Tex. Bus. & Com. Code § 17.46(a), (b).

446. Defendants engaged in and continue to engage in deceptive trade practices in violation of the Texas DTPA.

447. Defendants' false, misleading, and deceptive acts and practices have affected the people of Texas, causing harm.

448. Each deceptive act or practice as alleged herein constitutes a separate violation of

the Texas DTPA.

449. The Court should award injunctive relief and make all other orders or judgments necessary to prevent Defendants' deceptive trade practices and restore to any person any money or property acquired by means of such practices as authorized by Tex. Bus. & Com. Code § 17.47.

450. The Court should award civil penalties for each violation and costs and attorneys' fees as authorized by Tex. Bus. & Com. Code § 17.47 and Tex. Gov't Code § 402.006.

XVII. CONSUMER INJURY

451. Children and parents have suffered, are suffering, and will continue to suffer substantial injury because of the Defendants' violations of the FTC Act, the AK CPA, the Iowa Consumer Fraud Act, the NE UDTPA, and the Texas DTPA. Absent injunctive relief by this Court, Defendants are likely to continue to injure consumers and harm the public interest.

XVIII. PRAYER FOR RELIEF

Wherefore, the Plaintiffs request that the Court:

A. Enter a permanent injunction to prevent future violations of the FTC Act, the AK CPA, the Iowa Consumer Fraud Act, the NE UDTPA, and the Texas DTPA;

B. Award Alaska civil penalties, restitution, attorneys' fees and costs, and other appropriate relief as authorized by AS §§ 45.50.501, 45.50.551(b), and 45.50.537;

C. Award Iowa civil penalties, disgorgement, attorney's fees, costs, and other appropriate relief as authorized by Iowa Code;

D. Award Nebraska civil penalties and/or forfeiture for each violation of state law, and attorneys' fees and costs as provided under state law;

E. Award Texas civil penalties, restitution, attorneys' fees, costs, and all other

appropriate relief authorized by Texas law;

F. Award any additional relief as the Court determines to be just and proper.

Dated: August 18, 2026

Respectfully submitted,

FOR THE FEDERAL TRADE COMMISSION:

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EXHIBIT 1

DECLARATION OF SOREN ALDACO
Pursuant to 28 U.S.C. § 1746

I have personal knowledge of the facts set forth below and am competent to testify about them. If called as a witness, I could and would testify as follows:

1. I am over 18 years old, a woman, and live in Austin, Texas.

2. I was born in 2002 and grew up in Dallas, Texas. In middle school I lived with my mother and step-father, who was disabled and needed me to help him around the house. I did not go outside much and spent a lot of time online.

3. I first learned about cross-sex identity when I was approximately 11 years old, around 2012–2014, through online interactions on Nintendo devices.

4. This was a difficult time for me. I had trouble fitting in with my classmates and I went through puberty before most of them, which led me to feel self-conscious about my body. This discomfort was reinforced by exposure to social media and online pornography.

5. I liked the idea of being male. It seemed to offer an escape from the social challenges I faced at school, and it made sense to me because I enjoyed "masculine" hobbies like video games. I began using male avatars and going by male names online. Soon I also started binding my breasts some of the time, meaning that I created the appearance of a flat chest by wearing binders I bought online. Binders are rigid, restrictive garments shaped approximately like sports bras, with clasps on the side.

A Psychiatrist Validated My Online Identity

6. In December 2017, at age 15, I met my biological father for the first time. This caused additional emotional stress. The next month, these stressors culminated in a psychiatric episode. I was admitted to an inpatient psychiatric facility in Fort Worth, Texas.

7. While I was hospitalized a psychiatrist repeatedly questioned me about whether I identified as male. This was the first time a healthcare provider talked to me about my "gender identity." Before, being male had been a diffuse notion. But now it felt like something central to my well-being because a doctor was "affirming" it.

8. The psychiatrist did not meaningfully address my mental health conditions or help me deal with my complex family situation.

9. After my hospitalization, in the summer of 2018, I attended the Duke University Talent Identification Program, which was a summer camp for gifted teenagers. The adults in charge affirmed my male identity. I was housed with girls but otherwise treated socially as a boy. Nobody at the camp told my family about this, as far as I know.

10. I began spending weekends with my father, his wife, and their daughter (my younger half-sister). They supported me in identifying as male. Later in 2018, they began taking me to a support group called Transcendence International in the Dallas–Fort Worth, Texas area. At the support group we talked about

medical transition.

11. My father and stepmother attended a related support group for family members called Significant Others, Family, Friends, and Allies (SOFFA).

12. I was also seeing therapists during this time for issues including autism and ADHD. They mostly asked me questions about my male identity. They did not give me much counsel on my family dynamics or mental health issues.

13. I did not think of myself as male or female. But around most people I said I was male because it was easier to explain.

A Man from the Support Group Prescribed Me Testosterone

14. Through SOFFA, my father and step-mother met a nurse practitioner named Del Scott Perry. He attended the group and identified as the father of a transgender (adult) child who sometimes attended my support group. I learned that he prescribed cross-sex hormones to several kids I had met there.

15. When I was 17, around January 2020, my step-mother took me to Perry's clinic. The appointment lasted about 30 minutes, during which I filled out paperwork on an iPad and he took my vitals. There were no mental health professionals involved. Perry did not ask whether my step-mother had custody or medical decision-making authority over me (she did not).

16. I was not surprised that the appointment was perfunctory.

17. Perry prescribed me testosterone and an estrogen blocker and taught me how to inject the testosterone.

18. My mother's employer-sponsored Aetna health insurance covered the visit and drugs except for a $20 copay for the visit and a small amount for the drugs, which I paid. My step-mother took me to pick them up at CVS.

19. I did not ask my mother's permission or tell her about the prescriptions right away. We did not talk about it much when I did. I think she was not happy about me medically transitioning but had known for a while it was inevitable.

Testosterone Impacted My Body and Mind

20. I injected myself with testosterone the same day it was prescribed, in the kitchen with my father, step-mother, and sister gathered around. Soon I felt euphoric and energetic.

21. I began a routine of injecting testosterone every Wednesday before my shift at Starbucks. I called it "shot day" and looked forward to it all week because of how great I felt, physically and mentally, after the shot.

22. By Tuesday every week I would feel lethargic, tired, and depressed.

23. I also experienced physical changes such as voice deepening and facial hair growth.

24. I developed multiple health complications while on testosterone, including headaches, gastrointestinal issues such as gastritis and acid reflux, dizziness, chronic fatigue, hot flashes, rashes, and joint pain throughout my body. I also experienced injection site reactions, including itching throughout the week, warmth, and the development of scar tissue.

25. Testosterone wreaked havoc on my genitals. Soon after starting it my clitoris grew and developed excruciating cysts. I needed minor surgery to remove them. The health insurance company originally denied coverage because my sex marker was male, so it did not make sense for me to have a clitoris. (The cysts came back. Then I learned to wear different underwear, which seemed to prevent the problem.) Over the next year or so I developed vaginal atrophy, which meant the area was dry and painful.

26. I suffered intense mood swings while I was on testosterone. Around the end of 2020, I attempted suicide by overdosing.

27. Perry responded to my health complaints by referring me to numerous specialists, including gynecologists, neurologists, cardiologists, rheumatologists, and others. Many providers treated symptoms without identifying a cause.

I Paid a Surgeon to Remove My Breasts at 18

28. Beginning in my mid-to-late teenage years I wanted to have my breasts removed. In 2021, after turning 18, I pursued a double mastectomy.

29. I already had a therapist. I had told her about my suicidal ideation, both before and after using testosterone, and my history of being sexually abused. Now she affirmed my desire for surgery without question and wrote me a referral letter.

30. I contacted the Crane Clinic in Austin, Texas, paying approximately $200 for a phone consultation. During the consultation and preoperative process, I was

asked what I wanted and was told the clinic could provide it. I was informed about insurance options, including attempting appeals, but my Aetna insurance denied coverage because it was out of network. I signed a self-pay agreement for approximately $5,500, and the clinic assisted with appeal efforts. The clinic staff told me that they regularly helped patients successfully challenge insurance denials.

31. Ultimately the appeal was unsuccessful.

32. I saw that Crane billed my insurance over $20,000 for the surgery. Based on records I saw, I think Aetna paid Crane about $2,147.51. Then Crane refunded me $745.42. In total I paid Crane over $4,950.

33. In June of 2021, Dr. Ashley DeLeon performed my double mastectomy.

34. After surgery, I experienced severe complications, including extensive bruising across my chest and flanks, internal bleeding, swelling, and signs consistent with blood pooling. My concerns were initially dismissed by clinic staff, and my communications with the clinic resulted in delayed or inadequate responses.

35. As my condition worsened, including experiencing warmth, fullness, and dark bruising in my chest, I sought emergency care. I drove myself to UT Southwestern Hospital's Dallas location. I remained there for approximately eight hours before receiving treatment, except for minimal care to stabilize my condition.

36. The surgeon there who specialized in "transgender" operations refused to see

me that day. But clinicians from the oncology practice took my case, and they were very attentive. They cut my scars open, broke up blood clots that had formed, and drained blood and fluid that had accumulated. One of the assistants told me that my surgery had not proceeded within medical standards for mastectomy.

37. Following surgery, I required ongoing medical treatment, including additional procedures to address complications, scar tissue, and keloids (visible, overgrown scar tissue that extends beyond the original incision). I was mostly treated by breast oncology specialists; the "gender" surgeon only consulted on cosmetic issues.

38. During the entirety of this process, starting at the support group in the Dallas-Fort Worth, Texas area and while receiving medical transition treatments, including taking hormones and my double mastectomy, I learned about WPATH and its standards of care.

I Tried to Address My Health Problems

39. After these experiences I became concerned with improving my health. I wanted to get to the bottom of all my health issues. A rheumatologist told me that my joint pain was likely related to testosterone use, which made me wonder how else it affected me.

40. During this period, I was in a long-term relationship with another woman who identified as male. We began transitioning at approximately the same time and

attended hormone appointments together. We started dating when we were both around age 16, married a few years later in 2020, and divorced in 2021. I watched her mental health deteriorate over the years. In 2023 she assaulted me, then again in 2024. I now have a protective order against her.

41. During the winter of 2021-22 I still felt uncomfortable with my body and calling myself female. But I now saw my male/nonbinary identity as a way of running away from the discomfort. I decided to stop avoiding my discomfort and instead confront it, like a form of exposure therapy. I stopped taking testosterone and started acknowledging to people that I was female.

42. Some of my symptoms improved after stopping testosterone, although not all returned to baseline. I continue to experience ongoing health issues, including fatigue, joint pain, clitoral cysts, and a lot of pain and physical discomfort in my upper chest and shoulders. I also have nerve issues around my mastectomy scars. I get strong, weird sensations at the bottom of the scars.

43. I moved out of my childhood home in January 2022 and began focusing on improving my health and relationships, including making dietary changes and engaging in practices such as mindfulness. I earned a bachelor's degree from the University of Texas, winning an award for my thesis on social media's role in identity formation. I now study educational psychology as a graduate student at UT.

44. When I was transitioning, I believed that healthcare providers would only offer

me treatments that were safe and effective. But in hindsight, I think the clinicians who prescribed me transition drugs and performed my mastectomy were just giving me whatever I asked for. I regret taking their prescriptions and undergoing mastectomy.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on Aug. 17, 2026.

Soren Aldaco (Aug 17, 2026 09:10:53 CDT)

Soren Aldaco

EXHIBIT 2

DECLARATION OF CASSIDY ANDREWS
Pursuant to 28 U.S.C. § 1746

I have personal knowledge of the facts set forth below and am competent to testify about them. If called as a witness, I could and would testify as follows:

1. I am over 18 years old and reside in Marblehead, Massachusetts.
2. Online I sometimes use the alias "Claire Abernathy."
3. I am a 21-year-old woman. From around the age of 12 to 17 I considered myself male, "gender fluid," or "nonbinary." The latter two terms mean neither male nor female, and I considered them to be subcategories of "transgender" identities.
4. I was sexually abused by a family friend from around the age of 4 to 13, when my parents finally found out. At that time we were living near Dallas, Texas.
5. I started menstruating at 9 years old, which was earlier than my peers and caused me distress.
6. In middle school I felt afraid of becoming a woman and what that would mean, like being targeted by men and having a risk of becoming pregnant. I also felt self-conscious because I had large breasts. I wore G-cup bras by age 14.
7. Cross-sex identity was part of my cultural understanding as far back as I can remember. For example, I knew that the reality star Jazz Jennings was a "transgender girl" with a male body who was a few years older than myself.
8. Around age 11 I started researching alternative "gender identities" online. The idea of not being a girl appealed to me. In my mind, it meant being strong, not sexualized by men, and free of my breasts. I started compressing my breasts with binders (rigid, restrictive garments shaped like sports bras). I ordered them using gift cards for online stores like Amazon.

9. At 13 I told my parents I had a male "gender identity" and wanted to medically transition. They expressed skepticism, but they agreed to take me to a therapist to discuss it.
10. By this time I had developed anorexia. I hung out with a group of girls who would compete with each other over losing weight. Two of them identified as transgender before I did.

A Psychologist Advised My Parents that I Was Transgender

11. My parents took me to a therapist as they promised, Amiee Tanos. I told her I was a transgender boy and wanted to medically transition. My mother later told me that Tanos told her something like, "would you rather have a dead daughter or a trans son?"
12. Tanos referred me to GENECIS, a pediatric transition clinic in Dallas. I believe it was affiliated with UT Southwestern Medical Center.
13. Within a month, when I was still 13, my parents took me to see Dr. May Lau, an endocrinologist at GENECIS. She prescribed me Depo-Provera to suppress my period.
14. Dr. Lau said her colleague, a psychologist named Dr. Laura Kuper, could give me a diagnosis of "gender dysphoria" so that she (Lau) could prescribe testosterone.
15. In September 2018, when I was still 13 and in the 8th grade, I had an appointment with Dr. Kuper. She asked me a series of questions about my "gender." Her notes from that visit show that she filled out a checklist of seven items. Part of that document is attached as **Attachment 1**. The checklist included:
    - "A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)." The "yes" box is checked.

- "A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)." The "no" box is checked.

16. At the end of this appointment, Dr. Kuper told my parents I had "gender dysphoria" and the only treatment was medical transition to appear more masculine, meaning cross-sex hormones and surgery like double mastectomy.
17. My parents were skeptical. They asked Dr. Kuper if my distress with my body could be due to the sexual abuse I had experienced. Dr. Kuper said that was not possible because being sexually abused does not make a person transgender.
18. My parents asked Dr. Kuper how she knew that medical transition would help me. Dr. Kuper answered that WPATH recommended it. From the conversation, I understood WPATH to be an important medical organization.
19. Dr. Kuper told my parents that a large percentage of transgender kids try to kill themselves, but that number was greatly reduced if their parents "affirmed" them – meaning, if they consented to let doctors transition their child. This seemed to confirm what another therapist had previously said to my parents – that they could have a "dead daughter or a live son."
20. I had been cutting my wrists superficially. Dr. Kuper told my parents this was because I was transgender and they did not affirm me.
21. Dr. Kuper also told my parents that my eating disorder was due to being transgender.
22. I was in the room and heard Dr. Kuper say all this.
23. My told me later that she had expected Dr. Kuper to conclude I was not transgender. Dr. Kuper's conclusion that I was transgender surprised her. Since she saw Dr. Kuper as an

expert, and her advice was so dire, my mother then saw consenting to transition as a "no-brainer."

An Endocrinologist Prescribed Me Testosterone at Age 14

24. Dr. Lau prescribed me testosterone in November 2018, a week after my 14th birthday.
25. I told Dr. Lau I was interested in freezing my eggs (I had learned about that from a transgender YouTuber). She told me that would not be necessary to preserve my fertility.
26. One of the first changes I noticed was to my voice. Previously I had won awards for singing in the school choir and performing in musical theater. But after I started taking testosterone, not only did my voice become deeper, but I could no longer project properly. I could not scream. If I spoke continuously for a while, like giving a speech, my throat strained and felt weak. I began having nightmares of being in danger and unable to scream for help.
27. The clinicians had told me testosterone would lower my voice, but they did not warn me about the negative side effects.
28. Within months of starting testosterone, my clitoris enlarged. While I was warned about that, no one told me it would now chafe painfully against my clothing. I had to carefully choose underwear and pants that would not aggravate the problem.
29. I continued taking testosterone for about two years. My parents told me they paid between $3,000 and $4,000 out of pocket for visits to Dr. Lau and testosterone, and the rest was covered by our insurance.

I Pretended to Be Male at School

30. School officials knew about my medical transition and treated me like a boy. They let me use the boys' restroom and take athletics classes with boys. My classmates knew I was female. Most of the time, the boys seemed uncomfortable around me and would go easy on me in athletics class. (I am only five feet tall.) But once a group of them waited for me to be alone in the boys' locker room, cornered me, and taunted me in a sexually aggressive way.
31. I continued seeing Amiee Tanos during this time. Much of my conversations with her centered around being male and convincing other people I was male.
32. Throughout 8th grade, three more of my female friends adopted cross-sex identities.

Doctors Removed My Breasts at Age 14

33. I still felt self-conscious about my breasts. Now they were deformed from years of binding. I asked my parents for a mastectomy.
34. Three clinicians (Dr. Kuper, Dr. Lau, and Tanos) signed referral letters for me to receive a mastectomy from Dr. Alan Dulin, a surgeon affiliated with the American Institute for Plastic Surgery in Plano, Texas.
35. My parents were concerned, but Dr. Dulin's nurse assured my mother that the procedure would be easy for me because I was young. I was present for this conversation.
36. Dr. Dulin met me for about 15 minutes to discuss the procedure. Then he performed the mastectomy in June 2019, which was soon after I completed 8th grade. I was 14 years old.
37. My parents told me they paid $8,700 for my mastectomy.
38. Dr. Dulin's office did not show me the consent form (which describes risks and side effects) for mastectomy until the day of the surgery, after my parents had paid.

39. When I woke up from the surgery, I cried. It was hard to articulate why. Soon I had the realization that nothing had changed – I was not a boy and I had the same problems as before.

40. Recovering from the surgery was difficult. I was in a lot of pain at first and could not go out much for weeks.

41. I experienced complications from the surgery. My body rejected the nipple grafts, meaning they turned black and flaked off. Fluid built up behind them after my three-week follow-up appointment. I sent Dr. Dulin's office a message about this and they did not respond. The area was covered in sores. It looked gruesome and felt painful.

42. At the three-month follow-up appointment, Dr. Dulin made a face and said, "your nipples didn't do very well." He suggested that he could remove the grafts, leave the area smooth, and then tattoo nipples. I did not take that option.

43. To this day, I have strange and uncomfortable sensations in my chest. Around the scars, I feel an electrical sensation. When my boyfriend touches my chest, I feel pressure but I cannot say exactly where it is. In general I feel a vague pain in the area that I cannot locate. I do not have the erogenous sensation that other women describe having. I understand these issues to be caused by the mastectomy.

I Stopped Thinking of Myself as a Boy

44. In high school I started to think of myself more as nonbinary or genderfluid than male.

45. Around age 16 I stopped taking testosterone for a few reasons. First, I read that using it for four years could cause infertility – I knew I wanted to bear children. I read about that online; I did not hear it from my doctors. Second, I felt uncomfortable with the changes to my voice and body hair. Third, I researched online and found out my clinicians had

misled me. Medical transition is not the only treatment for girls like me who feel uncomfortable in their bodies.

46. At 17 I developed a crush on a classmate. I realized I wanted him to see me as a girl.

47. I moved with my family to another state during junior year of high school, in 2021. That helped me start over without a male identity. But it was still hard for me to explain myself to my parents because I did not want them to feel they had made a mistake. I knew how painful regret could be because that is how I felt.

48. Today I am a 21-year-old woman. I am studying for a career in child psychology. I hope to be a mother one day. I understand that if I carry a child, I will not be able to nurse him or her because of my mastectomy.

49. None of the clinicians, including Dr. Dulin, ever advised me that mastectomy would take away my ability to breastfeed in the future.

50. I underwent breast reconstruction surgery. The process began when I was 18.

51. I suffer from pelvic floor dysfunction and urinary incontinence. If my bladder becomes full, I experience intense pain. Sometimes I bleed from my urethra. Sometimes I lose control of my bladder entirely. There have been periods of my life when I had to wear adult diapers because of these urological issues. I did not have them before I started using testosterone, and I believe that is the cause. The clinicians did not advise me about any of these pelvic issues besides vaginal dryness.

52. My clitoris is still enlarged, and I still experience clitoral chafing. The pain has not subsided since stopping testosterone five years ago. I structure my wardrobe, movement, and daily life around avoiding genital discomfort. I understand that my only alternative would be an invasive corrective surgery that carries the risk of permanently destroying

sexual sensation in my clitoris. The clinicians did not warn me that clitoral growth could cause pain and discomfort.

53. I experienced vaginal atrophy while using testosterone, which means my vaginal walls thinned and my vagina lacked lubrication. I still suffer the consequences. Gynecological exams typically leave me injured and bleeding. Penetrative sex sometimes tears my vagina.

54. I now regret using testosterone and undergoing mastectomy. I feel that clinicians like Dr. Kuper and Dr. Lau misled my family and me by presenting medical transition as the only option to treat my distress and not warning me about many of the risks and side effects.

55. I share my story because I want families to understand the realities of medical transition for children so they can make more informed decisions.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on June 9, 2026.



Cassidy Andrews (Jun 9, 2026 16:19:41 EDT)

Cassidy Andrews

Attachment 1

DALLAS
1935 Medical District Drive
Dallas TX 75235

[redacted] Legal Sex: M
Visit date: 9/6/2018

09/06/2018 - Clinical Support in Dallas Endocrinology (continued)

Provider Notes (continued)

A. *A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:*

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics). ☒ Yes ☐ No
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics). ☒ Yes ☐ No
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender). ☒ Yes ☐ No
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender). ☒ Yes ☐ No
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender). ☐ Yes ☒ No

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning. ☒ Yes ☐ No

Criteria met: ☒ Yes ☐ No

Learning/Education	
Barriers to Learning	None
Preferred Learning Method	Reading, Listening
Patient Education Provided	Yes
Provided verbal communication to patient and mother on the following:	Explanation of the plan for care, treatment, and services Basic health practices and safety Safety plan
Response to education:	Patient and parents repeated information back in own words and acknowledged understanding.

Informed Consent
This clinician introduced herself, discussed her role as psychologist in the GENECIS program, and provided her name and contact information.

Discussed informed consent, limits of confidentiality, and record keeping with patient and mother. Patient and mother verbally expressed understanding regarding psychological services and mother provided written consent. A copy of the consent form for counseling and psychological services was placed in medical record. Provided the opportunity for patient and parents to ask questions.

I have communicated these findings directly with GENECIS team, patient, and parents and have formulated my plan and recommendations collaboratively with the GENECIS team. Please do not hesitate to contact me with questions or concerns or at the patient's request.

Laura Kuper, Ph.D.
Licensed Psychologist
Telephone: [redacted]

Electronically signed by Laura Elizabeth Kuper, PhD at 9/10/2018 10:29 AM

EXHIBIT 3

DECLARATION OF VANESSA SIVADGE
Pursuant to 28 U.S.C. § 1746

I have personal knowledge of the facts set forth below and am competent to testify about them. If called as a witness, I could and would testify as follows:

1. I am over 18 years old and reside in Houston, Texas.
2. I am a registered nurse. From June of 2021 until August of 2024, I worked for Texas Children's Hospital (TCH) in a multispecialty clinic.
3. For one day a week I worked with Dr. Richard Ogden Roberts, who is a pediatric endocrinologist. Many of his patients were minors seeing him for a type of treatment that TCH called "gender-affirming care." Dr. Roberts would prescribe them drugs affecting their sex trait development like puberty blockers and cross-sex hormones.
4. In total, I worked with about 20 to 30 transition patients and their families. Almost all were girls. Many of the charts showed that the patients had mental health diagnoses, for example, depression, anxiety, and a history of self-harm. Often Dr. Roberts prescribed a patient testosterone and puberty blockers in conjunction.
5. I was one of the nurses responsible for triaging Dr. Roberts' patients after they visited the clinic. That means that as part of my job responsibilities I responded to parents' messages, facilitated prescriptions, and dealt with insurance companies. I also reviewed his patients' charts and correspondence between him and the patients.
6. It was Dr. Roberts' regular practice to record notes in patients' charts when he saw patients. In my experience it was Dr. Roberts's consistent practice to write in a transition patient's chart that he told parents he was following WPATH's Standards of Care.
7. Once, Dr. Roberts noted that a patient's parents disagreed. One parent did not support medically transitioning the child. He wrote that he explained WPATH's Standards of Care

to the parent. Eventually he prescribed that patient cross-sex hormones.

8. In messages to parents, Dr. Roberts also frequently referenced WPATH.
9. I also observed some of Dr. Roberts' interactions with transition patients and their families in the course of my work.
10. I observed Dr. Roberts tell parents in person that there is a higher risk of a child harming herself if she is not "affirmed." By "affirmed," I understood Dr. Roberts to mean letting them use transition drugs and possibly undergo transition surgeries, like mastectomy.
11. I do not know of any case where Dr. Roberts declined to prescribe a transition patient the drugs or surgeries he or she asked for. I only know of one patient who did not proceed with medical transition after meeting him.
12. Many of the patient notes I reviewed in the course of my job responsibilities stated that Dr. Roberts had advised parents that puberty blockers are fully reversible.
13. I also reviewed parents' correspondence with Dr. Roberts in the course of my work at the clinic. The parents of transition patients often asked him about side effects their children experienced, most commonly pelvic pain, sweating, hot flashes, temperature irregularity, and acne.
14. Sometimes Dr. Roberts wrote referral letters for his underage transition patients to receive surgeries, like mastectomy. He used a template.
15. Most of Dr. Roberts' transition patients were referred to him by pediatricians.
16. Sometimes insurance companies would decline to cover transition drugs. I was expected to challenge the denials as part of my job. Sometimes I would succeed by submitting a letter signed by Dr. Roberts which claimed the treatment was "medically necessary."
17. TCH routinely recorded transition patients' sex incorrectly. Sometimes the state Medicaid

program would cover these patients' transition treatments even though state law banned such coverage. I reported this practice to state and federal law enforcement officials in May of 2024. I went public with these concerns in June of 2024.

18. TCH fired me in August of 2024. TCH told me verbally that I was fired at least in part because of my whistleblowing, in other words, my public statements about its billing practices.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on Jun 1, 2026.

vanessa sivadge
vanessa sivadge (Jun 1, 2026 14:09:01 CDT)
Vanessa Sivadge

EXHIBIT 4

DECLARATION OF CAROLINE MILLER
Pursuant to 28 U.S.C. § 1746

I, CAROLINE MILLER, hereby state that I have personal knowledge of the facts set forth below and am competent to testify about them. If called as a witness, I could and would testify as follows:

1. I am over 18 years old and reside in Festus, Missouri.
2. My son Lucas had a normal childhood. Growing up, he was interested in typical toys like Thomas the tank engine. He was an independent and creative child, and we had a good relationship.
3. Lucas is a performer. He likes to be the star of the show, and he liked being in theater at school. He also went through a period in middle school where he would frequently go to the nurse and complain of feeling dizzy or lightheaded. We took him to the neurologist who thought that he might have POTS, but the neurologist ultimately did not find anything wrong. Lucas was never diagnosed with depression or anxiety as a child.
4. In June 2020, Lucas was 13. Lucas told me that he was bisexual and that he hoped that I would still love and accept him. He asked me not to tell his father because he was not ready. I appreciated that Lucas chose to confide in me, and I was accepting and supportive. I told Lucas that I still love him, and that I would keep what he told me in confidence for as long as he needed. Lucas began wearing male clothing but with a more feminine aspect. I supported him in that. He also came home from a sleepover with girls with makeup on his face. The only thing that bothered me about that was that the makeup was applied badly. If he was going to wear makeup, I thought that he should have a more neutral look.

5. Without my knowledge, Lucas' father, my ex-husband, began taking Lucas to Children's Hospital St. Louis Gender Center for gender-related counseling, even though Lucas only identified as bisexual. He saw a psychologist named Sarah Girresch-Ward. I discovered this in the Fall of 2020.
6. My divorce decree with my ex-husband gave each of us equal custody over Lucas. It also required both of us to consent to medical treatment.
7. Around Christmas 2020, Lucas sent me a screenshot of something that he wanted for Christmas. It was some type of pin that I recognized as relating to transgender identity. I was surprised because Lucas had not said anything about being transgender. Lucas then began asking to go by she/her pronouns and to be called Arianna. Lucas did not have a direct conversation with me about being transgender. Based on my observations, I inferred that my ex-husband, with whom Lucas was primarily staying, was going along with Lucas being transgender by calling him a female name and using female pronouns.
8. My ex-husband and Girresch-Ward invited me to a meeting along with Lucas in July 2021.
9. At this point, Lucas was 14 and was not identifying as trans. He identified as non-binary, preferred to be called Alex, and used they/them pronouns.
10. The meeting was about half an hour to forty-five minutes. At that meeting, my ex-husband suggested that Lucas go on puberty blockers and Girresch-Ward supported that. Girresch-Ward mentioned bone problems, osteoporosis, and a threat to fertility. Girresch-Ward did not mention anything about other side effects or that this was experimental treatment. Girresch-Ward also did not present any alternative treatments.

11. I expressed concerns about these side effects, and especially Lucas' ability to understand them and to make decisions about something as important as having children at 14. Girresch-Ward suggested that we could freeze Lucas' sperm. It did not sit well with me that we were discussing freezing my 14-year-old's sperm because he might become infertile.
12. I also expressed that I did not see the point of a puberty blocker because Lucas was identifying as non-binary, and that I would not consent to estrogen or other permanent changes before Lucas was an adult.
13. Girresch-Ward then told me that Lucas was trying to figure out his gender identity, and that children who are not allowed to express their gender identity are much more likely to commit suicide.
14. Girresch-Ward also promised that puberty would resume as normal if Lucas changed his mind.
15. It seemed like Girresch-Ward was trying to rush and pressure me into consenting to a puberty blocker. Lucas had not been in counseling long, and had already gone from bisexual, to transgender, to non-binary in less than one year. I thought that he was trying to find his identity, so I did not want to consent to any treatment that could cause permanent damage.
16. I did not consent to the puberty blocker and left the meeting. Both Lucas and my ex-husband were upset with me and treated me like I was a terrible person.
17. In September 2021, I got a call from Karen Hamon, a nurse, who wanted to revisit the puberty blocker. We spoke for 45 minutes to an hour. I asked if anyone had given Lucas psychological testing, whether this was part of his prior attention-seeking behavior, or

what other screening had been done. Hamon acknowledged my concerns but did not address them. Hamon also said that puberty would resume as normal if Lucas decided to stop the puberty blocker.

18. At this point, I was worried that Lucas would commit suicide, and that it would be because I did not consent to the puberty blocker. I felt like I was under duress. I also thought that if all a puberty blocker is doing is pausing puberty and giving Lucas time to figure things out, I should consent. A couple of hours later I sent an email consenting to the puberty blocker. My ex-husband took him in for the procedure and he had the blocker implanted. This all happened in September 2021.
19. My relationship with Lucas improved. He turned 15 in October and we had a rainbow-themed party, and I did his makeup for homecoming.
20. Going into November and December 2021, Lucas' mental health declined. He was diagnosed with anxiety and depression, and put on medication.
21. As 2022 began, Lucas' anxiety and depression worsened. He also started having problems at school.
22. Lucas had good grades in his Fall 2021 semester which ranged from B- to A. But in the Spring 2022 semester, Lucas got no As and his grades dropped in each of his classes. For example, he failed Spanish after getting a B in the Fall, and his Algebra I grade dropped from an A- to a C. This persisted even into the Fall 2022 semester as five of Lucas' seven grades were in the C or D range.
23. Lucas' attendance also suffered. In the Fall 2021 semester, Lucas was absent from school for 6 days. In Spring 2022, Lucas was absent for 21 days.

24. Lucas was a shell of himself. He couldn't even talk sometimes. Doctors gave him additional medications to try and help his mental health, but they did not seem to work.
25. In April 2022, my ex-husband informed me that Lucas had threatened to kill himself. Lucas had suicidal ideation before, but this time he had enough of a plan that he needed to be hospitalized. The hospital put him on more medications. Nobody acknowledged the role that the puberty blocker might be playing.
26. Because I did not think that the puberty blocker was doing what Girresch-Ward and Hamon promised, I revoked my consent in June 2022. But because it would take surgery to remove the blocker, and my ex-husband did not consent to the removal, the blocker stayed in.
27. On July 28, 2023, Lucas reached the end of the treatment period for his blocker. They took the blocker out.
28. Since having the blocker out, Lucas has been doing much better. He is now 19, and he earned his High School Equivalency Diploma through the HiSET exam. He was excited when his voice deepened, is dating, has a job, and is living a normal life. He scored a 32 on his ACT, which I'm very proud of. He still goes by Alex, but he does not care what pronouns anyone uses. I use he/him. He says that he doesn't want to think about the time in his life when he had the puberty blocker anymore. Lucas is in regular counseling now and that seems to help. My relationship with my ex-husband has also improved.
29. In March 2023, I read an article by Jaime Reed in The Free Press describing her experiences as a case manager at the Washington University Transgender Center at St. Louis Children's Hospital. Reed's whistleblower account inspired me to reach out to her. I wanted to talk to somebody who cared about what was happening to my family.

30. The Free Press interviewed me for an article about our experience. A journalist also interviewed Lucas for about an hour. The Free Press published that article on April 3, 2023, entitled "'I Felt Bullied': Mother of Child Treated at Transgender Center Speaks Out."

31. Two States, Missouri and Ohio, asked me to serve as a witness for them in defending their laws against gender medicine for minors. I agreed in both instances because I thought that sharing my family's experience would help the judges understand the issue.

32. Although Lucas doesn't always agree with my criticism of gender medicine, we now have a strong and close relationship. I'm proud of the young man he's become and grateful that he did not continue treatment by the Gender Center.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on May 1, 2026.

Caroline Rose Miller (May 1, 2026 11:14:49 CDT)

Caroline Miller

EXHIBIT 5

DECLARATION OF ELISABETH BOURNE
Pursuant to 28 U.S.C. § 1746

I have personal knowledge of the facts set forth below and am competent to testify about them. If called as a witness, I could and would testify as follows:

1. I am over 18 years old and reside in Davis, California.
2. My ex-husband and I moved back to Davis in 2007 to raise our daughter and son because we felt at home in its progressive, college-town culture. We sent our kids to public schools. In 2011, we divorced and began sharing custody.
3. When my daughter was in the sixth grade, she started cutting herself. She seemed to have been traumatized by a sexual assault and emergency-room visit experienced by a close friend. She was put on an anti-depressant, Lexapro.
4. Near the end of the sixth grade, my daughter announced that she was bisexual.
5. My daughter started reading books about transgenderism. Several of her female friends declared themselves "transgender" at school. Later I found out that my daughter did too.
6. Around the beginning of the eighth grade, my daughter was cutting herself severely, which required a trip to an emergency room in or around October 2018.
7. In or around November 2018, when she was 13 years old, my daughter sent me a letter declaring that she was transgender, had adopted a new male first name, wished to have male pronouns used when referring to her, and wanted to socially transition at school. She also requested a chest binder but not medical-transition treatments.
8. By this time, in or around late 2018, my ex-husband and I were sharing custody of our children 50/50.
9. After we all learned the potential side-effects of puberty blockers and cross-sex hormones, my daughter, my ex-husband (who consistently affirmed our daughter's transgenderism), and I agreed that she could socially transition at school but would not medically transition until after she turned 18. I referred to her as "Ian," which was the male name she adopted. I also later consented for her to take Depo-Provera to stop her periods, which she requested, to feel more like a boy.
10. My daughter's teachers and counselors "affirmed" her new "gender identity" and put a "support plan" in place—in other words, they socially transitioned my daughter by using male pronouns and her new male first name. I felt that I did not have a choice but to consent to my daughter's social transition at school because I was worried that she might want to live with her father if I didn't. At the time, I did not want to appear unsupportive of my

daughter's transgenderism to the California schools or courts, out of fear of losing my custody rights.

11. In January 2019, my daughter emailed her father and me saying that she wanted puberty-blocking drugs. She said she knew such drugs are safe, citing Planned Parenthood and the Endocrine Society.

12. I was shocked by all of my daughter's announcements about her transgenderism. The situation was surreal and bewildering to me and challenged by ability to parent my own daughter because none of it made any sense to me.

13. My ex-husband affirmed our daughter's transgender identity, as did his extended family. They told me that she needed "gender-affirming care," by which they meant medical-transition interventions like puberty blockers and testosterone. But I soon discovered that this phenomenon—minors, most often teen girls, suddenly adopting transgender identities—was becoming increasingly widespread. This made me think I should learn more about gender dysphoria and the treatments for it.

14. In or around November 2019, when my daughter was around age 14, she started experiencing dizziness spells, so my ex-husband and I took her to a pediatrician at Kaiser. Following the practice of my ex-husband, the pediatrician used male pronouns when speaking to my daughter and referred to her using a male name. The pediatrician also enthusiastically asked my daughter if she wanted to change her medical records to indicate her sex as male. She agreed, so her medical records were altered to indicate that my daughter was now my son. The pediatrician then asked my daughter if she wanted a consultation appointment with the Kaiser Oakland gender clinic, which the pediatrician described as a "one-stop shop" for gender-affirming care. My daughter seemed excited about the invitation.

15. I was soon connected with a Kaiser endocrinologist, Francis Hoe, M.D., at Kaiser Permanente Roseville Medical Center, in Roseville, California.

16. Dr. Hoe told me that science shows medical transition reduces the risk of suicide and diminishes suicidal ideation among pediatric patients. He did not disclose to me any specific side effects of puberty blockers or testosterone.

17. Dr. Hoe claimed that my daughter likely would "feel better" if she stopped having periods and started attaining masculine physical traits through cross-sex hormone therapy.

18. Dr. Hoe stated that Kaiser had no handbook or standardized procedures for treating children or adolescents with hormones and that he follows the recommendations of WPATH and the Endocrine Society in his medical practice.

19. I asked Dr. Hoe for citations to supporting studies and other evidence. Shortly after our call, he sent me an electronic message that included, among other information, links to transition

guidelines from WPATH and the Endocrine Society. I clicked the links in this message and read through the information. A true and correct copy of Dr. Hoe's message to me, dated November 19, 2019, is attached hereto as **EXHIBIT A**, with my daughter's first name redacted for privacy. (The yellow highlighting was added by me.)

20. I asked my children's Kaiser pediatrician, Who would you refer a parent of a gender-dysphoric child to? The pediatrician mentioned PFLAG and other parent support groups, such as Gender Spectrum. All these groups advocate for medical transition to treat gender dysphoria in kids.

21. My ex-husband and I disputed for years over whether to let our daughter medically transition. We wound up litigating the issue. I won and retained my rights, so Kaiser could not medically transition my daughter without my consent. The legal battle cost me approximately $10,000 in attorney fees and costs.

22. My daughter seemed to view me as the bad guy. Following her 17th birthday celebration, near the beginning of her senior year in high school, my daughter sent me a written letter stating that she was cutting off all contact with me. That was devastating. But I was still able to see her at school events over the next year, for example, by serving as a chaperone for her choir class. I saw that she started putting on makeup, growing her hair long, and wearing dresses and feminine clothes. I am tremendously relieved, in part because some of my daughter's classmates had double mastectomies and, based on my understanding from communications I received from Kaiser, I believe that my daughter had contacted Kaiser about possibly having "top surgery."

23. Now my daughter is 20 years old, identifies as genderqueer, and as far as I know has never used testosterone or undergone transition surgery. On Instagram, she says her pronouns are they/them. She has chosen a new name for herself since beginning college (her fourth name overall). She seems to be flourishing. I believe I did the right thing by standing between her and medical transition when she was underage.

24. My own research and our family's experience made me suspicious of pediatric medical transition. At least two of my daughter's adolescent friends had double mastectomies as treatment for gender dysphoria. I wonder, Were the surgeries necessary? What if these young women have children one day and want to breastfeed?

25. Over the last few years, I have spoken at school board meetings and rallies, and testified before state legislatures, to challenge the belief that some kids are born in the wrong body and should medically transition.

26. My activism has cost me friends. Most painfully, I think it is why my daughter remains distant from me. But I can't just be quiet. I hope my daughter will understand and forgive me someday.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on Jun 6, 2026, 2026.

Elisabeth Bourne (Jun 6, 2026 23:13:53 PDT)

Elisabeth Bourne

EXHIBIT A



From: FRANCIS MYATUKASAE HOE MD
To: BETH BOURNE
Sent: Tuesday, November 19, 2019

Message body: Dear Ms. Bourne,

I appreciate the conversation we had recently about [redacted]

As you requested, here's the online links for some guidelines from different professional medical organizations for providing transgender care:
Endocrine Society: https://academic.oup.com/jcem/article/102/11/3869/4157558
WPATH: https://wpath.org/media/cms/Documents/SOC%20v7/Standards%20of%20Care_V7%20Full%20Book_English.pdf

In addition, here is a link for Gender Spectrum, a very good organization in the bay area that advocates for transgender youth.

If you have any additional questions, feel free to email me or call me at (916) 474-2250.

FRANCIS MYATUKASAE HOE MD
Pediatric Endocrinology
Kaiser Roseville

EXHIBIT 6

DECLARATION OF CLEMENTINE BREEN
Pursuant to 28 U.S.C. § 1746

I have personal knowledge of the facts set forth below and am competent to testify about them. If called as a witness, I could and would testify as follows:

1. I am over 18 years old, a woman, and reside in Los Angeles, California.
2. In sixth grade, when I was about 11 or 12 years old, I saw a counselor at school every other week. I was struggling with making friends and felt uncomfortable about starting puberty. I disliked growing body hair, but at the same time, I did not want to shave it because I just wanted to avoid dealing with my body. At approximately 5-foot-8, I felt self-conscious about my height. Other girls at my private school in Los Angeles wore tight and revealing outfits, like crop tops, but I preferred baggy clothing.
3. In hindsight, I think my anxiety and discomfort with my body were symptoms of trauma. I was sexually abused by a fifth-grade boy at school when I was in first grade. My counselor did not ask whether I had experienced anything like that, and I did not tell her.
4. By researching my feelings online, I came to believe that I had gender dysphoria and might be transgender. I reported that to my counselor, and she immediately echoed my belief that I was male. Eventually she told my parents what I had told her (without my permission).
5. My parents set up an appointment with the transition clinic at Children's Hospital Los Angeles. They told me at the time that they expected CHLA to determine I was not transgender since I had preferred "girl" clothing and toys as a child.

Children's Hospital Los Angeles Told Me I Was a Boy

6. At CHLA, in December of 2016, my parents and I met with Dr. Johanna Olson-Kennedy. I was 12. She acted very kind toward me.

7. First, I spoke with Dr. Olson-Kennedy privately. She asked me about my hobbies, interests, and friends. I told her I enjoyed video games and running track and my friends were mostly boys. She also asked my feelings about going through puberty. I told her the thought of growing breasts and having sex disgusted me. Dr. Olson-Kennedy told me that was typical for kids with gender dysphoria, and it meant I was probably a boy.
8. Dr. Olson-Kennedy explained to me that "transgender" people were born "in the wrong body." From what Dr. Olson-Kennedy told me I concluded that "transgender" people had to use medication to correct their body as much as possible. For many years after that conversation, I thought of myself as male – literally a boy or man.
9. Next, Dr. Olson-Kennedy met with parents and I waited outside. A few years later, they told me that she told them I was suicidal and firm in my male identity. Neither was true.
10. Next the four of us met together. My father looked upset. My mother was crying.
11. Dr. Olson-Kennedy spoke to my parents on my behalf, which I appreciated because I was feeling overwhelmed. She told them the only treatment for gender dysphoria was "affirming" me as male, which required hormone therapy. My parents asked if I could try talk therapy instead. Dr. Olson-Kennedy said no, that would not work. Her tone toward them was cold and confrontational.
12. Dr. Olson-Kennedy told us she could prescribe a puberty blocker. That would help me test out how I felt about medicalizing my male identity, give me a few years to think about my "gender," and put a "pause" on puberty. She did not explain how the drug would affect my body except for cosmetic issues, like stopping chest development and hair growth. She also said it would prevent me from getting a period (I had not started

menstruating yet). That was appealing to me because I felt anxious about becoming pregnant if I were ever assaulted again.

13. Dr. Olson-Kennedy never asked me about my past traumas or current home situation. In addition to my past trauma of sexual abuse, my home situation was stressful because my brother, who was about 19 at the time, was severely autistic and sometimes violent toward my parents and me.

14. My parents initially refused to consent to a puberty blocker. But after they had another appointment with Dr. Olson-Kennedy, they soon consented to Dr. Olsen-Kennedy administering a puberty blocker.

15. I had a Lupron puberty blocker implanted in my arm in November or December of 2016, when I was still 12. The procedure took less than thirty minutes and involved a topical numbing agent.

16. After the blocker was implanted, I felt sluggish and experienced brain fog. I could not concentrate and was a poor student. A few times a week I'd experience a hot flash of about 15 minutes. Sometimes a hot flash would wake me up at night.

Testosterone Made Me Confident and Popular

17. In September of 2017, when I was 13, Dr. Olson-Kennedy suggested I should use testosterone to stay "on track" with my male peers. I felt hesitant at first, but then I agreed because she said starting testosterone now would make it easier to pass as "cis male" later in life.

18. Dr. Olson-Kennedy prescribed me testosterone in January of 2018, when I was still 13 and in the seventh grade. The puberty blocker remained in my arm.

19. At first I was scared to handle the injections myself. I got the hang of it but still hated the routine.

20. I felt great when I started testosterone. Before, I had never fit in at my private school in Los Angeles. But when I started identifying as male and appearing more masculine, I joined the popular crowd. My classmates knew I was transgender and almost all seemed to approve. The same baggy clothes that had made me stick out as a girl now made me fit in as a boy.

21. My personality changed after starting testosterone. Before, I had been a big reader and very polite. Now I was a horrible student and joined the popular kids in bullying outcasts. I especially picked on a classmate who did not believe in the idea of "gender identity" determining sex. I would call him out in class for his views, make fun of him, and get people to laugh at him. I felt like I was entitled to be cruel to him because he did not believe I was a boy.

22. I experienced wild mood swings while on testosterone. Once in tenth grade I screamed at a classmate so viciously that she sobbed. The teachers ordered me to apologize and I refused. She had just bumped into me by accident, and I reacted by unleashing a torrent of insults at her.

23. Soon after starting on testosterone I developed painful acne all over much of my body, including my back, face, and chest.

24. My vagina became dry and painful. I had to quit track and cross country in ninth grade because of the pain.

25. Dr. Olson-Kennedy had mentioned the risk of vaginal atrophy when she first prescribed testosterone, but I did not know what "atrophy" meant at the time.

My Therapist Called My Parents "Transphobic"

26. After my parents agreed to the blocker, Dr. Olson-Kennedy referred me to a therapist, Susan Landon. Dr. Olson-Kennedy and Landon jointly ran a support group for transgender youth and their families that I attended.

27. Around age 12 to 14 I would complain to Landon that my parents did not fully support my transition because they did not consistently refer to me as male and my father would tell me I could change my mind about blockers and hormones any time.

28. Landon agreed with me that my parents were "transphobic." I thought they hated me for being transgender.

29. I saw Dr. Olson-Kennedy for short visits every few months. She also agreed with me that my parents were transphobic.

30. In eighth grade, when I was 14, I participated in musical theater. An upperclassman in the cast began pursuing me. At first I wanted to be friends with him, but then he began stalking me and coercing me into sex. If I was not willing to perform an act, he would slam my face into a wall or punch me in the stomach. This went on for several months. Sometimes it happened in the boys' bathroom or changing room, which I had to use because of my male identity.

31. I told Landon about this abusive relationship as it was ongoing. She did not give me any useful advice or report the assaults. At our sessions, we mostly talked about my transition.

32. I felt that I had been victimized because I was female, and the solution was to push ahead in my transition. By mid-way through eighth grade I felt like, *I need to have top surgery right NOW.*

33. Landon signed a referral letter so that I could receive a double mastectomy that spring, before eighth grade graduation. She did not ask any probing questions about why I wanted one.

A Surgeon Removed My Breasts While I Recovered from Sexual Assault at 14

34. Dr. Olson-Kennedy recommended that I seek surgery from Dr. Scott Mosser at the Gender Confirmation Center in San Francisco. That was far from my home in Los Angeles, but she said he was "the best" and that he had experience performing surgery on kids who were taking puberty blockers.
35. Dr. Olson-Kennedy and Landon provided referral letters for me which said their "[d]iagnoses and treatment were conducted in accord with the standards of the World Professional Association for Transgender Health (WPATH)."
36. Dr. Mosser did not ask me questions about my mental health or why I wanted the surgery.
37. I found out later that my parents paid out of pocket for the surgery, about $15,000 or $20,000. They told me they paid because Dr. Olson-Kennedy had said I might kill myself otherwise.
38. On May 14, 2019, at St. Francis Memorial Hospital, Dr. Mosser and his colleagues put me under anesthesia and amputated my breasts. I was 14 years old and in the eighth grade.
39. Going into surgery I felt emotionally numb. Dr. Olson-Kennedy and Landon assured me it would be easy. I did not research the surgery myself.
40. When I woke up from anesthesia, I felt like I had been hit by a truck. My chest ached despite the opioids I had been given. The hospital sent me home that day.

41. The first five weeks after surgery were brutal. I could hardly move my arms. I missed a lot of school and could not enjoy my eighth-grade graduation because of the pain and discomfort.

In Ninth Grade I Became Psychotic

42. For years leading up to the mastectomy I had trouble sleeping. Afterward, it got worse. I could barely sleep at all and felt restless all the time.

43. As ninth grade started, I was still hanging out with the popular kids and being treated like a boy. But I felt uncomfortable using the boys' bathroom. I felt distracted by little things in the corner of my eye, like people watching me. I started believing that people were stalking me. I would feel a bug crawling on my skin, then realize there was nothing there. I had panic attacks. For the first time, I began contemplating suicide.

44. It felt like there was something inside me that I could not get out. I began cutting myself.

45. I told Dr. Olson-Kennedy about these new mental problems during an appointment at her office with my parents. She advised my parents to bring me to a psychiatrist. My parents asked her whether testosterone could be causing the deterioration in my mental state. She dismissed their concerns.

46. My parents brought me to a psychiatrist. He prescribed Zoloft but my symptoms continued. In January I reported to the psychiatrist that I was hallucinating "small people" and "spiders" and experiencing migraines.

47. In February of 2020 I visited Dr. Olson-Kennedy. She described my psychiatric condition as "Appropriate mood and affect, Cooperative, Normal Judgment."

48. Soon afterward, the covid-19 pandemic began. I attended school virtually and did not leave my neighborhood much.

49. In March of 2020, I experienced intense delusions that my parents were demonic forces set against me. I would spend all night pacing up and down my street. I chain smoked, cut myself, and picked the scabs. I was tormented by hallucinations of shadow people, bugs, and distorted human faces.

50. In the summer of 2020 my father found me after I had slit my wrists in the bathroom. My psychiatrist prescribed me various anti-psychotic medications after this, which slowly began to improve my mental health.

51. Throughout this period of psychosis, Dr. Olson-Kennedy continued prescribing me testosterone. In fact, she increased my dose.

I Became Skeptical that I Was Male

52. I finally stopped hallucinating and feeling paranoid in 2022, when I was 17. By that fall, when I was a senior, I came off the anti-psychotic medications.

53. Around this time, Dr. Olson-Kennedy advised me that I should get a hysterectomy to affirm my male gender. My instant reaction was *NO, ABSOLUTELY NOT!* It seemed crazy to take organs out. She continued to advocate that I should get a hysterectomy. This conversation led me to find a new gender specialist because I felt uncomfortable with Dr. Olson-Kennedy.

54. I felt relieved to be off the anti-psychotic medications – which had strong side effects and made me feel numb – and this led me to question whether taking testosterone was worth the harm it did to my body. I asked myself, can I heal without T? What am I even healing?

55. The next year, as a freshman in UCLA's arts program, I started tapering off testosterone without consulting a doctor.

56. As I used less testosterone, I started to feel a lot better. I became less angry and intense. My acne diminished. I also got my period for the first time. I did not know what was happening and felt horrified.

57. That same year, I began talking to a therapist for the first time about being sexually abused as a child. I realized that experience had made me feel weak, like being a girl made me vulnerable, and that was why I hated being female for years afterward.

58. In December of 2024 I sued Dr. Olson-Kennedy, Dr. Mosser, and others involved in my transition for medical negligence. One reason I filed the lawsuit was because I want other families to learn from my experience. This set off a wave of verbal abuse against me online. I received messages saying I deserved to be raped again, I was a "transphobic cunt," and "kill yourself."

59. Many of the messages came from former friends I had met years earlier at a transgender summer camp. One had previously confided in me that she was disappointed in the results of her genital surgery and worried about her ability to have sex and find a partner. (I am using this person's preferred pronouns; the surgery involved the removal of male genitals.) Her message to me after I filed my lawsuit was vicious.

60. Today, my chest area is still weak and strange-feeling, and I have limited range of motion in my arms. My voice is deep. I have been told I might not be able to bear a child because of the puberty blocker and five years of testosterone use. My parents and I are finally on good terms. Last year I apologized to the middle school classmate I bullied for believing I was a girl.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on 6-12-2026.

Clementine Breen (Jun 12, 2026 11:10:12 PDT)

Clementine Breen

EXHIBIT 7

DECLARATION OF JONATHON SKINNER
Pursuant to 28 U.S.C. § 1746

I, Jonathon (Jonni) Skinner, hereby state that I have personal knowledge of the facts set forth below and am competent to testify about them. If called as a witness, I could and would testify as follows:

1. I am over 18 years old and reside in Michigan.
2. I was born in 2002 and grew up in small towns in southwest Michigan.
3. I am a gay man. As far back as I can remember, I have been feminine. From preschool onward I played kiss and tag with boys, my closest friends were girls, and I looked up to Disney princesses.
4. I was also just a regular kid. I loved gardening, playing in the woods, and drawing.
5. Once in preschool I held a boy's hand. This seemed to alarm the adults at school. They taught me that boys do not hold hands with each other and they kept us apart from then on. It was embarrassing.
6. My older brother, grandfather, and uncle used to tell me to "man up" and "stop acting like a sissy" when kids bullied me. Teachers would encourage me to defend myself, too. But I would just run away. I have never had any interest in physical conflict.
7. I always felt set aside and ridiculed for being different as a child. In hindsight I think of my effeminacy as natural – lots of gay men like me have similar childhood memories. But at the time I understood from adults that my gender-nonconformity was a symptom of autism, which I had been diagnosed with around age 4. They said I was confused about being a boy.
8. Christianity was a big part of the culture in my town. Around age 7 I became devout myself. While I found religion comforting in some ways, in other ways it was upsetting – I was aware of Leviticus's proscription on homosexuality from a young age, and I sensed

it applied to me. My pastor publicly said gay people were damned to hell and it seemed like the congregation agreed. I felt shunned at church.

9. In fifth grade I began attending a tiny Lutheran school. We once spent class discussing how the legalization of gay marriage was a sign of the end-times.

10. In middle school my older brother joked about me getting AIDS and asked me, "are you going to go around fucking dudes?" My mother's boyfriend at the time was vehemently opposed to gay relationships. My grandfather had been calling me names as far back as I can remember, like the F-slur. When a gay character would show up in one of our favorite TV shows, like Family Guy, the men in my home would often change the channel.

11. Getting through the school day was hard for me. Not only was I bullied for not fitting in, but I suffered from intrusive thoughts like scenes from a scary movie suddenly popping up in my head, or obsessing over feeling like a burden. I also experienced panic attacks.

I Did Not Want to Be Gay

12. By around age 12, I knew I was probably gay. I looked online for people to talk to about it.

13. Adult men would chat with me online. I already had a negative view of gay men from my family and church, and these icky interactions reinforced it. I sensed they saw me as a twink (a stereotypically ditzy young gay boy). It seemed like gay culture only valued feminine males for a few years while they were very young, and then they aged into irrelevance. My dream for the future was to marry a man and live a normal life.

14. I did not like how my appearance was changing – I felt like a troglodyte. I could not stand to have other people looking at me.

15. Online I learned about being transgender from influencers like Jazz Jennings and Gigi Gorgeous. Their childhood stories seemed similar to mine. Now they showed off that they had boyfriends, implying that was impossible when they were a "gay boy."

16. Then my math tutor [redacted], a family friend who was about ten years older than me, told me that she was transgender. She told me about a clinic that was helping her medically transition. Before that I had understood her to be a lesbian – everyone knew that about her. Seeing the excitement that [redacted] felt over being transgender, in addition to what I saw online, made me feel encouraged to take the next step.

17. At age 13, in February of 2016, I called my mom while she was at work and told her I thought I might be transgender. I also told her I was attracted to boys. Going into the call I was extremely nervous and sweating profusely, but she reassured me. She said I could grow my hair out and experiment with makeup, and she would love me no matter what.

I Sought Acceptance at an "LGBT" Medical Clinic

18. My mom set up an appointment for me with the gender clinic at Mott Children's Hospital, which was affiliated with the University of Michigan. It was about a four-hour drive from our home.

19. I felt hopeful. I imagined the clinic would be an "LGBT"-friendly environment that could connect me to older members of the community and provide counseling to help me figure myself out. I did not view it as someplace that would automatically recommend medical transition.

20. At my first appointment with the clinic, I met with a counselor named Sara E. Wiener. We had a long conversation about my effeminacy and feelings about boys. She said I had a "feminine essence."

21. Wiener reinforced my fears about being gay. She said that society did not accept effeminate men, and gay men were hostile toward effeminacy, too. I had the impression that one way or another, I would have to "man up" to be accepted. After this discussion I told her I could not picture a happy future as a gay man. "It is dark and sad and I do not want to live that way." She recorded this line in her notes.

22. Wiener also recorded:

> Jonathon meets DSM 5 criteria for Gender Dysphoria, and he meets WPATH Standards of Care version 7 criteria for the initiation of cross sex hormones.

23. Within a few weeks my mother and I met with the clinic's director, an endocrinologist named Dr. Daniel Shumer. Wiener was there too. I told them about the shame and fear I felt about being attracted to boys. They confirmed that being a feminine gay man was hard and told me that liking boys was a sign of a female gender identity.

24. Dr. Shumer explained to me that I was not a gay boy because gay boys had male brains. I ended up with a female brain, he said, because as a fetus I was not exposed to enough testosterone at a certain stage. He drew a diagram of a fetus or embryo on a whiteboard as he spoke. It made perfect sense to me.

25. For years after that conversation, I viewed my body as defective because I thought it was supposed to be female.

26. Dr. Shumer told me that cross-sex hormones had been used since the 1960s with great success and carried hardly any permanent or damaging side effects.

27. Dr. Shumer told me that cross-sex hormones would give me female musculature, enabling me to experience multiple full-body orgasms. He said this would make my sexual experiences better. At that point, I had never dated anyone or had an orgasm.

28. Dr. Shumer told my mom, in front of me, that 60% of transgender kids kill themselves if they are not medically transitioned. I took that to mean going through puberty would make me miserable. I already felt nervous about puberty, and that was like pouring gasoline on the fire.

29. During some of my appointments at Mott I was given grocery cards and cash. For the cash, they said it was for participating in a study.

30. When I first started medically transitioning, Dr. Shumer told me I was part of a long-term study on youth transition. I filled out online surveys about my experience for the study. The questions were about subjective matters like whether I felt happy and what my preferred pronouns were. But Mott stopped sending me them at some point.

31. The men in my family accepted the idea that I was a transgender girl. They did not bully me for being transgender the way they had for being a feminine boy. My brother was the first person in my personal life to consistently use she/her pronouns for me, and then my uncle.

My Health Deteriorated on Transition Drugs

32. Dr. Shumer prescribed me Spironolactone to inhibit my testosterone uptake in the summer of 2016. Within a few days I passed out at my grandmother's house with a hot flash. I was also suffering from dizzy spells. Dr. Shumer cut my dosage and then, about six weeks later, prescribed estrogen.

33. By now I was desperate not to develop masculine characteristics. Dr. Shumer told me that if I did, I would not be able to blend into society as a woman. I felt that I needed to hit pause. I was still 13.

34. Dr. Shumer suggested I also use a puberty blocker to prevent my body from producing testosterone. In November of 2016, when I was 13 or 14, I asked him questions about possible side effects (my mother had told me to). He said I could avoid taking medications to lower my testosterone levels by undergoing an orchiectomy after I turned 16. He described that procedure as removing my gonads and said it was more efficient treatment than medication at lowering testosterone levels.
35. The Spironolactone made me leak urine during the day, so I did not want to stay on that. Dr. Shumer prescribed a puberty blocker instead when I was 14, which he surgically implanted in my arm. I soon began experiencing hot flashes, night sweats, severe pains around my genitals (like the area was sharply seizing up), and full-body charlie horses. The muscle spasms made it impossible for me to ride my bike. I could not keep weight on because I had no appetite.
36. In 2017 my urine was strawberry colored and seemed to contain flakes of skin. It felt like I was dissolving inside – that is how painful it felt. This went on for months. Eventually the urine was dark red.
37. Dr. Shumer said this symptom was not from the puberty blocker. He did not offer any other explanation. In 2018, another doctor found I had a lesion on my bladder.
38. I googled the puberty blocker, Histrelin, and saw one of the listed side effects is blood in the urine.
39. Throughout this time I was also dealing with urinary incontinence, which meant having accidents in class. I wanted to see a specialist but worried that they might be biased against me for being feminine or transgender. Dr. Shumer recommended that I see his

colleague, Dr. Bryan Shanley Sack, at the University of Michigan Pediatric Urology Clinic.

40. In October 2018 I visited Dr. Sack. He did not give me any useful advice or prescription. My mother asked him if there were any connection between transition drugs and hematuria or incontinence. Dr. Sack insisted the answer was no. He said that these drugs had been used for decades. He wrote in my chart:

> I suspect her symptoms are secondary to dysfunctional social voiding / holding onto urine. She reports she will often hold onto her urine for long periods of time (due to issues with bathroom use at school).

41. I did not believe that "issues with bathroom use at school" caused my incontinence. I used the restroom in the nurse's office. I had always done that, even before I transitioned, because of germophobia. I could not have gone long periods without using the restroom even if I wanted to because of incontinence. I felt like my muscles were too weak to hold my urine.

42. I later read that in February 2026, Dr. Sack was arraigned on six felony charges related to possession of "child sexually abusive material."[1]

43. After Dr. Sack diagnosed my problem as "dysfunctional social voiding," Dr. Shumer wrote a letter to the school about my bathroom access. School officials took away my key to the nurse's office to encourage me to use the girls' room. (They were very supportive of my transition.)

44. Finally I got the puberty blocker removed from my arm in late 2018 when I was almost 16. Within a few months I stopped urinating blood.

[1] https://www.cbsnews.com/detroit/news/ann-arbor-doctor-arrested-child-sexually-abusive-material-charges/

45. My appointments at Mott were often unsatisfying. I did not get all my questions answered. The clinicians, including Dr. Shumer, were always talking about my appearance. Dr. Shumer would tell me how "pretty" I looked, for example, or explain how I could get face surgery in the future to shave down my brow (he said the University of Michigan would perform the operation on 16-year olds). I felt like they saw me as their art project.

46. Dr. Shumer prescribed Spironolactone again to inhibit my testosterone. Since it caused incontinence and I read online that it caused organ damage, I did not take the full dose. After a few years I stopped altogether.

47. Beginning at 13 I was also prescribed estrogen. For a time I was also on progesterone. I grew breasts that looked similar to a woman's.

48. For years while on estrogen I had a painful knot in one of my breasts. They both often leaked a milky white fluid. Doctors told me I was "lactating," as though that was typical for girls. Dr. Shumer said "welcome to womanhood." This problem limited what clothes I could wear because the fabric needed to camouflage the fluid.

Erections Felt Like Scraping Broken Glass Against My Penis

49. I had never experienced an orgasm before medical transition. While on transition drugs I experienced erections that were excruciatingly painful in a way that made me think of broken glass or stabbing needles.

50. Around age 14 I first asked Dr. Shumer if the painful erections could be connected to medical transition. Normally he was jolly but when I asked this, he shut down. His body language, facial expression, and tone became cold, and he did not make eye contact. His answer was essentially, No, medical transition does not cause painful erections.

51. Later when I brought up the subject of painful erections, Dr. Shumer would shift the conversation to something else. Once when I was 14 or 15, he said there are other ways to find sexual pleasure, and explained there are toys that can be used anally to stimulate the prostate.

52. At age 17 I confronted Dr. Shumer about my painful erections, incontinence, and other health issues over the phone. He denied that his prescriptions were the culprit. I cried after that call.

53. My mom took me to doctors all over Michigan and beyond to determine what was causing my urinary and erectile issues. They denied it could be the transition drugs. They all assured us that transition was "safe" and backed by major medical institutions.

54. The doctor at University of Chicago said he understood our frustration with Mott not answering our questions. Then he tried to sell us on switching to his hospital's pediatric transition clinic.

55. I researched painful erections online. No medical organization mentioned they could be caused by transition drugs. The most credible-seeming cause I could find was "botched circumcision." Around 2020 I became worried that something had gone wrong with my circumcision as an infant, and the consequences did not show up until puberty.

Transitioning Made Me Feel Hopeless

56. Dr. Shumer told me I would have a wider dating pool after developing like a woman because straight men would be attracted to me. He warned me at age 13 that if I did not immediately start medically transitioning, I would become unattractive to these men by growing masculine features that were impossible to reverse with medication. He said I

would be "clockable," meaning I would look like a man in a dress rather than like a woman.

57. The drugs seemed to work at stunting my growth. I only grew to be about 5-foot-8 (Shumer said I would grow over 6 feet tall without them) and I did not grow facial hair. I was also very skinny. I could not gain weight even though I tried.

58. When I started looking for a boyfriend in my late teens, the only men who seemed interested in me were middle-aged and had a specific interest in young males with breasts. I did not seem to have the same options as a regular straight teenage girl.

59. I often felt hopeless during my adolescence. Once I called the Trevor Project because I understood it to be a suicide hotline for "LGBT" kids like me. At first the person I spoke with was very kind and affirming. But as I explained how I thought the medical transition was hurting me, the person became quiet. Then they abruptly hung up. I cried myself to sleep that night.

60. I found an endocrinologist near my home around when I was 18, Amanda Morris. At first she prescribed me transition medication as I requested. Over time I confided in her about my medical problems, from incontinence to brain fog. I often cried in her office.

61. When I was 21, Dr. Morris explained how my medical problems could be caused by medical transition. She said she did not know what was happening because she had never treated a patient who was transitioned as young as I was. She suggested I take a break from the hormones to see if that helped. Her honesty was bracing. I cried because I thought I needed these drugs, but at the same time, I suspected she was right about them damaging my body.

62. Between December of 2023 and March of 2024, as an experiment, I decided to surrender to Mother Nature and stop taking the drugs.

I Stopped Believing I Had a Brain Condition

63. Around this time I started meeting people online with all different views on transition. Our conversations made me reflect on whether I could live my life as androgynous rather than "female."

64. In 2024 I was watching the news with my mom when a segment on pediatric transition aired. It mentioned WPATH (World Professional Association for Transgender Health). I recognized the name WPATH – I had heard it from Dr. Shumer and assumed it was a legitimate authority.

65. This led me to look up The WPATH Files, which was an article and collection of leaked videos and emails. The videos disturbed me. They showed doctors speaking cavalierly about infertility caused by pediatric transition. One joked about transgender young adults who realized they wanted a baby because "the dog isn't doing it for you anymore."

66. The doctors' casual tone reminded me of how my providers at Mott talked to me. They joked about how the world was an awful place that I would not want to bring children into. They were lighthearted about taking away my fertility, yet acted like developing a masculine jaw was the most serious thing in the world.

67. The WPATH Files confirmed for me that I should not use cross-sex hormones. I was never female in any sense, and estrogen was not a valid treatment for my mental health issues.

68. I requested my medical records from Mott in 2024. They were full of rosy accounts of my visits that left out many of the medical issues I reported at the time.

69. The Mott records referenced WPATH. For example,

> Our clinic is guided by The Endocrine Society Guidelines and WPATH Standards of Care for the care of transgender children and adolescents. According to The Endocrine Society Guidelines and WPATH Standards of Care, adolescent patients with persistent gender dysphoria are very likely to continue to be transgender into adulthood, and medical intervention is often extremely helpful.

70. In 2024 I worked as a cheese monger. We had a lot of gay clients from Chicago. Some of them were married couples. It struck me how similar I was to many of these men – we had the same mannerisms, way of talking, and sense of style. I saw them as successful. They had husbands and jobs. Socializing with them made me wonder, Why did I believe that being a feminine gay man was a horrible fate?

I Have Not Recovered from Medical Transition

71. I have now been free of transition drugs for over two years. I am 23 years old.

72. Going off estrogen seemed to cause withdrawal effects for several months. I experienced intense hot flashes where I would feel nauseous and lightheaded. I also experienced night sweats, muscle spasms, and soreness all over. This subsided after about six to eight months. Then I started to grow facial hair.

73. My breasts still feel sore and leak sometimes, but not as badly as before. They have shrunken a bit. I believe the clinical term for my chest growth is gynecomastia, but doctors never call it that.

74. Over the past two years I have developed bone growths on my feet, chest, and head that are painful. Sometimes I wake up with throbbing pain in my foot that is so bad I cannot even walk the dog. The growths keep spreading. Doctors have run X-rays and MRIs. They say the bones are just my natural skeleton.

75. I still suffer from urinary incontinence if I sneeze, cry, laugh, or lift something heavy. Just bending over can cause a trickle. I am like a faucet that does not turn off. It is just a constant drip, even though I have been to physical therapy and tried medications. I often wear multiple pairs of underwear or change my underwear throughout the day. I typically wear black pants in public to disguise the leaks.
76. I have never experienced an orgasm.
77. I am grateful that I never underwent surgery like brow shaving, jaw reduction, or vaginoplasty. I wanted those operations when I was a teenager but my mother steered me away from them.
78. Over the past few years I have testified in state legislatures and spoken at conferences about my experience with medical transition. I also speak privately with other survivors of pediatric transition who are struggling. I want people to understand that it is OK to be a feminine man or a masculine woman, and that transitioning is not safe for kids.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on May 18, 2026.

Jonathon Skinner (May 18, 2026 13:09:50 EDT)

Jonathon Skinner

EXHIBIT 8

DECLARATION OF MELISSA SKINNER
Pursuant to 28 U.S.C. § 1746

I have personal knowledge of the facts set forth below and am competent to testify about them. If called as a witness, I could and would testify as follows:

1. I am over 18 years old and reside in [redacted].
2. I have two sons. My youngest, Jonathon (who goes by Jonni now), was born in 2002.
3. Jonni was always different from other boys. He was gentle and soft-spoken. He has a sweet soul.
4. I come from a rough neighborhood in [redacted] where some people throw around homophobic slurs. I tried to raise my boys differently but it was hard to shield them. I worked practically all the time because my sons' fathers rarely paid child support (I received no more than a few thousand dollars from them total, combined), and I tried to avoid taking welfare.
5. My father called Jonni a "faggot" in front of other people in town when he was just in kindergarten. My brother and older son teased him for "running like a girl" and things like that. I fought with them. I said he was too young to be labeled, and he just seemed different because he was autistic. He had been diagnosed with that at age 4. The teachers and counselors said he was confused about how to behave as a boy because he was autistic.
6. My friend's daughter, [redacted] was called names for being a lesbian starting in childhood. She was about ten years older than Jonni and tutored him in math. When I opened my own secondhand auto dealership with a partner, I hired her to help with administrative tasks. It did not make a difference to me that she was a lesbian.

7. When Jonni was 13, in 2016, he called me at work. He sounded upset. He told me he thought he might be "transgender." He also told me [redacted] was transgender. He said he wanted to set up an appointment. I used the information that [redacted] and Jonni gave me to find a counselor in Michigan. She worked at the University of Michigan Mott Children's Hospital.

I Sought Help for My Son at the University of Michigan

8. I did not have a clear understanding of what "transgender" meant. My main concern was that I wanted Jonni to accept himself after being bullied his whole life for autism. In my mind the University of Michigan was the best provider in the state for healthcare and mental health treatment, so I set up the appointment that Jonni wanted.
9. Our first appointment was with a counselor named Sara Wiener. She met with Jonni alone for much of the time.
10. When we met together afterward, Wiener congratulated me on having a daughter. I did not understand. She then asked me, in front of Jonni, "Would you rather have a dead son or a living daughter?" She provided a statistic about how many transgender kids make it from 13 to 23 – she claimed that something like 60% of these kids commit suicide. Since Jonni was 13 and had already struggled with mental health issues, that upset me. I started crying.
11. Wiener offered to set up an appointment for us with an endocrinologist, Dr. Daniel Shumer, who she described as the best doctor around. I agreed to take Jonni to see him.
12. Going into the appointment, I trusted Dr. Shumer and Wiener. My mindset was that they were trying to save my kid's life. But I still needed to understand what they were proposing.

13. To answer my questions about what transgender meant, Dr. Shumer drew a diagram on a whiteboard. Embryos are all female, he said, but then testosterone makes some of them male. He said that my body did not deliver enough testosterone to Jonni at the right time, so he developed a male body without a male brain. He said that when Jonni heard voices (a problem I now think was due to obsessive-compulsive disorder) that was an inner person trying to come out. In order words, he was a girl in a boy's body or he had a girl inside of him.
14. I wanted to understand the difference between being transgender and being gay. Since I noticed Dr. Shumer had the same mannerisms as Jonni and seemed to be a gay man, I asked him whether he wanted to have transgender procedures. He said no because he knew he was a man, whereas Jonni did not know he was male.
15. Dr. Shumer seemed upset by the question. From then on I did not press Dr. Shumer about Jonni possibly being gay because I worried about sounding offensive.
16. Dr. Shumer performed an exam on Jonni with me outside the room. Afterward he told me we were running out of time to prevent Jonni from developing adult male characteristics, like strong face bones. He said he wanted to prescribe drugs to close Jonni's growth plates or else he would be over six feet tall, like his father.
17. Dr. Shumer told me that estrogen would be safe for Jonni because males already produce estrogen – this would just be changing the amount.
18. I had a lot of questions about how medical transition would affect Jonni's health. Dr. Shumer often seemed annoyed by them. Sometimes when I asked about certain side effects Jonni had, like breast pain and hematuria, Dr. Shumer responded in a sharp tone of

voice, something like, "that's not an appropriate question for me. I'm not that type of doctor." Eventually I stopped asking Dr. Shumer questions.

19. Ultimately I consented to allow Dr. Shumer to transition Jonni because I was afraid he would kill himself without that treatment, based on what the clinicians had told me.

Mott Children's Hospital Sent My Son to a Sex Shop

20. At one of our early visits to Mott, Wiener recommended I buy Jonni shaping forms at a store in Detroit (several hours from our home) called Janet's Closet. I thought she meant clothing.

21. I expected Janet's Closet to be some sort of women's store. When we finally arrived, I saw the purple building and thought it looked like a sex shop. I researched on my phone whether we could buy the items somewhere else, but I could not find anywhere in that area or near our home. So I took Jonni inside with me.

22. A man dressed up to resemble a woman was working inside. After looking over the papers Wiener had given me, he led us around a corner past lighted cases with dildoes and other sex toys. I tried to shield Jonni as much as possible, walking him to the outside.

23. Finally we arrived in a room that displayed body-shaping clothing in children's sizes. The man picked out a breast form in a halter top style for Jonni, and underwear with hips and a butt sewn into them. Altogether the items cost a few hundred dollars. Jonni said he did not think he would like wearing them. I did not think so either but I wanted to be open because I was worried about him becoming suicidal. Later he tried the items on and said he felt gross, so I threw it all in the garbage.

Mott Children's Hospital Targeted My Son While We Were Homeless

24. In one of the early meetings with Dr. Shumer I questioned the need for medical transition. He turned to Jonni and said, “if you don’t feel you’re in a supportive home, we can find you one.”
25. That chilled me. I was already worried about the state taking custody of Jonni because I was a single mother and we did not have a stable home at the time.
26. A few months before Jonni told me he was transgender, I had broken up with my longtime partner. I was losing the car dealership that I owned and our home, and I was in hundreds of thousands of dollars in debt. Jonni knew about this turmoil.
27. About a month after our first appointment at Mott, we were out of our house. I found new work as a trainer of managers and salespeople for AutoMax, and selling at event sales, which had me traveling all over the country every week. Jonni would stay with me at hotels. We kept our belongings with family in Michigan, but we did not maintain our own place there or anywhere.
28. I homeschooled Jonni for a time. Dr. Shumer advised us that would be best because he would be bullied in school.
29. Dr. Shumer knew about at least some of the disruptions in our lives. He wrote in Jonni’s records when he was 13 that we “continue to lead a nomadic existence.”
30. I would have liked to raise Jonni in one home, without constant travel and me working so many hours. But my professional options were limited because I did not complete high school.
31. At our early visits to Mott, the staff gave us money. First Wiener gave us a $100 grocery gift card. Then staff at Mott paid Jonni $50 for completing some sort of survey.

32. During our first visit with Dr. Shumer, he and Wiener said Jonni would have a "team" of professionals helping him. I took that to mean Wiener would be his therapist. But that turned out not to be the case. They did not offer mental health services to Jonni.

My Son Urinated Blood

33. The first drug Dr. Shumer prescribed to Jonni was Spironolactone to inhibit his testosterone uptake. About six weeks later Dr. Shumer added estrogen. Jonni was still 13 years old.

34. The men in my family were supportive of Jonni transitioning. My brother and son used she/her pronouns for Jonni, and my father did not object.

35. For the first few months of his treatment at Mott, Jonni seemed happy. Previously he had hidden inside his hoodie all the time, but now he was chatty and social. I took this to mean medical transition was helping him.

36. Now I think Jonni felt a boost of confidence because so many adults were vocally supporting him. I wonder: if his family and teachers had shown him the same support for being gay, would that have eased his depression and anxiety?

37. Soon Jonni began to experience harrowing health problems, including hematuria (blood in his urine) and incontinence. I took him to multiple doctors in Michigan and Illinois. They all dismissed my concern that medical transition could be causing the problems.

38. The doctor we saw at the University of Chicago was one of those doctors. He said Jonni's problems were not caused by transition medication. He encouraged me to stop bringing Jonni to Dr. Shumer and instead transfer his care to the University of Chicago's pediatric transition clinic, which he said was a better program.

39. Doctors often made me feel stupid when I questioned them about medical transition. They kept telling me his problems could not be caused by the transition medicine but did not explain why. I am aware of my own lack of training and I respected theirs, so I would just hope they were right. But I did continue to seek out second opinions over the years.

40. For most of the time Jonni was prescribed transition drugs as a minor, Medicaid paid for it. There was a period from about 2017 to 2018 when I had private insurance, and I would pay copays for his drugs and doctor appointments.

My Son Wanted a Surgeon to Make His Head Smaller

41. Jonni expressed concern to me about who he could marry in the future. He said Dr. Shumer told him straight men date transgender women. I told Jonni that did not sound realistic to me. But I expressed it in a gentle way and did not push the point. I felt Dr. Shumer was the authority on "LGBT" sexuality, not me.

42. Jonni used to say he felt self-conscious about his prominent brow, jaw, and chin. At age 13, Dr. Shumer told us that was why he needed to use puberty blockers right away. When Jonni was 14, Dr. Shumer told him the University of Michigan offered face surgeries to boys at age 16 to help them pass as female. For example, there was one to sand down a boy's brow bone and another to saw off part of his jaw. Jonni expressed interest in having these operations. (I was in the room for these conversations.)

43. I hoped Jonni would change his mind. Meanwhile I came up with excuses why he should not seek surgery from the University of Michigan: we could not afford it, or we should try to get an appointment with Jazz Jennings' surgeon.[1]

I Stopped Trusting Mott

[1] Jazz Jennings is a transgender activist who medically transitioned as a child. Jonni knew about Jennings because of the reality TV show, *I Am Jazz*.

44. For years I was ambivalent about pediatric transition. I suspected it was causing Jonni's health problems, but on the other hand I thought people who criticized it were likely coming from a place of bias against transgender people.

45. In 2024 Jonni and I saw a segment on the news about WPATH.[2] Then I looked for more information online. I learned that they commonly said "would you rather have a living daughter or a dead son" to parents. It reminded me of a sales tactic called "word track" that I know from training salespeople. It is like saying to customers, "do you want fries with that?" I had a sick feeling in my stomach.

46. Over the last few years I have felt proud to see Jonni stand up and advocate for kids like he once was by testifying in state legislatures and speaking publicly.

47. [redacted] died a few years ago, when she was 32. Her mother told me she had a heart attack in her sleep. She had been presenting herself as a man. I believe she used testosterone for years.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on May 29, 2026.

Melissa Skinner

Melissa Skinner (May 29, 2026 13:34:33 EDT)

Melissa Skinner

[2] World Professional Association for Transgender Health

EXHIBIT 9

DECLARATION OF [redacted]
Pursuant to 28 U.S.C. § 1746

I have personal knowledge of the facts set forth below and am competent to testify about them. If called as a witness, I could and would testify as follows:

1. I am over 18 years old and reside in [redacted].
2. My husband and I have three sons. Our middle son, [redacted] was a happy-go-lucky and extraordinarily intelligent child. [redacted] was diagnosed as autistic when he was a toddler, and he struggles with common sense. He also has a rare genetic disorder—8Q21.3-Q22.1—which is duplication of the 8q chromosome. That disorder caused some developmental problems. [redacted] saw a therapist for his challenges.
3. We sent [redacted] to school at [redacted], the local public school. We chose that school in part because it had a special education program that served [redacted] needs. [redacted] was on an Individualized Education Program until the present school year.
4. Our family was very close, in particular because of [redacted] developmental challenges. Our family is also open. We have gay friends and are accepting of gay people. I used to think that [redacted] might be gay because of his interest in stereotypically "feminine" things, and I was fine with that.
5. When COVID hit, the school had no program or plan for special-education students like [redacted] He was studying on his own and spent a lot of time online.
6. In 2024, [redacted], then 14 years old, handed me a written note which said that he was transgender. He seemed nervous.
7. We did not mind that [redacted] identified as transgender at first. We could not find much information, so we scheduled a doctor's appointment.

8. Our family doctor recommended that we go to the Phoenix Children's Hospital gender clinic. We scheduled an appointment and we were able to get in almost immediately, which was strange because usually getting an appointment there takes weeks. Our appointment was on April 9, 2024.
9. Our appointment was on Zoom because it occurred during COVID and the clinic was an hour away from our home. My husband and I attended the appointment with [redacted] all together on one computer.
10. Our appointment was with a social worker, S.J. Johnson. I thought that she was a doctor at first because our previous visits to Phoenix Children's Hospital had been with specialists. I was surprised when I discovered that she was not a doctor or a nurse.
11. Johnson asked [redacted] some questions. [redacted] told Johnson that he wanted a rounder face and that his shoulders were too broad. Johnson diagnosed [redacted] as transgender immediately and asked him what he wanted his female name to be.
12. My husband and I tried to ask questions about whether [redacted] was experiencing body dysmorphia, whether [redacted] might be gay, whether these feelings were a result of [redacted] autism or chromosome disorder, or whether this was regular teenage angst. Johnson shut us down immediately and insisted that [redacted] was transgender. She would not address any of our questions or explain why any alternative explanation was wrong.
13. Johnson said that it was too late for [redacted] to be put on puberty blockers, and that he needed to start cross-sex hormones as soon as possible. Johnson was adamant that we begin treatment immediately. Her certainty that [redacted] was transgender and insistence on beginning hormone treatment immediately after such a short initial conversation was startling.

14. We asked Johnson how hormones might affect [redacted] other medical issues. She said that it was "all fine," and did not discuss any side effects.

15. Johnson presented no alternative to hormones. When I asked questions about alternative explanations or treatments, Johnson asked us if we would rather have a live daughter or a dead son. I had never heard that before, and it bothered me that a social worker would bring up suicide in front of an impressionable teenager. Johnson also told me that if [redacted] committed suicide, that it would be my fault. She made it seem like [redacted] needed hormones, or he would die.

16. When Johnson asked to speak to [redacted] alone, we denied her permission to do so and ended the appointment. [redacted] never took hormones or puberty blockers.

17. [redacted] began expressing suicidal thoughts right after that appointment, which was strange as [redacted] had never done so previously. He was a happy child.

18. I believe that [redacted] only began acting this way because the therapist introduced the idea of suicide in the appointment.

19. [redacted] therapist, Obsidian DeLeau, also told me that if [redacted] committed suicide, it would be my fault.

20. The clinic had provided some materials on local groups, including PFLAG, a "LGBTQ" organization. We decided to go to a PFLAG meeting in Sedona. The people at the meeting tended to be older. The speaker at that meeting said that the two choices that parents have are "affirming" their child's chosen gender or their child committing suicide.

21. [redacted] did not ask to attend any more PFLAG meetings.

22. Because of [redacted] suicidal thoughts, we had to watch him 24/7 like a toddler. It was very upsetting because we felt like we might be going against medical advice by withholding consent to use cross-sex hormones.
23. [redacted] attends online school. I am concerned that local schools would "socially transition him" by pretending that he is female.
24. To find [redacted] affordable mental health support from someone who would not automatically "affirm" him as female, my husband and I had to hire someone who is based in Sweden. They seem to have a good rapport.
25. I also make sure that, at regular medical visits, doctors and dentists do not refer to [redacted] as female.
26. [redacted] is now 16 and his mental health has improved. He just got his bedroom back and we have unlocked the kitchen knives. When [redacted] is not fixating on the transgender subject, he likes history.
27. We must still be hypervigilant, however. When the subject of gender comes up, [redacted] backslides. He has been distant and fragile since the appointment at the gender clinic.
28. We spend roughly $500 per month on [redacted] therapy to keep him stable. Insurance does not cover it. This has been a financial burden on our family.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on 4/18, 2026.

[redacted]

EXHIBIT 10

DECLARATION OF [redacted]
Pursuant to 28 U.S.C. § 1746

I have personal knowledge of the facts set forth below and am competent to testify about them. If called as a witness, I could and would testify as follows:

1. I am over 18 years old and reside in [redacted]
2. I was born in [redacted] and grew up in the suburbs of [redacted] and [redacted]
3. I am a lesbian.
4. I was considered rowdy, aggressive, and "tomboyish" as a child. Based on this stereotypically masculine behavior, people would jokingly tell me I should have been a boy.
5. As I entered puberty in the fifth grade, in 2007, I became increasingly uncomfortable with the feminine changes to my body and the discord between those changes and my masculine behavior. I developed an attraction to other girls. In middle school, I did not consider myself to be straight but did not identify as a lesbian either—I tried not to consider that at all.
6. When I watched romantic movies, I identified with the male characters. They were chivalrous and admirable, and won the heart of the female lead. I wanted to be like them. I did not see representations of lesbians in those roles, or representations of women who had those masculine and chivalrous traits.
7. In music, movies, and interactions with my peers, lesbians were depicted in a feminine and hyper-sexualized manner that was heavily influenced by pornography. I did not identify at all with those depictions of lesbians.
8. The only person in my life who I understood to be a lesbian was a gym teacher at my school. I did not have a class with her, but from what I could tell she was a kind person

and good teacher. Nevertheless, students mocked her for her lack of femininity and called her ugly. I felt connected to her but I was afraid to look like her and what that would mean for me socially. This reinforced my view that being a masculine woman was shameful.

9. Other kids seemed to notice I was different from them. They called me a lesbian as an insult. I did not call myself that.

I Encountered the Idea that Some Girls Are Actually Boys

10. When I was around twelve I started engaging in self-harm cutting behavior that continued for the next few years, along with suicidal thoughts and attempts, resulting in several psychiatric hospitalizations. My diagnoses included bi-polar disorder and chronic adjustment disorder.
11. When I was fourteen I encountered the term "wrong-bodied" on Tumblr, which was a blogging and social media platform. I immediately internalized it along with the idea of being "transgender," meaning I was male but had a female body. This seemed right to me because I had always had masculine qualities and I felt uncomfortable with being female. I started identifying as male and researching medical transition.
12. I started by informing a friend from another school, and then my best friend at school. The summer before ninth grade I told my stepdad, and then by fall of ninth grade I came out as transgender on Facebook, to my whole community.
13. The reaction was mixed. Some of my friends were supportive. Many of my classmates bullied me for it, which felt like a continuation of how they treated me before (when they saw me as a lesbian).

14. I did not like attending school in part because of how my peers treated me, so I had truancy problems. I moved to live with cousins in [redacted]. I did not feel like I fit in there, either. I returned to [redacted] four months later.

15. I was still reading about transgender identity online. I cared very much about the proper medical standards for determining if someone was a strong candidate for transition. I read about them and believed I met them: I thought I had a male brain in a female body and was truly "transgender." In hindsight, I think the standards just described a butch lesbian.

16. In ninth grade, when I was 15, I was committed to a psychiatric ward after a suicide attempt. There, I was referred to the University of Minnesota Center for Sexual Health (CSH)[1] because I reported I was transgender. I had two intake visits at the CSH in May of 2012, both with a psychologist, Dr. Dianne Berg.

17. Later I continued seeing Dr. Berg for therapy and I began seeing a CSH endocrinologist, Dr. Jamie Feldman.

18. I now have my records from CSH. Where I quote from them below, they are consistent with my recollections.

The Center for Sexual Health Told Me I Was Male

19. Dr. Berg's notes from my first visit on May 16, 2012, show that I talked extensively about my crushes on girls and distressing romantic relationships with them. But, she wrote, "[d]ue to time constraints, [we] did not have the opportunity to discuss the meaning of the components of sexual identity (biological sex, gender identity, social role

[1] I believe CSH has since changed its name to the Eli Coleman Institute for Sexual and Gender Health.

and sexual orientation) in detail." (Emphasis in original.) Despite that, she concluded that I "clearly [met] the criteria for gender identity disorder."

20. On May 26, 2012, Dr. Berg met with my mother and me for several hours and asked us various questions about my life and mental health issues. She wrote that "this testing is encouraged as part of the requirements of the WPATH standards of care to receive hormone therapy."

21. Over several pages of notes, Dr. Berg did not mention my sexual orientation or internalized homophobia. I now think that was an oversight on her part, as confusion and discomfort with being a lesbian led me to identify as male.

22. Dr. Berg wrote in her notes on July 9, 2012, that my "current symptoms/status" included "distress related to stigma encountered due to gender identity[.]" This was how she often interpreted my psychological problems. She recorded the word "stigma" 22 times over two years.

23. My sessions with Dr. Berg rarely addressed my psychological issues other than wanting to transition. She explained why in her notes on September 6, 2012: "client continues to focus solely on timeline for hormones so [I] met the client where he [sic] is[.]"

24. That same day, Dr. Berg wrote that she "[e]ncouraged [me] to read the standards of care … as a way to gain insight into informed consent" for medical transition. I understood Dr. Berg to be referring to WPATH's "Standards of Care." I had learned about it from her either in individual therapy or group therapy (which she co-led). Based on Dr. Berg's guidance, I understood WPATH to be an official, authoritative medical organization.

The Center for Sexual Health Prescribed Me Testosterone at 15

25. Dr. Berg referred me to her endocrinologist colleague at CSH, Dr. Jamie Feldman in July of 2012. She prescribed me testosterone in October, after I turned 16.
26. Due to my mental health issues, I was prescribed a daily testosterone cream rather than weekly shots, in an attempt to reduce mood swings.
27. Initially, I was covered by state Medicaid and testosterone was not covered. As a result, instead of brand-name testosterone cream I obtained more affordable cream from compounding pharmacies. The quality and dosing was unreliable resulting in inconsistent results, but I was happy to be able to obtain it affordably. We wrote letters asking for testosterone to be covered, and there were changes to our coverage as my mother changed jobs. I am not sure why, but eventually my testosterone treatment was covered by insurance.
28. I had always had some facial hair due to genetics, and took this as a further sign that I was truly a boy. I consistently said I was male, and my providers affirmed and reinforced this as a medical fact.
29. In my youth/parent therapy group—which included girls as young as 13—providers told us that testosterone may cause a desire to have sex with men, even in those who previously had no attraction to men. I initially identified as a straight man (that is, a man attracted to women), but I felt pressure from this group and the online transgender community to not identify as straight.
30. Dr. Berg encouraged a "fluid" view of sexuality which meant, essentially, that everyone is bisexual.

31. At various points I identified to others as bisexual or even as a gay man. Despite adopting those sexual identities, even while taking testosterone I never experienced a sexual attraction to men.

32. There were some positive aspects of being on testosterone. The increased energy helped me get up for school in the morning and engage in social activities. I enjoyed the masculine physical changes, such as increased facial hair and deeper voice.

33. Largely, however, my health deteriorated while I was on testosterone. I began having vision issues and hallucinations. With the increased energy came increased anxiety and anger. I began having psychotic episodes for the first time, and attempted suicide several times. My providers did not attribute this deterioration to their treatment, and continued to encourage my medical transition.

The Center for Sexual Health Referred Me for Breast Amputation at 16

34. I had been binding my breasts for some time with bandages, and eventually got a real binder. I often wore it to sleep due to my own psychological discomfort with my body. I wanted to remove my breasts entirely. My providers supported this urge.

35. Although Dr. Berg and Dr. Feldman wrote letters authorizing my mastectomy, their employer, the University of Minnesota refused to perform the surgery on minors. So they referred me to a private plastic surgeon. I got the surgery when I was sixteen years old.

36. The process was extremely sudden. I had a consultation with the surgeon, Dr. Richard Tholen, in July of 2013 and scheduled the surgery for the following month. If the surgery had been postponed for a year, I do not know if I would have done it.

37. Dr. Tholen did not evaluate whether I needed the surgery. Instead he seemed to rely on the letters from Dr. Berg and Dr. Feldman, along with my mother's consent.

38. At the surgeon's office, I sat in a waiting room with women who I thought were there for cosmetic breast enhancements. When I met Dr. Tholen, he focused on the aesthetics of the procedure. He commented on my youthful and elastic skin. I felt objectified and uncomfortable.

39. Recovery was painful. I spent my seventeenth birthday at home, unable to move much. I was hunched over and could not straighten my back. I wondered if I would ever be able to walk normally. I felt like I had not had any choice but to get the surgery, and was cursed to be transgender and need such a painful intervention.

40. Insurance did not cover the $9,300 procedure, so my mother took out a loan to pay for it. A month before the surgery, in June 2013, Dr. Berg alluded to the tension over this in her notes: "Family Therapy to help [redacted] and his [sic] mother communicate more openly with each other about issues related to the feasibility of chest surgery during this summer given financial constraints[.]"

41. I later gave my mother $10,000 from my college fund as repayment for the mastectomy.

42. Dr. Feldman wrote in her notes in January 2014 that I "[h]ad top surgery" and there were "no complications."

43. Soon after that, I attempted suicide again.

I Moved on from the Center for Sexual Health

44. I stopped seeing Dr. Berg and Dr. Feldman because my primary care doctor was willing to continue the hormone therapy prescriptions.

45. No doctor ever suggested I stop using testosterone, even when I experienced acute psychiatric breakdowns and attempted suicide.

46. Over the following years, I continued to struggle with mental health issues, drug and alcohol abuse, self-harm, and I engaged in prostitution.

47. By 2020, when I was around 23 or 24, my conviction that I was a male had started to waver. I read and thought more about gender identity theory, and I saw that public figures were starting to question medical transitions. The online transgender community had become increasingly dominated by disturbing fetishism and attempts to convince people to identify as the opposite sex or nonbinary when they did not already.

48. I started to view myself as a woman living in a man's body. I met up with an old friend, a woman, and it felt like we were two girls having a sleepover. I was increasingly hesitant to put on testosterone gel. When I missed days, I sometimes experienced painful vaginal bleeding. I realized I needed to fully commit to living as a man, or stop testosterone treatment completely.

49. One day, I saw myself in the mirror and knew that I was a woman and that I wasn't going to live my life pretending to be a man. After that I stopped using testosterone.

50. My mental health improved soon after stopping testosterone. Within four to six weeks, my ability to process emotion was widened. Before, I had felt pent up, and my sadness was often expressed as anger. I cried once a year or less while on testosterone; since I stopped, I cry over happy and sad emotions.

51. I also became less irritable and more calm. That improved my relationship with my mother. It also helped that I was no longer contorting my life story to explain myself as a male – I could have more direct conversations.

52. I noticed my silhouette changed and became more feminine within a few months of stopping testosterone.

53. I lost the ability to scream normally when I started taking testosterone. I still cannot scream, and I have recurrent nightmares of not being able to scream when I need to.

54. I still grow facial hair, but it grows more slowly since I underwent 11 sessions of laser therapy. I plan to do about four to six more sessions when I can afford to. I paid about $440 for the last six sessions. The sessions are painful.

55. I experienced nerve pain and electrical sensations from the mastectomy, which continues to this day. I now wear prosthetic breasts, and the mild compression helps with my nerve pain while I am wearing them. I wear those or a sports bra when I am intimate with my girlfriend to modulate or buffer the raw nerves. With only a shirt on, or when my girlfriend lays on my bare chest, the pain is excruciating.

56. The "LGBTQ" community in [redacted] does not feel like it is for me, even though I am a lesbian, because those groups protest speakers like Chloe Cole, a detransitioner, and Kathleen Stock, a lesbian philosopher who questions "gender identity" theory.

57. Today I am comfortable with being a woman and a lesbian. I was never male.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on May 22, 2026.

[redacted]

EXHIBIT 11

DECLARATION OF GWEN TURECKI
Pursuant to 28 U.S.C. § 1746

I have personal knowledge of the facts set forth below and am competent to testify about them. If called as a witness, I could and would testify as follows:

1. I am over 18 years old and reside in Canton, Michigan.
2. My teenage son was considered in some respects at school to be intellectually gifted. He had some transgender friends. When the COVID pandemic hit in 2020, my son's social life narrowed significantly.
3. In 2020, my son announced that he was transgender in a text message to me, with a picture attached showing him dressed like a girl. I took the initial message very seriously and started to research transgenderism in teenagers.
4. Later I started having conversations with my son of a similar nature, including information about "hormone replacement therapy" (i.e., cross-sex hormones), so I started researching and learning about gender dysphoria on my own. I have training and experience in Library and Information Science. I concluded that my son was experiencing some kind of mental discongruity.
5. A pediatrician referred my son to the Gender Services at the University of Michigan Mott Children's Hospital in Ann Arbor, Michigan. I made an appointment for my son for sometime in or around February 2024.
6. My son (who was then 16 years old), my then-partner, and I attended a three-hour session at the gender clinic. The first hour of the appointment was a group discussion with a social worker, me, my then-partner, and our son in one room. The second hour was conducted by the social worker alone with our son. The third hour was essentially a debriefing session with next steps, with all four of us meeting together.
7. During the first hour of the session, I soon had the sense that the social worker had predetermined recommendations for our son. The social worker explained that the purpose of the first session was to help our son align his body with his self-image. She cited the World Professional Association for Transgender Health ("WPATH") as the "standard of care." By the end of the session, the social worker diagnosed our son with "gender dysphoria" and "transsexualism."
8. The social worker's narrative did not seem to be based in biological reality, and it emphasized the need to change our son's physical characteristics without first genuinely considering any of his underlying emotional problems—such as the stress of experiencing puberty, his isolation during the COVID lockdown, or the social contagion

of transgenderism. For example, when I asked the reason for the recent 4,000% increase in the number of trans-identifying girls in the United Kingdom, the social worker told me that society has simply become more accepting of transgenderism, making it easier for adolescents to declare themselves to be what they really are—transgender.

9. During the third hour of the session, the social worker repeatedly told my son that there was something he needed to tell us. I thought that was an attempt to coerce my son into saying something the social worker coached him to say during the second hour, when the social worker was alone with my son. I changed the subject and asked the social worker directly for a recommendation of next steps for my son.

10. The social worker recommended that my son meet with an endocrinologist, Dr. Daniel Shumer at the University of Michigan. I refused. My ex-partner and I eventually separated over our disagreement.

11. For the three-hour session with the social worker, I paid approximately $600 out-of-pocket, after receiving an explanation of benefits from my health insurer.

12. The gender clinic referred us to PFLAG, an "LGBTQ+" organization, to meet other families.

13. My son never received cross-sex hormones because I would not allow it. My son never met with an endocrinologist because I refused to consent to treatment and would not agree to schedule the appointment.

14. A few months later, after the three-hour session at the gender clinic, I asked my son about his transgender identity and he responded, "that would be like putting lipstick on a pig." He then announced that he wanted to grow a mustache. Today he is 18 years old, exceptionally bright, and thriving. He identifies as male. He told me that "falling into the transgender cult was the stupidest thing I've ever done."

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on May 28, 2026, 2026.

Gwen Turecki
Gwen Turecki (May 28, 2026 22:14:34 EDT)

Gwen Turecki

EXHIBIT 12

DECLARATION OF [redacted]
Pursuant to 28 U.S.C. § 1746

I have personal knowledge of the facts set forth below and am competent to testify about them. If called as a witness, I could and would testify as follows:

1. I am over 18 years old and reside in [redacted].
2. From July 2018 until November 2022, I worked as a case manager at the Washington University Transgender Center (the "Center") at St. Louis Children's Hospital. In that role, I met with minor patients two to three days a week in the clinic setting to provide medical case management and completed (with parents) the screening, triage, and intake for minor patients who were referred to the Center.
3. I began keeping track of the Center's patients in a spreadsheet in 2020. In the two-year period from 2020 to 2022, by my count the Center "transitioned" more than 600 minors. By "transition," I mean physicians prescribed puberty blockers or cross-sex hormones to modify the patient's sex traits.
4. I sought a job at the Center because I wanted to serve gender-nonconforming[1] children and teenagers who were in distress. At the time I thought of this cohort as "transgender kids" and "members of the LGBTQ community."[2] I am a lesbian who was a tomboy growing up and I married a "transgender man" (a woman who identified as a man)[3] so I felt I was part of that same community. I thought the Center would help "transgender kids" become their true selves.

[1] By "gender-nonconforming" I mean they defy stereotypes for their sex.
[2] The acronym changed over time. Later we would say "LGBTQIA+."
[3] She has since stopped identifying as male.

5. At my interview for the job in 2018, many of the questions were about my spouse's transgender identity and my connection to the "LGBTQ" community.
6. Most of the Center's staff either identified as "LGBTQ" or had a close relative who identified as transgender. For example, the founding director, Dr. Christopher Lewis, was a gay man; another physician, Dr. Sharon Vermont, transitioned her child; and the psychiatrist, Dr. Andrea Marie Giedinghagen, was a lesbian. Dr. Lewis was only a few years out of training when the hospital appointed him to lead the Center.
7. When I participated in a hiring committee for an educational liaison, we refused to interview anyone who did not identify as transgender (but they did not need to use cross-sex hormones or get surgery).
8. In my role at the Center, I personally witnessed physicians and other clinical staff provide misleading information about puberty blockers, cross-sex hormones, and surgery to the public, to minor patients, and to parents of minor patients.

How Patients Arrived at the Center

9. As part of my role at the Center, I trained local pediatricians to ask children for their gender identity and refer certain patients to the Center.
10. We experienced a spike in new patients during the time I worked at the Center. Many reported they had been referred by primary care physicians.
11. Once I trained clinicians who worked in the St. Louis Children's Hospital cystic fibrosis ward. Within three months the Center received a referral for one of the girls on that ward. After I trained doctors who saw children with sickle cell anemia, I heard that one of the patients asked to see Dr. Lewis.

12. Parents often told me they wanted their child to be assessed by a mental health professional to determine if they were transgender, or that they wanted to explore a non-medical pathway (like therapy) to address their children's gender dysphoria.
13. The Center did not offer such assessments or non-medical treatment pathways.
14. Nearly all minors who sought treatment at the Center presented with serious comorbidities, including autism, ADHD, depression, anxiety, PTSD, trauma histories, OCD, and serious eating disorders.

The Center's Services

15. The Center had four practice areas: Endocrinology, Adolescent Medicine, Psychiatry, and Psychology. I almost exclusively scheduled patients for Endocrinology or Adolescent Medicine because there was rarely space available to refer to Psychiatry or Psychology. The standard practice was not to book a patient for more than two visits with a psychologist.
16. Endocrinology would prescribe puberty blockers to children and young teenagers as soon as they started puberty. It would also prescribe cross-sex hormones to kids as young as 13. When Dr. Lewis implanted puberty blockers, he booked a surgical suite for the procedure, which let Endocrinology bill insurance companies at a higher rate.
17. The Center booked initial Endocrinology visits for sixty minutes. Toward the beginning of the hour, Dr. Lewis would deliver a lecture to the family about the science behind hormones, during which he would draw a diagram of the human body.
18. Some parents expressed afterward that they felt impressed by the amount of attention their children received at the initial Endocrinology appointment. But typically, none of the clinicians who met with the child were mental health providers.

19. Most of our patients paid using private insurance. I heard a physician state that after opening the Center, Endocrinology was now running "in the black." He said it had previously operated at a loss for years.
20. Adolescent Medicine prescribed cross-sex hormones to post-pubescent teenagers.
21. Adolescent Medicine also prescribed Depo-Provera to girls. Typically that medication is injected every 12 weeks to prevent pregnancy. The Center would administer it every 10-11 weeks. We advised the girls that this way, it would suppress menstruation and they would not get a period. We touted the treatment's lack of estrogen (in contrast to other types of birth control) as "gender-affirming."
22. Almost all parents would agree to let their daughter take Depo-Provera, even if they would not consent to testosterone. When they returned with their daughter for the next injection 10-11 weeks later, we would try to persuade them to consent to testosterone.
23. Typically, patients' health insurance covered Depo-Provera visits.

The Center's Criteria for Transitioning Minors

24. The Center relied on specific criteria that must be met before it medically transitioned a child. Based on my observations as an employee, including those that I describe below, the Center derived those specific criteria from Standards of Care version 7 ("SOC7") until September of 2022, at which point they were replaced by version 8 ("SOC8"). These documents were published by the World Professional Association for Transgender Health (WPATH).
25. First, the minor must have a history of gender nonconformity or gender dysphoria, which could mean discomfort with being a girl or a boy or identifying as something like "gender queer." Patients reported their own history. I never observed the Center challenge them.

26. The second criterion for the Center to medically transition a minor was a referral letter from a therapist.

27. The Center maintained a list of therapists to whom we sent patients for referral letters. At the Center's instruction, I co-drafted a template letter that most of the therapists on the Center's pre-approved list used. They would fill in blanks on the template, sign, and return the document to us.

28. The third criterion for the Center to medically transition a minor was one parent or legal guardian's consent. There were no other criteria or requirements.

How the Center Sought Consent from Parents

29. Center staff used certain tactics to obtain parental consent. I learned them by "shadowing" colleagues who were employing the tactics, which was the main way that the Center trained people. The "shadowing" model could be described as, "you watch, you do, you teach."

30. I observed Center staff, including physicians, express the following to parents many times:

    a. Puberty blockers are "fully reversible."

    b. Strongly implying the child would kill himself or herself if not medically transitioned. For example, dozens of times, I heard Center clinicians, including physicians, explicitly state either "would you rather have a living daughter or a dead son?" or "would you rather have a living son or a dead daughter?"

    c. Medical transition is the "standard of care" for kids with gender dysphoria.

    d. Transition is "medically necessary" or "transgender people need this care." We said this routinely at intakes.

e. Cross-sex hormones are safe. I routinely observed Center staff characterize the risks and side effects as similar to that of being the opposite sex. So, for example, I observed Center staff represent that a boy's risk of breast cancer would become the same as a girl's if he used cross-sex hormones.

31. I recited those same lines to parents because I had heard my colleagues say them. Sometimes I had social work students shadowing me when I said them, meaning they were supposed to repeat what I said to future patients.

32. We routinely said these things in front of the child, including the suggestion that he or she might commit suicide if not allowed to medically transition.

33. I created most of the handouts that the Center gave parents with the Center's nurse. I wrote that puberty blockers were "reversible," and Center physicians approved that language.

34. When a parent withheld consent, the physicians and other staff would typically disparage that person to each other. Dr. Lewis called them "assholes," "deadbeats," and "stupid." My colleagues at the Center expressed to me that these parents had weak relationships with their children and were neglecting their medical needs.

35. When a patient's parents disagreed, my coworkers and I would sometimes help the pro-transition parent find a family law attorney. We discussed their ongoing family court cases, including divorces, and Center staff told me they testified against parents who would not consent to medical transition.

36. Sometimes parents would challenge the Center's doctors by citing studies, which they said showed most kids naturally desisted from transgender identity. Dr. Lewis would

become visibly angry when that happened. I witnessed him tell these parents they didn't know how to read scientific research.

37. One father said he held a PhD in a scientific field. After he brought in studies to show us, Dr. Lewis barred him from attending appointments with his child. We had to meet with this father downstairs from our suite in a non-clinical room while hospital security guards stood by. I was not aware of any aggressive behavior by this father.

38. Many times, parents stated in my presence that they felt they were being pressured to consent to puberty blockers or cross-sex hormones.

The Center Relied on WPATH Standards of Care

39. The Center based its treatments on WPATH SOC7 until SOC8 replaced it in September 2022. The Center referenced SOC7 on its website.

40. Doctors regularly cited WPATH or the SOC by name, or in shorthand as "the guidelines," when talking to each other and to parents.

41. I was assigned the task of drafting a "standard operating procedures" document based on SOC7 and our administrative practices (e.g., how to schedule an appointment). There were no other written protocols at the Center.

42. I trained social work students who were training in the Center that WPATH's Standards of Care were the authoritative guidelines for them to follow.

43. The Center's physicians discussed reaching out to WPATH when they had questions about treating a patient. Individuals we associated with WPATH included Dr. Stephen Rosenthal and Dr. Johanna Olson-Kennedy. At least one of our doctors was herself a WPATH member.

44. The Center's doctors and nurse practitioner belonged to a listserv that they said was affiliated with WPATH and run by Dr. Olson-Kennedy. I observed that they read the listserv regularly and seemed interested in the answers provided by experts, including Dr. Olson-Kennedy. I saw some of the listserv traffic.

45. Staff at the Center used the listserv to learn strategies for securing insurance reimbursement. For example, staff would ask how to code a procedure that had previously been rejected for coverage. Dr. Vermont, who was a WPATH member, would relay information from the listserv on how to code procedures to get them approved for coverage and circumvent certain insurance requirements. This included changing the sex in the patient's records to the opposite sex and claiming that the patient suffered from abnormally low levels of the cross-sex hormone; and using "spaghetti codes," meaning, write down a variety of codes to see what sticks.

46. Dr. Rosenthal led a training on insurance coding. That included a slide deck shared with staff at the Center (including me) which cited WPATH regarding billing procedures for insurance coverage.

47. When WPATH published SOC8 in 2022, the Center held at least three Zoom meetings, each over an hour, about its changes from SOC7. Physicians and other staff were trying to understand what SOC8 meant and debating how to implement it. Getting it right was important because SOC8 was the guidebook for transitioning minors. I thought of it as the "standard of care" – the primary standard we had to set rules on the Center's practice.

The Center Harmed Children

48. As part of my job, I routinely gave out the names and contact information of surgeons to patients under the age of 18 so they could seek double mastectomy, facial feminization

surgery, hysterectomy, and vaginoplasty. I believed the individuals on the list were willing to perform transition surgery on minors.

49. I thought these surgeries were appropriate for our minor patients because the physicians at the Center said so.

50. Patients we referred did in fact obtain mastectomies as minors. I saw it documented in their charts.

51. I observed that the Center's female patients who were prescribed cross-sex hormones (testosterone) often experienced significant increases in blood pressure, cholesterol, hemoglobin, hematocrit, and body weight. Sleep apnea – which is linked to obesity – became so common that we began screening all girls on testosterone for it.

52. Some girls on testosterone experienced near-constant abdominal pain. They reported painful urination and frequent urination.

53. Some girls who had been prescribed testosterone told me their clitoris had grown in a way that made clothing uncomfortable. I gave them advice about what sort of underwear and pants to wear to avoid chafing. At least two girls had trouble walking normally. They told me they could not wear jeans anymore. They seemed very embarrassed and did not want to talk about it with their parents or anyone else.

54. One time we received a referral letter that said the patient, a girl, identified as transgender but wanted to avoid "bottom growth." Her unease stemmed from being a survivor of sexual abuse, according to the letter. Dr. Lewis prescribed her testosterone despite seeing the letter.

55. Acne is an expected side effect of testosterone. But I saw cases that were extreme: deep, cratering cysts all over girls' faces. We referred these patients to dermatologists.

56. Girls complained about genital pain that seemed to be caused by vaginal atrophy. The Center prescribed a topical estrogen cream.

57. The Center typically prescribed testosterone by injection. Patients and their parents reported that this caused site reactions like pain, swelling, and irritation. Sometimes the Center would switch these patients to testosterone gel, at least temporarily.

58. Some girls reported that testosterone changed their sexual orientation – they had been exclusively attracted to girls before using their prescription, but then were attracted to boys afterward. Some were upset by that and said they wished they had been warned.

59. I noticed that patients of both sexes often became withdrawn and anxious after they began using puberty blockers.

60. As part of my role, I took notice of patients' personal hygiene, engagement level, and eye contact when they came in for appointments. I would also ask them questions about how often they were getting out of the house or socializing. I routinely observed patients on puberty blockers decline on these measures.

61. Some patients began reporting suicidal ideation after receiving puberty blockers, when they had not done so before.

62. After one girl's mental health deteriorated so badly while on puberty blockers that she stopped attending school and was hospitalized for mental health issues, Dr. Lewis's response was to prescribe testosterone earlier than planned.

63. Boys on cross-sex hormones sometimes complained of testicular and genital pain. They said they could not sustain erections or reach orgasm.

64. I understood that boys who used puberty blockers followed by cross-sex hormones might not be able to achieve orgasm, ever. I heard the Center's clinicians rationalize this by

saying transgender people do not want to use their genitals for sex. Once when a patient's mother raised the issue, my colleague later expressed disgust that she had done so.

65. Some boys on cross-sex hormones reported that their nipples were leaking.

66. I consistently noticed that boys on cross-sex hormones were missing milestones like learning to drive and getting jobs. (We saw patients into early adulthood.) It seemed like they were not maturing.

67. I never observed a Center physician or nurse warn patients or their parents about the issues I describe above (¶¶ 51-66), aside from erectile dysfunction.

68. Even when a patient's physical health suffered, or the patient had a mental health crisis, the Center continued his or her medical transition.

69. The patterns of physical and psychological deterioration that I observed among the Center's patients alarmed me. I raised concerns about our practice to authorities within the Center.

70. The Center did not meaningfully respond to my concerns, so I sought a new job. In November 2022 I left the Center.

71. In February 2023 I became a whistleblower. I reported what I had witnessed at the Center to the government, testified at the Missouri state legislature, and began speaking with the media.

72. When I started working at the Center, I expected to serve patients who had appeared gender-nonconforming since childhood. But over time I began seeing more girls who had only recently expressed gender-nonconformity or declared discomfort with their sex. Some even presented in typically feminine ways – for example, they wore pink and had

long hair. I also saw a growing number of boys who did not appear particularly feminine. The Center medically transitioned these girls and boys.

73. Anyway, I now think it is harmful to medically alter a healthy minor's sex traits regardless of whether they have masculine or feminine personalities.

74. As a result of my experience at the Center, I founded a 501(c)(3) nonprofit organization [redacted]. We are a lesbian and gay advocacy group committed to promoting evidence-based medical care, ending the medicalization of gender nonconformity, safeguarding homosexual rights, and building a pathway back for LGB individuals who have undergone medicalization.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on June 15, 2026.

[redacted]

EXHIBIT 13

DECLARATION OF [redacted]
Pursuant to 28 U.S.C. § 1746

I, [redacted], hereby state that I have personal knowledge of the facts set forth below and am competent to testify about them. If called as a witness, I could and would testify as follows:

1. I am over 18 years old and reside in [redacted], [redacted].
2. My son was always a very smart, easygoing child. He liked camping and hiking, and he was in the Boy Scouts. He was also close to his dad. But he also often felt like he did not fit in. These feelings became strong around third grade, when he had a bad experience, and they worsened over time when his peers would bully him. We also are a military family, so we move regularly which may have contributed to my son feeling like he did not fit in.
3. My son also struggled with time management. He asked to see a therapist, so we arranged for him to see one.
4. In 2020, when COVID hit, we lived in [redacted], California and my son was a junior at [redacted] High School. He was 17.
5. He started going with a friend to the GSA club. At the time I thought that stood for "Gay-Straight Alliance," which was fine by me. But later I discovered that it was the "Gender Sexuality Alliance."
6. My son told me that he took an online quiz to try and figure out why he did not fit in. That online quiz told him that he was transgender, so he started researching transgender identity on the internet. He also talked about how he spent a lot of time on Discord, Reddit, and Tumblr.

7. I believe in early 2020 my husband received permanent change of station orders to Norfolk, VA. We decided he would go to VA, and I would stay behind in CA so the kids could remain in High School through to graduation.
8. In spring 2020, my son came back from seeing his therapist. He said that he was transgender, and that he wanted hormones right away. He was still 17. His therapist told me that he did not deal with gender issues, so he referred us to another therapist. I met with the other therapist once, but she told me she would affirm right away and that I would not be present for any of the following meetings. I decided to not send my son to that therapist yet because I wanted to consult with my husband before deciding what to do.
9. Given my son's past issues, I thought that something else was probably going on, but that seeing a specialist would help define the problem.
10. I went with my son to the Balboa Gender Clinic in July 2020. At the time, my husband and I thought that they would screen my son for other issues to eliminate other possible causes for his distress before deciding that he was transgender.
11. Dr. Erika Holtermann, a psychologist, saw my son and I at the clinic. At first, I gave her background information without my son present. I also expressed my belief that something else was likely going on with his mental health. When I raised alternative explanations for my son's distress, she dismissed them.
12. She then asked him to come in the room and affirmed him right away using pronouns such as she/her.

13. Next, Dr. Holtermann met with my son alone. When she brought me into the meeting, she told me that my son was transgender. It felt like she and my son were acting as a team and treating me as an outsider.
14. As we were walking out, Dr. Holtermann asked me if I would rather have "a dead son or a live daughter." She then told my son if he didn't feel safe at home he should call her.
15. Dr. Holtermann did not discuss alternative treatments like psychotherapy.
16. Dr. Holtermann's statements about suicide and my son being unsafe made me feel horrible and worried about suicide. I felt pressured to consent to treatment, and I think that Dr. Holtermann knew that her statements would be pressuring.
17. I did not consent to the hormones during this visit.
18. Dr. Holtermann referred us to an endocrinologist, Dr. Stacy Rustico. My understanding was that once Dr. Holtermann diagnosed my son, the endocrinologist would assume that my son was a good candidate for hormone treatment without making an independent assessment.
19. Within a week or two when my son turned 18, we went to see Dr. Rustico who provided the consent forms which discussed blood clots, strokes, and infertility as side effects. She provided him with a prescription for Estrogen and a Testosterone blocker. She did not say that cross-sex hormones could cause depression, brain fog, or anxiety.
20. After he went to college, my son became a trainwreck. He told me that he had panic attacks, often could not leave his room, and suffered from brain fog. My son also went for extended periods of time without answering his phone or attending classes, so we had to call people at his school to check on him.

21. He even went to the emergency room three times. The first visit was in Canada when he called me as he was having a panic attack. My husband told him to go to the emergency room, where they would help him. The second time, when my son was visiting home, he woke me up in the middle of the night and told me that he was thinking about hurting himself. I took him to the hospital where they put him on a psychiatric hold, and he stayed at an in-patient facility for several days.
22. He eventually had to return home permanently as he could not take care of himself on his own due to his inability to cope with his mental health problems. The first day he was back he had another panic attack and was taken by ambulance to the hospital for his third hospital visit due to panic attacks. He still lives with me and my husband today.
23. Doctors gave my son antidepressants and antianxiety medications, but they did not help.
24. My son had none of these problems before taking hormones. Just before COVID he became an Eagle Scout and was doing well, despite the bullying and not feeling like he fit in.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on May 5, 2026.



EXHIBIT 14

DECLARATION OF [redacted]
PURSUANT TO 28 U.S.C. § 1746

I, [redacted] have personal knowledge of the facts set forth below and am competent to testify about them. If called as a witness, I could and would testify as follows:

1. I am over 18 years old and reside in [redacted] [redacted] I work for a water treatment company.
2. My daughter, [redacted] is now 22 years old. When [redacted] was young, we fled from domestic violence. After that I raised her as a single mother.
3. When [redacted] was 13 or 14 years old, around 2017, a close female friend of hers started identifying as a boy. Then [redacted] began expressing confusion about her "gender identity."
4. Before this, [redacted] had been a confident and happy girl comfortable in her body. Afterward, I observed her become withdrawn, disheveled, and intent on hiding her body with oversized clothing.
5. [redacted] expressed a desire to use testosterone to develop a male body and voice.
6. I felt concerned about the treatment, including how it might affect her beautiful singing voice. The more I researched the side effects of testosterone, the more concerned I became.
7. Without my knowledge, [redacted] school began using a male name and male pronouns for her.
8. When [redacted] was in high school, approximately six to seven of her female friends identified as transgender, and at least four were on testosterone. [redacted] became increasingly preoccupied with "gender" and expressed suicidal ideation. She said that testosterone would make her feel better.

A Pediatrician Told Me to Take My Daughter to a Gender Therapist

9. [redacted] pediatrician at the time was Dr. Rebecca Frances Vickers of Arundel Pediatrics.
10. When [redacted] was 15, Dr. Vickers asked [redacted] what name and pronouns she preferred. I said I did not agree to using male pronouns. Dr. Vickers reacted by slamming down her tablet. She told me I needed to take [redacted] to a gender specialist. When I expressed reluctance, she said I was scared of what the gender specialist would tell me.
11. I told Dr. Vickers I wanted to try another approach to addressing [redacted] distress, like talk therapy, rather than have her put on testosterone. She insisted that I bring [redacted] to a

"gender therapist" off of a list she gave me, and she recommended I take her to an endocrinologist for possibly receiving a prescription for testosterone.

12. Dr. Vickers told me, "you'll feel guilty if she kills herself." [redacted] was present for this entire interaction.

Most Providers Offered No Alternative to "Affirmation"

13. I was determined to find [redacted] counseling from someone who would not automatically "affirm" [redacted] male identity, but rather explore the causes behind it.

14. I tried calling about ten therapist offices. Almost all the people who answered the phone told me that if my daughter said she was male, that meant she was my son. I asked them if their therapists would discuss with my daughter why she felt male, and these individuals told me no – if she says she is male, she is male.

15. To avoid taking [redacted] to Dr. Vickers again, I sought care at Bayside Pediatrics. During a consultation, a pediatrician told me the practice did not provide hormones or surgery, but he could refer [redacted] to transition clinics affiliated with Johns Hopkins University and the University of Maryland for the "full package" of hormones and surgeries, like mastectomy. When I asked about non-medical approaches, the pediatrician had no answer for me.

16. [redacted] also saw a nurse practitioner, Meghan Wellard, who advised us that chest binding could be done safely. Chest binding refers to flattening one's breasts with ace bandages or a rigid, restrictive medical device under one's shirt. I understood this was meant to "affirm" [redacted] male identity. Wellard provided no detailed guidance on how to bind safely.

17. [redacted] began binding around age 15 and continued for approximately five years. During that time, I noticed she experienced shortness of breath and difficulty participating in physical activity, like gym class. She also reported chest pain.

18. I wished [redacted] would stop binding but I let her do it because it seemed to make her less insistent on getting a mastectomy. Since we live near Baltimore and Washington, I worried she could access testosterone without my consent.

19. [redacted] was later diagnosed with premenstrual dysphoric disorder (PMDD), which is more severe than typical pre-menstrual syndrome. After beginning treatment around age 19, her mood improved significantly.

20. [redacted] has never used testosterone or undergone surgery. She now identifies as "nonbinary" (neither male nor female).

21. Prior to these events, I was not skeptical of medical transition. I identified as bisexual and had celebrated others' transitions. My views changed based on researching the risks and side effects of medical transition when my daughter sought it.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on June 3, 2026.

[redacted]

EXHIBIT 15

DECLARATION OF EVELYN NEEL
Pursuant to 28 U.S.C. § 1746

I have personal knowledge of the facts set forth below and am competent to testify about them. If called as a witness, I could and would testify as follows:

1. I am a woman, over 18 years old, and reside near Bunnell, Florida.

2. I grew up in an abusive home in San Diego, California. My father was a violent alcoholic, and he physically and sexually abused me. When I was nine years old, I attempted suicide by hanging myself with a scarf in my room and continued to spiral downhill until early adulthood.

Therapists Probed My "Gender Identity"

3. At age 11 or 12, I was admitted to a residential treatment facility for emotionally troubled children. Several girls on my floor identified as boys or nonbinary. A psychiatrist for inpatients there told me that girls often develop issues with their "gender identity" after suffering trauma at a young age, and asked if I felt distress about being a girl. I had never thought that I might want to be a boy, but the psychiatrist's remark planted a seed in my head. I thought that if I were a boy, perhaps my father would stop sexually abusing me.

4. A few months after I was discharged from the residential treatment facility, I began identifying as a boy. I started going by "Evan" and he/him pronouns at home with my mom.

5. I started researching transgender identity online. I found Hillcrest Youth Center in San Diego, a drop-in recreational center for "LGBTQ" youth. I quickly developed friendships and become part of the group. But that lasted only until I reported a 19-year-old man within that group (who identified as female) for making unwanted advances toward me. The leaders took no action, I did not feel safe, and my friends shunned me for making the report. Having lost my support group, my mental health declined once again.

6. I was in and out of various facilities—mental facilities, residential centers, group homes, and partial hospitalizations—until I was around 16. During this time, I was cutting myself with scissors or pencil-sharpener blades. I also attempted suicide several times. I was put on Prozac and later Abilify for depression, which caused me to gain 40 pounds in only three months. Horrified by my weight gain, I developed anorexia. I went to another inpatient facility for eating disorders.

7. During or shortly after the 9th grade, I decided I wanted to start taking testosterone and wearing a chest binder (a rigid, restrictive garment in the shape of a sports bra) to affirm my male identity. I saw a therapist, Cristy Mereles. We mainly discussed issues like how I felt when my mom did not use male pronouns for me or how I felt when people looked at

me strangely for wearing male clothes. We hardly discussed my past trauma. After four or five visits, she referred me to a pediatrician, Dr. Rachel Gianfortune, who could prescribe testosterone.

8. Ms. Mereles told me and my mother that testosterone would help my mental health. She implied it was lifesaving for kids like me who struggled with suicidal ideation. She said cross-sex hormones helped kids with depression and mood issues, and a lot of kids with suicidal ideation feel a lot better once they start hormones.

9. My mother often raised questions but I viewed her as supportive of my decision. She told me recently that Ms. Mereles made her feel like the decision belonged only to me, and she as my mother could not say no.

10. I continued therapy with Ms. Mereles and another therapist throughout my medical transition. The therapy continued to focus on my male identity rather than other issues like my past trauma.

Testosterone Made Me Intensely Irritable

11. When I was 15 or 16, Dr. Gianfortune prescribed testosterone to me and instructed me how to dose and inject it. She prescribed me testosterone during my first appointment.

12. The injections were difficult. I experienced extreme burning sensations at the injection site.

13. Aside from the injection-site pain, initially I felt wonderful on testosterone—energetic and upbeat. I was very happy to finally be transitioning from female to male.

14. After about two months and four injections of testosterone, I began to notice physical changes. My voice shifted much lower in tone. Before I started testosterone, I was active in musical theater and was a singer with a soprano voice. After three months on testosterone, my voice was an octave lower. Singing became difficult because my prior training and experience were at a higher pitch. I did not worry about it at the time, but I had to move from musical theater to general theater. I never performed again as a singer.

15. I also had menopause-like symptoms, such as a paused period and hot flashes. Dr. Gianfortune did not mention hot flashes as a potential side effect of testosterone.

16. I became moody, angry, and aggressive while taking testosterone. I fought frequently with my mom and behaved irrationally about minor problems. For example, I kicked a hole in my bathroom door when she took away my phone. I was never an angry person before taking testosterone but rather passive and non-confrontational. On testosterone, I was angry most of the time. Dr. Gianfortune did not mention anger or aggression as a potential side effect of testosterone.

17. I asked Ms. Mereles about my mood swings, and she told me that experiencing emotional highs and lows was a normal reaction to testosterone.

18. The hair on my scalp started to thin dramatically.

19. Vaginal atrophy and "bottom growth" (clitoral enlargement caused by testosterone therapy) caused me significant pain. Wearing underwear that was not loose became very uncomfortable—which is still often the case today. Dr. Gianfortune did not mention vaginal atrophy and pain from "bottom growth" as a potential side effect of testosterone. (I knew that bottom growth would happen but did not realize it would be painful or irreversible.)

Rady Children's Health Amputated My Breasts

20. Around age 16, I told Ms. Mereles I wanted a mastectomy. She reacted with enthusiasm and told me insurance would cover the costs. She was correct: Medi-Cal, California's Medicaid program, covered everything—hormones and surgery. My mom never paid out of pocket.

21. My mom suggested breast-reduction surgery instead. Ms. Mereles told her, in my presence, that my mental health would suffer if I did not have a full mastectomy.

22. All I wanted at that point was to be seen as male. I was 16 so I was not concerned about having children someday. I was not romantically involved with anyone. I did not feel desirable. I was completely focused on becoming a man, which I thought I could achieve through medical transition, and I could not imagine changing my mind.

23. My mastectomy was performed at Rady Children's Health, a hospital in San Diego, in May 2021 when I was 17. I trusted everyone at Rady. I had been a patient there before for mental health and other medical needs, and it is a huge hospital with an impressive building and strong reputation.

24. The Rady clinicians said that if I disliked the outcome, I could receive breast implants in the future. That claim turned out to be false. After I underwent the mastectomy, a doctor told me that I do not have enough healthy skin in that area for implants.

25. Throughout this time I was struggling emotionally and still self-harming.

26. After my surgery, I developed a serious infection where my breasts had been cut off. My chest was swollen, pus was entering my lungs, and I had to be admitted to an emergency room. I was in intensive care for two weeks. It was the most excruciating pain I have ever felt. My doctors said the infection could have been life-threatening had it not been caught in time.

27. During the recovery, I wore a compression binder around my chest because my doctors said my nipples could fall off if I did not.

28. After high school graduation, I moved to New York City because I wanted to attend fashion school. My mom came with me. We lived there for about a year and a half, until the end of 2021 or early 2022. I never enrolled in any school there. As soon as I got to New York, my mental health crashed. I started suffering more extreme side effects from the transition. My hair started thinning very badly. I often fell down while showering. Two of my ribs started flaring out, which I think was a result of wearing binders for years. I had terrible tightness in my chest near the mastectomy scars. My vaginal atrophy grew more painful.

29. I could not establish a supply of testosterone in New York, so I stopped using it. I also stopped therapy and all my psychiatric medications, because I could not afford any of it.

30. Soon my brain and thinking seemed to clear up. I started having second thoughts about transition and whether I wanted to continue. I met a new friend online who told me about detransitioning. He became my boyfriend.

31. I moved with my boyfriend to Florida and, just after my 19th birthday, started going by Evelyn and using she/her pronouns. I started reading more about detransitioners and soon realized that there are many people with stories similar to mine.

32. Doctors told me I would have trouble conceiving considering the damage testosterone did to my reproductive system. But two years ago I gave birth to a baby boy. I had to have a C-section because my cervix did not fully dilate, which a doctor told me could be a result of testosterone use. I wanted to breastfeed my son but could not because of the mastectomy.

33. Today I am 22 years old. I still have significant facial hair. I often feel a strange tingling numbness on my side. The skin on my chest is raw and hypersensitive to touch. I do not have erogenous sensation where my breasts used to be.

34. I regret using testosterone and undergoing mastectomy. I wish I had been able to breastfeed my son, and I wish I could still sing. I feel that my doctors and therapists misled me by failing to offer me other treatments for my distress and not informing me of the risks and side effects of medical transition.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on 06/09, 2026.

Evelyn Neel (Jun 9, 2026 21:03:06 EDT)

Evelyn Neel

EXHIBIT 16

DECLARATION OF [redacted]
Pursuant to 28 U.S.C. § 1746

I have personal knowledge of the facts set forth below and am competent to testify about them. If called as a witness, I could and would testify as follows:

1. I am over 18 years old and reside in [redacted], [redacted]
2. I have one child, [redacted] who is 15 years old. I work as a veterinarian.

My Ex Announced Our Son Was Transgender

3. I have lived in [redacted] since 2011. In September 2014, [redacted] was 3. I had separated from [redacted] other mother, [redacted] (but we were still living together). About a month later, his daycare teacher told me something like, "[redacted] thinks he is a girl." I did not think much of it. During the winter of 2014-15, [redacted] moved out.
4. In September 2015, with [redacted] now 4, [redacted] texted me that [redacted] was a transgender girl named [redacted]. I was blindsided.
5. [redacted] explained that [redacted] named himself after Rosa Parks. "[redacted]" means climbing rose.
6. [redacted]'s daycare teacher (2014-15 school year) identified as the mother of a transgender girl. So did his kindergarten teacher (2015-16 school year).
7. As a lesbian, it did not bother me that my child might defy sex stereotypes. But I was concerned about confusing him or locking in an identity when he might just be going through a phase. I was also concerned that the traumatic divorce contributed to this confusion. I also felt leery of the puberty blockers, cross-sex hormones, and surgeries that a trans-identified child might be offered.

8. I tried to keep an open mind, but I did not observe [redacted] to be gender-nonconforming. In fact, he seemed especially boyish. He liked sports and rough-and-tumble play. When [redacted] dressed him in "girl" clothes, he took them off as soon as he walked into my house.
9. Although I never insisted that [redacted] be referred to as a boy, I also did not go along with the idea that he was a girl. Instead I tried to stay neutral, for example by avoiding pronouns.
10. I regularly offered [redacted] options for clothing that included items from the girls' department and boys'. His only preference appeared to be for superhero themes. As for names, he said both [redacted] and [redacted] were OK.

A Gender Clinic Diagnosed [redacted] with Gender Dysphoria

11. [redacted] and I were in and out of court for years trying to resolve the divorce and custody. Our divorce was finalized in 2015.
12. In 2016, I agreed to a settlement with [redacted] that we would take [redacted] to the Gender Management Service (GeMS) at Boston Children's Hospital for an assessment, and then return to GeMS as GeMS recommended.
13. I expected GeMS to see what I saw: that [redacted] was under stress because of the divorce, he wanted to please both his mothers, and he was not transgender.
14. In October 2016, [redacted] [redacted] and I attended our first session at GeMS, along with our nanny. The clinicians we met were Dr. Amy Tishelman, a psychologist, and Dr. Coleen Williams, a post-doctoral fellow. [redacted] was almost six.
15. [redacted] told Dr. Tishelman that he preferred female pronouns and the name [redacted]. (By then he had changed the spelling from [redacted] according to [redacted].)

16. Dr. Tishelman's report did not describe [redacted] as distressed. She noted that "it is difficult to parse out the impacts of parental attitudes and beliefs on [redacted]'s gender presentation and exploration in each of her parent's home." Nevertheless, she described him using female pronouns and concluded, "Diagnosis: Gender Dysphoria in childhood, Unspecified." She also recommended we return to GeMS in a year or sooner.
17. Dr. Tishelman stressed in her report "the importance of … creating an atmosphere that allows children to flexible [sic] in their gender development." I tried to do that.
18. Meanwhile, [redacted] continued to insist [redacted] was a transgender girl. Almost everyone we knew embraced her perspective.
19. After our second GeMS visit, in October 2017, Dr. Tishelman filed another report about [redacted]'s supposed gender exploration. After discussing his feelings about names and pronouns, she concluded with the same recommendation to return in a year and a diagnosis of "Gender Dysphoria in childhood, Unspecified."
20. Soon afterward I challenged Dr. Tishelman about this diagnosis over the phone. She told me, "I'm not telling you that she is a girl."
21. In January 2019, we had another appointment with Dr. Tishelman. [redacted] was now eight. [redacted] met with her on a different date.
22. According to Dr. Tishelman's report, [redacted] told her he did not care what pronouns I used for him. He also said, according to her, that he was both a girl and a boy, and that he would be neither male nor female as an adult.
23. Dr. Tishelman wrote, "It is unclear … whether [redacted] is avoiding aligning with either parent by stating a gender that is something other male or female, or whether this expresses her current internal sense of her gender."

24. Dr. Tishelman did not note that [redacted] experienced any distress except that he seemed "guarded." Nevertheless, she diagnosed him with "Gender dysphoria in childhood" and recommended that he return in a year. This was a change in his diagnosis. I understood that the previous diagnosis meant he did not fulfill all the criteria for "gender dysphoria," but the new one meant he supposedly did.
25. During this appointment, Dr. Tishelman told me that we should start thinking about blocking [redacted] puberty. I said something noncommittal, although I felt confident he should not go on blockers.

I Fought for the Right to Keep My Son off Puberty Blockers

26. From 2015 to 2019, [redacted] and I were in and out of court litigating custody disputes, particularly concerning the right to make medical decisions. I was terrified that [redacted] would secure puberty blockers for [redacted] and ultimately lead him to believe he needed hormones and surgery.
27. It was difficult for me to find a lawyer willing to represent me in opposing [redacted] transition. Beginning around 2016, I interviewed at least four. Several turned me down after a consultation; one took a retainer from me but ultimately returned it.
28. Finally I found an attorney who was willing to represent me.
29. Although I came to believe that "gender" theory was not scientific, I bit my tongue because the judge expressed respect for it. At a hearing before trial, she said there are fifty genders. She said that if each of us pushed him into being a gender that he wasn't and he killed himself, that it would be on us.

30. This period of my life was a nightmare. I could hardly eat or sleep for several years. Every day I woke up and thought, "my son is going to be castrated." I would look at young men and almost cry thinking, '[redacted] won't get to be that."

31. I cannot disclose what happened at trial because the judge sealed the proceedings. The outcome was that I could make medical decisions for [redacted] without [redacted] participation. The judgment was issued in December 2019 giving me full legal custody and half physical custody.

32. The litigation was expensive. On top of paying my lawyer, I had to retain an expert witness and cover half the cost of a guardian ad litem. In total, I spent over $250,000 for the right to protect [redacted] from pediatric medical transition. That left me with no savings, no retirement, and about $50,000 in debt. As a result, I declared bankruptcy in 2020.

33. After the custody judgment, I transferred [redacted] to a different public school so that he could start fresh among people who did not know him as a girl. I also let him choose a new name. He chose [redacted] ([redacted] is still his legal name.)

34. [redacted] thrived. In the past his teachers reported he had trouble focusing. In the new school, they reported he was calm. He told me he regularly played football at recess with other boys. His grades improved.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on May 20, 2026.

[redacted]

IMAGE A



UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS, FORT WORTH DIVISION

FEDERAL TRADE COMMISSION,

STATE OF ALASKA,

STATE OF IOWA,

STATE OF NEBRASKA, *ex rel.* Michael T. Hilgers, Attorney General,

and

STATE OF TEXAS, *ex rel.* Ken Paxton, Attorney General,

Plaintiffs,

v.

WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH, INC., a Texas corporation,

WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH, INC., an Illinois corporation,

and

UNITED STATES PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH,

Defendants

Case No. 4:26-cv-00748-O

FIRST AMENDED COMPLAINT FOR PERMANENT INJUNCTION AND OTHER RELIEF

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Plaintiffs the Federal Trade Commission ("FTC" or "Commission"), the State of Alaska, the State of Iowa, the State of Nebraska *ex rel*. Michael T. Hilgers, Attorney General ("Nebraska"), and the State of Texas, ex rel. Ken Paxton, Attorney General ("Texas"), for their Amended Complaint allege:

1. Plaintiff the FTC brings this action for Defendants' violations of Sections 5(a) and 12 of the FTC Act, 15 U.S.C. §§ 45(a), 52. For these violations, the FTC seeks relief, including a permanent injunction pursuant to Section 13(b) of the FTC Act, 15 U.S.C. § 53(b).

2. Plaintiff Alaska brings this action for Defendants' violations of the Alaska Consumer Protection Act, AS §§ 45.50.471, 45.50.501, and 45.50.551. For these violations, Alaska seeks relief, including a permanent injunction, civil penalties, restitution, attorneys' fees and costs, and other appropriate relief as authorized by AS §§ 45.50.501, 45.50.551(b), and 45.50.537.

3. Plaintiff Iowa brings this action for Defendants' violations of the Iowa Consumer Fraud Act. Iowa Code § 714.16. For these violations, Iowa seeks relief including: a permanent injunction, civil penalties, disgorgement, attorney's fees, costs, and other appropriate relief as authorized by Iowa Code.

4. Plaintiff Nebraska brings this action for Defendants' violations of the Nebraska Uniform Deceptive Trade Practices Act ("NE UDTPA"), Neb. Rev. Stat. § 87-301 *et seq*. For these violations, Nebraska seeks relief, including a permanent injunction, civil penalties, attorneys' fees, costs and other appropriate relief as authorized by Neb. Rev. Stat. §§ 87-303(b), 87-303.05, and 87-303.11.

5. Plaintiff Texas brings this action for Defendants' violations of the Texas Deceptive Trade Practices Act, Tex. Bus. & Com. Code §§ 17.41-17.63. For these violations,

Texas seeks relief, including a permanent injunction, civil penalties, restitution, attorneys' fees, costs, and all other appropriate relief provided by Texas law.

I. SUMMARY OF THE CASE

6. The World Professional Association for Transgender Health ("WPATH") is an organization founded and incorporated in Texas that operates for the profit of its members by promoting the medical transition services that its members provide to children.[1] These services—drugs, surgeries, and other interventions—are sold to consumers whose children express dissatisfaction with, or report distress about, their sex-linked biological and anatomical characteristics (their "sex traits"). WPATH's membership predominantly consists of clinicians who profit from these services, including surgeons, endocrinologists, psychiatrists, and pediatricians.

7. To maintain and expand the market for transition services, WPATH provides its members and other clinicians with the means to promote the purchase of medical transition services in a variety of ways. Chief among them is the self-publication, distribution, and promotion of what it calls the "Standards of Care" ("SOC"). WPATH represents that the SOC—the latest version ~~being,~~ SOC-8, published in 2022—are evidence- and consensus-based clinical guidelines for providing medical transition services, including for children who express

[1] This Amended Complaint uses the common definition of "children" throughout. See Child, Black's Law Dictionary (12th ed. 2024) (defining a child as "1. An unemancipated person under the age of majority" or "3. A boy or girl; a young person"). WPATH often uses a different definition of "children," and refers to a child as an "adolescent" when he or she "reach[es] Tanner stage 2 of puberty," which may occur as early as 8 or 9 years old. Eli Coleman, *et al.*, Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 S44, S64 (2022) (hereinafter "SOC-8").

dissatisfaction with or report distress about their sex traits.[2]

8. The SOC recommends life-altering surgeries for children such as penis removal, facial surgery, and breast amputation. One woman who—at age 14—resided in the Dallas-Fort Worth area and underwent breast amputation elsewhere in Texas is now an adult, and provided the FTC with written consent to disclose an image taken of her scarred chest following the surgery. *See* Image A. The photograph clearly demonstrates the life-altering nature of these procedures.

9. In addition to representing that the SOC itself, and the life-altering surgeries it recommends, reflect expert consensus and high-quality evidence, WPATH represents in the SOC that these and other transition services are medically necessary and effective at preventing suicide in children, that puberty blockers are fully reversible, that cross-sex hormones improve mental health, and that breast amputations are safe, effective, and consistently and directly increase children's health-related quality of life.

10. WPATH's representations have further deceived many consumers into believing that its treatment guidelines are based on strong evidence derived from scientific methods. Numerous parents and patients, responding to an FTC Request for Information ("RFI") in 2025 about the medical transitioning of children, have expressed complete confidence that WPATH and its SOC are reliable and trustworthy sources. For example, one person stated that "[t]he guidelines of major professional organizations such as . . . WPATH . . . have been clear and

[2] This Amended Complaint may refer to diagnoses and treatments that occurred before 2022 and were undertaken by clinicians following SOC-7's provisions which were in effect at that time, and which are identical or materially similar to WPATH's current guidance in SOC-8. Because the injuries and harm due to those diagnoses and treatments were caused by clinicians following SOC-7 provisions that were identical or materially similar to that in SOC-8, those injuries and harm illustrate the injuries and harm that result from clinicians' use of SOC-8. Where clinicians before 2022 were conducting themselves in line with what SOC-8's guidance would become, the resulting harms and injuries can similarly exemplify the consequences of clinicians following SOC-8.

follow evidence-based care for these youth for optimal best outcomes." Another wrote, "[g]ender-affirming care for minors already has a number of medical standards and best-practices based on the . . . WPATH Standards of Care which have a substantial and proven research basis." Another commenter stated that "[s]cience shows that transitioning per WPATH . . . lowers the rate of suicide among individuals with in-congruence of gender with their assigned sex at birth."

11. Medical professionals have also been duped. One clinician responded to the RFI by stating that "[t]he WPATH standards of care does an excellent job providing recommendations and guidelines for practices that are evidence based and expert reviewed." Another said, "[a]s a mental health professional . . . affirming and coordinated healthcare, informed by recognized standards of care (including WPATH), provides young people and their families with stability, safety." Unfortunately, this is not the case.

12. WPATH recommends that medical transition services be provided to children as young as 8 or 9 years old. One form of genital surgery that WPATH approves for minors is "vaginoplasty," in which the surgeon cuts off the bulk of a child's testicles and penis. The surgeon restructures the patient's scrotum to mimic a "clitoris" and "labia." Finally, to simulate a vagina, the surgeon carves a wound next to the patient's anus, severs and discards the penile shaft and testicles while saving the penile skin, and lines the wound with the patient's emptied penile skin.

13. The significant number of children being medically transitioned in recent years is driven at least in part by WPATH's removal of age limits for most interventions. WPATH removed any age limitations for breast amputation, penis removal, or any other procedure except one specific type of genital surgery for girls in the final version of SOC-8. WPATH's removal of

these age limitations was not based on a change in the medical consensus or evidence. Indeed, one WPATH leader admitted to "struggl[ing] to find any sound evidence-based argument(s) underpinning" the removal of the age limitations. WPATH nonetheless removed the age limits, expanding the customer base of its members and exposing children to significant mental and physical harm.

14. The success of WPATH's systematic efforts to expand eligibility for transition services to children in order to profit its members is difficult to overstate. Through the SOC and its other efforts, WPATH has created and currently sustains a lucrative industry of pediatric medical transition services. Over roughly the past two decades, the number of pediatric medical transition providers has multiplied rapidly. The first pediatric medical transition clinic in the United States opened in 2007. By 2015, there were at least forty-one pediatric medical transition clinics across the United States, many embedded within major children's hospitals and academic medical centers. Between 2017 and 2021, the number of children who were diagnosed yearly with distress about their sex traits in the U.S. nearly tripled from around 15,000 in 2017 to about 42,000 in 2021.

15. Clinicians rely on WPATH's representations when diagnosing children, exactly as WPATH intends. Also as WPATH intends, in clinical encounters, clinicians repeat WPATH's assertions in the SOC and elsewhere about the necessity, safety, and purported benefits of medical transition when persuading children and their parents to purchase it. Clinicians also direct parents to WPATH's publications, website, and the SOC as authoritative sources of medical information. Many, if not most, sales of pediatric medical transition services would not happen without WPATH.

16. Major health insurance companies likewise rely on the SOC's determination of

medical necessity. That is no accident. In fact, WPATH crafted the SOC with the explicit goal of guaranteeing that insurers would classify medical transition services as medically necessary and therefore covered by their insurance plans. Indeed, SOC-8's drafters repeatedly emphasized in internal communications that SOC-8 should be written to guarantee insurance coverage—including by replacing objective criteria with provider discretion, removing age minimums, and issuing broad "medical necessity" declarations for nearly every medical-transition intervention. As a result, most major insurance companies now foot the bill for pediatric medical transition services, including services that parents would otherwise be unable or unwilling to purchase without insurance.

17. Through these and other efforts, WPATH's professional members have profited immensely from the organization's work. But this profit has come at the expense of children and their parents. To advance its members' financial interests, WPATH has made false, misleading, or unsubstantiated statements—both in the SOC and other public-facing materials—regarding medical consensus and medical necessity, as well as the safety and efficacy of medical transition.

18. WPATH falsely asserts that its recommendations are the result of rigorous scientific procedures and expert consensus, even though WPATH, in producing SOC-8, disregarded established guideline-development standards, ignored the results of its own evidence reviews, and removed age limits in response to external pressure rather than scientific evidence. WPATH further represents that puberty blockers are fully reversible despite internal admissions from SOC-8's authors that this claim required an "asterisk," and it repeatedly asserts that cross-sex hormones and breast amputations improve children's mental health even though WPATH's own leaders privately acknowledged "gaps in research," lack of "research basis," and very low quality evidence. WPATH also misleadingly characterizes pediatric medical transition as

"lifesaving" ~~and~~or "medically necessary," despite the absence of evidence that these interventions reduce the incidence of suicide or have significant health benefits.

19. As WPATH intends, its statements provide the means for medical providers to repeat misleading, false, incomplete, or unsubstantiated information when persuading parents to purchase medical transition services for their children. WPATH informs its members—expressly or by implication—that children who express dissatisfaction with or distress about their sex traits face a higher risk of suicide unless they undergo medical transition, and it repeatedly characterizes transition as "lifesaving" or "medically necessary" despite the absence of evidence that these interventions reduce the risk of suicide. Also as WPATH intends, clinicians recite these claims to parents, often presenting transition as the only alternative to a child's death. In many cases, including those discussed below, providers explicitly ask parents whether they "would rather have a live daughter or a dead son," or vice-versa. These statements echo WPATH's messaging, rely on WPATH's false and unsubstantiated assertions, and induce the purchase of pediatric transition services from WPATH members.

20. If that were not enough, WPATH has also failed to disclose material information about the significant risks and life-long side effects associated with medical transition drugs, surgeries, and other interventions. For example, although puberty blockers can cause hot flashes, lethargy, psychosocial harms, and long-term cognitive deficits, WPATH omits or minimizes these risks in the SOC. Likewise, WPATH fails to adequately disclose that cross-sex hormones carry significant harms for minors, including mood disturbances, vocal pain, pelvic pain, pelvic floor dysfunction, clitoral discomfort, vaginal pain, persistent sexual dysfunction continuing after cessation of use, and erectile pain—effects that can be permanent. And regarding breast amputations, WPATH does not meaningfully disclose the inability to breastfeed, nerve damage

that frequently follow these procedures, nor the serious risk of necrosis. By failing to disclose these material risks, WPATH provides the means by which clinicians can unequivocally recommend the purchase of medical transition services to parents and children. WPATH's misrepresentations and deceptive omissions are thus the means by which providers mislead parents and children to their detriment about the necessity, efficacy, safety, and scientific basis of pediatric medical transition. These misrepresentations and deceptive omissions have caused unspeakable physical and psychological harm to countless children, as reflected in the sworn statements attached hereto and described below. For example, parents and children have reported being told by clinicians that puberty would resume as normal if puberty-blocking drugs stopped being administered.[3] Others were not informed of the various side effects of puberty blockers,[4] such as brain fog and an inability to concentrate,[5] hot flashes,[6] anxiety or depression,[7] urinary incontinence or bloody urine,[8] and genital pain.[9] Serious side effects of cross-sex hormones also were frequently undisclosed or not adequately disclosed,[10] such as experiencing psychotic episodes and other mental-health problems,[11] genital ~~atrophy and~~ pain,[12] leaking from the nipples,[13] ~~inhibited body height,[14] and sexual dysfunction or~~and inability to orgasm.[15]

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[3] *E.g.*, Ex. 4, Decl. of Caroline Miller at ¶¶ 14, 17.
[4] *E.g.*, Ex. 5, Decl. of Elisabeth Bourne at ¶ 16.
[5] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 16.
[6] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶¶ 32, 35.
[7] *E.g.*, Ex. 4, Decl. of Caroline Miller at ¶¶ 20–21.
[8] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶¶ 35, 36–39, 44, 46; Ex. 8, Decl. of Melissa Skinner at ¶ 37.
[9] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 35.
[10] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 26; Ex. 9, Decl. of [redacted] at ¶ 14; Ex. 5, Decl. of Elisabeth Bourne at ¶ 16.
[11] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶¶ 43, 45, 49, 56; Ex. 10, Decl. of [redacted] at ¶¶ 33, 45; Ex. 1, Decl. of Soren Aldaco at ¶ 26.
[12] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶¶ 24–25; Ex. 7, Decl. of Jonathon Skinner at ¶¶ 49–50, 53; Ex. 1, Decl. of Soren Aldaco at ¶ 25.
[13] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 48.
[14] ~~*E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 57.~~
[15] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 76.

Complications from breast amputation were similarly undisclosed or insufficiently disclosed, such as extreme pain,[16] bruising, and internal bleeding.[17]

21. One Texas girl was admitted to a psychiatric facility in Fort Worth after a stressful family-related incident. There, a doctor repeatedly questioned her about whether she identified as a male—she liked stereotypically masculine hobbies like playing video games and was self-conscious about how her body was changing in puberty. The psychiatrist did not meaningfully address her complex family situation or existing mental health issues, but instead "affirmed" her as a male. ~~At~~She subsequently attended a support group in the Dallas-Fort Worth area~~, she learned that the treatment for her "cross-sex identity was~~ where they discussed medical transition~~" in accordance with the~~ and where she learned about WPATH and its "standards of care" ~~which "came from an organization called 'WPATH.'" Acting on that advice, this girl~~for the first time. This girl then underwent pediatric medical transition by injecting testosterone, blocking her estrogen, and undergoing breast amputation. Throughout the process of attending the Dallas-Fort Worth area support group and undergoing medical transition, she learned more about WPATH and the standards of care. She has since accepted that she is a woman and stopped taking testosterone, but she "continue[s] to experience ongoing health problems including fatigue, joint pain, clitoral cysts, and a lot of pain and physical discomfort in [her] upper chest and shoulders" from her medical transition treatments.[18]

22. Through this lawsuit, the FTC is taking action to stop the unconscionable harm inflicted by WPATH's ongoing furnishing of the means necessary for its members and other clinicians to make deceptive claims about the necessity, safety and efficacy of pediatric medical

[16] *E.g.*, Ex. 10, Decl. of [redacted] at ¶¶ 39, 55.
[17] *E.g.*, Ex. 1, Decl. of Soren Aldaco at ¶¶ 34–37.
[18] Ex. 1, Decl. of Soren Aldaco at ¶ 41.

transition drugs, surgeries, and other treatments on children and their parents. The FTC has received hundreds of reports from consumers of medical transition services, including patients and parents, as well as healthcare professionals. In particular, numerous parent and patient declarants have complained to the FTC about serious medical complications arising from medical transition services—and that the risks and side effects that they incurred were often not, or not adequately, disclosed to them. For example, one consumer complained that nobody disclosed "that taking cross-sex hormones and undergoing major surgery at 14 years old could leave me with pelvic floor dysfunction and urinary incontinence, problems I have to manage now as a young adult. I'm only 20 years old. They didn't tell me that these complications are common enough to be known risks, and yet they were hidden from me at an age where I didn't even understand what these terms meant, let alone the impact they would have on my daily life."

23. Additionally, consumers report serious harms that continue after they stop taking cross-sex hormones and identifying as the opposite sex:

- "Today, my chest area is still weak and strange-feeling, and I have limited range of motion in my arms. My voice is deep. I have been told I might not be able to bear a child because of the puberty blocker and five years of testosterone use."[19]
- "I still suffer from urinary incontinence if I sneeze, cry, laugh, or lift something heavy. Just bending over can cause a trickle. I am like a faucet that does not turn off. It is just a constant drip, even though I have been to physical therapy and tried medications. I often wear multiple pairs of underwear or change my underwear throughout the day. I typically wear black pants in public to disguise the leaks. I have never experienced an orgasm."[20]
- "I lost the ability to scream normally when I started taking testosterone. I still cannot scream, and I have recurrent nightmares of not being able to scream when I need to."[21]
- "I experienced nerve pain and electrical sensations from the mastectomy, which

[19] Ex. 6, Decl. of Clementine Breen at ¶ 60.
[20] Ex. 7, Decl. of Jonathon Skinner at ¶¶ 75–76.
[21] Ex. 10, Decl. of [redacted] at ¶ 53.

continues to this day. I now wear prosthetic breasts, and the mild compression helps with my nerve pain while I am wearing them. I wear those or a sports bra when I am intimate with my girlfriend to modulate or buffer the raw nerves. With only a shirt on, or when my girlfriend lays on my bare chest, the pain is excruciating."[22]

- "I continue to experience ongoing health issues, including fatigue, joint pain, clitoral cysts, and a lot of pain and physical discomfort in my upper chest and shoulders. I also have nerve issues around my mastectomy scars. I get strong, weird sensations at the bottom of the scars."[23]

24. ~~These~~The FTC's receipt of these consumer complaints ~~coincide~~coincides with mounting scientific and international criticism and rejection of WPATH's approach, including by the English National Health Service's Cass Review and by countries such as Sweden and Finland, all of which have examined the same body of evidence that WPATH claims to have analyzed, yet reached starkly different conclusions. The Cass Review found that several existing guidelines (including WPATH's) lack methodological rigor, and that no reliable data supports strong recommendations for puberty blockers and cross-sex hormones. Similarly, Sweden and Finland, after conducting their own systematic reviews, now classify pediatric medical transition as experimental, prohibit or severely restrict the use of puberty blockers and cross-sex hormones in children outside of research settings, or prohibit transition surgeries for children entirely.

25. In November 2025, the U.S. Department of Health and Human Services published a 400-page report titled "Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices" ("The HHS Report"), which assessed the evidence base for the medical interventions on children that WPATH recommends and concluded that it is exceptionally weak. The HHS Report also highlighted potential risks and side effects of medical transition services—and ultimately recommended psychological therapy as the generally appropriate treatment for

[22] Ex. 10, Decl. of [redacted] at ¶ 55.
[23] Ex. 1, Decl. of Soren Aldaco at ¶ 41.

children who express dissatisfaction with, or report distress about, their sex traits. The HHS Report's authors commented that their "[r]eview is published against the backdrop of growing international concern about pediatric medical transition. Having recognized the experimental nature of these medical interventions and their potential for harm . . . health authorities in a number of countries have imposed restrictions. For example, the U.K. has banned the routine use of puberty blockers as an intervention for pediatric gender dysphoria."

26. The FTC therefore has reason to believe that WPATH is violating or is about to violate laws enforced by the Commission. Specifically, WPATH's ongoing and intentional furnishing of the means and instrumentalities by which its members and other clinicians deceive consumers into purchasing pediatric medical transition services violates the FTC Act and must be enjoined. Alaska, Iowa, Nebraska and Texas similarly have reason to believe that the laws of their respective states have been violated and must be redressed.

II. JURISDICTION AND VENUE

27. This Court has subject matter jurisdiction pursuant to 28 U.S.C. §§ 1331, 1337(a), and 1345~~.~~ and supplemental jurisdiction over the related claims asserted by the States of Alaska, Iowa, Nebraska, and Texas pursuant to 28 U.S.C. § 1367(a).

28. Venue is proper in this District under 28 U.S.C. §§ 1391(b)(1), (c)(2), and (d); and 15 U.S.C. § 53(b).

III. PLAINTIFFS

29. The FTC is an agency of the United States Government created by the FTC Act, which authorizes the FTC to commence this district court civil action by its own attorneys. 15 U.S.C. §§ 41–58. The FTC enforces Section 5(a) of the FTC Act, 15 U.S.C. § 45(a), which prohibits unfair or deceptive acts or practices in or affecting commerce. The FTC also enforces

Section 12 of the FTC Act, 15 U.S.C. § 52, which prohibits false advertisements for food, drugs, devices, services, or cosmetics in or affecting commerce.

30. The State of Alaska is one of fifty sovereign states of the United States. Cori M. Mills is the duly appointed Attorney General of the State of Alaska and is empowered by the Alaska Consumer Protection Act, AS §§ 45.50.471, 45.50.501, and 45.50.551 to bring an action in the name of Alaska to restrain unfair or deceptive acts or practices, and to seek restitution and civil penalties therefor.

31. The State of Iowa is one of fifty sovereign states. Brenna Bird is the duly elected Attorney General of the State of Iowa and is empowered to bring an action in the name of the State of Iowa. *See* Iowa Code § 13.2. The Iowa Consumer Fraud Act provides a cause of action for deceptive practices. *See* Iowa Code § 714.16.

32. The State of Nebraska is one of fifty sovereign states of the United States. Michael T. Hilgers is the duly elected Attorney General of the State of Nebraska and is empowered by the Nebraska Uniform Deceptive Trade Practices Act, Neb. Rev. Stat. §§ 87-303.05, 303.11 to bring an action in the name of Nebraska to protect the public from deceptive or unconscionable trade practices.

33. The State of Texas is one of fifty sovereign states of the United States. Ken Paxton is the duly elected Attorney General of the State of Texas and is empowered by the Texas Deceptive Trade Practices Act to bring an action in the name of the State of Texas, and in the public interest, to protect the public from false, misleading, and deceptive acts and practices in the conduct of any trade or commerce. *See* Tex. Bus. & Com. Code § 17.47.

IV. DEFENDANTS

34. Defendant the World Professional Association for Transgender Health, Inc.,

("WPATH-TX") was incorporated in Texas in 1980. WPATH-TX remains an active Texas domestic corporation, with Northwest Registered Agent LLC serving as its registered agent in Texas and with a registered office in Texas. WPATH-TX's current bylaws state that it is a Texas corporation.

35. Thirty-seven years after WPATH-TX was organized, Defendant World Professional Association for Transgender Health, Inc., was incorporated in Illinois ("WPATH-IL") in 2017.

36. The United States Professional Association for Transgender Health ("USPATH") is an unincorporated affiliate of WPATH that WPATH controls.

37. At all times relevant to this Amended Complaint, WPATH-TX, USPATH, and WPATH-IL (collectively, "WPATH"), operated for the profit of their members.

V. COMMON ENTERPRISE

38. At all times relevant to this Amended Complaint, WPATH-TX, WPATH-IL, and USPATH have operated as a common enterprise.

39. The operations of WPATH-TX, USPATH, and WPATH-IL are managed by the same management company: Veritas Association Management, Inc.

40. Veritas Association Management, Inc. (which operated as Veritas Meetings Solutions, Inc. until 2020) ("Veritas") was co-founded by Sue O'Sullivan, who serves as Veritas' president. Veritas provides management services for "more than 44 . . . healthcare associations and professional meetings" and lists over 50 clients including WPATH and USPATH.

41. Veritas's president and co-founder incorporated WPATH-IL and serves as one of its directors.

42. Blaine Vella signed WPATH-TX's most recent filing with the Texas Secretary of

State, which listed her title as "Executive Director." The filing also lists Veritas's address as WPATH-TX's principal place of business. Indeed, at least at the time of that submission, Veritas employed Vella as its "Vice President for Client Leadership" while she simultaneously served as "Executive Director, World Professional Association for Transgender Health." WPATH-TX lists its principal place of business as Veritas's address, 1061 E Main St. STE 300, East Dundee IL 60118.

43. WPATH-TX and WPATH-IL have overlapping officers and directors

44. WPATH's website does not distinguish between the two WPATH entities and simply brands itself as "WPATH." WPATH's current website lists its Executive Committee and Board of Directors as: Asa Radix as President; Marci Bowers as Immediate Past-President; Loren Schechter as President-Elect; Chris McLachlan as Secretary; Stephen Rosenthal as Treasurer; Javier Belinky, Kamilla Kamaruddin, Scott Leibowitz, Beth McElrea, Tonia Poteat, Sari Reisner, and Josua Safer as Board members; and Annelou L.C. de Vries, Johanna Olson-Kennedy, Erika Castellanos, and Soufiane Benaouda as Board members and representatives of affiliate organizations.

45. In 2024, the website listed a single set of officers for "WPATH": President as Marci Bowers, Immediate Past President as Walter Pierre Bouman, President Elect as Asa Radix, Secretary as Jamie Veale, Treasurer as Loren Schechter, Board members: Christina Richards, Stephen Rosenthal, Sanjay Sharma, Scott Leibowitz, Chris McLachlan, Sari Reisner, and Joshua Safer. As filed with the Texas Secretary of State in 2024, WPATH-TX identifies its officers and directors as the identical set of twelve people: Marci Bowers (President), Pierre Bouman (Immediate Past President), Asa Radix (President Elect), Jamie Veale (Secretary), Loren Schechter (Treasurer). It listed its directors as: Christina Richards, Stephen Rosenthal, Sanjay

Sharma, Scott Leibowitz, Chris McLachlan, Sari Reisner, and Joshua Safer.

46. In its 2023 annual report, WPATH-IL listed its corporate officers and directors as four of the same people, plus Veritas' president: Marci Bowers (President), Jaimie Veale (Secretary), Loren Schechter (Treasurer), Sue O'Sullivan (Director), Marci Bowers (Director), Jaimie Veale (Director). In its 2026 annual report, WPATH-IL lists its officers and directors as five of the same people, plus Veritas's president: Asa Radix (President), Chris McLachlan (Secretary), Stephen Rosenthal (Treasurer), Marci Bowers (Director), Loren Schechter (Director), Sue O'Sullivan (Director). The WPATH website currently lists three of the same people as officers: Asa Radix as President, Chris McLachlan as Secretary, and Loren Schechter as President-Elect.

47. WPATH-TX and WPATH-IL intermingle their finances. For tax year 2022, 2023, and 2024 (the most recent year for which tax records are available), WPATH filed its tax returns with the Internal Revenue Service as a Texas corporation. For tax years 2020 and 2021, WPATH filed its tax returns as an Illinois corporation. WPATH used the same Employer Identification Number for all filings.

48. WPATH formed USPATH pursuant to WPATH-TX's bylaws, which permit the formation of "Regional Affiliate Organizations." Pursuant to WPATH-TX's bylaws, USPATH's representative (currently, USPATH president Johanna Olson-Kennedy) sits on WPATH's board as a "representative Director." USPATH members automatically become WPATH members, and WPATH members who reside in the United States are automatically USPATH members.

49. The WPATH entities operate the website domain "wpath.org" as the enterprise's main internet presence. USPATH's main internet presence is located on the WPATH website, at "wpath.org/USPATH/", where USPATH lists its Board of Directors, publishes press releases and

newsletters, and provides membership information.

VI. COMMERCE

50. At all times relevant to this Amended Complaint, Defendants have maintained a substantial course of trade in or affecting commerce, as Section 4 of the FTC Act defines "commerce." 15 U.S.C. § 44.

VII. BACKGROUND

A. Transition doctors founded WPATH to promote the transition service industry's financial interests after losing academic support and insurance coverage for medical transition services.

51. America's first "Gender Identity Clinic" opened at Johns Hopkins University in 1966 under the leadership of a plastic surgeon. It aimed to "reassign" patients' sexes using surgery.

52. Clinicians struggled to define the precise contours of the condition they were treating and many expressed concern that not everyone seeking such significant interventions was an appropriate candidate for them.

53. In 1974, psychiatrist Norman Fisk proposed "liberalizing the indications" for medical transition through "employing the diagnostic term gender dysphoria syndrome." Under this model, doctors initiated transition treatment based on the expressed desire to do so, which broadened the number of patients that would be referred to surgery.

54. Meanwhile, some mental health professionals criticized transition doctors for operating without evidence of long-term benefit. After one Johns Hopkins psychiatrist published a paper showing no objective patient benefit to transition, the university shut down its clinic in 1979. Other universities followed.

55. The loss of academic support for transition services posed an existential threat to

the burgeoning medical transition services industry. After a decade of growth, transition doctors were losing the support of insurance providers whose coverage decisions had facilitated that initial growth. In 1979, against this backdrop, transition doctors formed the organization that would become WPATH.

56. To address the growing problem that the loss of insurance coverage presented, WPATH published its "Standards of Care," which purported to establish clinical guidelines for the diagnosis and treatment of persons experiencing dissatisfaction with or distress about their sex traits.

B. ~~Through SOC-8,~~ WPATH fully embraces the medical transition of children.

57. Since 1981, WPATH has revised its "Standards of Care" seven times, culminating in SOC-8 in 2022. In the initial 1981 version of the Standards of Care, WPATH acknowledged that "[h]ormonal and surgical sex reassignment is extensive in its effects, is invasive to the integrity of the human body, has effects and consequences which are not, or are not readily, reversible, and may be requested by persons experiencing short-termed delusions or beliefs which may later be changed and reversed." WPATH emphasized that prospective patients often underestimated those risks, and that "published and unpublished case histories" revealed patients who ultimately "regretted" these treatments and found the final results "to be psychologically dehabilitating [*sic*]."

58. Recognizing these serious and often irreversible medical risks, WPATH concluded that "[h]ormonal and surgical sex reassignment may be conducted or administered only to persons obtaining their legal majority" or who had been legally emancipated.

59. But this guidance would quickly change. In 1987, Dr. Peggy Cohen-Kettenis, a psychologist who would later become a WPATH board member and leading voice within the

organization, founded a medical transition clinic for minors in Utrecht, Holland. At the time, no transition clinics worldwide were known to medically transition children before age 16, and surgical procedures were performed only on adults.

60. Dr. Cohen-Kettenis published articles about administering puberty blockers, pharmaceuticals which prevent natural pubertal development, in children beginning at age 12. Her co-author was a "professor of transsexuality," Dr. Louis Gooren, who believed that humans could possess a "brain sex" which was different from their "genetic, gonadal and genital sex."

61. Despite not having performed any studies on children who had been puberty-blocked at that age, they claimed that puberty blockers were "fully reversible; in other words, no lasting undesired effects are to be expected." Ferring Pharmaceuticals, a manufacturer of puberty blocking drugs, sponsored their work.

62. Dr. Cohen-Kettenis presented her research on cross-sex identified youth at international WPATH conferences beginning in the 1980s. She then served on WPATH's board for four-year terms beginning in 1995 and 2003; Dr. Gooren served on WPATH's board for the intervening term. By the 2000s, WPATH regularly hosted their presentations on pediatric medical transition.

63. In SOC 6, published in 2001, WPATH endorsed administering puberty blockers to children as soon as puberty begins. Dr. Cohen-Kettenis and Dr. Gooren served on SOC-6's drafting committee. At this time, only one published article purported to show evidence that puberty blockers are a safe and effective medical transition procedure: a case report on a single patient of Dr. Cohen-Kettenis. In that report, a young girl whose depression was improved by therapy but who continued to display tomboyish traits and express a desire to be a boy was administered puberty blockers, followed eventually (after the patient reached age 18) by

hormone therapy, a mastectomy, an ovariectomy, and a metoidioplasty (a procedure to surgically separate the clitoris from surrounding tissue to create the appearance of a "micropenis"). Dr. Cohen-Kettenis reported no physical side effects from any of the procedures, "slightly improved" results on most psychological questionnaires, and that the patient was subjectively satisfied with the procedures. Dr. Cohen-Kettenis reported this case to be "the first we know of to show that pubertal delay and subsequent hormonal and surgical intervention . . . has resulted in a positive outcome."

64. Despite only having a single report regarding a single person, WPATH issued a full-throated endorsement of administering puberty blockers at the onset of puberty. WPATH's recommendation for "fully reversible" puberty blockers remained in SOC-7, released in 2012, and remains in ~~SOC-8,~~ the current version, SOC-8, published in 2022.

65. Most children who begin taking puberty blockers proceed to cross-sex hormones. From 2017 to 2021, almost 15 thousand children were started on cross-sex hormone treatment. As explained in more detail below, cross-sex hormones attempt to induce physical changes to make a child more closely resemble the opposite sex. SOC-8 contains a chapter titled "Children," discussing diagnosis and treatment recommendations for pre-pubescent children, and an "Adolescent" chapter discussing diagnosis and treatment recommendations for children who have reached the onset of puberty. SOC-8 endorses cross-sex hormones for children who have "[r]eached Tanner stage 2," which is the onset of puberty—a threshold that many girls cross at age 8 and many boys at age 9.

66. WPATH also recommends various surgeries as a part of pediatric medical transition, including breast amputation and penis removal. WPATH removed any age limitations for breast amputation, penis removal, or any other procedure except one type of genital surgery

for girls in the final version of SOC-8. SOC-7 similarly endorsed breast amputations before the age of majority.

67. Over the past twenty years, the ranks of pediatric medical transition doctors have grown. The first pediatric medical transition services clinic in the United States opened in 2007, but by 2015, there were at least 41 pediatric medical transition clinics across the United States. From 2017 to 2021 the number of children who were diagnosed yearly with distress about their sex traits in the U.S. nearly tripled from about 15,000 in 2017 to about 42,000 in 2021. And in 2025, a single hospital in Colorado administered puberty blockers to 257 children for the purpose of medical transition. As the HHS report notes, "[r]eports from individual clinics suggest that medicalization is the norm, rather than the exception."

VIII. WPATH'S DECEPTIVE PRACTICES

A. WPATH developed SOC-8 without regard for scientific protocols

68. Typically, the medical profession develops what are called "trustworthy guidelines" to optimize medical care. According to the National Academy of Medicine ("NAM"), a competent and reliable guideline for medical care bears several "characteristics."

69. The methodology WPATH used to create SOC-8 does not satisfy accepted medical standards of evidence. Consequently, WPATH's assertions about the necessity, safety, and efficacy of pediatric medical transition drugs, surgeries, and other interventions are not supported by competent and reliable scientific evidence. Nor do they bear the hallmarks of a trustworthy guideline.

70. To begin with, the NAM explains that a trustworthy guideline is "based on a systematic review of existing evidence" and "on an explicit and transparent process that minimizes distortions, biases, and conflicts of interest." Conflicts of interests are "circumstances

that create a risk that professional judgments or actions . . . will be unduly influenced by a secondary interest" such as "financial interests" and non-financial interests including "the pursuit of professional advancement and recognition." The "potential for conflicts of interest are great when funding for [clinical practice guideline] development . . . comes from . . . specialty societies, which might benefit or whose members might gain from guideline recommendations." "Potential sources of bias in the development of clinical practice guidelines include professional affiliations and practice specialization, reimbursement incentives, intellectual preconceptions and previously stated positions, and the desire for recognition and career advancement." Particular concern exists when those creating the guidelines are practicing physicians. Their "secondary interest (*i.e.,* increased income from increased services) has the potential to bias physicians' primary interest in their patients' welfare" resulting in "harm [to] patients who receive unnecessary services." Thus, groups developing practice guidelines should severely restrict the influence of biased professionals including by "exclud[ing] panel members with conflicts from deliberating, drafting, or voting on specific recommendations."

71. According to the NAM, a trustworthy guideline should further "provide a clear explanation of the logical relationships between alternative care options and health outcomes." And it should "provide ratings of both the quality [certainty] of evidence and the strength of the recommendations."

72. WPATH's SOC-8 fails to meet these criteria for multiple reasons: WPATH selected authors who had conflicts of interest; WPATH ignored the consensus protocol that SOC-8 purports to follow; WPATH failed to adhere to proper protocols both in evaluating scientific and medical evidence and in making recommendations based on that evidence; and WPATH made material changes to its recommendations in response to external pressure rather

than scientific evidence.

73. SOC-8 claims, just as SOC-7 did, to be based on "the best available science and expert professional consensus." As WPATH knows, its members and others use the SOC to make claims to parents and children. Thus, WPATH's assertions that its recommendations represent evidence-based and "consensus-based expert opinion" give members and other clinicians the means to misrepresent to consumers that the SOC reflects expert scientific consensus and to repeat the unsubstantiated statements therein when persuading parents and children to purchase pediatric medical transition services in accordance with WPATH's recommendations.

74. For example, one parent visited an endocrinologist to discuss purchasing pediatric medical transition services for her child. That doctor sent the parent a link to WPATH's then-current SOC-7 after she asked for information supporting cross-sex hormones.[24] And another parent visited a transition clinic but was reluctant to purchase pediatric medical transition services. A clinic worker responded by informing this parent that WPATH's guidelines were the standard of care.[25]

i. WPATH failed to disclose biases and conflicts of interest in the development of SOC-8.

75. WPATH provides to members and other clinicians the means to falsely convey to parents and patients that WPATH's guidelines are based on a reliable methodology which follows established scientific procedures, including by minimizing biases and conflicts of interest amongst its drafters. That false representation about process is crucial to WPATH's claims regarding the necessity, safety, and efficacy of pediatric medical transition and specific transition

[24] Ex. 5, Decl. of Elisabeth Bourne at ¶ 19.
[25] Ex. 11, Decl. of Gwen Turecki at ¶ 7.

services—claims that clinicians also convey to parents.

76. For example, SOC-8 claims that it followed the NAM and World Health Organization ("WHO") standards on managing conflicts of interest. Yet WPATH ignored WHO standards requiring that those "who have major conflicts of interest, be they financial or nonfinancial, cannot be appointed to the [guideline development group]." And it likewise ignored the NAM standards, which provide that subject matter experts with conflicts of interest "can share their expertise with the [guideline development group] as consultants and as reviewers . . . but generally should not serve as members of the [guideline development group]." And even where it is necessary for a guideline development group to have members with conflicts of interest, the NAM cautions that "[m]embers with [conflicts of interest] should represent not more than a minority of the [guideline development group]" and that "[t]he chair or cochairs should not be a person(s) with [conflicts of interest]."

77. Far from attempting to manage or minimize conflicts of interest, WPATH's author selection process ensured that SOC-8's drafters would harbor biases and conflicts of interest. Thus, SOC-8 is a product of bias and financial conflicts of interest, and therefore not based on a reliable methodology that follows established scientific procedures.

78. The WHO warns against allowing "intellectual conflicts of interest" to taint the development of guidelines, and the NAM warns that individuals with "intellectual relationship[s] that may impact [their] ability to approach a scientific question with an open mind," and whose "community standing" might be impacted by voicing dissent have conflicts of interest. Nevertheless, WPATH exclusively selected authors for SOC-8 who already supported medical transition services. For example, the selection criteria for SOC-8 Revision Committee co-chairs and Chapter Leads required that each be a "[l]ongstanding WPATH Full Member in good

standing" and a "[w]ell recognized advocate for WPATH and the SOC."

79. These conflicts of interest were not merely intellectual—SOC-8 authors often stood to benefit personally and financially from guideline recommendations. WPATH's former president and current board member Dr. Marci Bowers is a prime example of the conflicts of interest that affected SOC-8's development. Dr. Bowers, who has advocated for performing genital surgeries on children, made more than a million dollars in a single year from transition surgeries but declared it "absurd" to disclose that conflict or attempt to account for it in SOC-8.

80. Those conflicts were not limited to Dr. Bowers. Dr. Eli Coleman, a leader of the SOC-8 drafting effort, testified in a deposition that "most participants in the SOC-8 process had financial and/or nonfinancial conflicts of interest." Dr. Coleman himself was the director of the University of Minnesota's Institute for Sexual and Gender Health—which provides puberty blockers and cross-sex hormones to children—for over three decades. In May 2023, after SOC-8 was published, the Institute renamed itself the Eli Coleman Institute for Sexual and Gender Health.

81. The leader of an external review team lamented that "[d]isclosure, and any necessary management of potential conflicts, should take place *prior* to the selection of guideline members" but "this was not done here."

82. Notwithstanding these conflicts of interest, WPATH falsely represents that SOC-8 complied with WHO and NAM standards in reviewing "[c]onflicts of interests . . . as part of the selection process" and determining that "[n]o conflicts of interest were . . . significant or consequential."

83. But WPATH's selection process, as a leading SOC-8 author admitted, resulted in most—if not all—SOC-8 authors having conflicts of interest that were significant and

consequential.

ii. Contrary to its claims, WPATH failed to obtain consensus on consequential changes to recommendations in SOC-8 regarding the provision of transition services to children

84. WPATH knowingly provides members and other clinicians the means to convey to parents and children that medical consensus supports the provision of transition services to children. WPATH represents in SOC-8 that it developed its recommendations through a specific process that yielded expert consensus. But WPATH failed to follow that process and failed to obtain consensus among SOC-8 drafters for key recommendations regarding pediatric medical transition services. It published its recommendations and represented them as the product of medical consensus nevertheless.

85. WPATH claims that SOC-8 used the "Delphi process," which is a formal method of developing recommendations based on expert consensus.

86. The Delphi process ensures a level of consensus by posing a question to experts who answer anonymously. Those answers are collated, ranked, and voted upon. That process continues until a consensus statement is reached based on the highest ranked choice.

87. WPATH failed to follow Delphi when developing SOC-8. The most glaring example of SOC-8's departure from this framework is the removal of age minimums for pediatric medical transition drugs, surgeries, and services including cross-sex hormones, breast amputations, surgical penis removal, and facial surgery. The initial draft of SOC-8 included age minimums ranging from 14 to 17 years old for cross-sex hormones, chest surgeries, facial surgeries, genital surgeries,[26] and other surgeries. These age limits were the product of

[26] As in the final draft, an age limit of 18 was set for phalloplasty.

WPATH's "expert consensus" but were removed at the last minute because of external pressure, as discussed in more detail below.[27]

88. The removal of age minimums did not itself go through Delphi. At least one WPATH member could not "see how we can simply remove something that important from the document—without going through a Delphi—at this final stage of the game."

89. WPATH failed to disclose that it disregarded the results of the Delphi process with respect to age limits and thus its statement that "[c]onsensus on the final recommendations was attained using the Delphi process" is false.

iii. WPATH misrepresented the quality of evidence underlying its guidelines for pediatric medical transition services

90. Publicly, WPATH provides members and other clinicians the means to convey to parents and children that its recommended transition services reflect quality medical evidence and established scientific methodology. Privately, SOC-8 drafters knew that they did not have sufficient medical evidence to support their recommendations. Moreover, WPATH did not follow its stated methodology for grading the quality of evidence and exaggerated the quality of evidentiary support for medical transition services.

91. Dr. Coleman acknowledged in a 2023 strategy memo to his fellow drafters that "[a]ll of us are painfully aware that there are many gaps in research to back up our recommendations."

92. In 2024, Dr. Amy Tishelman, the lead drafter of SOC-8's Children chapter, admitted in an NPR interview that she and her peers had no "research basis" for making decisions or a sufficient "evidence base to know what the best treatments are":

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[27] See *infra,* ¶¶ 107–116.

> TISHELMAN: [W]e're talking about assessments [prior to transitioning a child], but we really don't have research on what assessments are effective. Right now, we don't have a research basis for making those decisions, but at least we could bring together a diversity of sophisticated clinicians who do believe that transgender youth exist, to come up with some guidelines about what we mean by assessment.
>
> NPR: That is so remarkable. We don't even know yet what the best assessments are, let alone we don't have an evidence base to know what the best treatments are.
>
> TISHELMAN: No.

93. But that lack of evidence did not deter the SOC-8 authors, who knew "what we should end up with" in SOC-8 despite the lack of evidence. In other words, WPATH's SOC-8 authors had prejudged that SOC-8 would ultimately make strong recommendations in favor of pediatric medical transition regardless of whether the quality of the evidence supported such recommendations.

94. In February 2026, Dr. Tishelman justified transitioning children despite not understanding "the etiology [of desiring transition], or why," by comparing pediatric medical transition to knowing "that the sun and the moon existed before we understood anything about why. Lots of things we observe in life, we know to be true, and we don't understand them."

95. Although WPATH had recommended prescribing puberty blockers to children as early as SOC-6, in connection with the preparations for SOC-8 members of WPATH's guideline development group acknowledged that "there is no agreement on [the use of puberty blockers] within pediatric endocrinologists," that "a global consensus on 'puberty blockers' does not exist," that various European countries had begun restricting puberty blockers and expressing skepticism about their use, and that they did not believe that SOC-8's recommendation "is supported by the data."

96. Moreover, as former WPATH board member Dr. Erica Anderson explained in

2025, there is not "a lot of long term research on the use of puberty blockers," so experts "don't know" whether they "affect not just the advance of physical development but also . . . cognitive development . . . and emotional development" amongst other side effects. Thus, SOC-8 lacked sufficient medical and scientific basis for its strong recommendation that puberty blockers be administered to children because WPATH could not support the claim that "there are few downsides of" doing so.[28]

97. Despite the acknowledged lack of evidence, SOC-8 purported to use a version of the "GRADE" system. That system asks a clinical question that is then answered by a systematic literature review of available evidence. Reviewers then assess the evidence and assign it a value of "very low, low, moderate, or high." Next, the reviewers weigh the evidence and make a recommendation for or against a particular medical intervention. Finally, the reviewers classify that recommendation as "strong" or "weak."

98. The quality of evidence reflects the certainty of that evidence. High quality evidence means that a reviewer is "very confident that the true effect" of a treatment "lies close to that of the estimate of the effect." Very low quality evidence means that a reviewer has "very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect."

99. Evidence quality can suffer for several reasons, including risk of bias, unexplained variations in results, evidence that is not directly applicable to the research question, precision flaws like small sample sizes or wide confidence intervals, publication bias, selective reporting, and other problems.

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[28] See *infra,* ¶ 103 (noting SOC-8's representations regarding the requisite level of evidentiary support for its recommendations).

100. Low-quality and very-low-quality evidence often contain serious flaws, including failure to account for comorbidities, failure to control for the placebo effect, selective inclusion of respondents, unrepresentative respondents, lack of comparison groups, lack of controls for differences with comparison groups if any were present, and short follow-up intervals.

101. According to the NAM, a trustworthy guideline should "provide ratings of both the quality [certainty] of evidence and the strength of the recommendations."

102. But WPATH decided not to include the results of its GRADE review of evidence in SOC-8. This was a deliberate decision to obfuscate the strength of the evidence supporting WPATH's recommendations and allow WPATH to overstate the strength of its evidence.

103. SOC-8's misleading methodology purports to rely on GRADE despite not following the GRADE system. SOC-8 states that the phrase "we recommend" is a "strong recommendation" which indicates that: "the evidence is of high quality," that "there is a high degree of certainty [that the intervention's] effects will be achieved in practice," that "there are few downsides of [the] therapy/intervention/strategy," and that "there is a high degree of acceptance among providers and patients or those for whom the recommendation applies." Conversely, the term "we suggest" is a "weak recommendation."

104. With respect to children, SOC-8 "recommend[s] . . . surgical interventions for eligible*" children, referring the reader to the summary criteria for eligibility contained in SOC-8 Appendix D and the Adolescents chapter generally for eligibility criteria. Appendix D lists surgeries including "breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery." By using "we recommend," SOC-8 represents that its recommendations for these surgeries are "[s]trong recommendations" because the "evidence is of high quality" with few accompanying downsides.

105. WPATH's recommendations are false and misleading because they represent that they are supported by high-quality evidence and that the treatments in question have few downsides. In reality, WPATH's recommendations are unsupported by high-quality evidence, and the recommended procedures often have severe and permanent negative physical and psychological side effects. Indeed, at least some of WPATH's recommendations are contrary to the results of WPATH's consensus process. Thus, WPATH provides the means by which clinicians deceive parents when claiming that strong evidence and scientific consensus support pediatric medical transition.

106. For example, in initial drafts of SOC-8, WPATH included a strong recommendation in favor of administering puberty blockers "after [children] first exhibit physical changes of puberty," despite WPATH grading the supporting evidence as "moderate." In the published final version of SOC-8, WPATH decided to omit its "moderate" grade. Thus, because SOC-8 claims that a "strong recommendation" reflects that "the evidence is of high quality," the omission of WPATH's "moderate" grade misrepresents that the evidence supporting administering puberty blockers is of high quality. Clinicians rely on SOC-8's representations about the strength of the evidence when assuring parents that purchasing puberty blocker treatment is medically necessary to treat their children.

iv. Improper external pressure, not scientific or medical evidence, also led to WPATH's recommendations in SOC-8 pertaining to pediatric medical transition services

107. Finally, WPATH's claim that its guidelines are the product of scientific evidence and medical consensus is also untrue as to key portions of SOC-8, including the lack of age minimums for nearly all aspects of pediatric medical transition other than phalloplasty for girls, because those recommendations are the result of external pressure, not scientific or medical

evidence. Specifically, WPATH provides the means that enable clinicians to deceive parents and children by representing or implying that that SOC-8 reflects evidence-based scientific consensus.

108. For example, Admiral Rachel Levine, then serving as the Assistant Secretary for Health at the United States Department of Health and Human Services, was "extremely supportive of the SOC 8" and "very eager for its release—so to ensure integration in the US health policies of the Biden government." As shown below, Admiral Levine's office pressured WPATH to lift age limitations on medical transition services and that pressure contributed to WPATH's decision to lift all age limitations.

109. SOC-8's drafters initially included recommended minimum ages for various pediatric medical transition services. These recommendations had gone through SOC-8's Delphi process. But these age limits would have reduced the pool of potential customers for pediatric medical transition services by restricting provision of those services to those above the specified ages.

110. In July 2022, Admiral Levine's Chief of Staff spoke with a SOC-8 author and expressed concern that WPATH's then-proposed minimum ages for a variety of pediatric medical transition services (which underscore that patients are children) would "result in devastating legislation" limiting those services. Such legislation would also have damaged the careers and livelihood of many of WPATH's members, who profit from the legality of pediatric medical transition service. Accordingly, Admiral Levine's Chief of Staff asked "if the specific ages can be taken out."

111. WPATH members discussed this request in light of their shared financial objective of "help[ing] in the fight against" what they termed "the conservative anti trans

agenda." A co-lead of SOC-8's Adolescent chapter explained that if age minimums were in SOC-8, "[t]he conservatives will only hone in on the ages and say that WPATH is supporting 'cutting off healthy girl breasts at 15 years old.'" If SOC-8 stayed silent on ages, the reasoning went, "[i]t doesn't give them the headline."

112. Some WPATH members expressed concerns that acquiescing to external pressure would harm the "messaging and marketing" of SOC-8. For example, then-WPATH president Dr. Walter Pierre Bouman stated that it would not be "appropriate to take any feedback from a nonmedical professional seriously." But those concerns were ignored. Indeed, one SOC-8 author wrote that, in a meeting, Admiral Levine "asked us to remove" references to minimum ages. Another WPATH member wrote, after suggesting a "compromise" solution, that "it is frustrating to have politics in our brains as we make these decisions. But it is what it is!"

113. The outside pressure continued. According to a WPATH leader, the American Academy of Pediatrics threatened to "actively publicly oppose" SOC-8 if WPATH did not remove the age minimums. Dr. Bouman expressed "surprise[] that a 'reputable' association" like "the AAP [wa]s so thin on scientific evidence" for its demands. Dr. Bouman likewise "struggle[d] to find any sound evidence-based argument(s) underpinning" the AAP's demanded changes.

114. But WPATH made the change anyway. Specifically, WPATH caved to this external pressure and removed the age minimums, which, relative to the initial SOC-8 draft, broadened the class of potential patients to whom its members could sell transition services to include children of even younger ages. And WPATH did this to further the profits of its members, despite the acknowledged absence of high-quality evidence supporting the change and in violation of its own stated procedures, including by disregarding the Delphi process that it

purported to follow.

115. One WPATH committee member acknowledged that it was "the most strange experience" to see WPATH eliminate minimum age recommendations at the "last minute" after internal discussion made clear that "nobody [on the committee] wanted to [eliminate] them, and personally not agreeing with the change."

116. Ultimately, the removal of age limits at the behest of interested third parties was intended to—and did—increase the profits generated by WPATH's members by expanding the pool of potential patients to include more and younger children.

B. WPATH knows that its recommendations are not supported by scientific evidence or a medical consensus

i. WPATH commissioned an evidence review, then blocked the results from being published

117. SOC-8's authors commissioned systematic reviews of evidence regarding pediatric medical transition from Johns Hopkins University. A team led by Dr. Karen Robinson was to conduct those reviews, grade the evidence, and present the results to the SOC-8 drafters to inform their work.

118. Dr. Robinson told a government official in 2020 that she and her team had "completed and submitted reports of reviews (dozens!) to WPATH."

119. In commissioning these reviews, WPATH secured significant control over the creation and use of any of the Johns Hopkins reports, including whether they would ultimately be published. Among other things, WPATH required that the Johns Hopkins team "use the Data[29]

[29] WPATH's policy defines "Data" to include essentially any work done by Dr. Robinson's team in connection with SOC-8, to include "raw data, research data, records, reports, notes, tables, writing, sound recordings, pictorial reproduction, drawings or other graphical representations, and works of any similar nature (whether or not copyrighted) which are generated or specified to be delivered by Dr. Robinson and her team in connection with the update and development of the SOC8."

for the benefit of advancing transgender health in a positive manner" and "involve[] at least one member of the transgender community in the design, drafting of the article, and the final approval of the article." Only after meeting these criteria could Johns Hopkins seek final approval from the WPATH Board of Directors for publication.

120. Johns Hopkins ~~examined~~attempted to gather scientific studies concerning "multiple types of ~~[pediatric medical transition]~~ interventions (surgical, hormone, voice therapy . . .)," ~~and~~but "found little to no evidence about children and adolescents."

121. WPATH ~~rejected~~obstructed the distribution of multiple Johns Hopkins manuscripts, causing Dr. Robinson to express frustration that WPATH was "trying to restrict our ability to publish."

122. This was not the only notable evidentiary exclusion from SOC-8. For example, two preliminary articles regarding a study by later USPATH president Dr. Johanna Olson-Kennedy and others formed the evidence base of SOC-8. Two subjects of that study committed suicide during the period of observation. Yet SOC-8 did not disclose or discuss those deaths and how they might undermine SOC-8's conclusion that pediatric medical transition improved psychological well-being.

123. Because WPATH fears that open scientific debate will result in less profit and business for its members, WPATH routinely suppresses opposing scientific viewpoints by intentionally concealing information. For example, one WPATH member complained on a "WPATH Member Forum" in 2021 that when WPATH members publicly disagree with each other, "[i]t doesn't help me with my corporate, HR, and DEI clientele." This WPATH member feared that open discussion of detransitioners, or those who undergo medical transition but later return to living as their sex, potentially jeopardized his or her income. Indeed, the WPATH

member complained that public debates "reduce[] the inclusion/exclusion battle to mutually opposing academics with paychecks at stake, which means companies are less likely to invest in trans and gender expansive infrastructure."

124. A WPATH member forwarded this post to WPATH leaders, commenting that "it is very well articulated feedback for WPATH."

125. Thus, WPATH works to protect its members' revenues by quashing internal debate, including the type of debate that is necessary to the scientific process and development of medical guidelines. Relatedly, those associated with WPATH have worked to keep crucial details concerning patient encounters, patient outcomes, and their efforts to expand the market for medical transition services hidden to reduce potential criticism. Dr. Kellan Baker, whose doctorate is in health policy and management, lectured WPATH conference attendees in 2023 to "[k]eep it simple" because "[i]t is really, really, really detrimental right now for us to provide, unfortunately, a lot of detail about who we are, who our patients are, what our work looks like."

126. WPATH also suppresses debate and dissension by engaging in personal attacks and invective. As the Cass Review, an independent review commissioned by England's National Health Service, noted, "the toxicity of the debate" around transition services "is exceptional," and "[t]here are few other areas of healthcare where professionals are so afraid to openly discuss their views, where people are vilified on social media, and where name-calling echoes the worst bullying behaviour."

127. WPATH contributes to that toxicity. For example, the American Medical Association privately declined to "endorse" SOC-8 because it generally does not back "standards of care" as they "fall outside of [the AMA's] expertise." WPATH's then-president, Dr. Walter Pierre Bouman, forwarded the AMA's email to other WPATH leaders, speculating that "the

AMA and its current custodians" were "probably some white heterosexual cisgender hillbillies from nowhere."

ii. WPATH has falsely represented in SOC-8 that pediatric medical transition is the standard of care for children experiencing dissatisfaction with or distress about their sex traits

128. Despite the low-quality evidence supporting pediatric medical transition, WPATH represents that pediatric medical transition is the "Standard of Care" for children who express dissatisfaction with or distress about their sex traits.

129. A "standard of care" typically reflects the collective judgment of the medical community and best available research evidence regarding the diagnosis of specific conditions and safe and effective treatment. A "standard of care" informs medical malpractice law, where the standard of care sets the bar that physicians must meet based on the norms of a given practice area.

130. By titling its publication "Standards of Care," WPATH purposely represents that the SOC has the hallmarks of traditional standards of care used by the medical community and courts of law. But as WPATH's president-elect Dr. Loren Schechter conceded under oath, despite bearing the name, the SOC "is not considered" by courts to be "the standard of care" for treating sex-trait-related dissatisfaction or distress. When asked why WPATH nonetheless titles its marquee publication "Standards of Care," Dr. Schechter quipped, "I didn't come up with that in 1979. I was 17 years old." Yet WPATH continues to represent that its recommendations are in fact the "standard of care" for children's medical care.

131. As the HHS report notes, SOC-8's recommendations do not represent medical consensus as to the appropriate manner of care for pediatric medical transition services. To the contrary, "[t]here is currently no international consensus about best practices for the care of

children and adolescents with gender dysphoria." WPATH's use of the term "standards of care" with respect to medical transition (including cross-sex hormones, puberty blockers, and surgical interventions), and WPATH's recommendations for those treatments, additionally implies that such treatments are standard, appropriate, and universally and widely accepted. In fact, those procedures are not and never were standard and are, in fact, prohibited or discouraged in many states and countries. The procedures are the subject of significant medical debate as to their appropriateness and effectiveness and evidence supporting performing them on children is weak or nonexistent.

iii. WPATH is aware of myriad factors that lead children to experience distress about their sex traits, but still directs clinicians to medically transition children notwithstanding potential alternative diagnoses and treatments

132. There are numerous potential root causes of a child's distress about or discomfort with their sex traits. For example, some minors who seek to transition are girls who want to escape being girls because they were sexually assaulted,[30] or gay teenagers who are uncomfortable with or confused about their sexual orientation.[31] At first glance, WPATH appears to acknowledge this fact—at least as to mental illness and trauma. In practice, however, WPATH leads clinicians to disregard it, directing children to medical transition procedures instead of the care they need.

133. WPATH acknowledges that patients who express discomfort with or distress about their sex traits have "a higher prevalence of depression," "anxiety," and "suicidality" and have often experienced "complex trauma," "discrimination," and "violence." SOC-8 notes that "it is critical to differentiate gender incongruence from specific mental health presentations"

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[30] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 57.
[31] *See* Ex. 10, Decl. of [redacted] at ¶¶ 5–9; Ex. 7, Decl. of Jonathon Skinner at ¶¶ 3–11.

including "trauma," "parent/child interaction difficulties," "obsessions and compulsions," "broader identity problems," and even "psychotic thoughts."

134. This is a frequent problem due to the prevalence of mental health morbidities for children who express discomfort with or distress about their sex traits. A Finnish study covering all Finnish adolescents referred for medical transition services between 1996 and 2019—over 2,000 children and over 16,000 control-group individuals—found that 45.7% of the adolescents referred to medical transition services had psychiatric morbidity, while only 15.0% of the control group presented psychiatric morbidities.

135. Despite the awareness of these potential alternative causes of distress, SOC-8 discourages "gatekeeping practices" which WPATH decries as a "barrier to the provision of" what it deems necessary medical transition procedures. "Gatekeeping," however, simply refers to a clinicians' diligent application of eligibility criteria to determine whether to administer medical transition procedures.

136. Even if WPATH legitimately encouraged clinicians to investigate whether medical transition treatment is appropriate for a given child, SOC-8 offers no genuine method for making such a determination. Indeed, WPATH defines "gender incongruence" as a subjective "experience" that is "deeply felt" by the child. It offers no objective diagnosis criteria for clinicians. SOC-8 asserts that some distress about sex traits stems from biological factors that exist "from birth," while other distress is "a developmental process," and that "it is not possible to distinguish between those" causes in individual cases. It is likewise "impossible to delineate the contribution of various factors contributing" to a child's dissatisfaction or distress with their sex traits. As the HHS Report notes, "the diagnosis of gender dysphoria is based entirely on subjective self-reports and behavioral observations, without any objective physical, imaging, or

laboratory markers." Instead, it "centers on attitudes, feelings, and behaviors that are known to fluctuate during adolescence."

137. Thus, at face value, SOC-8 purports to require rigorous diagnostic procedures, namely that clinicians "undertake a comprehensive biopsychological assessment of adolescents who present with gender identity-related concerns and seek medical/surgical transition-related care." In practice, however, this is an empty requirement that lacks any concrete, objective criteria. The assessments are framed only in broad, indeterminate terms, telling clinicians they "should aim to understand the adolescent's strengths, vulnerabilities, diagnostic profile, and unique needs to individualize their care." WPATH's procedures do not specify what these factors mean, how they should be evaluated, or how they should influence clinical decisions. Instead, what these factors mean, and how they should be determined or weighed, WPATH leaves entirely to individual clinicians.

138. That indeterminate and desultory guidance is unsurprising since, as the lead drafter of SOC-8's Children chapter conceded, "we don't have a research basis for making those decisions." Indeed, that is why WPATH effectively discourages clinicians from seeking to understand and address the source of a child's distress. Presenting at a WPATH conference, psychologist Dr. Laura Kuper of the University of Texas Southwestern Medical Center mocked a clinician who tried to "understand" a child patient's "sexuality" before beginning medical transition, stating: "Well, wait a minute, I'm a grown woman and I don't even quite know exactly which box I'd want to tick, so I—Are you asking [the child] to pigeonhole?"

139. A responsible clinician faced with a child who expresses distress about their sex traits might wish to engage in ~~in~~ therapy or treatment to encourage a child to become comfortable with their sex traits. SOC-8 emphatically forecloses this option. It dismisses such

approaches as "reparative" and "conversion therapy" and provides a strong recommendation against attempting them. Indeed, it states that such "efforts may be viewed as a form of violence."

140. Despite providing no tools to determine the source of a child's distress, SOC-8 tells clinicians that, when faced with a child who expresses that they are the opposite sex, clinicians need not—indeed, should not—seek to resolve a child's issues regarding mental health and trauma before administering cross-sex hormones and performing medical transition surgeries. SOC-8 makes clear that "not all mental health challenges can or should be resolved completely" before administering transition procedures and tells clinicians not to allow "addressing mental illness and substance use disorders" to be "a barrier to" medical transition. They are advised only to ensure that "any mental health concerns are treated sufficiently" so that medical transition treatments "can be provided optimally," meaning that the child will take their transition medications consistently, "attend follow up medical appointments," and exercise "self-care, particularly in a postoperative course," that is, after a mastectomy or genital surgery has been performed.

141. The practical—and intended—result is that SOC-8 permits disregarding and leads clinicians to disregard other causes of distress and encourages proceeding to medical transition as soon as possible. As a result, many medical transition clinics lack adequate mental health staff. If they do provide some form of talk therapy, it often focuses on the child's aesthetic preferences. For example, a WPATH member and the medical director of a public university's transition clinic, explained that the clinic's "psychology and social work" interactions with a 17-year-old boy uncovered that "Frank-N-Furter from Rocky Horror [Picture Show] really aligns with [the patient's] gender expression, and so began to explore what that would look like and we

were able to access breast forms in a corset and [the patient] reported that this really feels affirming to them."

142. SOC-8 also fails to acknowledge that many children expressing distress about their sex traits as puberty approaches are simply gay or lesbian.

~~142.~~143. To the contrary, ~~it~~SOC-8 discourages clinicians from adequately pursuing this possibility, asserting that clinicians "must be sensitive to the history of (mis)use of sexual identity and orientation as a gatekeeping function to exclude transgender people from" receiving medical transition procedures. As a result, clinicians perform medical transition procedures on children instead of helping them to become comfortable with their sexuality.

~~143.~~ For example, ~~one endocrinologist at~~upon receiving an "immediate" diagnosis of gender dysphoria after only a ~~university medical center, who has testified to following~~cursory virtual examination of their son via Zoom, two parents questioned the ~~WPATH Standards of Care when treating his patients, told a 13-year-old boy who felt anxious about his attraction to other boys~~clinician by suggesting that ~~he~~perhaps their son was ~~not a~~merely gay ~~boy but rather had a "female brain."~~[32]

144. ~~One woman in recalls~~. But the clinician "shut us down immediately and insisted that ~~growing up, she felt like a boy in a girl's body. She identified with male romantic leads in movies and~~ [the son] was ~~rowdy and aggressive. Even though she had crushes on girls in middle school, she could not fathom being gay – she did not personally know any lesbians except a gym teacher whom her classmates mocked. She adopted a "~~transgender~~" identity and visited a public university's pediatric medical transition clinic, where a psychologist agreed with the woman's~~

[32] ~~Ex. 7, Decl. of Jonathon Skinner at ¶ 24; *see* Ex. 8, Decl. of Melissa Skinner at ¶ 13.~~

~~theory that she~~. She would not address any of our questions or explain why any alternative explanation was ~~a male. An endocrinologist and WPATH conference presenter prescribed this woman testosterone when she was 16. After using testosterone for years and undergoing breast amputation at 16, this woman now recognizes that she is a lesbian, not a man.~~[33] wrong."[34]

C. Independent reviews and guidelines reinforce that WPATH's recommendations and claims regarding pediatric medical transition are unsupported by competent and reliable scientific evidence

145. The independent reviews conducted by several European government entities reinforce that SOC-8's guidelines and recommendations for providing transition services to children are unsupported by competent and reliable scientific evidence.

146. For instance, the English National Health Service commissioned an Independent Review, known as the Cass Review after Dr. Hilary Cass, the Chair of the Independent Review. Dr. Cass published the review in 2024.

147. The Cass Review sought to definitively examine the current state of the medical evidence regarding care for children who express discomfort with or distress about their sex traits. To that end, the Cass Review "commissioned systematic reviews on a range of issues from epidemiology through to treatment approaches, and international models of current practice."

148. As the Cass Review noted, systematic reviews provide "the highest form of evidence" by summarizing "the literature on a particular question" and "us[ing] explicitly defined and reproducible methods to systematically search, critically appraise, and synthesize primary research information." In doing so, systematic reviews are "designed to be reproducible, reliable and to eliminate bias." Using these standardized and reproducible methods "ensures that,

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~~[33] Ex. 10, Decl. of [redacted] at ¶¶ 4–7, 8, 11, 19–23, 25, 35–36, 57.~~
[34] Ex. Decl. of [redacted] at ¶¶ 11–12.

as far as is possible, different people appraising a paper will come to similar conclusions."

149. For the Cass Review, the University of York conducted an "independent research programme" which provided "the best available collation of published evidence."

150. The Cass Review examined existing guidelines addressing pediatric medical transition and concluded that "[o]nly five" of the twenty-three such "guidelines published between 1998 and 2022" claimed to employ a "systematic approach to searching for and/or selecting evidence."

151. According to the Cass Review, most guidelines, including SOC-8, scored "poorly on the rigour of development, applicability and editorial independence domains."

152. The Cass Review noted that "it was difficult to detect what evidence had been reviewed and how this informed development of the recommendations. For example, most of the guidelines described insufficient evidence about the risks and benefits of medical treatment in adolescents, particularly in relation to long-term outcomes. Despite this, many," including SOC-8, "then went on to cite this same evidence to recommend medical treatments."

153. The Cass Review also noted that "[e]arly versions of two international guidelines - the Endocrine Society 2009 and WPATH [SOC] 7 - influenced nearly all the other guidelines, except for the recent Nordic guidelines." And the Endocrine Society and WPATH guidelines were themselves "closely interlinked, with WPATH adopting Endocrine Society recommendations, and acting as a co-sponsor and providing input to drafts of the Endocrine Society guideline." SOC-8 is also a product of this incestuous cycle, as it "cited many of the other national and regional guidelines to support some of its recommendations, despite these guidelines having been considerably influenced by WPATH [SOC] 7."

154. The Cass Review concludes that "[t]he circularity of this approach may explain

why there has been an apparent consensus on key areas of practice despite the evidence being poor." That circular approach, combined with other problems including the failure to "follow[] the international standards for guideline development" and "lack [of] developmental rigour," "raise[] serious questions about the reliability of current guidelines" like SOC-8. The Cass Review also found that SOC-8 "overstates the strength of the evidence in making [its] recommendations."

155. For example, there is "insufficient and/or inconsistent evidence about the effects of puberty suppression on psychological or psychosocial health," which is a conclusion "in line with the finding of . . . other systematic reviews, apart from the systematic review commissioned by WPATH." As for why WPATH reached a different conclusion, the Cass Review explained that "eight of the 12 studies" that WPATH considered "were rated as low quality."

156. Notably, the Cass Review reported that the two systemic guidelines which WPATH had not influenced, "the recent Nordic guidelines" from Sweden and Finland, had a far stronger evidentiary basis than WPATH's guidelines. Specifically, as part of the Cass Review, the University of York evaluated guidelines using "AGREE II [Appraisal of Guidelines, Research, and Evaluation] . . . which is the most commonly applied and comprehensively validated appraisal tool" for clinical guidelines. Among other things, that tool evaluates "rigour of development," which "is an important bedrock of guideline development" that "includes systematically searching the evidence, being clear about the link between recommendations and supporting evidence, and ensuring that health benefits, side effects and risks have been considered in formulating the recommendations." The Cass Review found that SOC-8 scored 38% on "rigour of development."

157. Only the Swedish and Finnish guidelines "scored above 50% for rigour of

development." In contrast to WPATH, the Swedish and Finnish guidelines concluded that there was a "lack of robust evidence about medical [transition] treatments," leading "to a recommendation that treatments should be provided under a research framework or within a research clinic." The Cass Review further observed that the Nordic guidelines were "the only guidelines that have been informed by an ethical review conducted as part of the guideline development." Accordingly, the Cass Review concludes that "only the Finnish (2020) and the Swedish (2022) guidelines could be recommended for use in practice."

158. Unsurprisingly, the Finnish and Swedish guidelines recommend a significantly different treatment approach to SOC-8. For example, rather than undertake a process where a doctor's role is simply to assist a child with accomplishing "embodiment goals," the Swedish guidelines restrict the use of puberty blockers and cross-sex hormones by children to narrowly defined exceptional cases in the context of clinical research, with surgeries likewise limited to exceptional circumstances. Even then, the Swedish guidelines still prohibit medical transition services without significant additional precautions, including that clinicians identify and successfully treat any other mental health conditions before proceeding with these experimental treatments.

159. The Finnish guidelines impose similar restrictions. They categorize pediatric medical transition as an "experimental practice," prohibit pediatric medical transition surgery, and also prohibit administering puberty blockers and cross-sex hormones if the patient has any major untreated psychiatric comorbidities. Taken together, the Cass Review and guidelines from Sweden and Finland illustrate that there is no consensus concerning pediatric medical transition services.

160. Accordingly, the Cass Review and practices in Sweden and Finland underscore

the absence of competent and reliable scientific evidence supporting WPATH's SOC-8. Nevertheless, WPATH disseminates SOC-8 to clinicians, knowing and expecting that they will convey these unsubstantiated recommendations to consumers and children, thereby providing the means and instrumentalities for others to make unsubstantiated claims about medical transition interventions.

D. WPATH falsely claims that pediatric medical transition is "lifesaving" or "medically necessary" and, in so doing, misrepresents the risks and benefits of pediatric medical transition

161. Medically transitioning children can involve blocking the onset of puberty with drugs, administering cross-sex hormones, and performing surgeries on the face, chest, and genitals. These medical interventions have serious, physically harmful, and irreversible effects.

162. Importantly, the overall quality of evidence purporting to show a benefit to pediatric medical transition is very low.

163. Despite the low-quality of evidence supporting pediatric medical transition, WPATH represents that its recommendations—which by and large recommend the medical transitioning of children—are the "Standard of Care" for treating children who express dissatisfaction with or distress about their sex traits.

i. WPATH's representation that medical transition is necessary and effective to prevent suicide in children is false, misleading, or unsubstantiated

164. SOC-8 asserts that "chest dysphoria" can lead to anxiety, depression, and distress, all of which can be treated by mastectomy. SOC-8 additionally asserts that not providing medical transitioning can lead to depression and anxiety. SOC-8 further claims that "hormone therapy is considered a lifesaving intervention," and that medical transition "is associated with a substantial reduction in the risk of suicide attempt[s]."

165. To reach these and other conclusions, WPATH relies on spurious studies that

frequently fail to control for the placebo effect or contain other serious defects. WPATH also ignores or dismisses evidence that suggests there are no benefits to pediatric medical transitioning, or that pediatric medical transition harms mental health. Despite arguing against legal restrictions that had been placed on pediatric medical transition services, counsel for the American Civil Liberties Union in *United States v. Skrmetti* conceded to the Supreme Court at oral argument in that case that "there is no evidence [] in the studies that [transition] treatment reduces completed suicide."

166. WPATH nevertheless asserts that medical transition is "lifesaving" or "medically necessary" despite the lack of evidence to substantiate the claim that medical transition is necessary and effective at preventing suicide.

167. Although WPATH does not explicitly claim in SOC-8 that medical transition reduces completed suicide, WPATH instead asserts that medical transition treatments reduce "suicidality" and "suicidal ideation." But a reasonable consumer, hearing that pediatric medical transition "reduces suicidality" would understand those claims to mean that medical consensus and scientific evidence establish that medical transition is necessary and effective to prevent suicide. Thus, regardless of whether WPATH refers to "suicidality" or "suicide" in the materials (SOC-8) that it provides to its members and other clinicians, the net impression that consumers take away is the same.

168. Indeed, that medical transition is lifesaving—*i.e.*, necessary and effective to prevent suicide—is precisely the message that WPATH intends to convey. As Dr. Johanna Olson-Kennedy, the current president of USPATH, told ABC News, "[w]e often ask parents, [w]ould you rather have a dead son than a live daughter?"

169. WPATH has deceived consumers by claiming that "high quality evidence"

supports its treatment recommendations and its assertion that medical transition is "lifesaving" —or "medically necessary"—causing many parents and patients to reasonably, but incorrectly, believe that SOC-8 is grounded on reliable methods and solid evidence. Numerous consumers, responding to an FTC Request for Information ("RFI") in 2025 about the medical transitioning of children, expressed their reliance upon or confidence in WPATH's guidelines. For instance, one commentator stated, "for trans and gender diverse people, especially youth, access to gender affirming care is imperative and life-saving. The current recommendations provided by . . . WPATH for gender-affirming care [prevent an eight-fold increase in the risk of children] attempt[ing] suicide." Another wrote, "WPATH ha[s] stated that this care is safe, and necessary. The amount of harm that will be caused by restricting or banning gender affirming care will be life threatening to trans children."

170. WPATH's representations thus leverage parents' fear that their child might commit suicide to obtain parental consent for the purchase of medical transition services, despite the lack of evidence that such treatments will in fact alleviate the child's distress and reduce their risk of suicide.

ii. WPATH's representation that puberty blockers are fully reversible is false, misleading, or unsubstantiated

171. Puberty is the stage between childhood and adulthood during which a person becomes capable of reproduction. The onset of puberty typically occurs between ages 9 and 14 in boys and 8 and 13 in girls. SOC-8 recommends that clinicians begin medical transition when children reach puberty.

172. Puberty begins and proceeds through complex endocrine signaling. In the brain, the anterior pituitary gland secretes gonadotropin hormones, which act on the gonads (ovaries or testes) to stimulate the synthesis of sex steroids (testosterone in boys; estrogen and progesterone

and in girls) and promote gametogenesis, the biological process of forming mature germ cells (sperm in boys and eggs in girls). During puberty, sex steroid hormones promote skeletal growth, muscle and nerve development, reproductive development, and cognitive development in both sexes.

173. Puberty blockers impede these developments and come in two forms. A doctor may inject the drug on a regular schedule (*e.g.*, monthly) or implant a device in the child's arm that lasts for a certain period (*e.g.*, twelve months) and then is typically removed.[35]

174. The Food and Drug Administration ("FDA") has approved various pharmaceuticals classified as gonadotropin-releasing hormone agonists—commonly called "puberty blockers" or GnRHas—for the treatment of "precocious puberty," which occurs when a child's pituitary gland activates prematurely. Puberty blockers act directly on the pituitary gland to significantly reduce the release of gonadotropins, which prevents the onset or further pubertal development. Once a child reaches a normal age at which to begin puberty, the use of puberty blockers is discontinued.

175. These drugs have other FDA-approved uses, such as in androgen deprivation therapy for adult males with prostate cancer and for estrogen deprivation in adult females with endometriosis.

176. The FDA has not approved puberty blockers for the treatment of patients who express dissatisfaction with or distress about their sex traits, or for healthy children of normal pubertal age. Their use in pediatric medical transition is thus "off-label," a term that refers to doctors prescribing FDA-approved medications for a purpose, dosage, or population not listed on

[35] *See* Ex. 12, Decl. of [redacted] at ¶ 16 (describing process of implanting puberty blockers); *e.g.*, Ex. 4, Decl. of Caroline Miller at ¶¶ 18 (discussing implantation), 27 (discussing removal).

the FDA-approved label.

a. WPATH asserts that puberty blockers are fully reversible

177. WPATH recommends that puberty blockers be prescribed to children despite serious side effects that can include bone issues and psychosocial harms (*i.e.*, mental, emotional, and social harms), while failing to adequately disclose, discuss, and warn against other side effects, which include hot flashes, long-term cognitive deficits, and lethargy.

178. Despite the side effects, SOC-8 recommends that clinicians begin medical transition as early as 8 or 9 years old and represents that puberty blockers are "fully reversible." ~~It~~WPATH repeats that representation elsewhere, too. For example, in a presentation that WPATH continues to publish on its website entitled "Applying and Understanding the WPATH Standards of Care (SOC) Through the Healthcare Providers Lens," WPATH asserts that puberty blockers are "fully reversible."

179. Consumers are deceived by these assertions. For example, a respondent to the FTC's 2025 RFI stated, "[t]here are multiple organizations that support providing gender affirming care to both adults and children … [including] WPATH. The care given to minors is safe and completely reversible."

180. While SOC-8 purports to emphasize "the importance of addressing other risks and benefits of pubertal suppression," rather than proceeding to disclose and discuss the aforementioned risks and side effects, WPATH instead focuses on purported benefits by suggesting that puberty blockers will result in "improvement in romantic and sexual satisfaction for adolescents."

181. Despite these risks, WPATH claims that the use of puberty blockers "is generally safe with the development of hypertension being the only short-term adverse event" when used

for medical transition of children. It further asserts that there are "no known long-term adverse events" when used for its FDA-approved purpose on children experiencing precocious puberty, and claims that puberty blockers are "medically necessary" for children being medically transitioned.[36]

182. As shown below, these recommendations wrongly state and imply that puberty blockers' off-label use to medically transition children is scientifically established as safe and effective.

b. WPATH's representation that puberty blockers are safe, effective, and reversible is false, misleading, or unsubstantiated

183. When clinicians administer puberty blockers as part of pediatric medical transition, they prevent naturally timed puberty in children. That causes a condition known as hypogonadotropic hypogonadism ("HH"). HH occurs because puberty blockers cause the pituitary gland's release of gonadotropins to stop, meaning the gonads cannot produce the sex steroids testosterone or estrogen and, consequentially, pubertal development halts, disrupting the progression of the child's physical, cognitive, and reproductive development.

184. Additionally, HH is associated with a range of increased health risks including anemia; headaches, fatigue, and hot flashes;[37] impaired brain development and functioning; diminished mental health and depression;[38] decreased bone mineral density, osteoporosis, and bone fractures; and sexual dysfunction.

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[36] SOC-8's predecessor was similarly deceptive; despite mentioning "concerns about negative physical side effects of [puberty blockers] (e.g., on bone development and height)" and admitting that "long-term effects can only be determined when the earliest treated patients reach the appropriate age," SOC-7 still labeled puberty blockers' effects "fully reversible."

[37] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 35 (hot flashes, muscle spasms, "could not keep weight on"); Ex. 6, Decl. of Clementine Breen at ¶ 16 (hot flashes and "sluggish[ness]").

[38] *E.g.*, Ex. 12, Decl. of [redacted] at ¶¶ 60–62; Ex. 4, Decl. of Caroline Miller at ¶¶ 21, 25; Ex. 6, Decl. of Clementine Breen at ¶ 16 (brain fog).

185. Although these children remain stalled in a prepubertal or early pubertal stage, their classmates progress through puberty, impeding the puberty-blocked child's social development and undermining that child's psychological well-being.

186. During adolescence, the brain undergoes substantial reorganization that involves profound structural and functional changes aimed at increasing efficiency and maturity. At least one study has found that children who undergo puberty blockers for more than one year have decreased executive function compared to those who do not block puberty, prompting concerns that puberty blockers may temporarily or permanently disrupt brain maturation and cause significant neuropsychological consequences.

187. The accrual of peak bone mass typically occurs during puberty. Sex steroid hormones play an essential role in the mineralization of the skeleton.

188. Failure to reach peak bone density may lead to increased risk of osteoporosis and fractures later in life, including debilitating fractures of the spine and hip.

189. Studies on pediatric patients undergoing medical transition have consistently demonstrated decreases in bone density with the use of puberty blockers.

190. No studies have considered the effects of medical transition on the bone health of pediatric patients into middle age or late adulthood.

191. When children receiving puberty blockers later receive cross-sex hormones, bone mineralization typically increases, but a critical period for bone-density accrual during adolescence may have been missed or shortened, because bone density accrual slows during the patient's twenties and then begins to decline. Children administered puberty blockers may therefore never reach their possible peak bone density. Although SOC-8 does disclose that "[a] prolonged hypogonadal state in adolescence," including due to "GnRHa monotherapy," "is often

associated with an increased risk of poor bone health later in life," it immediately proceeds to minimize this risk, noting that "bone mass accrual is a multifactorial process that involves a complex interplay between endocrine, genetic, and lifestyle factors."

192. Puberty blockers also inhibit or prevent genital growth during a possibly critical period, with potential harms to future sexual function in both boys and girls. Research on sexual-function outcomes in children who undergo pediatric medical transitioner is also meager and lacking.

193. Transition drugs, including puberty blockers, are linked to erectile pain for boys and men. This is a common patient complaint. But when a teenage boy in Michigan tried to investigate why arousal created a sensation of broken glass scraping against his penis, doctors repeatedly assured him it was not caused by the transition drugs.[39]

194. Safety data for puberty blockers as used in children of normal pubertal age are meager or absent. Despite the lack of research, SOC-8 provides a "strong recommendation" that clinicians administer puberty blockers to children, thereby asserting that "the evidence [for the intervention] is of high quality," "there are few downsides," and "there is a high degree of acceptance among providers" for the treatment.

195. WPATH knows that its representations about the reversibility of puberty blockers are deceptive. Dr. Scott Leibowitz, who co-authored the relevant chapter of SOC-8, acknowledged behind closed doors that the claim puberty blockers are "reversible" should have an "asterisk" next to it.

iii. WPATH's representation that cross-sex hormones are safe, effective, and improve mental health is false, misleading, or unsubstantiated

[39] Ex. 7, Decl. of Jonathon Skinner at ¶¶ 49–50, 52–53.

196. Transition doctors administer cross-sex hormones to help children reach their "embodiment goals," *i.e.*, to shape the way their sex characteristics develop to control their appearance. For example, transition doctors prescribe testosterone to girls to make them appear more like boys. Indeed, as the HHS report notes, these "embodiment goals" often "serve as the primary guide for treatment decisions." SOC-8 directs doctors to honor these goals as "medically necessary."[40]

197. Cross sex-hormones are FDA-approved for conditions like hypogonadism (when the gonads produce little or no sex steroids) or menopause. The use of cross-sex hormones for pediatric medical transition is off-label and not FDA approved.

198. In SOC-8, WPATH strongly recommends that clinicians administer cross-sex hormones to children who have "Reached Tanner stage 2," which is the onset of puberty—an extension from SOC-7's proclamation that adolescents are medically "eligible" for cross-sex hormones with parental consent.[41] In other words, SOC-8 recommends that WPATH members and clinicians inject girls as young as 8 with testosterone, if that 8-year-old has begun puberty and expresses discomfort with her sex traits.[42]

a. WPATH represents that cross-sex hormones are safe, effective, and improve mental health

199. In SOC-8, WPATH represents that cross-sex hormones are medically necessary for children who express discomfort with or distress about their sex traits, and that cross-sex

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[40] SOC-7 similarly labels cross-sex hormones in the treatment of gender dysphoria as "medically necessary."

[41] See, *e.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 47 (describing being prescribed estrogen at 13); Ex. 6, Decl. of Clementine Breen at ¶ 18 (describing being prescribed testosterone at 13); Ex. 9, Decl. of [redacted] at ¶ 13 (describing clinical worker advocating for cross-sex hormone treatment for declarant's 14-year-old); Ex. 2, Decl. of Cassidy Andrews at ¶ 24 (girl prescribed testosterone at 14).

[42] Ex. 9, Decl. of [redacted] at ¶ 13 (describing clinical worker advocating for cross-sex hormone treatment for declarant's 14-year-old in 2024).

hormone use is an appropriate treatment as early as the onset of puberty.[43]

200. WPATH claims in public statements that the administration of cross-sex hormones is "safe" for children and asserts in SOC-8 that cross-sex hormone therapy "has been shown to improve quality of life and to decrease depression and anxiety."

201. WPATH asserts that hormone therapy "positively impact[s] the mental health and quality of life of [children]" and "is considered a lifesaving intervention."

202. WPATH therefore represents, expressly and by implication, that the administration of cross-sex hormones to children is lifesaving, medically necessary, safe, effective, and improves mental health.

203. WPATH makes these representations despite a panoply of side effects that it acknowledges exist, along with additional side effects that it fails to disclose. Among the side effects that WPATH acknowledges are hyperkalemia, hypertriglyceridemia, weight gain, cardiovascular disease, cerebrovascular disease, meningioma, hypertension, erectile dysfunction, type 2 diabetes, low bone mass, hyperprolactinemia, polycythemia, infertility, acne, and androgenic alopecia.

204. WPATH notes other potential side effects of the administration of cross-sex include "problematic sexual health outcomes" including "impact [on] sexual function, pleasure and sexual self-expression," and the potential "to impact reproductive functions and fertility," while noting that the "consequences are heterogenous" (*i.e.*, varied). But WPATH presents such

[43] SOC-7 similarly contemplates children's use of cross-sex hormones may be necessary, explaining that they "may be eligible to begin feminizing/ masculinizing hormone therapy" and explains the dangers of "withholding puberty suppression and subsequent feminizing and masculinizing hormone therapy" to include "prolong[ing] gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization [which] … is strongly associated with the degree of psychiatric distress during adolescence." "[W]ithholding" hormones "is [accordingly] not a neutral option for adolescents." And in subsequent discussion, SOC-7 describes "[f]eminizing/masculinizing hormone therapy … [a]s a medically necessary intervention."

impacts as reversible once the administration of cross-sex hormones ceases: "If hormonal therapy is discontinued and gonads are retained, many physical changes will revert to pre-hormone therapy status . . . including . . . erectile dysfunction."

205. SOC-8 fails to adequately disclose the existence and severity of additional effects for children treated with cross-sex hormones,[44] which include mood disturbances, vocal pain, pelvic pain, pelvic floor dysfunction, clitoral discomfort, vaginal pain, persistent sexual dysfunction continuing after cessation of use, and erectile pain.

206. Cross-sex hormones halt a child's normal pubertal development. Cross-sex hormones do not induce opposite-sex pubertal development. The natural endpoint of puberty—sexual maturation and reproductive capacity—does not result so long as cross-sex hormones continue to be administered. In fact, continued use can suppress or eliminate entirely the child's potential for sexual maturity and fertility.

207. For example, an endocrinologist, who has testified to following the WPATH Standards of Care when treating his patients, implanted a puberty blocker in a boy who had never experienced erections and prescribed cross-sex hormones. The boy, now a 23-year-old man, stopped using transition drugs several years ago. But he has still never experienced an orgasm.[45] Nonetheless, in SOC-8,[46] WPATH has failed to adequately disclose that sexual health dysfunction can persist even after a patient stops taking cross-sex hormones. Indeed, as noted

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[44] SOC-7 is similarly flawed: Despite providing a non-exhaustive list of health risks associated with hormone therapy *in adults*, SOC-7 omits that information in its chapter on children and adolescents.

[45] Ex. 7, Decl. of Jonathon Skinner at ¶ 76; *see* Ex. 12, Decl. of [redacted] at ¶ 64 (describing this as a common side effect). That this 23-year-old man received treatment while SOC-7 was in effect makes no difference here; SOC-7 and SOC-8 contain materially similar content on this point, and therefore, SOC-8 will cause and is causing the same harms. *Supra* n.2; *infra* n.46.

[46] SOC-7 similarly described the effects of puberty blockers as "fully reversible" and, concerning the risks of cross-sex hormones as relevant to this declarant's side effects, mentioned only "variable impact on sexually stimulated erections[,]" which among other associated risks "may be considered minor or even desired, depending on the patient."

above, WPATH represents that sexual function "will revert to pre-hormone therapy status."

208. SOC-8 recommends cross-sex hormones even where there are alternative medical explanations for the child's expressed discomfort. For example, it endorses "hormone treatment if a transgender and gender diverse individual requires admission to a psychiatric . . . unit." And it advises that "the presence of [psychosis] symptoms does not necessarily equate to an inability to give consent" for interventions.

209. Leveraging WPATH's guidance, transition doctors push hormonal interventions onto consumers—which can have detrimental psychoactive effects—even when children experience mental health crises.[47] For example, ~~USPATH president Dr. Olson-Kennedy increased a 16-year-old girl's testosterone dose as she spiraled into "psychosis."[48] For another,~~ a Missouri doctor reacted to a girl's avoidance of school and hospitalization for mental health issues while on puberty blockers by prescribing her testosterone.[49]

b. WPATH's representation that the administration of testosterone to girls is safe and effective and improves mental health is false, misleading, or unsubstantiated, including because of side effects that WPATH has failed to adequately disclose

210. Testosterone comes in multiple forms. Patients may inject it on a regular basis (*e.g.*, weekly) or apply a less potent gel.

211. In girls, high doses of testosterone may cause changes in musculature, thickening of vocal cords causing voice deepening, differences in fat distribution, increased facial and body hair, cystic acne, and male pattern hair distribution or loss. Serious health risks include high blood pressure, worsened cholesterol and lipid blood levels, insulin resistance, vaginal atrophy,

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[47] *E.g.*, Ex. 12, Decl. of [redacted] at ¶¶ 54, 62, 68. Ex. 6, Decl. of Clementine Breen at ¶¶ 43–51; Ex. ~~12, Decl. of [redacted] at ¶¶ 54, 62, 68; Ex.~~ 10, Decl. of [redacted] at ¶ 33~~.~~

[48] ~~Ex. 6, Decl. of Clementine Breen at ¶¶ 43–51.~~

[49] Ex. 12, Decl. of [redacted] at ¶ 62.

persistent pelvic pain and discomfort, pelvic floor dysfunction, and cardiovascular problems. Emotional and mental instability may be additional consequences.[50]

212. Girls and young women have also reported vocal issues including pain when speaking, inability to sing, and inability to scream after starting testosterone. Thickened vocal cords are a permanent effect of testosterone; they do not return to original size when the patient stops using testosterone. Although SOC-8 does note that many patients "experience difficulties such as inadequate pitch lowering, compromised voice quality, vocal loudness, vocal endurance, pitch range, and flexibility," in SOC-8, like in SOC-7, WPATH does not disclose vocal pain as a side effect.

213. Clitoral enlargement is an effect of testosterone in girls.[51] This can cause chafing against underwear and tight pants.[52] Girls and young women have reported strange feelings or dulled sensation in their clitorises after using testosterone.

214. A Texas woman reports that she began developing painful cysts on her clitoris after starting testosterone as a minor. The problem has not resolved since she stopped using testosterone years ago.[53] SOC-8, like SOC-7, contains no mention of painful clitoral cysts as a risk associated with masculinizing hormones.

215. Certain effects of testosterone in girls, such as thick vocal cords, changes to clitoral size and sensation, and hair growth, are irreversible.

216. Testosterone use in girls can cause reproductive organ atrophy, including thinning

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[50] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶¶ 21, 42–51; Ex. 10, Decl. of [redacted] at ¶ 33; Ex. 1, Decl. of Soren Aldaco at ¶ 26.
[51] Ex. 12, Decl. of [redacted] at ¶ 53.
[52] Ex. 12, Decl. of [redacted] at ¶ 53.
[53] Ex. 1, Decl. of Soren Aldaco at ¶¶ 25, 41. That this woman received treatment while SOC-7 was in effect makes no difference here; SOC-7 and SOC-8 contain materially similar content on this point, and therefore, SOC-8 will cause and is causing the same harms. *Supra* n.2.

of vaginal epithelium; symptoms mimicking polycystic ovary syndrome; persistent pelvic pain and discomfort; and pelvic floor dysfunction leading to incontinence, constipation, and chronic pelvic pain. SOC-8 discloses "pelvic floor dysfunction" as a potential side effect only in connection with vaginoplasty, not the administration of testosterone or other cross-sex hormones.

217. To resolve the pelvic pain that testosterone use causes, transition doctors advise girls and young women to undergo hysterectomy. This operation renders the patient sterile.

218. Vaginal atrophy is painful and has significant consequences. It can make penetrative sex unbearable and even dangerous, as the thinned walls can rupture and hemorrhage. Such pain can impair other activities as well. For example, a 9th-grade girl undergoing medical transition had to quit cross country and track because she developed intense vaginal pain after starting testosterone.[54]

219. SOC-8 notes that cross-sex hormones "may affect mood." The reality is much worse. People using cross-sex hormones for medical transition have reported mood disturbances including anxiety, depression, mood swings, suicidal ideation, and homicidal ideation. A California woman recalls transforming from being a "big reader and very polite" to "a horrible student" who "bull[ied] outcasts" after, at age 13, she took testosterone prescribed to her by Dr. Olson-Kennedy. After using testosterone for about 18 months, she began hallucinating that people were "stalking" her and that bugs were "crawling on [her] skin," having panic attacks, experiencing "intense delusions that [her] parents were demonic forces set against" her, and cutting herself because she "felt like there was something inside [her] that she could not get

[54] Ex. 6, Decl. of Clementine Breen at ¶ 24. That this woman received treatment while SOC-7 was in effect makes no difference here. *Supra* n.49.

out."[55] SOC-8 fails to disclose these severe psychological side effects.

220. Testosterone causes weight gain, which in turn causes more health problems.[56] A St. Louis transition clinic saw so many of its young female patients develop sleep apnea after gaining weight on testosterone that it began routinely screening every girl for the condition.[57]

221. Girls and women using testosterone can become dependent on it.

c. WPATH's representation that the administration of estrogen and progesterone to boys is safe, effective, and improves mental health is false, misleading, or unsubstantiated, including because of side effects that WPATH has failed to adequately disclose

222. In boys, transition doctors frequently administer a cocktail of estrogen, progesterone, and finally—to block testosterone production or uptake—a puberty blocker or anti-androgen medication, such as Spironolactone (Aldactone). Spironolactone is a potassium-sparing diuretic that blocks androgen receptors and inhibits testosterone production. Its primary on-label uses include managing high blood pressure and treating fluid retention associated with heart failure, liver cirrhosis, or kidney disease. It is not an FDA-approved treatment for medical transition.

223. Side effects of estrogen use in boys include blood clots; high blood pressure; potential cardiovascular issues like a stroke, heart attack, or venous thromboembolism; decreased libido; erectile dysfunction; erectile pain; infertility; weight gain; mood swings; fluid leaking

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[55] ~~Ex. 6, Decl. of Clementine Breen at ¶¶ 21, 43–51.~~ Ex. 6, Decl. of Clementine Breen at ¶¶ 21, 43–51. That this California woman underwent this treatment while SOC-7 was in effect does not matter here. SOC-7 similarly failed to disclose these severe psychological side effects to using testosterone for these purposes; SOC-7 warns only that "testosterone or other androgenic steroids may increase the risk of hypomanic, manic, or psychotic symptoms in patients with underlying psychiatric disorders that include such symptoms," which this young woman did not have before using testosterone. Because SOC-7, like SOC-8, is materially similar in that it omits relevant side effects, SOC-8 will cause and is causing the same harms. *Supra* n.2

[56] Ex. 12, Decl. of [redacted] at ¶ 51.

[57] Ex. 12, Decl. of [redacted] at ¶ 51.

from nipples; and pain near the nipple.[58]

224. Transition drugs, including estrogen, can cause erectile pain for boys and men. A presentation at a WPATH conference in 2021 reported that over half of respondents in a survey "reported experiencing painful erections while on hormone therapy." Despite these common patient reports of erectile pain,[59] SOC-8, like SOC-7, does not disclose this risk.

225. Many effects of estrogen in boys, such as breast growth, shrunken testicles, and stunted or arrested fertility, are generally irreversible.

226. Many boys and young men on cross-sex hormone regimens complain of "brain fog," or inability to think clearly. Their parents report that these boys and young men seem unable to regulate emotions or cope with social interactions.[60]

iv. WPATH's representations that breast amputation for girls is safe, effective, and consistently results in better health and quality of life are false, misleading, or unsubstantiated

227. WPATH's assertions in SOC-8 concerning the purported safety, efficacy, and health and quality of life benefits of breast amputation for minors are not supported by reliable evidence and fail to disclose the known risks associated with the procedure. By characterizing breast amputation as a routine, medically necessary intervention that consistently improves health-related quality of life, WPATH provides the means by which clinicians deceive consumers into purchasing breast amputations for children. These representations, and the omissions accompanying them, operate to mislead consumers regarding both the evidentiary basis for the procedure and the scope and severity of its potential adverse outcomes.

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[58] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶¶ 48, 73; Ex. 12, Decl. of [redacted] at ¶ 65.
[59] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶¶ 49–50; *see* Ex. 12, Decl. of [redacted] at ¶ 63.
[60] *E.g.*, Ex. 13, Decl. of [redacted] at ¶¶ 19–24; *see* Ex. 12, Decl. of [redacted] at ¶ 66.

a. WPATH represents that breast amputations are safe and effective, and consistently result in better health and quality of life

228. WPATH represents in SOC-8 that breast amputations are safe, effective, and consistently result in better health and quality of life for girls experiencing dissatisfaction with or distress about their sex traits. SOC-8 states that "[t]he efficacy of top surgery has been demonstrated in multiple domains, including a consistent and direct increase in health-related quality of life," and a "consistent increase in satisfaction with body and appearance." WPATH adds that "the evidence demonstrates top surgery to be a safe and effective intervention." In sum, SOC-8 presents breast amputations as routine, medically necessary procedures that result in better health and quality of life.

229. SOC-8 discloses minimal potential risks and side effects associated with breast amputations.[61] It says that "[c]hest surgeries" such as "mastectomy" "may adversely affect erogenous sensation." It recommends that patients should be "abstinent from tobacco/nicotine prior to gender-affirmation surgery" because "[t]obacco use has been associated with worse outcomes in plastic surgery, including overall complications, tissue necrosis, and the need for surgical revision." SOC-8 further recommends that "[i]ndividuals who undergo gender-affirming surgery of the chest should have ongoing breast cancer surveillance."

b. WPATH's representations that breast amputation for girls is safe, effective, and consistently results in better health and quality of life are false, misleading, or unsubstantiated

230. Breast amputation, or mastectomy, involves removal of the mammary glands together with the ducts that transfer milk from the glands to the nipple. Breast amputation

[61] Its predecessor, SOC-7, similarly contained minimal disclosures of potential risks and side effects; it warned only, for example, that "[c]omplications of subcutaneous mastectomy can include nipple necrosis, contour irregularities, and unsightly scarring."

typically results in an inability to breastfeed and loss of erogenous sensation.

231. Clinicians have referred girls for breast amputations at age 12.

232. The immediate aftermath of breast amputation can be incredibly painful, and patients typically require intimate care for weeks afterward. For example, a WPATH member performed a breast amputation on a 14-year-old girl in San Francisco. The teen woke up from the operation feeling like she "had been hit by a truck" and found herself "hardly" able to "move [her] arms.~~"[62]~~"[63]—none of which are side effects disclosed by WPATH in SOC-8 or its predecessor SOC-7.

233. Breast amputation is associated with numerous surgical complications, such as necrosis, seroma or lymphedema (fluid buildup and swelling), hematoma (localized clotted or pooled blood outside blood vessels), scarring, and nerve damage resulting in chronic pain or loss of sensation.

234. Breast amputation can involve removing the nipples and then sewing them back on—what SOC-8 refers to as nipple grafts. Some women who began transition as minors report experiencing "nipple necrosis" or that their nipples turned black and fell off afterward.[64] But SOC-8 describes "necrosis" as a potential risk only in connection with the use of tobacco. Some surgeons try to avoid this side-effect by advertising no-nipple breast amputations to girls and women who identify as nonbinary. Regardless, skin at the site of breast-amputation scars tends to

~~[62] Ex. 6, Decl. of Clementine Breen at ¶¶ 40–41.~~

[63] Ex. 6, Decl. of Clementine Breen at ¶¶ 40–41. That this woman received treatment while SOC-7 was in effect makes no difference here; SOC-7 and SOC-8 are materially similar on this point in that neither contain those side effects, and therefore, SOC-8 will cause and is causing the same harms. *Supra* n.2

[64] ~~Ex. 2, Decl. of Cassidy Andrews at ¶¶ 41–42.~~ *E.g.*, Ex. 2, Decl. of Cassidy Andrews at ¶¶ 41–42. While this cited treatment occurred while SOC-7, which did explicitly warn of nipple necrosis as a side effect of breast amputation, was in effect, SOC-8 notably removed mention of that as a side effect, thus contributing to WPATH's misleading representations that breast amputations breast amputation for girls is safe, effective, and consistently results in better health and quality of life.

droop in an effect known as "dog ears."

235. Though SOC-8 discloses that breast amputation "may adversely affect erogenous sensation," this brief, qualified disclaimer substantially downplays the potential adverse outcomes from breast amputation. Many girls and women report strange sensations in their chests years after breast amputation, including rawness around scars, numbness near nipples, pain, and electrical sensations. Some cannot locate exactly where sensations are coming from, which could be a result of nerve damage. A Washington woman who underwent the surgery at 16 must wear a sports bra during intimacy to modulate the electrical sensations.[65] A California woman whose breasts were amputated at age 13 now experiences "extreme slicing sensations" in the area. A Massachusetts woman who underwent breast amputation at age 14 now feels an electric sensation in her scars and a deep pain below the skin that is hard to place. When her boyfriend touches her chest, she senses pressure but cannot say exactly where it is.

236. USPATH president Dr. Olson-Kennedy, who referred a 14-year-old girl for breast amputation while she was recovering from sexual abuse,[66] dismisses concerns about breast amputation, declaring that "[i]f you want breasts at a later point in your life, you can go and get them." But the effects of breast amputations are irreversible. Implants will not function as a girl's natural breasts did—she will not regain erogenous sensation or the ability to breastfeed a baby. And even if the procedure avoids potential harms including failed reconstruction, the patient's reconstructed breasts will never look or feel normal.

237. In sum, WPATH's representation that breast amputation is safe, effective, and consistently results in better health and quality of life is false, misleading, or unsubstantiated,

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[65] Ex. 10, Decl. of [redacted] at ¶ 55.
[66] Ex. 6, Decl. of Clementine Breen at ¶¶ 30, 35.

including because of significant side effects that SOC-8, like SOC-7, fails to adequately disclose.

v. WPATH recommends surgical amputation of a child's penis and testicles as treatment for dissatisfaction or distress regarding sex traits

238. One form of genital surgery performed on children is "vaginoplasty," in which the surgeon cuts off the bulk of a child's testicles and penis. The surgeon restructures the child's scrotum to mimic a "clitoris" and "labia." Finally, the surgeon carves a wound next to the child's anus, empties the penile skin, and lines the wound with the child's emptied penile skin.

239. It is inherently harmful and unsafe to surgically remove a child's healthy and functioning genitals. Nevertheless, WPATH deems it "medically necessary" for treating dissatisfaction with or distress about sex traits. WPATH represents that vaginoplasty is "associated with a low rate of complications." SOC-8 deems boys eligible for vaginoplasty after just twelve months of hormone therapy—though that requirement can be waived if the hormone therapy is not "required[] to achieve the desired surgical result." SOC-8 claims that "there may be a benefit" to performing vaginoplasty on children, and indeed "recommend[s] surgeons consider" performing them on children. This is despite acknowledging that "[l]imited data are available on the outcomes for youth undergoing vaginoplasty."

240. SOC-8 cites a 2017 article, "Age Is Just a Number: WPATH-Affiliated Surgeons' Experiences and Attitudes Toward Vaginoplasty in Transgender Females Under 18 years of Age in the United States." This title reflects the views of Dr. Marci Bowers, a plastic surgeon who is WPATH's immediate past president and a current board member. Dr. Bowers "advocate[s] for 17 as the new norm" for vaginoplasty and "continue[s] to maintain that 17 may indeed be the ideal age for surgery."

241. This is in part due to the brutality of the procedure. Recovery from vaginoplasty requires the patient to "dilate" the new wound 3-4 times daily for months so that it does not heal.

For this reason, some transition doctors, including Dr. Bowers, believe performing the surgery while the boy is a minor still living with his parents is preferable, rather than when the boy is living in a communal setting with limited privacy.

242. WPATH clinicians lead children to vaginoplasty in other ways, as well. The erectile pain that often results from administering transition drugs to children can be so severe that it drives boys to seek surgical penis removal. A research team at UCLA found that "a huge chunk of" male medical transition patients "were not planning to have bottom surgery, but then change[d] their mind[s] as a result of the erectile pain."

243. WPATH calls a common version of the vaginoplasty operation "penile inversion." This is misleading. While the procedure involves inverting the skin of the child's penile shaft, the shaft itself is removed and discarded along with the child's testicles.

244. Likewise, "vaginoplasty" is inapt, as is WPATH's advertisement of a "neovagina," because the surgically-created wound is not any sort of vagina. It is constructed of different material, it does not have the same stretch and elasticity, it does not keep itself clean, it does not self-lubricate, and it cannot deliver a baby.

245. Despite the risks and lack of benefits, this procedure is shockingly common. One pediatric medical transition clinic "routinely" referred minor boys seeking this surgery to surgeons willing to perform it.[67] An academic study surveyed twenty WPATH-member surgeons, many of whom advertised their services on WPATH's public provider directory, and over half of the surgeons reported having performed a vaginoplasty on a child. These WPATH surgeons' "preferred method" was the "penile inversion" surgery, where the child's penile shaft

[67] Ex. 12, Decl. of [redacted] at ¶ 48.

was severed and discarded. One of the WPATH surgeons reported performing this operation on twenty different children.

IX. WPATH OPERATES FOR ITS MEMBERS' PROFIT

246. WPATH misrepresents scientific and medical consensus and makes false, deceptive, or unsubstantiated claims regarding pediatric medical transition and related services for a simple reason: WPATH's members generate significant profit because of the organization's representations and guidance.

247. WPATH's members predominantly work in fields related to the provision of transition services, including professionals who provide medical transition services to children. WPATH's members include doctors who prescribe drugs and perform surgery to modify patients' sex traits by, for example, amputating their breasts or instigating facial hair growth. Two of the five current members of WPATH's executive committee are surgeons who specialize in medical transition procedures, and a third member specializes in medical transition procedures for children. For example, Dr. Marci Bowers, WPATH's former president and current Executive Committee member, earned more than a million dollars in net income in 2023, mostly from performing transition surgeries. Each of these WPATH members, among many others, profits from WPATH's misrepresentations.

248. Other members earn income in related work. For example, one "WPATH certified member/mentor" offers a $249 "Transgender & Intersex Cultural Competence Training" for healthcare "staff and contractors" covering interactions with transition patients. Others counsel patients who purchase transition services or conduct corporate trainings about how to accommodate such patients in the workplace. WPATH engages in a variety of acts and practices that increase these members' profits.

249. Notably, pediatric medical transition services present lucrative opportunities for clinicians. Children can be put on puberty blockers. And puberty blockers are the first of many expensive interventions that will continue for the rest of the child's life as that child undergoes genital, chest, and face surgeries, have their gonads removed, and rely on exogenous cross-sex hormones. A vast majority of children prescribed puberty blockers as transition medicine eventually proceed to cross-sex hormones. Many eventually return for surgery.

250. Critically, through its representations and guidelines, WPATH has successfully worked to expand public and private insurance payments to its members for transition services, including drugs and surgeries. As a result of WPATH's claimed status as the authority on medical transition, WPATH has secured substantial insurance coverage for its members' pediatric medical transition drugs, surgeries, and services.

251. The growing population of patients who have undergone medical transition also yields business for WPATH's non-physician members.

252. As the Supreme Court explained in *California Dental Association v. FTC*, when an organization acts to secure insurance coverage for its members and "engages in lobbying, litigation, marketing, and public relations for the benefit of its members' interests," there is "no difficulty in concluding" that the organization acts for the profit of its members.[68] WPATH engages in those activities and therefore acts for the profit of its members.

[68] *California Dental Ass'n v. FTC*, 526 U.S. 756, 767–68 (1999); see *FTC v. National Comm'n on Egg Nutrition*, 517 F.2d 485, 487–88 (7th Cir. 1975) (holding that the FTC had jurisdiction over an organization which made health claims because the organization "promote[d] the general interests of the egg industry" and made statements "to encourage the consumption of eggs by allaying fears the public may have about" them).

A. WPATH has pushed—and continues to push—to expand insurance coverage to benefit its members

253. Since WPATH's members have sought to offer pediatric medical transitioning since 2007, a primary obstacle to their profitability has been whether insurance companies would cover transition services.

254. Generally, private insurance companies and Medicaid provide coverage to consumers only for services that are "medically necessary." The U.S. Centers for Medicare & Medicaid Services, an agency within the Department of Health and Human Services, defines the term as "[h]ealth care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine."

255. Insurance companies and State Medicaid offices maintain policies delineating what services are "medically necessary" to diagnose or treat particular conditions, and therefore what services their insurance policies will cover.

256. The majority of Americans receive their health insurance from private insurers. Additionally, Medicare, Medicaid, and various government health insurance programs cover people, including children, who meet specific age, income, or health criteria.

257. Health insurance typically does not cover all medical costs or services. Exclusions or limitations on coverage are listed in the policy contract, typically in a "Summary of Benefits Coverage" section. Typical exclusions include cosmetic surgery, alternative medicine (*e.g.*, acupuncture, herbal healing), weight-loss surgery (*e.g.*, gastric bypass and bariatric surgery), unapproved medical care (~~*i.e.g.*~~, procedures not pre-approved by the insurer), experimental procedures (~~*i.e.g.*~~, treatments that use new technology or methods lacking proven outcomes), and elective surgeries (~~*i.e.g.*~~, non-medically necessary procedures).

258. In the absence of insurance coverage, the market for transition services was

severely constrained due to the exorbitant cost of these drugs, surgeries, and other interventions—some of which require a lifetime of care. For example, in 2012, pediatric medical transition providers lamented that without insurance coverage, the "incredibly high cost" of pediatric medical transition means that "[m]any, if not most" children "deemed appropriate candidates" were "unable to obtain the treatment."

259. Starting in 2008, WPATH recognized that tapping into insurance payments was crucial to WPATH members' profits. Accordingly, WPATH acted, and continues to act, to ensure that its members are able to secure insurance payments for their services.

i. WPATH developed its clinical guidelines to trigger maximum insurance coverage for pediatric medical transition services

260. In 2008, WPATH first declared that medical transition is "not 'cosmetic' or 'elective' or for the mere convenience of the patient," but instead was "understood to be medically necessary." It further "urge[d] insurance carriers and healthcare providers in the United States to eliminate transgender or trans-sex exclusions and to provide coverage for" what it deemed "the medically prescribed sex reassignment services necessary for their treatment and wellbeing." WPATH's statement of "medical necessity" was proposed and drafted by WPATH board member Jamison Green. Green did not have a medical degree, but rather a Master of Fine Arts in creative writing and was at the time engaged in what Green termed "lucrative" work "consulting with many corporations negotiating trans health with their insurance companies." Green argued that WPATH "needed to be advocating for insurance coverage" more aggressively and that the declaration of "medical necessity" was "necessary to move forward on the insurance front, and it would also be helpful in some of the legal cases LGBT legal organizations were engaged in."

261. When WPATH released SOC-7 in 2011,[69] it added new language dubbing cross-sex hormones and transition surgery "medically necessary." And when WPATH published its latest medical transition guidelines, SOC-8, in September of 2022 it further urged "health care systems to provide these medically necessary treatments and eliminate any exclusions from their policy documents and medical guidelines that preclude coverage for any medically necessary procedures or treatments." The "medical necessity statement" spans several pages of SOC-8 and begins by recommending that "health care systems should provide medically necessary gender-affirming health care for transgender and gender diverse people." It quotes the American Medical Association's definition of "medical necessity" and then applies that label to roughly 30 medical transition interventions.

262. In fact, SOC-8 labels as "medically necessary" virtually every pediatric medical transition service that a transition doctor could perform for a fee, including administering puberty blockers, "voice surgery," "counseling,"[70] and "hair removal from . . . genital areas for gender affirmation," among many other transition services.

263. WPATH does not limit its declarations of medical necessity to attempts to treat distress or discomfort regarding sex traits. They also include the pursuit of "embodiment goals," *i.e.*, changing patients' sex characteristics not because they are in distress, but simply because they want to look different. This pursuit of "embodiment goals" is not limited by age. Under SOC-8, a doctor can prescribe testosterone to a seventh-grade girl not because the girl identifies as male or is in distress about her female body, but because her goal is to become more muscular. And under SOC-8, such an intervention is considered "medically necessary."

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[69] Its official publication date by WPATH's journal is 2012.
[70] SOC-8 places limits on what the counselors may say, as discussed *infra* ¶ 139.

264. The only pediatric medical transition service that SOC-8 does not deem "medically necessary" is one type of genital surgery, phalloplasty, on minor girls. WPATH may have conceded this point because such operations would likely violate statutes that criminalize female genital mutilation. In other words, performing such surgeries could hurt WPATH members rather than profit them.

265. WPATH's maximalist labeling of medical transition services as "medically necessary" is not rooted in medical or scientific evidence, as demonstrated above. Rather, WPATH makes unsubstantiated medical necessity claims to obtain maximum insurance coverage for its members' pediatric medical transition services, thereby helping its members profit. As SOC-8 itself explains, "[m]edical necessity is central to payment, subsidy, and/or reimbursement."

266. WPATH kept its objective—to obtain maximum insurance coverage for pediatric medical transition services—front-of-mind when drafting SOC-8. WPATH member and SOC-8 contributor Dr. Daniel Karasic wrote in August 2021 that SOC-8 "should allow for medical necessity to be determined by clinician assessment." WPATH adopted this approach because it would force "insurance regulatory bodies and independent medical reviewers" to wholly defer to transition service providers—generally WPATH members—rather than apply an objective standard when determining whether to cover transition services. Despite some WPATH members' concerns that clinicians were using WPATH's guidelines to medically transition too many children, WPATH nevertheless pursued insurance coverage for these members. SOC-8 further exhorts "governments" to "ensure" that medical transition coverage is "established, extended or enhanced (as appropriate) as elements in any Universal Health Care, public health, government subsidized systems, or government-regulated private systems that may exist."

267. The lead drafter of SOC-8's mental health chapter, Dr. Karasic, wrote his colleagues that he "cannot overstate the importance of SOC 8 getting this right[,]" as "important lawsuits" were ongoing that concerned whether transition services are "medically necessary vs experimental or cosmetic." Dr. Karasic also prodded his co-drafters to "consider adding a medical necessity statement for care of minors."

268. In May 2022, Dr. Karasic argued that SOC-8 should include a general statement on medical necessity. He reminded his co-drafters that "[m]edical necessity is at the center of dozens of lawsuits in the US right now over state actions to make trans care inaccessible [to children], as well as being at the center of all reimbursement for trans care in the US." Another drafter responded, "I fully support what [Dr. Karasic] is saying."

269. One drafter thanked the team for drafting a "Medical Necessity Statement" because "we needed a tool for our attorneys to use in defending access to care here [in the United States]."

270. Given the importance of insurance coverage to members' profits, WPATH was not content to let SOC-8 speak for itself. Shortly after disseminating SOC-8 to its members, WPATH created, published, and disseminated a presentation titled "Insurance Coverage of Gender Affirming Healthcare: WPATH SOC-8 Updates" explaining that "Insurers Must Update Adolescent Surgery Eligibility Criteria to be in Alignment with SOC-8" to include no lower age limit for surgery so long as the child has sufficient "emotional and cognitive maturity" to consent to the procedures.

ii. WPATH successfully secured insurance payments for the profit of its members

271. After WPATH's original 2008 "medical necessity" statement, WPATH leadership was "amazed" at the "powerful effect" it had and the changes in insurance coverage that resulted.

By 2022, as an article in the New York Times Magazine reported, WPATH's Standards of Care had "influence[d] . . . the coverage offered by health insurers and national health services around the world." As the HHS Report notes, "[m]any U.S. public and private health insurers and regulatory bodies rely on SOC-8 when making coverage determinations."

272. SOC-8's recommendations are designed to allow almost any child who expresses a desire for medical transition treatments to receive them, and to have those procedures paid for by insurance providers. And where SOC-8 includes some prerequisite for treatment, like recommending that surgeons require letters of referral from mental health professionals, such requirements are a façade.

273. Today, many of the largest health insurance providers, both public and private, defer to WPATH's and SOC-8's declaration that medical transition drugs, surgeries, and services are medically necessary in determining whether to cover those interventions. For example:

A. Aetna invoked SOC-7 in denying coverage for specific "irreversible surgical interventions for minors," but updated its policy to cover such surgeries with no age restriction once WPATH published SOC-8. Throughout its policies, Aetna cites WPATH in covering pediatric medical transition drugs, surgeries, and services as medically necessary. For example, "Aetna considers gonadotropin-releasing hormone medically necessary to suppress puberty in trans identified adolescents if they meet World Professional Association for Transgender Health (WPATH) criteria."

B. In covering medical treatments, Kaiser Foundation Health Plan "commits to following the World Professional Association for Transgender Health (WPATH) most up to date standards of care." In at least one region, relying on WPATH

guidance and consistent with SOC-8, Kaiser has no age limitation on covered transition procedures, including genital surgery. Kaiser also provides "clinical practice recommendations" for pediatric medical transition providers which explicitly rely on WPATH's SOC-8.

C. Cigna applies WPATH's recommendations to cover transition services, including in its coverage of off-label use of puberty blockers. Its guidelines state that "GnRH agonists can also be used off-label for the treatment of gender-dysphoric/gender incongruent persons to suppress physical changes of puberty and gonadal function," citing SOC-8 in one of two footnotes.

D. Elevance's 2021 clinical guidelines stated that the company's "medical necessity criteria . . . [were] based upon the Standards of Care (SOC) . . . Seventh Version, published by the World Professional Association for Transgender Health (WPATH) (2013). This document is widely accepted as the definitive document in the area of gender dysphoria treatment." When SOC-8 was published, Elevance "[u]pdated" its guidelines to add "WPATH SOC-8 criteria and recommendations" with respect to a number of procedures.[71]

274. The net result of WPATH's efforts has been that, in the words of WPATH's then-president Dr. Bowers, "insurers look to the" SOC "to set criteria for their members to be covered."

iii. WPATH's efforts led to significant profits for its members

275. WPATH's successful efforts to obtain insurance coverage for pediatric medical

[71] Elevance expressly declined to follow SOC-8's recommendations that genital surgeries be performed on children.

transition services have unlocked enormous profits for WPATH's members.

276. In 2024, while president of WPATH, Dr. Bowers testified to personally receiving more than a million dollars in income over the previous year, the vast majority of which came from performing transition surgeries. Most of Dr. Bowers' patients had private insurance.

277. The Congressional Budget Office estimated in 2025 that Medicaid alone would pay transition providers $445 million over ten years, just for the medical transition of children.

278. Pediatric medical transition is a profitable market for transition doctors because most children will naturally desist, or cease experiencing discomfort with or distress about their sex traits, if clinicians delay medical transition procedures.

279. But by preventing the normal development of sex traits through puberty blockers, cross-sex hormones, and surgeries, clinicians instead reinforce the child's cross-sex identification creating a self-fulfilling prophecy. Clinicians profit from the procedures that otherwise would not have been performed, and they further profit from what is likely to be a lifetime of medical appointments, hormone prescriptions, and further procedures.

280. Data from 2015 estimated the fixed costs of surgery to range from $10,308 to $22,025, with annual costs of $2,175 thereafter. Another study showed a significant increase in total expenditures on cross-sex hormone therapy from 2015 to 2019, corresponding with a significant increase in the number of "newly identified transgender" children over that period, and estimated the mean costs for medical transition surgeries to be $41,236 per person, with up to $3,792 in annual costs from hormones alone. Another source estimates the cost of medical transition procedures from childhood through adulthood for a single male patient, including puberty blockers, cross-sex hormones, and surgical interventions, as between $87,300 and $410,600 over one's lifetime. That cost for a female patient is estimated between $66,500 and

$605,500. The Human Rights Campaign, which advocates for insurance coverage of medical transition services, estimates that the cost of medical transition for a single patient can be as high as $75,000. But, as just explained, this is likely a low estimate.

281. WPATH's members who work in hospital settings can become highly valued employees thanks to the revenue that pediatric medical transition attracts.

282. Researchers at an academic medical center reported that the surgical transition procedures were a significant source of profit for self-pay and privately insured patients (where insurance covered those procedures). Overall, especially as the proportion of privately insured and self-pay patients increased, researchers found that providing surgical transition procedures "is profitable for both the surgical department and the hospital system" and thus providing medical transition procedures "can be a favorable addition to academic medical centers in the US." This financial lifeline to academic medical centers comes at a time many are struggling to operate in the black.

283. Pediatric medical transition clinics find ways to squeeze as much money as possible from the insurance industry. For example, a St. Louis clinic augmented its revenue by booking surgical suites for the quick, simple procedure of implanting a puberty blocker in a child's arm since insurance companies may pay more for interventions provided in a surgical suite.[72] That pediatric medical transition clinic's revenue put the hospital's entire endocrinology department "in the black" after operating at a loss for years, according to one of its physicians.[73]

284. One surgeon and WPATH member interviewed by an academic journal regarding transition surgeries on minors stated that "the biggest reason for why everyone is doing it now, is

[72] Ex. 12, Decl. of [redacted] at ¶ 16.
[73] Ex. 12, Decl. of [redacted] at ¶ 19.

the money is flowing. Because now insurance is paying. And now all these institutions have to have a program yesterday."

285. According to the program manager at a major university's transition clinic, in its first two years of operation, 2019 to 2021, the clinic "really blew" its financial goals "out of the water."

286. Doctors at a large university medical center have noted behind closed doors that transition "surgeries bring in a lot of money" and that genital surgeries on women are "huge money makers."

287. One doctor at another prominent university medical center claims that transition doctors can enhance the profitability of "healthcare systems" by "training" other healthcare professionals on referring potential patients to transition clinics and "getting people to surgery," a "high money producing" intervention.

288. Hospitals and clinicians quickly realized the profitability of pediatric medical transition. By 2017, there were at least 41 pediatric medical transition clinics across the United States. Some prescribe transition drugs to hundreds of children each year. Pediatric medical transition clinics widely follow WPATH guidelines. The clinics typically administer puberty blockers and cross-sex hormones. They also promote surgery to minors and provide referrals to surgeons, some of whom work within the same hospital system.[74] Where insurance companies require letters from mental health professionals, pediatric medical transition clinics supply templates to speed the process. For example, on a webpage advertising "breast augmentation" for 15-year-old boys (which has since been taken down), Boston Children's Hospital noted that

[74] Ex. 12, Decl. of [redacted] at ¶¶ 48–50; Ex. 3, Decl. of Vanessa Sivadge at ¶ 14.

"Sample letters are available on request from gendersurgery@childrens.harvard.edu."[75]

B. WPATH provides other economic benefits to members

289. WPATH membership provides other pecuniary benefits.

290. One perk of membership is business advice. WPATH has used a listserv to counsel its members on securing payment from insurance companies for transitioning minors.[76] Its private conferences (discounted for members) train attendees on founding their own pediatric medical transition clinics and promoting their pediatric practice in the media.

291. WPATH's recommendations also provide legal cover to WPATH members. For example, at WPATH's annual conference following the release of SOC-8, Dr. Amy Tishelman, one of the Guidelines Development Group members, stated that minimum ages for medical transition procedures were removed from SOC-8 to protect clinicians from lawsuits, should the clinician decide to provide a treatment to someone younger than WPATH's previously specified age minimums.

C. WPATH promotes the purchase of its members' pediatric medical transition services

292. WPATH directly promotes its members' services to the public. Until it became aware of the FTC's investigation earlier this year, WPATH operated a public provider directory that allowed users to view "Certified Members" only. And it advertised "[i]nclusion in the online WPATH 'Find a Provider' search tool" as a perk of WPATH membership.

293. WPATH also promotes pediatric medical transition by employing a large public relations firm and undertaking "education" campaigns which advertise pediatric medical transition. The clear goal of these public "education" campaigns is to encourage the purchase of

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[75] *See also* Ex. 12, Decl. of [redacted] at ¶ 27.
[76] Ex. 12, Decl. of [redacted] at ¶¶ 44–45.

pediatric medical transition services, including by allaying concerns that children and parents may have about pediatric medical transition.

294. As more American doctors opened pediatric medical transition practices, WPATH and its members repeatedly called for children to be "educated" about transition. This amounted to a marketing campaign advancing WPATH members' financial interests.

295. In SOC-7, WPATH called for mental health professionals to "educate and advocate on behalf of clients within their community" at "schools," adding that "[t]his role may involve consultation with school counselors, teachers, and administrators."

296. As WPATH's public relations firm, BerlinRosen, has explained, "[h]ealth care providers are widely trusted to speak with authority and educate broad audiences."

297. In a seminal 2012 article on transitioning children, Dr. Spack and Dr. Edwards-Leeper—who would soon become a leader within WPATH—announced themselves as committed to "educating the public through organized discussions and appropriate media outlets." They had already achieved deferential coverage in Time (2007), NPR (2008), The Atlantic Monthly (2008), and the Boston Globe (2008).

298. Dr. Johanna Olson-Kennedy, another future WPATH board member then practicing at Children's Hospital Los Angeles, received coverage of her pediatric medical transition practice on ABC (2007). Her CHLA colleague Dr. Melvin Belzer promoted child transition on CNN (2007) and MSNBC (2007).

299. BerlinRosen advises WPATH's members on how to speak with the media, including by suggesting that WPATH members claim that medical transition "is safe and effective and endorsed by all leading medical associations," among other similar claims.

300. WPATH also urges other doctors to carry WPATH's message to children.

301. For example, Dr. Scott Leibowitz, a SOC-8 drafter and WPATH member who has been affiliated with Nationwide Children's Hospital in Columbus, Ohio, argues that transition doctors should "ensure that gender is the fabric of all healthcare for all kids" by training pediatricians. According to Dr. Leibowitz, "[t]hat will help . . . pediatricians be able to ally with those parents who wouldn't even consider coming to a clinic that we provide." Such training includes directing pediatricians to ask children about their gender identities.[77]

302. A St. Louis transition clinic saw rapid results from such trainings. After transition doctors trained their colleagues in the cystic fibrosis ward, the clinic received a referral for a child within three months.[78] And after training colleagues who treated sickle cell anemia, a child with that condition asked to see a transition doctor.[79]

303. In 2015, Dr. Edwards-Leeper and other WPATH leaders drafted guidance for the American Psychological Association about the care of "transgender and gender-nonconforming" ("TGNC") people. Under the banner of the APA, they advised psychologists to direct their gay patients toward a cross-sex identity, asserting that some people who "assume that they must be gay, lesbian, bisexual, or queer" may simply lack "awareness of a TGNC identity." Thus, "[p]sychologists may need to provide" these supposedly unaware "TGNC people with information about TGNC identities."

304. In 2016, Dr. Edwards-Leeper co-authored "Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents" with 19 other clinicians, many of whom have been active in WPATH. They advised mental health professionals to screen autistic children for cross-sex identity by asking questions which

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[77] Ex. 12, Decl. of [redacted] at ¶ 9.
[78] Ex. 12, Decl. of [redacted] at ¶ 11.
[79] Ex. 12, Decl. of [redacted] at ¶ 11.

could reveal "gender concerns," and trigger "a referral . . . to an appropriate gender specialist."

305. These training-and-referral systems financially benefit WPATH's members and the institutions at which they work. One doctor at a major public university explained that "[h]ealth care systems rely heavily on high money producing medical interventions to fund themselves, particularly surgeries." Thus, an "institution [that] has a surgical program for" medical transition will profit from a "training" that "will improve getting people to surgery somehow." This doctor encouraged clinicians to "[l]ink the two" concepts and understand that that conducting WPATH trainings will increase the number of people having transition surgeries, which increases the revenue of the institution.

306. WPATH's advertising efforts have been effective at increasing demand for its members' services. According to the Centers for Disease Control, 2% of high school students identified as "transgender" by 2017. Few had done so before WPATH began promoting that identity to children. In the 2010s, the rate of "adolescent gender dysphoria" increased by over 1,000%.

307. These are far from WPATH's only efforts to promote pediatric medical transition. Even SOC-8 is a tool to promote pediatric medical transition to children and parents directly. SOC-8 encourages "individuals, their families, and social institutions" to "use the SOC-8 to understand how it can assist with promoting optimal health for" people, including children, who express dissatisfaction with or distress about their sex traits.

308. WPATH also posts statements on its website deceptively claiming that transition is "safe," "lifesaving," backed by "rigorous research" and "expert consensus," "evidence-based," and "medically necessary." Past WPATH president Jamison Green explains that such statements are "good strong documents that can be used by . . . members of the public to assist in the

securing of transgender health and services."

309. However they first become exposed to cross-sex identity, many children soon find themselves at a pediatric medical transition clinic staffed by WPATH members. The clinics' practice, in accordance with WPATH guidelines, is never to challenge what children say about their sex or suggest talk therapy to reconcile with their physical characteristics. When children say they want to modify their sex traits, the clinics' general practice—consistent with SOC-8's instructions—is to express support for that desire and carry it out.[80] And as discussed below, once a child enters a transition clinic, a clinician quickly diagnoses that child as being dissatisfied with or having distress about sex traits and pressures parents to immediately consent to pediatric medical transition.

D. WPATH also profits itself by leveraging its position as the *de facto* authority on transition medicine in the United States

310. WPATH also profits itself by claiming to be the authority on transition medicine, then leveraging that authority to sell trainings and otherwise conduct profitable business.

311. Self-publishing the so-called "Standards of Care" is one component of this business strategy. Those unaware of SOC-8's shortcomings and disinclined to closely examine its underlying evidence are deceived by WPATH's claims that it arrived at its recommendations via robust evidentiary review that comported with international standards of medical guidelines.

312. Another component of WPATH's business strategy is its Global Education Initiative. The Initiative is WPATH's curriculum for training medical professionals on medical transition, both in the United States and around the world. Official collaborators include the American Medical Student Association and the World Health Organization.

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[80] *See* Ex. 12, Decl. of [redacted] ¶¶ 12–13, 15.

313. American hospitals, medical schools, and transition clinics rely on SOC-8 and the Initiative when setting standards, creating fellowships, and conducting other activities which touch on medical transition. For example, Mt. Sinai has established a "transgender psychiatry fellowship" in which fellows participate in WPATH's bi-annual conferences. Oregon Health and Sciences University provides a "gender surgery fellowship program" led by a WPATH member. Harvard Medical School provides continuing medical education led by senior WPATH leadership and SOC-8 drafters.

314. Some governmental authorities require a WPATH certification—obtained through the Initiative—for certain types of employment. For example, the Washington State Department of Corrections requires that doctors performing medical transition treatments must either already be WPATH-certified or obtain that certification within two years. The Oregon Health Authority has a similar requirement. And California requires insurance companies to enroll in training offered by WPATH. Regulators projected that the training would result in an annual cost to insurance companies—and revenue to WPATH—of $163,400.

315. WPATH's strategy has thus successfully rendered WPATH the self-appointed, *de facto* authority on transition medicine in the United States, bringing significant wealth to WPATH and its members.

X. WPATH HAS PROVIDED TO CLINICIANS THE MEANS BY WHICH THEY DECEIVE CHILDREN AND THEIR PARENTS INTO PURCHASING PEDIATRIC MEDICAL TRANSITION SERVICES

316. WPATH's false, misleading, or unsubstantiated representations have caused substantial consumer injury, including grievous bodily and psychological harm, to children experiencing dissatisfaction with or distress about their sex traits. WPATH also has injured these children's parents who paid for harmful medical transition treatments either out-of-pocket or in

co-pays or insurance premiums. These injuries have occurred primarily through the means that WPATH supplies to clinicians.

317. Clinicians base their diagnoses on WPATH's false, misleading, or unsubstantiated statements and guidance, repeat WPATH's false, misleading, or unsubstantiated statements to consumers—children and their parents—and recommend specific drugs, surgeries, and other interventions based on WPATH's false, misleading, or unsubstantiated representations, all while failing to disclose to children and parents the significant harmful side effects because WPATH fails to disclose them or downplays them in SOC-8. Although the experience of every child and parent is unique, sworn testimony, affidavits, and other evidence that the FTC has gathered demonstrate a consistent pattern: clinicians follow WPATH's script, and children and parents rely on those representations in deciding to purchase transition services, leading to significant physical, mental, financial, and psychological harm.[81]

318. Historically, children identified by clinicians as candidates for pediatric medical transition were typically those who did not conform to stereotypical social roles associated with their sex. Prior to widely available medical transition, most of these children desisted—*i.e.*, they ceased feeling dissatisfaction with or distress about their sex traits—and ultimately identified as gay.

319. ~~More recently, children~~Children identified by clinicians as candidates for pediatric medical conditions often present with serious mental health conditions such as anxiety,

[81] That some of the events described in testimony, affidavits, and other evidence relied on in this Amended Complaint to establish this consistent pattern may have occurred before 2022 does not undermine their support for these allegations against WPATH and SOC-8. *Supra* n.2.

depression, and suicidality;[82] distress from a traumatic event or situation;[83] or neurodevelopmental difficulties like autism spectrum disorder.[84] These mental health and developmental challenges often correspond to or coexist with social problems which make these children feel like they do not fit in.[85]

320. These children experience social pressure to consider their sex as the cause of their challenges. That pressure can manifest in various ways, including online and media influence,[86] homophobia,[87] peer influence,[88] and influence from adult figures in a child's life.[89] Many girls going through puberty feel like they are not feminine enough to fit in as girls.[90] Many of these children who feel that they do not fit in with members of their sex express dissatisfaction with or distress about sex traits to a parent,[91] or another authority figure, like a school

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[82] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 11 (panic attacks, intrusive thoughts, and obsessive thoughts); Ex. 10, Decl. of [redacted] at ¶ 10; Ex. 14, Decl. of [redacted] at ¶ 8; Ex. 1, Decl. of Soren Aldaco at ¶¶ 4, 6; Ex. 15, Decl. of Evelyn Neel at ¶ 2; Ex. 12, Decl. of [redacted] at ¶ 14.

[83] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶¶ 3, 13, 31–32, 57 (sexual assault, difficult home situation, and abusive relationship); Ex. 5, Decl. of Elisabeth Bourne at ¶ 3 (friend was sexually assaulted and went to the ER); Ex. 14, Decl. of [redacted] at ¶ 2 (fled with mother from domestic violence); Ex. 1, Decl. of Soren Aldaco at ¶ 6; Ex. 2, Decl. of Cassidy Andrews at ¶ 4; Ex. 15, Decl. of Evelyn Neel at ¶ 2 (sexual abuse); Ex. 12, Decl. of [redacted] at ¶ 14.

[84] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 7 (diagnosed with autism at age 4); Ex. 9, Decl. of [redacted] at ¶ 2 (child diagnosed with autism and a rare genetic developmental disorder); Ex. 8, Decl. of Melissa Skinner at ¶ 5; Ex. 1, Decl. of Soren Aldaco at ¶ 12; Ex. 12, Decl. of [redacted] at ¶ 14.

[85] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 2; Ex. 7, Decl. of Jonathon Skinner at 4–11; Ex. 13, Decl. of [redacted] at 2; Ex. 8, Decl. of Melissa Skinner at ¶¶ 5, 8; Ex. 1, Decl. of Soren Aldaco at ¶ 4.

[86] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 4; Ex. 7, Decl. of Jonathon Skinner at ¶ 15; Ex. 13, Decl. of [redacted] at ¶ 6; Ex. 9, Decl. of [redacted] at ¶ 5; Ex. 10, Decl. of [redacted] at ¶ 11; Ex. 1, Decl. of Soren Aldaco at ¶ 3; Ex. 2, Decl. of Cassidy Andrews at ¶ 8.

[87] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶¶ 5–10; Ex. 10, Decl. of [redacted] at ¶¶ 5–9.

[88] *E.g.*, Ex. 13, Decl. of [redacted] at ¶ 5; Ex. 11, Decl. of Gwen Turecki at ¶ 2; Ex. 5, Decl. of Elisabeth Bourne at ¶ 5; Ex. 14, Decl. of [redacted] at ¶¶ 3, 8.

[89] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 16 (adult math tutor and family friend identified as opposite sex); Ex. 4, Decl. of Caroline Miller at ¶¶ 5, 7 (child's father took him to gender-related counseling despite the child identifying as bisexual and "affirmed" the child as transgender); Ex. 15, Decl. of Evelyn Neel at ¶ 3 (psychiatrist "planted a seed in my head").

[90] *E.g.*, Ex. 6, Decl. of Clementine Breen ¶ 2, Ex. 10, Decl. of [redacted] ¶¶ 4–5, Ex. 1, Decl. of Soren Aldaco ¶¶ 4–5.

[91] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 17; Ex. 13, Decl. of [redacted] at ¶ 8; Ex. 9, Decl. of [redacted] at ¶ 6; Ex. 8, Decl. of Melissa Skinner at ¶ 7; Ex. 10, Decl. of [redacted] at ¶ 12; Ex. 11, Decl. of Gwen Turecki at ¶ 3; Ex. 14, Decl. of [redacted] at ¶¶ 3, 5.

counselor.[92]

321. Many parents ask a family doctor or mental health professional about their child's distress.[93] These individuals typically do not specialize in sex-trait modification and refer children to a specialized provider, like a transition clinic,[94] particularly if a local transition clinic has asked them to make such referrals.[95] Other parents schedule appointments with these clinics directly.[96] And some children are sent to transition clinics after being placed on psychiatric holds.[97]

322. Regardless of where they end up, children and parents are unlikely to avoid being influenced by WPATH's deceptive claims and omissions. Indeed, WPATH board member and former president Dr. Marci Bowers claims that "the vast majority of mental health providers in the country that [Dr. Bowers is] familiar with follow the WPATH standards of care."

323. Clinicians begin selling parents and children on medical transition procedures once they arrive at a medical transition provider's clinic. Sometimes, clinicians make the sale by directly invoking WPATH's name and providing parents with the SOC or other material containing WPATH's deceptive claims. Other times, clinicians repeat WPATH's deceptive claims without attribution. And even without telling parents, clinicians often rely on WPATH's deceptive claims in making diagnoses and recommending treatment.

324. Parents sometimes expend considerable resources paying for pediatric medical

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[92] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 4 (school counselor).
[93] *E.g.*, Ex. 13, Decl. of [redacted] at ¶ 8; Ex. 9, Decl. of [redacted] at ¶¶ 7–8; Ex. 11, Decl. of Gwen Turecki at ¶ 5; Ex. 14, Decl. of [redacted] at ¶ 11.
[94] *E.g.*, Ex. 13, Decl. of [redacted] at ¶ 8; Ex. 9, Decl. of [redacted] at ¶ 8; Ex. 11, Decl. of Gwen Turecki at ¶ 5; Ex. 14, Decl. of [redacted] at ¶ 11.
[95] *See* Ex. 12, Decl. of [redacted] at ¶ 9.
[96] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 5; Ex. 7, Decl. of Jonathon Skinner at ¶ 18.
[97] *E.g.*, Ex. 10, Decl. of [redacted] at ¶ 16; Ex. 1, Decl. of Soren Aldaco at ¶ 7; Ex. 15, Decl. of Evelyn Neel at ¶¶ 3, 6.

transition treatments and managing their side effects. For example, parents have paid between $9,300 and $20,000 for breast-amputation surgery.[98] In many other cases, parents are able to pay for the procedure through insurance coverage[99]—coverage that would not exist but for WPATH's deceptive statements that the treatment is medically necessary and purportedly backed by expert consensus. The result is that, in numerous cases and for numerous reasons, WPATH's deceptive statements provide clinicians with the means and instrumentalities to mislead consumers into subjecting their children to unnecessary medical transition services.

A. Clinicians invoke WPATH and provide families with WPATH's deceptive material

325. Clinicians directly invoke WPATH's "Standard of Care" in encouraging their patients to purchase transition services.[100] Clinicians also cite or provide materials citing WPATH and the "Standards of Care" when discussing diagnoses and pediatric medical transition with parents.[101] Parents and children often consider and trust this information when they agree to medical transition procedures.

326. For example, a pediatric endocrinologist in California told a pediatric patient's mother that he follows the recommendations of WPATH. When the patient's mother asked for supporting studies and other evidence for medical transition, the doctor sent her a web link directly to WPATH's SOC-7, which she then read.[102] Boston Children's Hospital Center for Gender Surgery cited "WPATH standards of care" on its page advertising breast implants for

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[98] *See* Ex. 6, Decl. of Clementine Breen at ¶ 37; Ex. 10, Decl. of [redacted] at ¶ 40.
[99] *E.g.*, Ex. 1, Decl. of Soren Aldaco at ¶ 18; Ex. 8, Decl. of Melissa Skinner at ¶ 40; Ex. 3, Decl. of Vanessa Sivadge at ¶ 16; Ex. 12, Decl. of [redacted] at ¶ 19.
[100] *E.g.*, Ex. 10, Decl. of [redacted] ¶ 24, Ex. 1, Decl. of Soren Aldaco at ¶¶ 10, 16; Ex. 2, Decl. of Cassidy Andrews at ¶ 18.
[101] *E.g.*, Ex. 11, Decl. of Gwen Turecki at ¶ 7; Ex. 5, Decl. of Elisabeth Bourne at ¶ 19.
[102] Ex. 5, Decl. of Elisabeth Bourne at ¶¶ 18–19.

children. One online medical transition clinic asserts that it follows SOC-8 and promises to provide monthly prescriptions for transition services without an in-person visit, covered by major US insurers. It asserts that "puberty blockers are fully reversible" and that "children can begin their medical transition with puberty blockers." Stanford Medicine's Transgender Surgery team promises that it "follows the World Professional Association for Transgender Health (WPATH) guidelines to ensure patients are appropriate surgical candidates."

327. One 13-year-old girl visited a Dallas, Texas clinic with her parents. A psychologist who has presented at WPATH conferences told the girl's parents that their daughter needed to undergo medical transition, including cross-sex hormones and breast amputation. When these parents expressed skepticism and asked how the psychologist "knew that medical transition would help" their daughter's distress, the psychologist "answered that WPATH recommended it."[103]

328. One doctor at a large public university encouraged one 15-year-old patient to read the SOC. The girl, who was later prescribed testosterone and had her breasts amputated, believed based on her interaction with the doctor that WPATH was an official, authoritative medical organization.[104]

329. A nurse, who worked at Texas Children's Hospital, recalls that a pediatric endocrinologist at that hospital recorded in patient charts that he "told parents he was following WPATH's Standards of Care" and "explained WPATH's Standards of Care" to parents.[105] This doctor "frequently referenced WPATH" when communicating with parents.[106]

B. Clinicians repeat and rely on WPATH's claims without attribution to sell

[103] Ex. 2, Decl. of Cassidy Andrews at ¶¶ 12–18.
[104] Ex. 10, Decl. of [redacted] ¶ 24.
[105] Ex. 3, Decl. of Vanessa Sivadge at ¶¶ 6–7.
[106] Ex. 3, Decl. of Vanessa Sivadge at ¶ 8.

transition procedures

330. Even without directly referencing WPATH and the Standards of Care, clinicians often repeat deceptive phrases or concepts from SOC-8.

331. Clinicians emphasize the need for pediatric medical transition by stating or strongly implying that if parents do not consent to medical transition, their children will commit suicide.[107] Some clinicians tell parents that if their children die, the parents will be to blame.[108] Clinicians often ask parents if they would "rather have a dead son or a living daughter," or vice versa.[109]

332. Clinicians make these statements because WPATH represents that medical transition is "lifesaving" and SOC-8 expressly represents that medical transition is "medically necessary" and reduces suicidality, thereby providing clinicians with the rationale that they use to pressure parents into consenting. This approach aligns with that taken by USPATH president Dr. Johanna Olson-Kennedy, who has admitted to using such tactics to persuade parents to purchase transition services for their children.

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[107] *E.g.*, Ex. 12, Decl. of [redacted] at ¶ 30(b). ~~*E.g.*, Ex.~~ Like SOC-8, SOC-7 emphasized the need for medical transition and, for adolescents, even provides guidelines on the "Risks of Withholding" such treatments to include "abuse and stigmatization" and "psychiatric distress during adolescence" before warning that "withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents." On that basis, while SOC-7 was in place, clinicians similarly emphasized the need for pediatric medical transition by stating or strongly implying that if parents do not consent to medical transition, their children will experience "psychiatric distress" to include suicide. Ex. 7, Decl. of Jonathon Skinner at ¶ 28 (clinician claimed that "60% of transgender kids kill themselves if they are not medically transitioned"); Ex. 6, Decl. of Clementine Breen at ¶ 9 (recounting that her parents told her "that [the clinician] had told them that I was suicidal and firm in my male identity. Neither was true"); Ex. 13, Decl. of [redacted] at ¶¶ 14, 16; Ex. 4, Decl. of Caroline Miller at ¶¶ 13, 15; Ex. 9, Decl. of [redacted] at ¶ 15; Ex. 8, Decl. of Melissa Skinner at ¶ 10; Ex. 5, Decl. of Elisabeth Bourne at ¶ 16; Ex. 14, Decl. of [redacted] at ¶ 12; Ex. 2, Decl. of Cassidy Andrews at ¶¶ 11, 19; Ex. 15, Decl. of Evelyn Neel ¶ 8~~; Ex.~~. Because SOC-7 and SOC-8 contain materially similar content on this point, SOC-8 will cause and is causing the same harms. ~~12, Decl. of [redacted] at ¶ 30(b).~~

[108] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 37 (doctor told parents that their daughter might kill herself if her parents did not pay for a double mastectomy); Ex. 4, Decl. of Caroline Miller at ¶¶ 15, 18; Ex. 9, Decl. of [redacted] at ¶¶ 15, 19; Ex. 14, Decl. of [redacted] at ¶ 12.

[109] Ex. 8, Decl. of Melissa Skinner at ¶ 10; Ex. 13, Decl. of [redacted] at ¶ 14; Ex. 9, Decl. of [redacted] at ¶ 15; Ex. 2, Decl. of Cassidy Andrews at ¶ 11; Ex. 12, Decl. of [redacted] at ¶ 30(b).

333. For example, a Missouri clinician attempted to pressure a mother into consenting to puberty blockers for her son by rejecting her concerns and strongly implying that her son would commit suicide if she did not consent.[110] Dr. Olson-Kennedy told a girl's parents that the girl was suicidal and convinced that she was male, when neither was true. This caused the girl's mother to cry.[111] And an Arizona clinician addressing a boy and his parents asked if they would rather "have a live daughter or a dead son," telling the parents that if their son killed himself, it would be their fault.[112] A medical transition-supporting therapist repeated that these parents would be to blame if their son committed suicide.[113] And a Texas endocrinologist, who told parents that he was following WPATH's Standards of Care, warned them that there was a higher risk of a child harming themselves if the child is not "affirmed" in their desire to transition.[114]

334. Clinicians maintain that pediatric medical transition is the only effective option and reject any alternative treatment options for a child's distress.[115] They repeat WPATH's claims that pediatric medical transition is the "standard of care" and is "medically necessary."[116]

335. Dr. Johanna ~~Olsen~~Olson-Kennedy told a twelve-year-old girl that people who express distress about their sex traits are born in the wrong body; the girl concluded that medical treatment was required to correct her body. Dr. ~~Olsen~~Olson-Kennedy also told the girl's parents that the only treatment for that distress was medical transition, which requires hormone therapy. When the parents asked whether talk therapy was an option, Dr. ~~Olsen~~Olson-Kennedy claimed

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[110] Ex. 4, Decl. of Caroline Miller at ¶¶ 13, 15.
[111] Ex. 6, Decl. of Clementine Breen at ¶¶ 9–10.
[112] Ex. 9, Decl. of [redacted] at ¶ 15.
[113] Ex. 9, Decl. of [redacted] at ¶ 19.
[114] Ex. 3, Decl. of Vanessa Sivadge ¶¶ 6, 10.
[115] *E.g.*, Ex. ~~6, Decl. of Clementine Breen at ¶ 11; Ex. 13, Decl. of [redacted] at ¶ 15; Ex.~~ 9, Decl. of [redacted] at ¶ 15; Ex. ~~10, Decl. of [redacted] at ¶ 23; Ex. 2, Decl. of Cassidy Andrews at ¶ 16; Ex.~~ 12, Decl. of [redacted] at ¶¶ 36–37~~; *see also* Ex. 10, Decl. of [redacted] at ¶¶ 36–38 (noting rushed nature of breast removal and a lack of determination by the surgeon of whether that surgery was necessary).~~.
[116] Ex. 12, Decl. of [redacted] at ¶ 30(c–d).

that it would not alleviate their daughter's distress.[117] And Dr. Olson-Kennedy explicitly referenced "standards of the World Professional Association for Transgender Health (WPATH)" as the basis for her "diagnoses and treatment."[118]

336. Clinicians' claims are effective because SOC-8, like its predecessor SOC-7, frames these interventions as medically necessary, emphasizes early initiation of medical transition at the onset of puberty, and asserts that delaying such interventions may have "harmful effects." Relying on the SOC ~~-8~~, clinicians further create a sense of urgency by insisting that children immediately start taking drugs like puberty blockers ~~or cross sex hormones~~ regardless of the parents' uncertainty over the source of a child's distress.[119]

337. Under the guise that the treatments are necessary ~~and~~or lifesaving, clinicians sometimes take drastic measures to convince parents to consent to medical transition services. Some clinicians attempt to drive a wedge between parents and their children by sabotaging their relationship.[120] If parents disagree with one another about consenting to medical treatment, clinicians have encouraged the consenting parent to obtain an attorney.[121] A California transition doctor, speaking with both a young patient and his mother, told the son that if he felt unsafe at home, he should call the doctor.[122] One Georgia doctor recommended at a WPATH conference that doctors should threaten unsupportive parents by "letting parents know that" "[t]here are at least some child protective service workers who are willing to enforce the need for affirmation

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[117] Ex. 6, Decl. of Clementine Breen at ¶¶ 8, 11.
[118] Ex. 6, Decl. of Clementine Breen at ¶ 35.
[119] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 21, 25–28; Ex. 6, Decl. of Clementine Breen at ¶¶ 11–13; Ex. 13, Decl. of [redacted] at ¶¶ 16, 18; Ex. 4, Decl. of Caroline Miller at ¶¶ 12–13, 15, 17–18; Ex. 9, Decl. of [redacted] at ¶ 13; Ex. 11, Decl. of Gwen Turecki at ¶ 10.
[120] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶¶ 27–29; Ex. 13, Decl. of [redacted] at ¶¶ 13–14; Ex. 8, Decl. of Melissa Skinner at ¶ 24.
[121] Ex. 12, Decl. of [redacted] at ¶ 35.
[122] Ex. 13, Decl. of [redacted] at ¶ 14.

by parents."

C. Clinicians follow and rely on WPATH in failing to adequately disclose side effects

338. Clinicians also downplay, deny, or omit serious side effects of puberty blockers, cross-sex hormones, surgeries, and pediatric medical transition generally,[123] consistent with SOC-8's failure to adequately disclose or otherwise downplay those side effects.[124],[125] which it carried over from SOC-7. For example, Kaiser Permanente provides a handout of frequently asked questions to parents and children who are considering puberty blockers. To the question "Are puberty blockers safe?" Kaiser Permanente responds: "The Endocrine Society and World Professional Associate [*sic*] for Transgender Health support the use of puberty blockers for youth who want to delay or prevent unwanted physical changes of puberty." Parents and children do not hear about how, for example, cross-sex hormones may cause fatal cardiovascular issues or how puberty blockers may lead to long-term cognitive deficits.

339. Clinicians suggest that the side effects that they do acknowledge are not permanent and can be remedied.[126] Clinicians similarly repeat SOC-8's claim that puberty blockers are "fully reversible."[127],"[128] which was identical to that in SOC-7.

340. Collectively, WPATH's deceptive statements and material omissions cause

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[123] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶¶ 32–61; Ex. 6, Decl. of Clementine Breen at ¶¶ 12, 16, 22–25, 39–51; Ex. 13, Decl. of [redacted] at ¶¶ 19–24; Ex. 4, Decl. of Caroline Miller at ¶¶ 10, 21–28; Ex. 9, Decl. of [redacted] at ¶ 14; Ex. 8, Decl. of Melissa Skinner at ¶¶ 17–18, 37–39; Ex. 5, Declaration of Elisabeth Bourne at ¶ 16; Ex. 2, Decl. of Cassidy Andrews at ¶¶ 25, 27, 28, 35, 42, 49, 51, 52; Ex. 15, Decl. of Evelyn Neel at ¶¶ 15, 16, 19, 24, 34; Ex. 12, Decl. of [redacted] at ¶ 30(d–e).

[124] ~~See *supra* ¶¶ 161–245.~~

[125] See *supra* ¶¶ 161–245.

[126] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶ 26; Ex. 4, Decl. of Caroline Miller at ¶ 11.

[127] ~~Ex. 12, Decl. of [redacted] at ¶¶ 30(a), 33; *see* Ex. 4, Decl. of Caroline Miller at ¶¶ 14 (clinic worker "promised that puberty would resume as normal" upon stopping puberty blockers), 17 (same).~~

[128] Ex. 12, Decl. of [redacted] at ¶¶ 30(a), 33; *see* Ex. 4, Decl. of Caroline Miller at ¶¶ 14 (clinic worker "promised that puberty would resume as normal" upon stopping puberty blockers), 17 (same).

parents to worry that their children are in mortal peril and that the only effective solution is to consent to pediatric medical transition.[129] In many cases, the pressure created by WPATH's unlawful conduct—and the fear it creates—causes parents to purchase pediatric medical transition drugs, surgeries, or services.[130]

D. Clinicians use SOC-8's deceptive diagnosis and treatment guidelines to sell medical transition services

341. By proclaiming SOC-8 to represent expert consensus, and that pediatric medical transition is the standard of care, WPATH gives clinicians justification to follow SOC-8's diagnosis and treatment guidelines, deceiving parents and children into agreeing to unnecessary and harmful treatments.

342. In line with SOC-8's amorphous diagnosis guidelines, (a characteristic shared by SOC-7), clinicians often diagnose children based on superficial and innocuous traits. The basis for these diagnoses often includes asking a child if they want to look different,[131] if they fear or dislike puberty,[132] if they are attracted to the same sex,[133] if they want to be referred to by cross-sex pronouns,[134] or if they enjoy hobbies or other activities commonly associated with the opposite sex,[135] without questioning whether the child's reported distress is truly caused by the child's sex traits.[136] One boy was told by an endocrinologist that being both feminine and attracted to boys indicated that he was female, which convinced the boy that he should have a

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[129] *E.g.*, Ex. 4, Decl. of Caroline Miller at ¶ 18; Ex. 9, Decl. of [redacted] at ¶ 15; Ex. 6, Decl. of Clementine Breen at ¶¶ 9–10; Ex. 13, Decl. of [redacted] at ¶ 16; Ex. 12, Decl. of [redacted] at ¶ 38.
[130] *E.g.*, Ex. 4, Decl. of Caroline Miller at ¶ 18.
[131] *E.g.*, Ex. 9, Decl. of [redacted] at ¶ 11.
[132] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 7.
[133] *E.g.*, Ex. 7, Decl. of Jonathon Skinner at ¶¶ 23–24.
[134] *E.g.*, Ex. 16, Decl. of [redacted] at ¶¶ 22–24 (psychologist diagnosed 8-year-old boy with "gender dysphoria," despite lack of distress, after he said he did not care what pronouns she used for him).
[135] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 7.
[136] *E.g.*, Ex. 12, Decl. of [redacted] at ¶ 25.

female body.[137]

343. Social workers, not doctors, often diagnose children with "gender dysphoria" and provide referrals to endocrinologists,[138] even after asking little more than how the child felt about his or her body.[139] A case worker at a transition clinic routinely saw pediatric patients who did not even moderately present as the opposite sex and who had only recently expressed distress about their sex traits.[140] Clinicians follow WPATH's "Standards of Care" in making such diagnoses.[141][142] and represent that they follow WPATH's "Standards of Care" to their pediatric patients and their parents.[143]

344. Regardless of the screening performed, transition clinics routinely diagnose children as experiencing distress about their sex traits and recommend pediatric medical transition, often after one short and perfunctory examination which typically involves separating children from parents.[144]

345. Parents reasonably expect transition specialists to conduct a thorough examination of their children and exclude alternative causes of their children's distress, such as trauma, distress about sex-same attraction, autism, depression, or other mental-health issues, before

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[137] Ex. 7, Decl. of Jonathon Skinner at ¶¶ 23–25.
[138] *E.g.*, Ex. 11, Decl. of Gwen Turecki at ¶ 7.
[139] *E.g.*, Ex. 9, Decl. of [redacted] at ¶¶ 10–11.
[140] *E.g.*, Ex. 12, Decl. of [redacted] at ¶ 72.
[141] ~~*E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 35; Ex. 12, Decl. of [redacted] at ¶ 24; Ex. 3, Decl. of Vanessa Sivadge at ¶ 6; Ex. 7, Decl. of Jonathon Skinner at ¶¶ 22, 69.~~
[142] *E.g.*, Ex. 12, Decl. of [redacted] at ¶ 24; Ex. 3, Decl. of Vanessa Sivadge at ¶ 6; Ex. 7, Decl. of Jonathon Skinner at ¶¶ 22, 69.
[143] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 35.
[144] *E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 6–12; Ex. 13, Decl. of [redacted] at ¶¶ 8, 11–14; Ex. 9, Decl. of [redacted] at ¶16; Ex. 8, Decl. of Melissa Skinner at ¶¶ 9–10; Ex. 11, Decl. of Gwen Turecki at ¶¶ 6–7; Ex. 1, Decl. of Soren Aldaco at ¶¶ 7, 14–15; Ex. 2, Decl. of Cassidy Andrews at ¶¶ 15–16.

recommending pediatric medical transition.[145] But following the SOC-8, clinicians instead proceed directly to medical transition.

346. A case manager at a transition clinic in St. Louis, Missouri, frequently encountered parents who wanted their children to be assessed by a mental-health professional to determine whether they were experiencing distress related to their sex traits—and to possibly pursue non-medical intervention as a treatment for that distress. Her clinic offered neither mental-health assessments nor non-medical therapies. The clinic's mantra—simply repeating the SOC-8—was that medical transition is medically necessary.[146]

347. When parents offer an alternative basis for a child's distress, clinicians routinely reject that explanation, no matter how plausible or grounded it is in a parents' direct observations of their own children.[147] This pattern is a direct consequence of SOC-8, which explicitly and implicitly instructs clinicians not to allow mental-health conditions, trauma histories, autism, internalized homophobia, or other alternative causes of distress to "delay" medical transition, thereby giving clinicians the means and justification to disregard these explanations.[148] Indeed, consistent with SOC-8's general directions, clinicians have rejected out of hand that a child's

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[145] ~~*E.g.*, Ex. 6, Decl. of Clementine Breen at ¶ 5 (noting that her parents told her that they expected the clinic to determine that she was not transgender); Ex. 13, Decl. of [redacted] at ¶¶ 9–10 (suspecting that "something else was probably going on" and hoping that "seeing a specialist would help define the problem"); *see also* Ex. 7, Decl. of Jonathon Skinner at ¶ 18 (expressing hope that the clinic would "help me figure myself out" and would not "automatically recommend medical transition"); *cf.* Ex.~~ *E.g.*, Ex. 12, Decl. of [redacted] at ¶ 12 (explaining that parents wanted a gender clinic "to determine if [their children] were transgender, or that they wanted to explore a non-medical pathway (like therapy) to address their children's gender dysphoria~~") .~~"); Ex. 9 Decl. of [redacted] at ¶¶ 11–13.

[146] Ex. 12, Decl. of [redacted] at ¶¶ 2, 12–13, 15, 30(d).

[147] ~~*E.g.*, Ex. 13, Decl. of [redacted] at ¶ 11; Ex. 9, Decl. of [redacted] at ¶ 12; Ex. 8, Decl. of Melissa Skinner at ¶¶ 14–15; Ex. 11, Decl. of Gwen Turecki at ¶ 8; Declaration of [redacted] at ¶ 14; *see also* Ex. 10, Decl. of [redacted] at ¶ 22; Ex. 7, Decl. of Jonathon Skinner at ¶ 23 (rejecting the notion that the declarant, a male who is attracted to men, is gay, and declaring that he instead has "a female brain"); Ex. 2, Decl. of Cassidy Andrews at ¶ 17 (psychologist denies sexual abuse led to declarant's cross-sex identity);~~ *E.g.*, Ex. 9, Decl. of [redacted] at ¶ 12; Ex. 11, Decl. of Gwen Turecki at ¶ 8.

[148] See *supra* ¶¶ 132–344, 33.

distress or discomfort could be caused by a diagnosed chromosome disorder,[149] autism,[150] ~~trauma from sexual assault,~~[151] body dysmorphia,[152] internalized homophobia or simply being gay,[153] ~~social problems~~,[154] or the normal search for identity that often accompanies puberty.[155]

348. For example, at the outset of a session conducted by a Michigan medical transition clinic, a social worker told a family that the purpose of their meeting was to determine how to align their son's body with his self-image, citing WPATH as the standard of care, without first considering any of the child's many underlying emotional problems.[156]

349. An Arizona boy was diagnosed with autism and a rare genetic disorder, which required both private therapy and a special education program at his public school. When his parents brought him to a transition clinic at age 14, a social worker diagnosed the root of his distress as discomfort with his sex traits and recommended cross-sex hormones after just a few questions about his feelings over his physical appearance—and with an apparent disregard to his developmental and other mental-health issues.[157]

~~350. Another boy growing up in rural Michigan was taunted for being a "sissy." His own grandfather called him a slur that refers to gay men. Around age 12 he looked online for people to talk to about being gay. He found "transgender" influencers like Gigi Gorgeous and Jazz Jennings instead. Living in a community that was hostile to homosexuality, this boy believed that the influencers could have boyfriends only because they were medically~~

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[149] *E.g.*, Ex. 9, Decl. of [redacted] at ¶ 12.
[150] *E.g.*, Ex. 9, Decl. of [redacted] at ¶ 12.
[151] ~~*E.g.*, Ex. 2, Decl. of Cassidy Andrews at ¶ 17.~~
[152] *E.g.*, Ex. 9, Decl. of [redacted] at ¶ 12.
[153] ~~*E.g.*, Ex. 9, Decl. of [redacted] at ¶ 12; Ex. 7, Decl. of Jonathon Skinner at ¶¶ 20–24.~~
[154] *E.g.*, Ex. ~~13~~9, Decl. of [redacted] at ~~¶¶ 2, 8~~¶ 12.
[155] *E.g.*, Ex. ~~4, Decl. of Caroline Miller at ¶ 15; Ex. 4~~9, Decl. of [redacted] at ¶ 12.
[156] Ex. 11, Decl. of Gwen Turecki at ¶¶ 5–8.
[157] Ex. 9, Decl. of [redacted] at ¶¶ 2–3, 9–13.

~~transitioning. At 13, this boy, prompted by real-life and online messages that he was not masculine enough to be a real boy, told his mother he thought that he might be "transgender."[158]~~

~~351. In a separate encounter, parents went to a California transition clinic and explained their son's social and mental health problems to a psychologist who immediately dismissed each as a potential cause of their son's distress. The psychologist immediately addressed their son with she/her pronouns.[159]~~

~~352. USPATH president Dr. Johanna Olsen Kennedy diagnosed a twelve-year-old girl as distressed over her sex traits and suicidal after a solo consultation in which the doctor asked the girl about her feelings regarding puberty, which were negative, but asked nothing about her past trauma (from sexual assault while she was in the first grade) or her difficult family situation.[160]~~

~~353.~~350. A Michigan clinician seemingly ignored a boy's psychological distress in quickly diagnosing him with "transsexualism" and recommending that he see an endocrinologist for cross-sex hormone therapy.[161] His mother rejected the recommendation and he stopped identifying as female within months.[162]

XI. WPATH CAUSES INJURY IN AND TO ALASKA

~~354.~~351. Plaintiff Alaska has sustained or will sustain injury because of Defendants' unlawful activities.

~~355.~~352. Defendants' "Standards of Care" framework has been consulted, referenced by, or otherwise relied-upon by health care providers and/or their associated clinics or

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~~[158] Ex. 7, Decl. of Jonathon Skinner ¶¶ 6, 10, 12, 15, 17.~~
~~[159] Ex. 13, Decl. of [redacted] at ¶¶ 2, 11–12.~~
~~[160] Ex. 6, Decl. of Clementine Breen at ¶¶ 3, 6–13.~~
[161] Ex. 11, Decl. of Gwen Turecki at ¶ 7.
[162] Ex. 11, Decl. of Gwen Turecki at ¶¶ 13–14.

hospitals in the State of Alaska.

~~356.~~353. Within the State of Alaska, multiple health care providers and/or their clinics or hospitals provide hormone therapy, medical transition surgical referrals, and other medical transition procedures, counseling, or services in reliance upon Defendants' activities or practices, such as their "Standards of Care" framework.

XII. WPATH CAUSES INJURY IN AND TO IOWA

~~357.~~354. Plaintiff Iowa has sustained or will sustain injury because of Defendants' unlawful activities.

~~358.~~355. Defendants' "Standards of Care" framework has been consulted, referenced by, or otherwise relied on by health care providers and their associated clinics or hospitals in the State of Iowa.

~~359.~~356. In the State of Iowa, multiple health care providers and their clinics or hospitals provided hormone therapy, medical transition, surgical referrals, and other medical transition procedures, counseling, or services in reliance on Defendants' activities or practices, such as their "Standards of Care" framework.

~~360.~~357. The proliferation of Defendants' deceptive practices into Iowa prompted the Iowa Legislature to enact Iowa Code § 147.164, which prohibits pediatric medical transition related procedures for children.

~~361.~~358. That law sadly came too late to protect many Iowa children from the harms caused by Defendants' deceptive practices.

XIII. WPATH CAUSES INJURY IN AND TO NEBRASKA

~~362.~~359. Plaintiff Nebraska has sustained or will sustain injury because of Defendants' unlawful activities.

~~363.~~360. The proliferation of Defendants' deceptive practices into Nebraska prompted the Nebraska Legislature to enact the "Let them Grow Act," Neb. Rev. Stat. § 71-7301 *et seq.*, in 2023, to protect children under the age of nineteen from pediatric medical transition.

~~364.~~361. Notwithstanding the "Let Them Grow Act," Defendants' deceptive conduct continues to impact Nebraska. Even with the enactment of the "Let Them Grow Act," the Act grandfathers in children who were receiving prohibited treatment, including puberty-blocking drugs, cross-sex hormones, or both, prior to October 1, 2023.

~~365.~~362. Further, groups that are aligned with Defendants' deceptive practices, such as the Trans Youth Emergency Project, operate to assist Nebraska children to leave the territorial jurisdiction of Nebraska to obtain procedures that are prohibited by Nebraska law, meaning Nebraska cannot effectively legislate away harm to its citizens while Defendants' deceptive practices continue.

~~366.~~363. The "Let Them Grow Act" also came too late to protect many Nebraska children from the harms caused by Defendants' deceptive practices. One such child was Luka Hein.

~~367.~~364. Luka has a pending lawsuit in state district court in Douglas County, Nebraska,[163] against her mental health counselor, physicians, and the hospital that performed a double mastectomy and prescribed testosterone when she was sixteen years old.

~~368.~~365. Luka's story has been widely publicized. Her publicly available complaint tells a tragic story of a 13-year-old girl who was grappling with her parents' divorce, victimization, and serious mental health issues, when she was misled into attributing her distress

[163] *Luka Hein v. UNMC Physicians, et al.*, Case No. CI 23-7318.

to her sex traits, consistent with Defendants' misrepresentations regarding children in Nebraska and elsewhere.

~~369.~~366. The facility where Luka underwent a double mastectomy and received testosterone, Nebraska Medicine at the University of Nebraska Medical Center (UNMC), advertised that it followed and implemented WPATH's "Standards of Care," then SOC-7, in the treatment of children who express dissatisfaction with or distress about their sex traits.

~~370.~~367. Luka's treatment providers at UNMC implemented WPATH's "gender affirming" model in her treatment and relied on WPATH's standards. Both her mental health counselor who recommended the double mastectomy and her physician prescribing testosterone were publicly identified "WPATH members."[164] Before the medical procedures, Luka's parents—who were required to consent to the procedure—were asked if they would rather have a live son or a dead daughter.

~~371.~~368. In 2023, after the harm caused by the removal of her breasts and years of testosterone, Luka detransitioned and questioned the legitimacy of her "treatments."

~~372.~~369. Luka is just one example of a child harmed by Defendants' misrepresentations in Nebraska.

XIV. WPATH CAUSES INJURY IN AND TO TEXAS

~~373.~~370. Plaintiff Texas has sustained or will sustain injury because of Defendants' unlawful activities.

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[164] Although Luka alleges these self-identified "WPATH members" ignored WPATH's guidance in one aspect—that breast removal surgery should occur "preferably after . . . one year of testosterone treatment"—they otherwise relied on WPATH's standards in their treatment of Luka, including that such surgery could be carried out prior to Luka reaching the age of majority. See World Professional Association for Transgender Health, Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version 21 (2011), https://themeltzerclinic.com/wp-content/uploads/2025/04/Standards-of-Care-V7-2011-WPATH.pdf.

~~374.~~371. Defendants' "Standards of Care" framework has been consulted, referenced by, or otherwise relied on by health care providers and their associated clinics or hospitals in the State of Texas.

~~375.~~372. In the State of Texas, multiple health care providers and their clinics or hospitals provided hormone therapy, medical transition, surgical referrals, and other medical transition procedures, treatment, counseling, or services in reliance on Defendants' activities or practices, such as their "Standards of Care" framework.

~~376.~~373. The proliferation of Defendants' deceptive trade practices into Texas prompted the Texas Legislature to pass Senate Bill 14, which prohibits physicians and healthcare providers from providing medical transition treatment to minors. *See* Tex. Health & Safety Code Ann. § 161.702 *et seq*.

~~377.~~374. Sadly, Senate Bill 14 came too late to protect many Texas children from the harms caused by Defendants' deceptive trade practices.

XV. CORE DECEPTIVE STATEMENTS

~~378.~~375. In conclusion, this Amended Complaint seeks relief for ten specific unlawful misrepresentations or omissions, including:

(1) WPATH misrepresents that pediatric medical transition is medically necessary to prevent suicide in children who express dissatisfaction with or report distress about their sex traits.

(2) WPATH misrepresents that pediatric medical transition is effective at preventing suicide in children who express dissatisfaction with or report distress about their sex traits.

(3) WPATH misrepresents that puberty blockers are fully reversible.

(4) WPATH misrepresents that cross-sex hormones improve mental health.

(5) WPATH misrepresents that performing breast amputations on children is safe, effective, and consistently results in better health and quality of life.

(6) WPATH misrepresents SOC-8 to be the result of unbiased, evidence-based expert consensus.

(7) WPATH misrepresents that pediatric medical transition is the "standard of care" for children who express dissatisfaction with or report distress about their sex traits.

(8) WPATH fails in SOC-8 to adequately disclose certain side effects of puberty blockers including hot flashes, lethargy, and cognitive problems.

(9) WPATH fails in SOC-8 to adequately disclose certain side effects of cross-sex hormones including mood disturbances, vocal pain, pelvic pain, pelvic floor dysfunction, clitoral discomfort, vaginal pain, persistent sexual dysfunction continuing after cessation of use, and erectile pain.

(10) WPATH fails in SOC-8 to adequately disclose certain side effects of breast amputations including inability to breastfeed, nerve damage, and necrosis of the nipples.

~~379.~~376. WPATH made each of these ten misrepresentations or omissions expressly or by implication, WPATH knew they were false or misleading, and WPATH further knew—and intended—that they would provide WPATH members and other providers of medical transition services with the means to mislead consumers. Each of these ten misrepresentations was, and is, important to WPATH members and other providers of transition services. Each of these representations were, and are, important to the children, who receive, and parents, who pay for, those services. As a result of these ten central misrepresentations and omissions, and as pleaded herein, unlawful deception occurred and continues to occur.

~~380.~~377. Each of these ten misrepresentations or omissions occurred at least in certain specific instances detailed herein. In particular:

Misrepresentation (1): WPATH misrepresents that pediatric medical transition is medically necessary to prevent suicide in children who express dissatisfaction with or

report distress about their sex traits.

~~381.~~378. WPATH asserts that medical transition is "lifesaving" or "medically necessary" despite the lack of evidence to substantiate the claim that medical transition is necessary and effective at preventing suicide.[165]

~~382.~~379. In 2008, WPATH misleadingly asserted that medical transition is "not 'cosmetic' or 'elective' or for the mere convenience of the patient," but instead was "understood to be medically necessary."[166]

~~383.~~380. WPATH asserts in SOC-8 that not providing medical transitioning services can lead to depression and anxiety.[167]

~~384.~~381. When WPATH released SOC-7 it added new language dubbing cross-sex hormones and transition surgery "medically necessary."[168] And when WPATH published SOC-8 it further urged "health care systems to provide these medically necessary treatments and eliminate any exclusions from their policy documents and medical guidelines that preclude

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[165] See, *e.g.*, SOC-8 at S126 ("[I]n many cases, hormone therapy is considered a lifesaving intervention."); WPATH, Inc. & USPATH, WPATH and USPATH comment on the Cass Review at 2 (May 17, 2024), https://wpath.org/wp-content/uploads/2024/11/17.05.24-Response-Cass-Review-FINAL-with-ed-note.pdf (last visited June 16, 2026) (hereinafter "WPATH Cass Review Comment") (referring to administering puberty blockers to children as "widely recognized as medically necessary, and often reported as lifesaving"); WPATH, Inc. & USPATH, Statement of Opposition to Legislation Banning Access to Gender-Affirming Health Care in the US (Mar. 8, 2023), https://wpath.org/wp-content/uploads/2024/11/USPATH_WPATH-Statement-re_-GAHC-march-8-2023.pdf (last visited June 16, 2026) (characterizing medical transition as "lifesaving care") ; GLAAD *et al*., New York Times Sign On Letter at 1–3, https://glaad.org/nytimes (last visited June 16, 2026) (WPATH signing a letter characterizing medical transition as "lifesaving"); WPATH, Inc. & USPATH, USPATH and WPATH Respond to NY Times Article "They Paused Puberty, But Is There a Cost?" (Nov. 22, 2022) https://media.glaad.org/wp-content/uploads/2023/02/10142224/USPATHWPATH-Statement-re-Nov-14-2022-NYT-Article-Nov-22-2022.pdf (last visited June 16, 2026) (repeating claims that puberty blockers administered to children "can be a life-changing and lifesaving treatment").

[166] WPATH, Inc., WPATH Clarification on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A. at 3 (June 17, 2008).

[167] *See*, *e.g.*, SOC-8 at S66 (stating that "chest dysphoria" correlates to "anxiety, depression, and distress," which can be treated by mastectomy), S106 (claiming that those who experience distress about their sex traits not undergoing medical transition leads to "depression, anxiety, [and] suicidality"), S126 (claiming that cross-sex hormones "positively impact the mental health and quality of life of" patients).

[168] *See* Eli Coleman, *et al.*, Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People at 5, 8, 33, 54 (2012) (hereinafter "SOC-7").

coverage for any medically necessary procedures or treatments"[169]

~~385.~~382. The "medical necessity statement" spans several pages of SOC-8 and begins by recommending that "health care systems should provide medically necessary gender-affirming health care for transgender and gender diverse people."[170] It quotes the American Medical Association's definition of "medical necessity" and then declares that roughly 30 medical transition interventions are medically necessary.[171]

~~386.~~383. In SOC-8, WPATH labeled as "medically necessary" virtually every pediatric medical transition service that a transition doctor could perform for a fee, including administering puberty blockers, "voice surgery," "counseling,"[172] and "hair removal from . . . genital areas for gender affirmation," among many other transition services.[173]

~~387.~~384. WPATH also posts statements on its website falsely claiming that pediatric medical transition is "medically necessary."[174]

Misrepresentation (2): WPATH misrepresents that pediatric medical transition is effective at preventing suicide in children who express dissatisfaction with or report distress about their sex traits.

~~388.~~385. SOC-8 claims that "hormone therapy is considered a lifesaving intervention,"[175] and that medical transition "is associated with a substantial reduction in the risk of suicide attempt[s]."[176]

~~389.~~386. WPATH asserts in SOC-8 that medical transition treatments reduce

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[169] SOC-8 at S18.
[170] SOC 8 at S16.
[171] SOC-8 at S16–S18.
[172] So long as the counseling is not intended to encourage a child to feel comfortable with their natal sex traits. *See* SOC-8 at S53.
[173] SOC-8 at S18.
[174] WPATH Cass Review Comment at 1–2.
[175] SOC-8 at S126.
[176] SOC-8 at S174.

"suicidality" and "suicidal ideation."[177]

~~390.~~387. WPATH also makes public statements falsely claiming that medical transition is "lifesaving."[178]

Misrepresentation (3): WPATH misrepresents that puberty blockers are fully reversible.

~~391.~~388. WPATH represents in SOC-8 that puberty blockers are "fully reversible."[179]

Misrepresentation (4): WPATH misrepresents that cross-sex hormones improve mental health.

~~392.~~389. WPATH claims in SOC-8 that the administration of cross-sex hormones "has been shown to improve quality of life and to decrease depression and anxiety."[180]

~~393.~~390. WPATH asserts in SOC-8 that hormone therapy "positively impact[s] the mental health and quality of life of [children]."[181]

Misrepresentation (5): WPATH misrepresents that performing breast amputations on children is safe, effective, and consistently results in better health-related quality of life.

~~394.~~391. WPATH represents in SOC-8 that breast amputations are safe, effective, and result in better health and quality of life for girls experiencing dissatisfaction with or distress about their sex traits.[182] SOC-8 claims that "[t]he efficacy of [breast amputation] has been demonstrated in multiple domains, including a consistent and direct increase in health-related quality of life."[183] Thus, WPATH concludes that "the evidence demonstrates [breast amputation]

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[177] *E.g.*, SOC-8 at S47, S106, S126.
[178] See *supra* n.~~148~~152.
[179] SOC-8 at S43, S112.
[180] SOC-8 at S174.
[181] SOC 8 at S126.
[182] SOC-8 at S18 (asserting that all "[g]ender-affirming interventions . . . are safe and effective"), S43 (noting that SOC-7 recommended breast amputation beginning at age 16), S128 (declaring breast amputations to be "a safe and effective intervention").
[183] SOC-8 at S128.

to be a safe and effective intervention."[184]

~~395.~~392. SOC-8 makes "strong recommendations" with respect to surgical interventions for children, thereby asserting that "the evidence [for the intervention] is of high quality," "there are few downsides," and "there is a high degree of acceptance among providers" for the treatment.[185]

Misrepresentation (6): WPATH misrepresents SOC-8 to be the result of unbiased, evidence-based expert consensus.

~~396.~~393. WPATH misrepresents that SOC-8 is "consensus-based expert opinion."[186]

~~397.~~394. WPATH makes public statements falsely claiming that medical transition is backed by "expert consensus[.]"[187]

~~398.~~395. WPATH falsely claims that SOC-8 follows WHO and NAM standards on managing conflicts of interest.[188]

~~399.~~396. WPATH falsely represents that it complied with these standards when it reviewed "[c]onflicts of interests . . . as part of the [SOC-8 committee member] selection process" and concluded that "[n]o conflicts of interest were . . . significant or consequential."[189]

~~400.~~397. WPATH falsely claims that SOC-8 used the "Delphi process," which is a formal method of developing recommendations based on expert consensus.[190]

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[184] SOC-8 at S128.
[185] SOC-8 at S111, S129, S250.
[186] SOC-8 at S247; WPATH, WPATH and USPATH response to the HHS report on gender dysphoria (May 2, 2025), https://wpath.org/wp-content/uploads/2025/05/WPATH-USPATH-Response-to-HHS-Report-02May2025-3.pdf (describing SOC-8's recommendations regarding hormone therapy and puberty blockers as "research and consensus-based").
[187] WPATH, WPATH and USPATH response to the HHS report on gender dysphoria (May 2, 2025), https://wpath.org/wp-content/uploads/2025/05/WPATH-USPATH-Response-to-HHS-Report-02May2025-3.pdf (last visited June 16, 2026); WPATH Cass Review Comment (claiming "professional consensus").
[188] SOC-8 at S8, S247; see *supra* ¶ 76.
[189] SOC-8 at S177.
[190] SOC-8 at S250.

401.398. WPATH falsely claims that SOC-8 followed the "GRADE" system.[191]

402.399. SOC-8 makes "strong recommendations" with respect to cross-sex hormones, puberty blockers, and surgical interventions for children, thereby asserting that "there is a high degree of acceptance among providers" for the treatment.[192]

Misrepresentation (7): WPATH misrepresents that pediatric medical transition is the "standard of care" for children who express dissatisfaction with or report distress about their sex traits.

403.400. Despite the low-quality evidence supporting pediatric medical transition, WPATH represents that pediatric medical transition is the "standard[] of care" for children who express dissatisfaction with or distress about their sex traits.[193]

404.401. In SOC-8, WPATH represents that cross-sex hormones are medically necessary for children who express discomfort with or distress about their sex traits, and that cross-sex hormone use is an appropriate treatment as early as the onset of puberty.[194]

405.402. SOC-8 makes "strong recommendations" with respect to cross-sex hormones, puberty blockers, and surgical interventions for children, thereby asserting that "the evidence [for the intervention] is of high quality," "there are few downsides," and "there is a high degree of acceptance among providers" for the treatment.[195]

Omission (8): WPATH fails in SOC-8 to disclose or to adequately disclose certain side effects of puberty blockers.

406.403. SOC-8 provides a "strong recommendation" that clinicians administer puberty blockers to children, thereby asserting that "the evidence [for the intervention] is of high

[191] SOC-8 at S250.
[192] SOC-8 at S111, S129, S250.
[193] SOC-8 at S1.
[194] SOC-8 at S110–11, S114–15, S256–57.
[195] SOC-8 at S111, S129, S250.

quality," "there are few downsides," and "there is a high degree of acceptance among providers" for the treatment.[196] But SOC-8 fails to disclose or to adequately disclose risks and side effects like hot flashes, lethargy, and cognitive issues when puberty blockers are used for pediatric medical transition.[197]

Omission (9): WPATH fails in SOC-8 to disclose or to adequately disclose certain side effects of cross-sex hormones.

~~407.~~404. SOC-8 makes "strong recommendations" with respect to administering cross-sex hormones to children, thereby asserting that "the evidence [for the intervention] is of high quality," "there are few downsides," and "there is a high degree of acceptance among providers" for the treatment.[198] But SOC-8 fails to disclose or to adequately disclose the existence and severity of risks and side effects associated with cross-sex hormones, including mood disturbances, vocal pain, pelvic pain, pelvic floor dysfunction, clitoral discomfort, vaginal pain, persistent sexual dysfunction continuing after cessation of use, and erectile pain.[199]

Omission (10): WPATH fails in SOC-8 to disclose or to adequately disclose certain side effects of breast amputations.

~~408.~~405. SOC-8 makes "strong recommendations" with respect to surgical interventions for children, including breast amputation, thereby asserting that "the evidence [for the intervention] is of high quality," "there are few downsides," and "there is a high degree of acceptance among providers" for the treatment.[200] But SOC-8 fails to disclose or to adequately disclose risks and side effects associated with breast amputations, like its effects on non-

[196] SOC-8 at S111, S250.
[197] See generally SOC-8.
[198] SOC-8 at S111, S129 S250.
[199] SOC-8 at S254; see generally SOC-8.
[200] SOC-8 at S111, S129, S250.

erogenous sensation, inability to breastfeed, nerve damage, and necrosis of the nipples.[201]

XVI. VIOLATIONS OF THE FTC ACT, AK CPA, IOWA CONSUMER PROTECTION ACT, NE UDTPA, AND TEXAS DTPA

~~409.~~406. Section 5(a) of the FTC Act, 15 U.S.C. § 45(a), prohibits "unfair or deceptive acts or practices in or affecting commerce."

~~410.~~407. Misrepresentations or deceptive omissions of material fact constitute deceptive acts or practices prohibited by Section 5(a) of the FTC Act.

~~411.~~408. Section 12 of the FTC Act, 15 U.S.C. § 52, prohibits the dissemination of any false advertisement in or affecting commerce for the purpose of inducing, or which is likely to induce, the purchase of food, drugs, devices, services, or cosmetics. For the purposes of Section 12 of the FTC Act, 15 U.S.C. § 52, puberty blockers and cross-sex hormones are a "drug" as defined in Section 15(c) of the FTC Act, 15 U.S.C. § 55(c).

Count I: Means and Instrumentalities to Engage in Deception—Deceptive Establishment and Efficacy Claims

~~412.~~409. Defendants have created, disseminated, and furnished to medical providers selling pediatric medical transition services false, misleading, or unsubstantiated representations, guidance, materials, training, and other content that represent, directly or indirectly,

A. Pediatric medical transition is medically necessary to prevent suicide in children who express dissatisfaction with or report distress about their sex traits.

B. Pediatric medical transition is effective at preventing suicide in such children who express dissatisfaction with or report distress about their sex traits.

C. Puberty blockers are fully reversible.

D. Cross-sex hormones improve mental health.

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[201] See generally SOC-8.

E. Performing breast amputations on children is safe, effective, and consistently results in better health and quality of life.

~~413.~~410. By furnishing this guidance, materials, and training containing false, misleading, or unsubstantiated representations describe in Paragraph ~~412~~409, Defendants have provided the means and instrumentalities for the commission of deceptive acts and practices.

~~414.~~411. Therefore, Defendants' representations as described in Paragraph ~~412~~409 constitute deceptive acts or practices and the making of false advertisements in violation of Sections 5(a) and 12 of the FTC Act, 15 U.S.C. §§ 45(a), 52.

Count II: Means and Instrumentalities to Engage in Deception—Misrepresentations Regarding the Standards of Care

~~415.~~412. Defendants have created and furnished medical providers who sell pediatric medical transition services with guidance, materials, and training containing false or misleading representations which claim, directly or indirectly, expressly or by implication, that:

A. Defendants' SOC-8 represents unbiased, evidence-based expert consensus.

B. Pediatric medical transition is the "standard of care" for children who express dissatisfaction with or report distress about their sex traits.

~~416.~~413. By furnishing the guidance, materials, and training containing the false or misleading representations described in Paragraph ~~415~~412, Defendants have provided the means and instrumentalities for the commission of deceptive acts and practices.

~~417.~~414. Therefore, Defendants' representations as described in Paragraph ~~415~~412 constitute deceptive acts or practices and the making of false advertisements in violation of Sections 5(a) and 12 of the FTC Act, 15 U.S.C. §§ 45(a), 52.

Count III: Means and Instrumentalities to Engage in Deception—Failure to Disclose Side Effects

~~418.~~415. Defendants have created and furnished medical providers who sell pediatric medical transition services with guidance, materials, and training that fails to disclose the existence or extent of detrimental effects of drugs, surgeries, or other pediatric medical transition treatments, including that:

A. The side effects of puberty blockers include hot flashes, lethargy, and cognitive problems.

B. The side effects of cross-sex hormones include mood disturbances, vocal pain, pelvic pain, pelvic floor dysfunction, clitoral discomfort, vaginal pain, persistent sexual dysfunction continuing after cessation of use, and erectile pain.

C. The side effects of breast amputations include inability to breastfeed, nerve damage, and necrosis of the nipples.

~~419.~~416. In furnishing guidance, materials, and training that fail to disclose the material information described in Paragraph ~~418~~415, Defendants have provided the means and instrumentalities for the commission of deceptive acts or practices.

~~420.~~417. Therefore, Defendants' practices as set forth in Paragraph ~~411~~415 constitute deceptive acts or practices and the making of false advertisements in violation of Sections 5(a) and 12 of the FTC Act, 15 U.S.C. §§ 45(a), 52.

Count IV: Violations of the Alaska Consumer Protection Act (By Plaintiff State of Alaska)

~~421.~~418. Alaska repeats and realleges the facts above and incorporates them herein by reference.

~~422.~~419. Alaska brings this action for Defendants' violations of the Alaska Consumer Protection Act ("AK CPA"), AS § 45.50.471 *et. seq*. For these violations, Alaska seeks relief, including a permanent injunction, civil penalties, attorney's fees, costs and other

appropriate relief as authorized by AS §§ 45.50.501, 45.50.551(b), and 45.50.537(d).

~~423.~~420. AK CPA specifies multiple acts or practices which, when conducted in the course of business, constitute deceptive trade practices. AS § 45.50.471(b).

~~424.~~421. Defendants engaged in and continue to engage in deceptive trade practices in violation of AS § 45.50.471.

~~425.~~422. Defendants' false or misleading representations have affected the people of the State of Alaska causing harm.

~~426.~~423. Each deceptive act or practice as alleged herein constitutes a separate violation of AK CPA.

~~427.~~424. The Court should award injunctive relief and make all other orders or judgments necessary to prevent Defendants' deceptive trade practices or restore to any person any money or property acquired by means of such practices as authorized by AS § 45.50.501.

~~428.~~425. The Court should award civil penalties for each violation of AK CPA as authorized by AS 45.50.551(b).

~~429.~~426. The Court should award costs and attorneys fees as authorized by AS § 45.50.537.

Count V: Violations of the Iowa Consumer Fraud Act (By Plaintiff State of Iowa)

~~430.~~427. Iowa repeats and realleges the facts above and incorporates them by reference.

~~431.~~428. Iowa brings this action for Defendants' violations of the Iowa Consumer Fraud Act. Iowa Code § 714.16. For these violations, Iowa seeks relief including: a permanent injunction, civil penalties, disgorgement, attorney's fees, costs, and other appropriate relief as authorized by Iowa Code.

~~432.~~429. The Iowa Consumer Fraud Act specifies multiple acts or practices which, when conducted in the course of business, are deceptive trade practices.

~~433.~~430. Defendants engaged in and continue to engage in deceptive practices in violation of Iowa law.

~~434.~~431. Defendants' false or misleading representations have affected the people of Iowa, causing harm.

~~435.~~432. Each deceptive act or practice or course of conduct as alleged constitutes a separate violation of Iowa Code.

~~436.~~433. The Court should award injunctive relief and make all other orders or judgments necessary to prevent Defendants' deceptive trade practices and restore to any person any money or property acquired by means of such practices authorized by Iowa law.

~~437.~~434. The Court should award civil penalties for each violation and attorneys' fees as authorized by Iowa law.

Count VI: Violations of the Nebraska Uniform Deceptive Trade Practices Act (By Plaintiff State of Nebraska)

~~438.~~435. Nebraska repeats and realleges the facts above and incorporates them herein by reference.

~~439.~~436. Nebraska brings this action for Defendants' violations of the Nebraska Uniform Deceptive Trade Practices Act, Neb. Rev. Stat. § 87-301 *et. seq*. For these violations, Nebraska seeks relief, including a permanent injunction, civil penalties, attorney's fees, costs and other appropriate relief as authorized by Neb. Rev. Stat. §§ 87-303(b), 87-303.05, and 87-303.11.

~~440.~~437. The NE UDTPA specifies multiple acts or practices which, when conducted in the course of business, constitute deceptive trade practices. Neb. Rev. Stat. § 87-302.

~~441.~~438. Defendants engaged in and continue to engage in deceptive trade practices in violation of Neb. Rev. Stat. § 87-302(a).

~~442.~~439. Defendants' false or misleading representations have affected the people of the State of Nebraska, causing harm.

~~443.~~440. Each deceptive act or practice as alleged herein constitutes a separate violation of the NE UDTPA.

~~444.~~441. The Court should award injunctive relief and make all other orders or judgments necessary to prevent Defendants' deceptive trade practices and restore to any person any money or property acquired by means of such practices as authorized by Neb. Rev. Stat. § 87-303.05(1).

~~445.~~442. The Court should award civil penalties for each violation of the NE UDTPA as authorized by Neb. Rev. Stat. § 87-303.11(1). The Court should award costs and attorney's fees as authorized by Neb. Rev. Stat. § 87-303(b).

Count VII: Violations of the Texas Deceptive Trade Practices Act (By Plaintiff State of Texas)

~~446.~~443. Texas repeats and realleges the facts above and incorporates them herein by reference.

~~447.~~444. Texas brings this action in the public interest for Defendants' violations of the Texas Deceptive Trade Practices Act, Tex. Bus. & Com. Code §§ 17.41-17.63. For these violations, Texas seeks relief, including a permanent injunction, civil penalties, restitution, attorneys' fees, costs, and all other appropriate relief provided by Texas law. *See e.g.* Tex. Bus. & Com. Code § 17.47.

~~448.~~445. The Texas Deceptive Trade Practices Act specifies multiple acts or practices which, when conducted in the conduct of any trade or commerce, are deceptive trade

practices. Tex. Bus. & Com. Code § 17.46(a), (b).

~~449.~~446. Defendants engaged in and continue to engage in deceptive trade practices in violation of the Texas DTPA.

~~450.~~447. Defendants' false, misleading, and deceptive acts and practices have affected the people of Texas, causing harm.

~~451.~~448. Each deceptive act or practice as alleged herein constitutes a separate violation of the Texas DTPA.

~~452.~~449. The Court should award injunctive relief and make all other orders or judgments necessary to prevent Defendants' deceptive trade practices and restore to any person any money or property acquired by means of such practices as authorized by Tex. Bus. & Com. Code § 17.47.

~~453.~~450. The Court should award civil penalties for each violation and costs and attorneys' fees as authorized by Tex. Bus. & Com. Code § 17.47 and Tex. Gov't Code § 402.006.

XVII. CONSUMER INJURY

~~454.~~451. Children and parents have suffered, are suffering, and will continue to suffer substantial injury because of the Defendants' violations of the FTC Act, the AK CPA, the Iowa Consumer Fraud Act, the NE UDTPA, and the Texas DTPA. Absent injunctive relief by this Court, Defendants are likely to continue to injure consumers and harm the public interest.

XVIII. PRAYER FOR RELIEF

Wherefore, the Plaintiffs request that the Court:

A. Enter a permanent injunction to prevent future violations of the FTC Act, the AK CPA, the Iowa Consumer Fraud Act, the NE UDTPA, and the Texas DTPA;

B. Award Alaska civil penalties, restitution, attorneys' fees and costs, and other

appropriate relief as authorized by AS §§ 45.50.501, 45.50.551(b), and 45.50.537;

C. Award Iowa civil penalties, disgorgement, attorney's fees, costs, and other appropriate relief as authorized by Iowa Code;

D. Award Nebraska civil penalties and/or forfeiture for each violation of state law, and attorneys' fees and costs as provided under state law;

E. Award Texas civil penalties, restitution, attorneys' fees, costs, and all other appropriate relief authorized by Texas law;

F. Award any additional relief as the Court determines to be just and proper.

Dated: ~~June 17~~August 18, 2026

Respectfully submitted,

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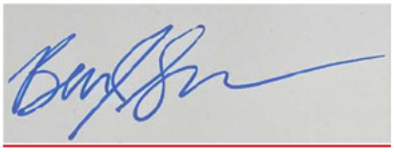
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~~EXHIBIT 1~~

EXHIBIT 1

DECLARATION OF SOREN ALDACO
Pursuant to 28 U.S.C. § 1746

I have personal knowledge of the facts set forth below and am competent to testify about them. If called as a witness, I could and would testify as follows:

1. I am over 18 years old, a woman, and live in Austin, Texas.

2. I was born in 2002 and grew up in Dallas, Texas. In middle school I lived with my mother and step-father, who was disabled and needed me to help him around the house. I did not go outside much and spent a lot of time online.

3. I first learned about cross-sex identity when I was approximately 11 years old, around 2012–2014, through online interactions on Nintendo devices.

4. This was a difficult time for me. I had trouble fitting in with my classmates and I went through puberty before most of them, which led me to feel self-conscious about my body. This discomfort was reinforced by exposure to social media and online pornography.

5. I liked the idea of being male. It seemed to offer an escape from the social challenges I faced at school, and it made sense to me because I enjoyed "masculine" hobbies like video games. I began using male avatars and going by male names online. Soon I also started binding my breasts some of the time, meaning that I created the appearance of a flat chest by wearing binders I bought online. Binders are rigid, restrictive garments shaped approximately like sports bras, with clasps on the side.

A Psychiatrist Validated My Online Identity

6. In December 2017, at age 15, I met my biological father for the first time. This caused additional emotional stress. The next month, these stressors culminated in a psychiatric episode. I was admitted to an inpatient psychiatric facility in Fort Worth, Texas.

7. While I was hospitalized a psychiatrist repeatedly questioned me about whether I identified as male. This was the first time a healthcare provider talked to me about my "gender identity." Before, being male had been a diffuse notion. But now it felt like something central to my well-being because a doctor was "affirming" it.The psychiatrist did not meaningfully address my mental health conditions or help me deal with my complex family situation.

8. After my hospitalization, in the summer of 2018, I attended the Duke University Talent Identification Program, which was a summer camp for gifted teenagers. The adults in charge affirmed my male identity. I was housed with girls but otherwise treated socially as a boy. Nobody at the camp told my family about this, as far as I know.

9. I began spending weekends with my father, his wife, and their daughter (my younger half-sister). They supported me in identifying as male. Later in 2018, they began taking me to a support group called Transcendence International in the Dallas–Fort Worth, Texas area. At the support group we talked about medical transition. I learned that the "standards of care" for treating cross-sex identity was medical transition and those standards came from an organization called "WPATH."

the Dallas-Fort Worth, Texas area. At the support group we talked about medical transition.

11. My father and stepmother attended a related support group for family members called

10. Significant Others, Family, Friends, and Allies (SOFFA).

12.11. I was also seeing therapists during this time for issues including autism and ADHD. They mostly asked me questions about my male identity. They did not give me much counsel on my family dynamics or mental health issues.

13.12. I did not think of myself as male or female. But around most people I said I was male because it was easier to explain.

~~because it was easier to explain.~~

A Man from the Support Group Prescribed Me Testosterone

14.13. Through SOFFA, my father and step-mother met a nurse practitioner named Del Scott Perry. He attended the group and identified as the father of a transgender (adult) child who sometimes attended my support group. I learned that he prescribed cross-sex hormones to several kids I had met there.

15.14. When I was 17, around January 2020, my step-mother took me to ~~Perry's~~Perry's clinic. ~~The~~

The appointment lasted about 30 minutes, during which I filled out paperwork on an iPad and he took my vitals. There were no mental health professionals involved. Perry did not ask whether my step-mother had custody or medical decision-making authority over me (she did not). ~~whether my step-mother had custody or medical decisionmaking authority over me (she did not).~~

~~16.~~15. I was not surprised that the appointment was perfunctory. ~~In the support group I had learned that WPATH said medical transition was the only way to go for kids like me, and I understood WPATH to be the authority.~~

~~17.~~ Perry prescribed me testosterone and an estrogen blocker and taught me how to inject the

~~18.~~16. testosterone. My ~~mother's~~mother's employer-sponsored Aetna health insurance covered the visit and drugs except for a $20 copay for the visit and a small amount for the drugs, which I paid. My step-mother took me to pick them up at CVS.

~~19.~~ I did not ask my ~~mother's~~mother's permission or tell her about the prescriptions right away. We

17. did not talk about it much when I did. I think she was not happy about me medically transitioning but had known for a while it was inevitable.

Testosterone Impacted My Body and Mind

~~20.~~18. I injected myself with testosterone the same day it was prescribed, in the kitchen with my father, step-mother, and sister gathered around. Soon I felt euphoric and energetic.

~~21.~~19. I began a routine of injecting testosterone every Wednesday before my shift at Starbucks. I called it ~~"~~"shot day~~"~~" and looked forward to it all week because of how great I felt, physically and mentally, after the shot.

~~22.~~20. By Tuesday every week I would feel lethargic, tired, and depressed.

~~23.~~21. I also experienced physical changes such as voice deepening and facial hair growth.

22. I developed multiple health complications while on testosterone, including headaches, gastrointestinal issues such as gastritis and acid reflux, dizziness, chronic fatigue, hot flashes, rashes, and joint pain throughout my body. I also experienced injection site reactions, including itching throughout the week, warmth, and the development of scar tissue.Testosterone wreaked havoc on my genitals. Soon after starting it my clitoris grew and developed excruciating cysts. I needed minor surgery to remove them. The health insurance company originally denied coverage because my sex marker was male, so it did not make sense for me to have a clitoris. (The cysts came back. Then I learned to wear different underwear, which seemed to prevent the problem.) Over the next year or so I developed vaginal atrophy, which meant the area was dry and painful.

23. I suffered intense mood swings while I was on testosterone. Around the end of 2020, I attempted suicide by overdosing.

24. Perry responded to my health complaints by referring me to numerous specialists, including gynecologists, neurologists, cardiologists, rheumatologists, and others. Many providers treated symptoms without identifying a cause.

I Paid a Surgeon to Remove My Breasts at 18

25. Beginning in my mid-to-late teenage years I wanted to have my breasts removed. In 2021, after turning 18, I pursued a double mastectomy.

26. I already had a therapist. I had told her about my suicidal ideation, both before and after using testosterone, and my history of being sexually abused. Now she affirmed my desire for surgery without question and wrote me a referral letter.

27. I contacted the Crane Clinic in Austin, Texas, paying approximately $200 for a phone

phone consultation. During the consultation and preoperative process, I was asked what I wanted and was told the clinic could provide it. I was informed about insurance options, including attempting appeals, but my Aetna insurance denied coverage because it was out of network. I signed a self-pay agreement for approximately $5,500, and the clinic assisted with appeal efforts. The clinic staff told me that they regularly helped patients successfully challenge insurance denials.

28. Ultimately the appeal was unsuccessful.

30.29. I saw that Crane billed my insurance over $20,000 for the surgery. Based on records I saw, I think Aetna paid Crane about $2,147.51. Then Crane refunded me $745.42. In total I paid Crane over $4,950.

31.30. In June of 2021, Dr. Ashley DeLeon performed my double mastectomy.

32.31. After surgery, I experienced severe complications, including extensive bruising across my chest and flanks, internal bleeding, swelling, and signs consistent with blood pooling. My concerns were initially dismissed by clinic staff, and my communications with the clinic resulted in delayed or inadequate responses.

32. As my condition worsened, including experiencing warmth, fullness, and dark bruising in my chest, I sought emergency care. I drove myself to UT Southwestern ~~Hospital's~~Hospital's Dallas location. I remained there for approximately eight hours before receiving treatment, except for minimal care to stabilize my condition.

33. The surgeon there who specialized in "transgender" operations refused to see ~~me that day.~~me that day. But clinicians from the oncology practice took my case, and they were very attentive. They cut my scars open, broke up blood clots that had formed, and drained blood and fluid that had accumulated. One of the assistants told me that my surgery had not proceeded within medical standards for mastectomy.

34. Following surgery, I required ongoing medical treatment, including additional procedures to address complications, scar tissue, and keloids (visible, overgrown scar tissue that extends beyond the original incision). I was mostly treated by breast oncology specialists; the "gender" surgeon only consulted on cosmetic issues.

35. During the entirety of this process, starting at the support group in the Dallas-Fort Worth, Texas area and while receiving medical transition treatments, including taking hormones and my double mastectomy, I learned about WPATH and its standards of care.

I Tried to Address My Health Problems

~~33.~~36. After these experiences I became concerned with improving my health. I wanted to get to the bottom of all my health issues. A rheumatologist told me that my joint pain was likely related to testosterone use, which made me wonder how else it affected me.

~~34.~~37. During this period, I was in a long-term relationship with another woman who ~~identified~~ identified as male. We began transitioning at approximately the same time and

attended hormone appointments together. We started dating when we were both around age 16, married a few years later in 2020, and divorced in 2021. I watched her mental health deteriorate over the years. In 2023 she assaulted me, then again in 2024. I now have a protective order against her.

38. During the winter of 2021-22 I still felt uncomfortable with my body and calling myself female. But I now saw my male/nonbinary identity as a way of running away from the discomfort. I decided to stop avoiding my discomfort and instead confront it, like a form of exposure therapy. I stopped taking testosterone and started acknowledging to people that I was female.

39. Some of my symptoms improved after stopping testosterone, although not all returned to baseline. I continue to experience ongoing health issues, including fatigue, joint pain, clitoral cysts, and a lot of pain and physical discomfort in my upper chest and shoulders. I also have nerve issues around my mastectomy scars. I get strong, weird sensations at the bottom of the scars.

40. I moved out of my childhood home in January 2022 and began focusing on improving my health and relationships, including making dietary changes and engaging in practices such as mindfulness. I earned a ~~bachelor's~~bachelor's degree from the University of Texas, winning an award for my thesis on social ~~media's~~media's role in identity formation. I now study educational psychology as a graduate student at UT.

~~35.~~41. When I was transitioning, I believed that healthcare providers would only offer ~~me~~

me treatments that were safe and effective. But in hindsight, I think the clinicians who prescribed me transition drugs and performed my mastectomy were just giving me whatever I asked for. I regret taking their prescriptions and undergoing mastectomy.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.
Executed on ~~June 16~~Aug. 17, 2026.

Soren Aldaco (Aug 17, 2026 09:10:53 CDT)

Soren Aldaco