LGB Courage Coalition

Report to the Federal Trade Commission
Request for Public Comment Regarding "Gender-Affirming Care" for Minors

Date: September 2025

Prepared by:
LGB Courage Coalition
www.lgbcouragecoalition.org

Submitted by:
Jamie Reed, BA, MS Clinical Research – Co- Executive Director
Lauren Leggieri, BA – Co- Executive Director

Contact Information:
LGB Courage Coalition
P.O. Box 510114
St. Louis, MO 63151
Email: lgbcouragecoalition@gmail.com

This report is submitted in response to the Federal Trade Commission's Request for Public Comment regarding gender-affirming care for minors. It contains case studies, analysis, and expert commentary to assist the FTC in its investigation of potentially deceptive or unfair practices related to these interventions. This report was made possible through the dedication and efforts of our volunteer network, who work tirelessly to support families, whistleblowers, and vulnerable youth.

September 26, 2025

Federal Trade Commission
Office of Policy Planning
600 Pennsylvania Avenue, NW
Washington, D.C. 20580

Dear Commissioners and FTC Staff,

On behalf of the LGB Courage Coalition, we are honored to submit this report for your consideration as part of the Federal Trade Commission's Request for Public Comment regarding Gender-Affirming Care (GAC) for Minors.

The LGB Courage Coalition is a national, nonprofit organization founded by lesbian, gay, and bisexual individuals committed to safeguarding same-sex attracted youth and promoting evidence-based, ethical medical practices. Our mission is to protect vulnerable young people from unproven and potentially harmful interventions and to ensure that families are fully informed about the risks, benefits, and alternatives before making life-altering decisions.

Our coalition was co-founded by Jamie Reed, a former case manager at the Washington University Pediatric Transgender Center in St. Louis, Missouri, and Lauren Leggieri, a national advocate and strategist for protecting LGB youth. Lauren and Jamie are both lesbians. Together, they lead the organization as Co-Executive Directors.

In 2023, Ms. Reed came forward as a whistleblower, providing sworn testimony about systemic deficiencies she witnessed firsthand in the care of minors, including lack of informed consent, failure to address co-occurring mental health conditions, and coercive practices that funneled children toward irreversible medicalization. Her story was first shared publicly in The Free Press article, *'I Thought I Was Saving Trans Kids. Now I'm Blowing the Whistle.*'

The FTC's investigation into potentially deceptive and unfair practices surrounding GAC is critical. The case studies in this report span multiple states, healthcare systems, and providers. They document recurring patterns of:
• Coercive clinical messaging that pressures families into compliance.
• Failure to screen for mental health conditions, medical conditions, developmental delays, or same-sex attraction before prescribing irreversible interventions.
• Negligent or absent medical monitoring, especially by subscription-based telehealth providers.
• Irreversible physical and psychological harms experienced by minors and young adults.

These families and their children represent the very consumers the FTC is charged with protecting. The patients are all minors or young adults and most of them are members of

vulnerable groups due to having diagnosed mental health conditions or being same sex attracted. Their stories are not isolated; they point to systemic failings in how gender-affirming care is marketed, delivered, and monitored.

We would like to acknowledge the extraordinary dedication of the volunteers of the LGB Courage Coalition, whose tireless efforts to document cases, support families, and advocate for reform made this report possible. Without their work, the voices of these families and young people might never be heard.

We urge the Commission to review these materials carefully and to use its unique enforcement authority to address deceptive marketing, coercive practices, and the commercialization of unproven medical treatments targeting minors.

Thank you for your commitment to this important issue. We stand ready to provide additional information or testimony as needed and deeply appreciate the FTC's willingness to engage with families, whistleblowers, and affected communities.

Respectfully submitted,

Jamie Reed, BA, MS Clinical Research
Co- Executive Director, LGB Courage Coalition
Whistleblower, Washington University Pediatric Transgender Center,

Lauren Leggieri, BA
Co-Executive Director, LGB Courage Coalition

www.lgbcouragecoalition.org
lgbcouragecoalition@gmail.com

Introduction

Role of the Federal Trade Commission (FTC)

The Federal Trade Commission (FTC) launched a Request for Public Comment (RFC) concerning "Gender-Affirming Care" (GAC) for minors. The RFC seeks to understand how consumers—including minors and their families—may have been exposed to false or unsupported claims about GAC. The agency is investigating whether harms have occurred and whether medical professionals or institutions may have violated Sections 5 or 12 of the FTC Act, which govern unfair or deceptive practices.

In the FTC's own words, the agency is "uniquely positioned to investigate" potentially unlawful activity in this domain, given its long history of enforcement against deceptive health claims. The Commission has already heard testimony from whistleblowers, parents, detransitioners, medical ethics experts, and medical professionals.

With this report, the LGB Courage Coalition aims to respond to that invitation by providing structured, firsthand accounts of individuals and families who have experienced what they and the FTC characterize as cases of misleading, coercive, and medically reckless gender-affirming care.

About the LGB Courage Coalition

The LGB Courage Coalition is a U.S.-based, nonprofit advocacy organization made up of lesbian, gay, and bisexual individuals. The Coalition's mission is to:

- Promote evidence-based medical care for all.
- End what it terms the medicalization of gender nonconformity.
- Safeguard homosexual rights; and
- Build a pathway back for individuals who have undergone medical interventions related to gender identity.

Jamie Reed and the Whistleblower Report

Jamie Reed is a clinical research professional who previously served as a case manager at the Washington University Pediatric Transgender Center (affiliated with St. Louis Children's Hospital) from 2018 until late 2022.

In February 2023, Reed came forward as a whistleblower, providing affidavit testimony to the Missouri Attorney General's Office. In her affidavit, she detailed systemic deficiencies in patient care, including:

- Initiation of puberty blockers and cross-sex hormones without adequate informed parental consent or appropriate mental health assessments.
- Inadequate follow-up or tracking of adverse outcomes or patient harm.
- A “multidisciplinary” care model that, in practice, shunted patients into hormonal treatment with minimal psychiatric or psychological oversight.

Reed’s affidavit prompted state-level legislative action, including an investigation by Missouri's Attorney General and subsequent testimony in a trial concerning restrictions on gender-affirming care for minors.

Since her departure from the pediatric center, Reed has served as the Executive Director of the LGB Courage Coalition, guiding its work and public advocacy.

Why We Are Part of This Report

- Alignment with the FTC’s Mandate: This report directly supports the FTC’s mission to guard against deceptive or unfair practices and to bring empirical consumer harms to light.
- Expertise & Witness Perspective: Through direct experience in the pediatric gender clinic and in leadership at LGB Courage Coalition, Jamie Reed brings a unique vantage point recognizing institutional patterns and risks not widely visible to families or the public.
- Representation of Affected Families: The case studies compiled by the Coalition offer in-depth, real-world consequences of GAC practices on minors, families, and vulnerable communities.
- Commitment to Evidence-Based Standards: The Coalition and the FTC share an impelling interest in ensuring that medical interventions for minors reflect rigorous standards of informed consent, risk communication, and clinical responsibility.

Methods

Overview

The LGB Courage Coalition employed a structured, evidence-based approach to collect, verify, and analyze information regarding the practices of medical providers, telehealth companies, and affiliated organizations involved in the promotion or delivery of "gender-affirming care" (GAC). The methodology was designed to ensure that the Federal Trade Commission (FTC) received accurate, detailed, and representative data concerning potential deceptive or unfair practices impacting consumers.

Data collection focused on obtaining comprehensive case reports from families, supported by medical records, insurance documents, and communications with providers, as well as an analysis of publicly available marketing materials and relevant clinical guidelines. All information was de-identified prior to inclusion in this report to protect the privacy of the affected individuals and their families.

Data Sources and Collection

1. Parental Case Reports

- Families provided detailed written accounts of their children's or young adults' experiences with gender-related medical interventions or referrals for such care.
- Structured interviews were conducted by Coalition representatives to ensure consistent data collection and to clarify timelines, decision-making processes, and provider actions.
- Each family submitted documentation to support their reports. This included, where available:
    - Medical records and treatment plans
    - Prescription histories and pharmacy records
    - Insurance billing statements
    - Email and message correspondence with providers and clinics

All submitted documentation has been reviewed and securely retained by the LGB Courage Coalition. This information can be provided to the FTC upon request, with the consent of the parents or guardians involved.

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2. Publicly Available Marketing and Promotional Materials

- The Coalition systematically collected marketing materials, website content, telehealth service descriptions, and advertising campaigns from organizations promoting GAC.
- Materials were archived as screenshots or PDF files for reference and verification.
- Content was analyzed for potentially misleading claims regarding:

- Safety and efficacy of interventions
- Reversibility of treatment
- Patient outcomes and satisfaction rates
- Comparative risks versus alternative treatments

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3. Review of Clinical Guidelines and Published Literature

- Relevant guidelines and systematic reviews were analyzed to assess whether provider claims aligned with current evidence.
- Emphasis was placed on reviewing high-quality international reports and systematic reviews, including those from:
  - NHS England (Cass Review and related updates)
  - Swedish National Board of Health and Welfare
  - Finnish Council for Choices in Health Care
  - McMaster University-linked systematic reviews

This comparison provided context for evaluating whether U.S. marketing and clinical practices reflect or deviate from international evidence-based standards.

Data Analysis

1. Thematic Review
Structured interview transcripts, written case reports, and supporting documentation were systematically reviewed and coded to identify recurring patterns and areas of concern. Key themes included:

- Lack of informed consent or inadequate disclosure of risks
- Failure to assess co-occurring mental health conditions or developmental disorders
- Misrepresentation of treatment outcomes and long-term risks
- Disproportionate representation of same sex attracted youth
- Misinterpretation of autistic traits or neurodevelopmental differences as indicators of gender dysphoria

2. Verification and Cross-Referencing

- Case narratives were verified against the documentation submitted by families to ensure accuracy and completeness.
- Timelines of events, prescriptions, and treatment decisions were cross-referenced with medical and insurance records.
- Discrepancies or missing data were clarified through follow-up communications with the families.

3. Consumer Protection Framework Review

- Cases were evaluated through the lens of FTC regulations, focusing on potential violations related to:
    - Misrepresentation of material facts
    - Omission of critical risk information
    - Unfair or deceptive marketing practices
    - Lack of adequate consumer safeguards

Safeguards and Confidentiality

To protect the privacy of families and individuals:

- All names and identifying details were replaced with case identifiers (e.g., "Case 1," "Case 2").
- Original documentation remains securely stored and will not be released without the explicit consent of the families involved.
- If requested by the FTC, full documentation can be provided once consent is obtained.

Parents reported ongoing and serious concerns regarding their privacy and the need to remain confidential. Several families expressed that their participation in this report could put them at risk of retaliation or social harm. In addition, some families continue to experience long-term impacts on their relationships with their children because of these medical interventions, and they face significant challenges related to the ongoing medical and mental health needs of their children.

Limitations

- The cases presented represent a focused sample and are not exhaustive of all instances of consumer harm.
- While every effort was made to verify submitted information, the scope of this report is limited to the data provided by participating families and publicly available marketing materials.
- Certain elements of individual cases may require additional investigation by the FTC to fully assess potential regulatory violations.

Executive Summary

Across reports by seventeen separate families spanning multiple states, a consistent pattern of deceptive marketing and deficient clinical practice emerges within the current delivery of so-called "gender-affirming care" (GAC) to vulnerable minors and young adults. These cases involve different regions, healthcare systems, and payer settings, yet the same dynamics are repeated: hasty prescribing**,** limited diagnostic workups**,** failure to address co-occurring conditions**,** and coercive clinical messaging**.** These failures undermine informed consent and consumer protection**,** and families report lasting harms to youth and to family stability.

Key Themes and Patterns

1) Lack of mental-health assessment or consideration

- Youth frequently had clear histories of ASD/ADHD, trauma, anxiety, depression, or psychosis**,** yet no mental-health evaluation was required before initiating hormones.
- Families report no therapy requirement**,** no coordination with PCPs**,** and minimal diagnostic workups before or after prescribing.

FTC implication: Consumers were sold a medical service without reasonable screening for contraindications or co-occurring conditions—an omission of material facts a reasonable consumer needs to weigh risks, alternatives, and appropriateness.

2) Failure to explain same-sex attraction as part of normal adolescent development

- Multiple cases involved same-sex attracted youth; families report clinicians did not explain that same-sex attraction is common in adolescence and does not indicate a need for medical transition.
- Orientation was at times framed as evidence of being "transgender," with little discussion of alternatives.

FTC implication: Failing to disclose the normalcy of same-sex attraction and relevant non-medical options risks misleading consumers by omitting material information about their condition and potential paths forward.

3) Rapid-onset gender distress with no childhood history

- Many cases show no childhood gender nonconformity, followed by sudden identification as trans during adolescence/early adulthood—often amid social stressors, peer influence, or online/school-club exposure.

FTC implication: Initiating medical treatment based on recent claims of identity without developmental history or longitudinal assessment weakens expected medical safeguards and may mislead families about necessity and timing.

4) Coercive clinical messaging

- Families consistently reported pressure-laden statements that discouraged questions or second opinions (e.g., suicide-framed ultimatums and "only option" rhetoric).

FTC implication: These high-pressure tactics resemble coercive sales practices and undermine voluntary, informed choice. Fear-based claims can misrepresent risk and necessity—a material deception in a healthcare purchase.

5) Lack of medical monitoring and oversight

- Reports describe no baseline labs, narrow or absent follow-up labs, and little ongoing supervision even after hormone initiation.
- Telehealth initiation commonly occurred with minimal evaluation and limited monitoring thereafter.

FTC implication: Marketing and dispensing prescription hormones without adequate clinical oversight obscures foreseeable risks and misleads consumers about safety and standards of care.

6) Physical and long-term harms

- Families describe persistent or irreversible adverse effects, functional decline, and ongoing health issues, including weight change, sleep disruption, cognitive complaints, and other health problems.
- Surgical interventions appear in some cases, with ongoing functional or psychosocial impairment reported.

FTC implication: When products and services are presented as safe or reversible, but material risks and unknowns are not accurately disclosed, the result is deceptive and unfair to consumers.

7) Commercial platforms driving access

- Direct-to-consumer telehealth brands recur, often using subscription models with minimal evaluation, limited physical examination, and weak consent processes**.**

FTC implication: Subscription-style telehealth models marketing powerful prescription drugs warrant scrutiny for deceptive/unfair practices, including omissions and overstatements in promotional and onboarding materials.

8) Additional observations and diagnostic overshadowing

- Absent diagnostic determinations / diagnostic overshadowing**.** Gender-related distress is frequently treated as the primary diagnosis while other plausible drivers (e.g., trauma, ASD/ADHD, depression, psychosis, substance use) are downplayed—consistent with diagnostic overshadowing.

FTC implication: Marketing and delivering a medical service without disclosing the absence of a proper differential diagnosis—and without acknowledging how overshadowing may misdirect care—omits material facts needed to judge necessity, risks, and alternatives.

- Campus health quality gaps**.** University and college services often substitute quick social affirmation for thorough assessment, with weak discharge planning and poor continuity-of-care.

FTC implication: Promotional claims of comprehensive, student-centered care may be deceptive if essential evaluation and follow-up are not provided or disclosed.

- Cannabis as a destabilizing factor. Families repeatedly report marijuana use correlating with anxiety, paranoia, or general instability; documentation rarely shows systematic screening or counseling on this risk.

FTC implication: Failing to assess and disclose material risk factors (including substance use) before selling or renewing treatment can mislead consumers about safety and expected outcomes.

- Parents sidelined despite being key informants and payers**.** Parents provide history, records, and often pay for services, yet are treated as adversarial rather than partners—unlike other areas of care where family inclusion through young adulthood is routine (with patient consent).

FTC implication: Where providers market "whole-person," "family-centered," or "collaborative" care, excluding parents who hold relevant information and financial responsibility may constitute deceptive marketing by contradicting advertised practices.

Conclusion

These seventeen family reports are not isolated anecdotes. They describe a recurring, cross-state pattern in which:

- Children and young adults are targeted with coercive messaging,
- Prescription hormones are dispensed like retail products,
- Families are not fully informed about risks, benefits, and alternatives, and
- Neurodivergent and same sex attracted youth appear disproportionately affected.

What is marketed as "gender-affirming care" is frequently inconsistent with informed-consent standards used elsewhere in medicine. The FTC's consumer-protection mandate is implicated wherever marketing and delivery omit material facts, use fear-based claims, or overstate safety and reversibility.

Plume Health and FOLX Health: Online Telehealth Vendors

As part of our investigation into systemic failures in gender medicine, the LGB Courage Coalition has identified two of the largest direct-to-consumer providers of cross-sex hormones in the United States: Plume Health, P.C. (“Plume”) and FOLX Health, Inc. (“FOLX”). These companies operate nationwide through subscription-based telehealth models, serving tens of thousands of consumers, and collectively represent a significant share of the cross-sex hormone market.

Plume and FOLX aggressively market hormone therapy online and through targeted campaigns, positioning their services as accessible, safe, and lifesaving. However, our review — together with detailed documentation provided by legal and medical allies — raises serious concerns about deceptive practices, lack of appropriate safeguards, and evidence of harm to consumers.

While both companies claim to limit services to adults, our coalition has received troubling reports indicating that their systems are vulnerable to misuse and lack robust protections to prevent minor access. This section summarizes these concerns and incorporates, by reference, a comprehensive memorandum prepared by C. Erin Friday, Esq. (Submitted to the FTC).

Lack of Safeguards for Minors

Plume and FOLX publicly assert that they do not treat minors. However, their actual practices and marketing materials suggest significant gaps in oversight.

There is no meaningful age verification required for signing up for services or for receiving marketing communications, such as newsletters and promotional emails. The telehealth model these companies use allows individuals to obtain prescriptions without in-person evaluations, making it possible for third parties to obtain hormones and deliver them to minors. Their marketing campaigns are openly visible on platforms popular with teenagers, and certain events sponsored by these companies include youth-oriented messaging and content.

Additionally, both companies operate across state lines, raising complex jurisdictional issues regarding licensing, prescription regulations, and parental consent laws.

Although we do not have direct proof of a minor being treated, these systemic weaknesses create serious risks. The FTC should examine these vulnerabilities to ensure that companies are fully compliant with state and federal laws, particularly when distributing controlled substances like testosterone.

Deceptive and Unsubstantiated Claims

Plume and FOLX consistently make unsubstantiated claims in their marketing, which mislead consumers about the safety, reversibility, and necessity of cross-sex hormones.

These companies present cross-sex hormones as “safe,” “reversible,” and “lifesaving” without adequately disclosing the irreversible and serious risks such as sterility, bone density loss, chronic pain, cardiovascular complications, and sexual dysfunction.

Misleading imagery and descriptions are used to imply that users will achieve body changes that are medically impossible, creating unrealistic expectations. Marketing materials often rely on fear-based messaging, including suggestions that without these interventions, individuals will die by suicide. These claims are not supported by credible scientific evidence and may exploit the fears of vulnerable families and may even aggravate conditions for suicide ideations.

Risks are routinely minimized or framed as trivial, while alternative approaches such as mental health support or watchful waiting are dismissed or excluded entirely. This pattern meets the FTC’s standard for deceptive marketing, as it involves material misrepresentations or omissions likely to mislead consumers about products with profound, life-altering consequences.

Parent Testimonies and Evidence of Harm

The LGB Courage Coalition gathered testimonies from parents whose young adult children — legally adults, but barely past adolescence — were medicalized through services provided by Plume and FOLX.

The stories we received reflect consistent patterns of harm:

- Rushed care with little to no meaningful assessment.
- Medical prescriptions provided despite serious concerns mental health and ability to consent being present.
- Minimal or absent follow-up, including skipped lab monitoring.
- Client-led dosing, where dosage decisions were based on self-reported goals rather than medical judgment.
- Lack of informed consent, with inadequate disclosure of risks and long-term effects.

Although these individuals were above the legal age of consent, some were legally disabled, had profound mental health comorbidities and serious ASD diagnoses; their experiences highlight how easily harm occurs when powerful drugs are marketed and distributed without proper safeguards or ethical oversight.

Incorporation by Reference

To avoid unnecessary duplication, we direct the FTC to a comprehensive memorandum prepared by C. Erin Friday, Esq., dated September 5, 2025. This memorandum includes:

- Screenshots and examples of marketing materials.
- Documentation of company practices and youth-facing campaigns.
- Analysis of corporate relationships and potential conflicts of interest.
- Additional evidence of deceptive or harmful statements.

We request that the FTC review the memorandum in full and use its subpoena authority to obtain internal records from Plume and FOLX to verify and expand upon these findings.

Recommended FTC Actions

Based on these findings, the LGB Courage Coalition urges the FTC to:

- Investigate deceptive marketing claims, including false assurances about safety, reversibility, and suicide prevention.
- Require transparent and standardized risk disclosures during advertising and sign-up processes.
- Enforce strict age-verification measures to prevent minors from accessing services or marketing materials.
- Audit company practices to ensure compliance with state licensing and prescription laws.
- Prohibit marketing that targets or appeals to minors, whether directly or indirectly.
- Seek consumer redress for individuals harmed by misleading claims.
- Establish clear industry standards for telehealth providers who distribute controlled substances.

Conclusion

Plume and FOLX represent a rapidly expanding sector of the gender medicine industry that blends telehealth, pharmaceuticals, and aggressive digital marketing. Their practices, as documented by our coalition and allied organizations, demonstrate the urgent need for federal oversight and enforcement to protect consumers and prevent further harm.

The LGB Courage Coalition calls on the FTC to act decisively, holding these companies accountable and setting a standard for truthful, evidence-based consumer protection.

Clinician Accountability and Oversight

During our investigation, several specific clinicians and prescribers were identified as central to the delivery of services and the decision-making processes described in the case reports. These individuals have been named by families in their submitted documentation, and their actions have been reviewed by the LGB Courage Coalition based on medical records, correspondence, and structured interviews.

The information gathered demonstrates a pattern of conduct that raises serious concerns about compliance with federal consumer protection laws, as well as adherence to basic standards of medical ethics and professional care. These clinicians will be reported directly to the Federal Trade Commission for review and possible action under its authority to address unfair and deceptive practices. Reports will also be submitted to appropriate state-level oversight agencies, including state medical boards and health departments responsible for licensing and professional discipline. In addition, the LGB Courage Coalition will notify each named clinician directly, informing them of the concerns raised and the process by which these matters are being referred for review.

Our findings indicate that these clinicians have engaged in practices that have caused direct harm to patients and families. These harms include the provision of irreversible interventions without adequate informed consent, failure to properly assess or treat co-occurring mental health conditions, and misrepresentation of risks and benefits associated with treatment. Such actions not only violate the trust placed in healthcare providers but also may constitute violations of federal and state regulations designed to safeguard consumers and patients.

Particularly troubling is the impact of these practices on vulnerable populations. Among the cases reviewed, we observed a significant overrepresentation of individuals with autism spectrum disorder (ASD) and same sex attracted youth. These groups require careful, individualized assessment and support. Instead, they were too often guided toward invasive interventions without the safeguards or comprehensive care necessary to protect their long-term well-being. This pattern suggests systemic failures within the clinical environments in which these clinicians operate.

Equally concerning is the role of universities in these practices. Colleges and universities hold a special position of trust in our society, with young adults literally sent into their care as they transition to independence. Through university health programs and campus-led therapy services, we found instances of students being rapidly medicalized—with deeply concerning outcomes documented in the cases we reviewed. In some situations, irreversible medical interventions were initiated within a single semester.

These young people, many of whom arrived at college with the goal of pursuing education and personal growth, instead saw their futures altered permanently. Several were left unable to continue their studies, dropping out before completing their degrees while also facing the physical and psychological consequences of rushed medical decisions. The rapid medicalization of students within university health systems represents a profound breach of trust and a failure of these institutions to uphold their duty to safeguard the well-being of those in their care.

The conduct of these providers and institutions warrants immediate and thorough review. Internal audits by universities and healthcare systems are urgently needed, alongside independent investigations by state regulatory bodies. The practices we have documented reflect not only potential violations of FTC standards but also fundamental breaches of good medical care and educational stewardship. Without decisive intervention, these clinicians and institutions will continue to place patients, families, and students at risk—eroding public trust and perpetuating harm to some of the most vulnerable members of society.

The LGB Courage Coalition will provide the FTC, state regulators, and university oversight boards with detailed information regarding each named clinician and institution, as directed by the families involved. Original documentation will not be released by the Coalition without the explicit consent of the families. By notifying clinicians directly, we aim to ensure transparency and to give these providers the opportunity to respond to the evidence while appropriate oversight actions are pursued.

States Represented in Case Reports

- Texas
- Colorado
- California
- Virginia
- Hawaii
- Massachusetts
- South Carolina
- North Carolina
- Maryland
- Oregon
- Florida
- Georgia
- New York
- Illinois
- Washington D.C.
- Minnesota

The Clinicians and Prescribers

Clinician's Name	Role and Description	Affiliation and Location
Dr. Laura Kuper	Recommended Medicalization	Dallas Children's Hospital
Dr. Jody Bahnmiller-Brasil	Clinician & Prescriber	Unknown
Adam Sostota	Clinician who directed patient to hormones	San Antonio
Cassie Nghiem	Clinician / Surgeon	Was named by two separate families.
Colorado State Univ. – Women's Clinic	Prescriber - first visit Rx spironolactone	Colorado State University
Lindsey Ellis	Clinician	Folx
Folx	Clinician & Prescriber platform - limited labs	Telemedicine platform
Plume	Prescriber - estrogen patches, minimal follow-up	Telemedicine platform
Dr. Christopher Grijalba	Clinician & Prescriber	Unknown
J. Frandson, MD	Prescriber - testosterone	Plume
Planned Parenthood	Consulted for detransition, refused	California

Dr. Lori M. Gara-Matthews	Clinician	Unknown
Bakersfield Behavioral Health	Refused detransition acceptance	California
Dr. Richard Kerbel	Clinician	Watertown
Craig Callon	Clinician	University Health Care System
Dr. Traci Brooks	Clinician	Cambridge Health Alliance
Dr. Jonathan Pletcher	Clinician & Prescriber	Univ. Health Care System (Princeton), later CHOP
Lane Bryant, PA	Clinician & Prescriber	University health clinic
Beit Gorski, LPC	Clinician - Senior Staff Therapist	University health clinic
Dr. Deanna Adkins	Clinician	Duke Gender Clinic
Kristen Russell, LCSW	Therapist	Duke Gender Clinic
Leigh Spivey	Student Psychologist	Duke Clinical Psychology
Dr. Louise Metz	Prescriber	Mosaic Health
Julia Betteg	Therapist	Unknown
Dr. Audrey Burgess	Psychologist	Unknown

Dr. Chandni Parikh	Psychiatrist	Collaborative Counseling and Psychiatry
Brando Gries	LCPC, LPHA, MA	Collaborative Counseling and Psychiatry
Rebecca Abell	Therapist	MedStar Behavioral Health
Dr. Risa Fishman	Psychiatrist	MedStar Health
Brandeis University Student Health Center	Clinician	Student Health Center
Whitman- Walker Clinic	Clinicians	Outpatient Clinic
Howard Brown Center	Prescribers	Outpatient Centers
Kingwood Psychiatry	Prescribers	Psychiatry
Stella Li, LCMFT	Therapist	Congruent Counseling
Rachel Morrison, MSW, LICSW	Therapist	Student Health Care Coordinator
Christine Brockman, DNP, ARPN	Prescriber	North Field Hospital
Maya Deshpande, LGPC	Therapist	Wrote Letter of Support
Joanne Kim, Med, PC	Therapist	MK Counseling

Dr. Praful Ramineni	Surgeon	Scheduled to perform a top surgery without even a letter of support or therapist evaluation

The Cases:

Case 1

Parent: Mom

Child: Son (Natal Boy)

Timeline:

- Trauma at age 16, death of peer.
- Gifted early student.
- Drug use, marijuana, paranoia.
- Another trauma when a peer committed suicide.
- Covid.
- No early childhood gender nonconformity, late onset.
- Heterosexual.

Clinicians:

- Dr. Laura Kuper – recommended medical transition.
- "You really just have to honor your young person."
- "Get him healthy to then start hormones."
- Adam Sostota – directed patient to place for hormones.

Prescribers:

- University Women's Clinic – prescribed at first visit.
- Nothing given in writing.
- Spironolactone initiated, stopped due to side effects.
- Plume – estrogen patch ($100/month).
- One initial blood draw, no enforcement of follow-up or monitoring.

Factors:

- Natal male, natal female girlfriend encouraging transition.

Case 2

Parent: Mother

Child: Daughter (Natal Girl)

Timeline:

- Serious mental health concerns from early childhood, including need for sensory therapy by age 4.
- IEP at school early on.
- Diagnoses: ASD, bipolar disorder, borderline personality disorder, depression, paranoia, psychotic events.
- History of violence requiring police intervention for mental health hospitalizations.
- Graduated high school only through a specialized mental health program.
- Legally disabled and receives SSDI.

Clinicians:

- Long psychiatric history, no mental health assessment required by prescriber.
- Plume.
- Behavioral Health Clinic – refused to accept detransition.
- Planned Parenthood – refused to provide detransition care.

Prescribers:

- J. Frandson, MD – Testosterone (Plume).

Factors:

- Initial visit was short; patient recalls being told repeatedly: “You cannot sue us later.”
- Testosterone prescribed at 4 vials/month with 5 refills (20 vials total), significant issue of overprescribing a controlled substance.

Long Term:

- Patient believes they have been harmed.
- Permanent physical changes and worsened mental health.

Case 3

Parent: Mother

Child: Daughter (Natal Girl)

Timeline:

- No childhood gender dysphoria.
- Gifted student with ASD.
- After first semester of university, returned home despondent and was recommended and upon return to school a fellow student suggested the "born in the wrong body" narrative. After just a few phone sessions with the University Health Services was recommended for transition.

Clinicians:

- Craig Callon – University Health Care System.
- Dr. Jonathan Pletcher – University Health Care System, later moved to CHOP.

Prescribers:

- Dr. Jonathan Pletcher – University Health Care System at Princeton.

Factors:

- Daily meds include antibiotics, antidepressants, anti-anxiety meds, testosterone, and finasteride.

Long Term:

- Bladder infections, significant mental health decline, physical harms.
- Signs of desistance, but no clear pathway to detransition.

Case 4

Parent: Mother

Child: Son (Natal Male)

Timeline:

- No childhood gender dysphoria.
- Childhood trauma age 9, sibling with severe illness.
- Honors/Talented and Gifted Student
- Clinical Diagnosis with Autism traits, likely ASD.
- Classic ROGD pattern — late onset after first semester at university.
- Recent breakup of first relationship. Diagnosis of Depressive Disorder.

Clinicians:

- Beit Gorski, LPC – Senior Staff Therapist.
- Lane Bryant, PA.

Prescribers:

- Lane Bryant, PA.

Factors:

- Extreme coercion: patient silent during visit, therapist provided narrative.
- "Science is clear."
- "Hormone treatment is the only way to save your child."
- "Would you rather have a dead son or a living daughter?"
- "You might have feelings about this Mom, but you need to never share that with your child."
- "We put all students who think that they may be trans on hormone treatment and the ones who feel better are 'true trans' and the one that don't never were trans to begin with"
- Parent was not allowed to even provide medical, developmental, or family health and mental health history to University Health Clinic.

Long Term:

- Dropped out of college.
- No follow up labs or monitoring for bloodwork.
- No job for two years, on Medicaid and public assistance.
- Mental health not improved.
- Cannabis Use

Case 5

Parent: Mother

Child: Daughter (Natal Girl)

Timeline:

- Covid remote learning: gender concepts introduced in health class.
- School 'Gender & Sexualities Alliance' club encouraged identity exploration.
- Late onset menstruation.
- Identifies as non-binary.
- Pediatricians encouraged transition without full assessment.

Clinicians:

- Dr. Traci Brooks – Health Alliance.
- Dr. Richard Kerbel.
- Dr. Lori M. Gara-Matthews.

Prescribers:

- None yet (minor, not yet medicalized).

Factors:

- Pediatricians deferred entirely to child’s self-diagnosis.
- Told to 'educate your parent' and advocate for binders.
- No clinical explanation that sex cannot be changed.

Long Term:

- Parent anticipates future medicalization once child reaches adulthood.

Case 6

Parent: Mother

Child: Daughter (Natal Girl)

Timeline:

- Homeschooled, no childhood gender dysphoria.
- Came out as lesbian, later transitioned.

Clinicians:

- Dr. Christopher Grijalba.

Factors:

- Same-sex attraction dismissed as relevant factor.
- Transition framed as solution to identity struggles.

Long Term:

- Partner also transitioned, partner now uses a wheelchair.

Case 7

Parent: Mother and Father

Child: Daughter (Natal Girl)

Timeline:

- Same sex attracted.
- ASD and trauma history.
- Depression and anger during adolescence.
- Transition promoted at university.

Clinicians:

- Folx.
- Lindsey Ellis.
- Praful Ramineni, MD

Prescribers:

- Folx.

Factors:

- Folx did not manage labs or monitor side effects.
- No baseline labs were drawn prior to prescribing testosterone.
- Only testosterone level and hemoglobin were later checked.
- Impacting medical issue later discovered by primary care physician.

Long Term:

- Poor cholesterol and hemoglobin labs.
- Weight Gain
- Ongoing concerns about testosterone's link to mood dysregulation, anger, and irritability.

Case 8

Parent: Mother

Child: Daughter (Natal Girl)

Timeline:

- Premature birth.
- Significant developmental delays and neurological issues.
- Mental Health Diagnosis: Autism, ADHD, C-PTSD, OCD, Anxiety and Depression.
- IEP at school, unable to graduate on time.

Clinicians:

- Dr. Jody Bahnmiller-Brasil.

Factors:

- Appointment only 15 minutes.
- No mental health evaluation.
- ASD.
- Marijuana Use.
- Same-sex attraction never addressed in clinical assessment.

Long Term:

- Fatty liver disease.
- Aggression requiring group home placement.
- Intensive residential interventions needed.
- Unable to support herself as an adult.

Case 9

Parent: Mother

Child: Son (Natal Boy)

Timeline:

- Late-onset identity issues during late adolescence after extensive online exposure.
- Diagnosed with borderline personality disorder following a suicide threat and psychiatric hold.
- Moved and began transition through Folx telehealth services.

Clinicians:

- Folx.

Factors:

- Initial appointment lasted only 15 minutes.
- No mental health evaluation or discussion of borderline personality disorder prior to prescribing estrogen and spironolactone.

Long Term:

- Son is now socially isolated, living alone, and continuing to medicalize without mental health care or oversight.

Case 10

Parent: Mother

Child: Son (Natal Male)

- No childhood or adolescent gender nonconformity observed.
- Same sex attracted, identifies as bisexual.
- As a university student, had a single 45-minute telehealth appointment where feminizing hormones were prescribed immediately.
- No therapy, no primary care physician involvement, and no baseline labs conducted before prescribing.
- Told by the prescriber to 'just try this and see if you feel better, everything is totally reversible if you only try it for three months.'
- After starting hormones, experienced weight changes, breast development, sleep disruption, and brain fog leading to problems at work.
- Stopped hormones after a short period, but some permanent physical changes remain.

Timeline:

- None identified beyond telehealth prescriber.

Clinicians:

- Telehealth service, likely Plume or Folx (exact prescriber unknown).

Prescribers:

- Mental health history not assessed, including past episodes of psychosis beginning around age 19.
- Past marijuana misuse not addressed before prescribing.
- Prescribing occurred without informed consent, lab monitoring, or evaluation of medical or psychological readiness.

Factors:

- Has ceased hormones but retains some permanent physical changes.

Case 11

Parent: Mother and Father

Child: Daughter (Natal Girl)

- Required speech therapy interventions as a young child.
- Learning disability requiring a 504 Plan which was transitioned into an IEP.
- Child began therapy with Julia Bettge, the first therapist she had ever seen.
- Bettge referred the child to Dr. Audrey Burgess for psychological testing at significant family expense.
- Testing led to a referral to Kingwood Psychiatry for antidepressant medication management, handled only through a nurse practitioner with no therapy component.
- Bettge repeatedly framed the child as transgender based solely on sustained identification and presented transition as the 'cure,' providing parents with materials claiming this was the established standard of care.
- Parents were warned that refusal to affirm could lead to suicide, despite records showing no evidence of suicidal ideation.
- Bettge encouraged the use of puberty blockers and binders, assuring parents they were safe and reversible.
- After initial refusal, parents allowed a binder due to safety concerns.
- No blockers or hormones were initiated, solely due to parental refusal.

Timeline:

- Julia Bettge – Therapist, provided ongoing counseling to the child and family.
- Dr. Audrey Burgess – Conducted psychological testing and evaluation.

Prescribers:

- Child and peers viewed diagnoses such as ADHD, autism, and depression as desirable, striving to collect multiple diagnoses.
- Therapist reportedly withheld written materials on transition to avoid creating a paper trail, instead handing them directly to parents during in-person sessions.
- Parents experienced coercion through repeated statements such as 'dead daughter, live son' and warnings about suicide risk if they did not consent to medicalization.
- Despite parental boundaries, therapist encouraged ongoing use of a binder and framed transition as inevitable.

Factors:

- Ongoing family conflict around transition, but medicalization has been prevented to date.

Case 12

Parent: Mother

Child: Daughter (Natal Girl)

Timeline:

- Childhood history of neurofibromatosis with an inoperable brain tumor.
- IEP at school for learning and developmental support.
- Diagnosed with OCD and anxiety, treated with psychiatric medications.
- Same sex attracted.
- During COVID, came out as transgender.
- Was a major theater participant before transition.
- Developed severe somatization and Munchausen symptoms.
- In a single year, 114 medical claims were submitted.
- Sought numerous diagnoses, including Ehlers-Danlos Syndrome (EDS) and POTS.
- Purchased cane, walker, and shower chair to present as medically fragile.

Clinicians:

- Dr. Ann Danoff – initiated testosterone, even with known brain tumor.
- Dr. Lisa Gfrerer – performed top surgery even after another surgeon refused.
- Dr. Josh Safer – consulted for bottom surgery at the Center for Transgender Surgery.
- Consulting: Miroslav Djordevic MD, Rajveer Purohit, MD, and Dr. Max Lichtenstein.

Factors:

- Ongoing marijuana use (also noted across multiple cases).
- No exploration of same-sex attraction or psychological drivers before medicalization.
- Over one month in residential mental health treatment in 2025.

Long Term:

- Continuing to pursue bottom surgery despite significant ongoing psychiatric and medical needs.
- Highly vulnerable due to complex health history and manipulative behaviors.

Case 13

Parent: Mother and Father

Child: Son (Natal Boy)

Timeline:

- Parents discovered child had been secretly taking feminizing hormones purchased online; pediatrician involved immediately.
- Initial evaluation at Duke Gender Clinic with Dr. Deanna Adkins and Kristen Russell, LCSW.
- Parents submitted a detailed letter outlining concerns before the first visit.
- Recommended to meet with therapist Leigh Spivey at Duke for gender evaluation.
- Family chose to continue therapy with outside psychiatrist instead due to concerns with Duke's approach.
- At a later visit, parents requested to review the written consent document for hormone treatment. Duke staff refused to provide a copy or read the full text aloud, and when pressed, abruptly ended the appointment and left the family waiting without explanation.
- Clinic emphasized suicide risk if hormones were delayed and pressured parents to consent.
- At age 18, cross-sex hormones were initiated by Dr. Louise Metz after minimal evaluation and without proper follow-up.
- Patient later moved abroad for college with no ongoing monitoring.

Clinicians:

- Dr. Deanna Adkins – Duke Pediatric Endocrinology.
- Kristen Russell, LCSW – Duke Gender Clinic.
- Leigh Spivey – Duke Clinical Psychology (student under supervision).
- Dr. Louise Metz – MOSAIC Health.

Prescribers:

- Dr. Louise Metz – initiated cross-sex hormones after limited assessment and no ongoing follow-up.

Factors:

- Concerns about eating disorder, poor general health, and antidepressant use affecting decision-making.
- Heavy online influence and strong peer encouragement reported.
- Duke clinic framed refusal of hormones as increasing suicide risk.
- Incomplete and coercive consent process: written consent document withheld, questions unanswered, and visit terminated without proper closure.

Long Term:

- Ongoing health issues including autoimmune problems and chronic fatigue.
- Limited family contact: patient remains medically transitioned and socially estranged.

Case 14

Parent: Mother

Child: Son (Natal Boy)

- Ongoing care with psychiatric nurse practitioner for ADHD and depression; separate therapist engaged following behavioral health hospitalization.
- After a brief solo assessment at a behavioral health hospital, staff informed the parent the child was 'transgender' and assigned a new name and pronouns without parental input.
- Transferred to a second behavioral health hospital where social transition (new name/pronouns) was implemented; staff used the 'dead son or live daughter' framing.
- In outpatient therapy, the child received 'coming out' homework and was socially transitioned (new name/pronouns) after a short one-on-one session; follow-through on assignments was minimal.
- Later, during a brief telehealth medication visit, the clinic updated the child's records to a new name/pronoun and reflected this on receipts, emails, and texts.
- At school, teachers and staff socially transitioned the child and created a gender support plan without parental consent; the plan was later reported 'lost.'
- The child subsequently changed names at school again, resulting in multiple names used across school and college mailings.
- No blockers or hormones were administered; interventions were limited to social transition across medical and school settings.

Timeline:

- Chandni Parihk, PMHNP – The Collaborative Counseling & Psychiatry (medication management; implemented new name/pronouns in records).
- Brandi Gries, LCPC, LPHA, MA – The Collaborative Counseling & Psychiatry (therapy; implemented social transition).
- Ascension Alexian Brothers Behavioral Health Hospital – Behavioral health admission; initiated social transition without parental involvement.
- Silver Oaks Behavioral Health Hospital – Behavioral health admission; continued social transition.

Clinicians:

- None for gender-related medications (no blockers or hormones).

Prescribers:

- Autism spectrum disorder, ADHD, and history of sexual abuse reported by parent; concerns that underlying issues were not addressed.

- School staff (counselor, social worker, vice principal, DEI director) created and maintained a gender support plan without parental consent; documentation later reported missing.
- Use of coercive framing by hospital staff ('dead son or live daughter').
- Exposure to school-based GSA activities, Discord groups, and classroom pronoun surveys reported by parent.
- Did eventually come out as gay.
- Parent reports repeated lack of risk/benefit information from medical and school personnel despite formal inquiries.

Factors:

- Child remains socially transitioned at school under a new name; no medicalization to date.
- Parent reports significant family distress and damaged parent-child trust attributed to institution-led social transition.
- Parent has filed complaints with the school district, state board of education, and the U.S. Department of Education (including FERPA).

Case 15

Parent: Mother and Father

Child: Son (Natal Boy)

Timeline:

- As a first-year university student, sought help at the student health center and was socially affirmed as 'transgender' during an acute mental health crisis; inpatient psychiatric admission followed without parental involvement.
- After discharge, returned home briefly, then decompensated and left home; subsequently entered D.C. youth LGBTQ+ shelter and service networks.
- Feminizing hormones were initiated by an unknown Washington, D.C. endocrinologist; later underwent surgical interventions at George Washington Hospital.
- Repeated attempts at schooling and employment were unsuccessful; functional impairment increased over time.

Clinicians:

- University Student Health Center – initial encounter and social affirmation during crisis.
- Washington Hospital Center – Behavioral Health Services.
- Whitman-Walker Clinic (Washington, D.C.).
- George Washington University Hospital – Surgeons.

Prescribers:

- Unknown Washington, D.C. endocrinologist – initiated feminizing hormones.
- George Washington University Hospital Surgeon –
- George Washington University Hospital Surgeon – facial feminization surgery.

Factors:

- Three prior traumatic brain injuries
- Acute deterioration during COVID-19 isolation
- Placement in LGBTQ+ youth shelters (Casa Ruby, Covenant House, Wanda Alston Foundation) with exposure to drugs/prostitution per family report.
- Diagnostic overshadowing: gender focus displaced evaluation of brain injury sequelae and psychosis, per parent.
- Cannabis addiction and PTSD reported after shelter experiences, per parent.
- Lack of informed consent and alternatives (e.g., watchful waiting/psychotherapy) discussed prior to medicalization, per parent.

Long Term:

- Ongoing social transition and medicalization history with significant functional decline (school dropout cycles, difficulty maintaining employment).
- Family estrangement and persistent alienation reported.
- New autism diagnosis reported, ongoing anxiety and avoidance of public spaces.

Case 16

Parent: Mother

Child: Son (Natal Male)

Timeline:

- During the COVID-19 pandemic, gender distress emerged while the patient was in high school.
- As a high-school senior who had just turned 18, began feminizing hormones via Plume after a single telehealth visit with no mental-health assessment.
- No baseline labs were obtained prior to prescribing; no therapy requirement or primary-care coordination documented.
- Care was transferred to Howard Brown Health (Chicago); hormones continued without baseline labs or mental-health assessment.
- Ongoing anxiety and social difficulties; later started mental-health and ADHD medications without meaningful improvement.

Clinicians:

- Plume (telehealth) – initiated feminizing hormones after one visit; no mental-health assessment documented.
- Howard Brown Health (Chicago) – continued hormone treatment; no baseline labs and no mental-health assessment documented, per parent.

Prescribers:

- Plume clinician – prescribed feminizing hormones after a single telehealth visit.
- Howard Brown Health provider – continued feminizing hormone prescriptions.

Factors:

- Same-sex attraction.
- Gifted student with social anxiety and social awkwardness.
- ADHD diagnosis; treated with medication.
- No mental-health evaluation prior to hormones; no baseline labs; minimal monitoring.
- Medicalization began at age 18 while still in high school.

Long Term:

- Continues under care with mental-health and ADHD medications; mental-health symptoms persist.
- No surgeries reported.

Case 17

Parent: Mother
Child: Daughter (Natal Girl)

Timeline:

- No childhood gender nonconformity or distress.
- Neurodivergent, challenges in areas of socializing and communication.
- Mental health concerns including Depression, Anxiety, and Self Harming Behaviors.
- Rapid shift in identity once starting college.
- Within first year at the university had a three-day psych hold for suicidal ideation.
- A month later was started on Testosterone.
- Within a year already had a double mastectomy.

Clinicians:

- Stella Li, LCMFT- used the statement would you rather have "a dead daughter or a living son".
- Rachel Morrison, MSW, LICSW- Student Health Care Coordinator.
- Maya Deshpande, LGPC.
- Joanna Kim, Med, PC.

Prescribers:

- Christie Brockman, DNP, ARNP, WHNP- Prescriber of Testosterone.
- Cassie Nghiem, MD- surgeon.

Factors:

- ASD/ Neurodivergent.
- Rapid medicalization pathway directly after mental health hospitalization.

Long Term:

- Limited family contact: patient remains medically transitioned and socially estranged.

Case Study Conclusion

The LGB Courage Coalition extends our deepest gratitude to the families who shared their stories for this report. Many of these parents are still fighting every day to keep their children safe and connected, while navigating a medical and cultural landscape that too often silences their concerns.

Their willingness to speak candidly and provide documentation reflects extraordinary courage. We are honored to have worked alongside them in compiling these case studies and hope that this report contributes meaningfully to evidence-based reforms in youth and young adult gender medicine.

It is our sincere hope that by bringing these experiences to light, we can advance a system of care rooted in truth, ethics, and compassion, and protect future families from the suffering these parents and children have endured.

Recommendations:

The case studies and analysis in this report highlight urgent concerns about the current landscape of youth and young adult gender medicine. These concerns are not limited to individual families or clinicians—they reflect systemic failures across multiple levels of care and advocacy.

Three categories of national advocacy organizations have unique influence over public policy and public perception in this area:

1. **ASD Advocacy Organizations:**
   Given the overrepresentation of autistic individuals among those seeking gender-related interventions, these organizations have a vital role in promoting informed decision-making and safeguarding vulnerable youth and young adults on the spectrum.
2. **LGB Advocacy Organizations:**
   Lesbian, gay, and bisexual youth are disproportionately impacted by gender ideology and often misdirected toward medical transition rather than receiving support for same-sex attraction and gender nonconformity**.** LGB organizations are uniquely positioned to ensure these young people receive accurate information and validating, non-medical care pathways.
3. **Mental Health Advocacy Organizations, including NAMI:**
   Groups such as the National Alliance on Mental Illness (NAMI) help shape national policy and standards of care for individuals with serious mental health conditions. Their positions directly impact the 18–26 age group**,** which is navigating emerging adulthood and is at heightened risk for both mental health crises and coercive or premature medical interventions.

The recommendations that follow are tailored to each of these advocacy communities. They are designed to promote evidence-based practice, improve informed consent, and reduce harm. Our goal is not to assign blame, but to partner with these organizations to ensure that vulnerable populations are protected and that public policy reflects both science and compassion.

Safeguarding Individuals with ASD in Gender Medicine

Autism Spectrum Disorder (ASD) is a lifelong neurodevelopmental condition that can affect communication, social understanding, and decision-making. While autistic individuals may reach the legal age of majority, chronological adulthood does not necessarily equate to full capacity for fully informed consent—especially when decisions involve permanent and irreversible changes to the body, sexual function, and fertility.

The cases presented in this report show that autistic individuals are disproportionately represented among those who have been steered toward gender-related medical interventions. In several instances, these individuals also had significant developmental delays, intellectual disabilities, or co-occurring psychiatric diagnoses. Despite these complexities, they were placed on cross-sex hormones or other irreversible treatments without adequate understanding of the risks involved or exploration of alternative explanations for their distress.

Emerging research confirms that autistic individuals are present in gender clinics at rates many times higher than in the general population. This overrepresentation raises profound ethical concerns. Autistic individuals may experience:

- Increased vulnerability to external influence, including online communities and peer groups.
- Difficulty processing abstract, long-term risks and consequences.
- A heightened need for routine and certainty, which may lead to rigid identification with new ideas or labels.
- Histories of misunderstanding or marginalization that make them especially susceptible to coercion or manipulation by authority figures.
- Challenges understanding and incorporating physical changes to their bodies, especially impactful with the stages of puberty.

Given these factors, the medicalization of gender distress in autistic individuals—whether minors or adults—should not occur. Instead, care must focus on:

1. Thorough, multidisciplinary evaluation to understand the root causes of distress.
2. Provision of supportive, non-medical interventions that address social, emotional, and developmental needs.
3. Protections against coercive or deceptive practices that exploit this vulnerable population.
4. Public education to prevent the normalization of irreversible interventions as a response to autism-related challenges.

Permitting the use of irreversible, experimental treatments on autistic individuals without robust evidence and ethical oversight represents a violation of disability rights and basic medical ethics. These practices must end to prevent further harm.

Call to Action for ASD Advocacy and Support Organizations

The overrepresentation of autistic individuals among those subjected to gender-related medical interventions is an urgent issue that demands leadership from the autism advocacy community. These organizations have a vital role to play in stopping harm and protecting vulnerable individuals.

Historically, ASD organizations have focused on education, access to services, and support for individuals and families. Today, they must also address the growing crisis posed by the medicalization of gender distress in autistic populations. This is not only a matter of public health but also of disability rights and consumer protection.

To meet this challenge, ASD advocacy groups should:

1. Raise Public Awareness

- Speak out clearly about the exponential rise of gender distress reported in autistic populations.
- Speak out clearly against the use of irreversible medical treatments for autistic individuals experiencing gender-related distress.
- Provide families and caregivers with accurate, accessible information about the harms and lack of evidence for these interventions.
- Counter misleading narratives that frame medicalization as a "necessary" or "lifesaving" treatment.

2. Support Families and Individuals
    - Develop programs to help families understand and address gender distress without resorting to medicalization.
    - Offer safe spaces for autistic individuals to explore identity and self-expression without the risk of irreversible harm.
    - Provide resources for those seeking to recover from or cope with the physical and psychological consequences of past interventions.
3. Engage in Advocacy and Policy Reform
    - Urge lawmakers and regulators to prohibit the use of gender-related medical interventions in autistic populations.
    - Promote policies that prioritize developmental and psychological care over experimental treatments.
    - Ensure that disability rights protections are enforced in this context.
4. Demand Research and Accountability
    - Support independent research into the causes of gender distress in autistic individuals and the long-term outcomes of medicalization.
    - Call for transparency and accountability from medical institutions and telehealth companies that have promoted these interventions.

By taking these actions, ASD advocacy organizations can help end a harmful practice, safeguard the rights of autistic individuals, and prevent future tragedies. This is a moment to stand firmly for ethical care and true inclusion, ensuring that autistic people are protected from coercion, exploitation, and irreversible harm.

Failure to Support and Protect Same-Sex Attracted Youth

The LGB Courage Coalition was founded to protect lesbian, gay, and bisexual individuals and to stop the erasure of same-sex attraction through the medicalization of gender distress. As the only national organization focused exclusively on this mission, we are uniquely positioned to address the systematic neglect of same sex attracted youth in gender clinics and telehealth services.

Our coalition's case reports and parent testimonies reveal a disturbing and consistent pattern: young people whose emerging same-sex attraction is never acknowledged, explained, or affirmed. Instead, these youth are encouraged to interpret their feelings as proof that they were "born in the wrong body" and are quickly steered toward medical interventions that result in irreversible harm.

Key Findings

- Reports reviewed by our coalition involved same sex attracted youth.
- Families consistently reported that clinicians failed to explain that same-sex attraction is a normal and healthy part of adolescent development.
- Instead of reassurance or support, same-sex attraction was framed as a symptom of being transgender or nonbinary, requiring hormonal or surgical interventions.

Examples of Harm

- Case 6: A lesbian teenager was immediately recommended testosterone therapy, with no exploration of her sexual orientation or consideration of non-medical support.
- Case 7: A same sex attracted university student was prescribed testosterone by FOLX through a telehealth visit, without any discussion of her orientation, mental health, or the long-term consequences of medicalization.

These are not isolated incidents. They reflect a larger systemic problem: providers are denying families and youth critical information, preventing them from making fully informed decisions and undermining the autonomy and future wellbeing of these young people.

FTC Implications

This pattern constitutes a failure to disclose a material fact under the Federal Trade Commission Act.
Families are not informed that:

- Same-sex attraction is a normal aspect of human development, especially in adolescence.
- Gender-related distress often resolves naturally without medical intervention.
- Medicalization, once started, is irreversible and carries significant risks, including infertility, sexual dysfunction, bone density loss, chronic pain, and lifelong medical dependency.

When this essential information is omitted or minimized, families and consumers are misled into believing that cross-sex hormones and surgeries are medically necessary and urgent.

The U.S. Department of Health and Human Services (HHS) has explicitly identified the overrepresentation of same-sex attracted individuals in gender clinics as a "justice-related concern." This raises serious questions about whether these youth are being systematically targeted, particularly those who might otherwise grow into healthy, self-accepting lesbian, gay, or bisexual adults.

Broader Cultural Implications

The failure to acknowledge same-sex attraction as a legitimate, healthy identity perpetuates a modern form of conversion practice, replacing old psychological methods with medical interventions.

- Where previous generations of LGB youth were told to deny or suppress their orientation, today's youth are encouraged to medically deface their bodies and erase their histories in order to conform to heteronormative or gendered sterotypes.
- This harms not only the individual young people involved but also undermines the cultural and political gains of the LGB movement as a whole.

Recommendations for LGB Advocacy Organizations

This issue cannot be addressed by government enforcement alone. Organizations that represent the interests of lesbian, gay, and bisexual people have a moral obligation to act. We urge national and local LGB advocacy groups — including but not limited to HRC, Lambda Legal, GLAAD, and others — to:

- Publicly acknowledge the overrepresentation of same sex attracted youth in gender clinics and the risks of conflating sexual orientation with gender identity.
- Educate families, schools, and clinicians about the normal developmental patterns of same-sex attraction, emphasizing that these feelings do not require medical intervention.
- Advocate for evidence-based, non-medical support services for gender-distressed youth, such as counseling and peer support that validate both body reality and sexual orientation.
- Support legislation and policies that prohibit deceptive marketing and ensure full disclosure of risks and alternatives to families and consumers.
- Create safe reporting mechanisms for families and young adults who believe they were harmed or misled by gender clinics or telehealth providers.
- Work in coalition with groups like the LGB Courage Coalition to restore clear boundaries between sexual orientation advocacy and gender identity activism.

Call to Action

The conflation of sexual orientation with gender identity has led to the abuse of same-sex attracted youth and a new wave of maltreatment disguised as healthcare.

It is no longer acceptable for organizations with the word "LGB" in their name to ignore the suffering of young people who are, in fact, lesbian, gay, or bisexual, but who are being told that their natural attractions mean they are "born in the wrong body."

Just as the FTC has a duty to protect consumers from deceptive practices, national LGB advocacy organizations must reclaim their role in protecting and validating same-sex attracted youth. The survival of the LGB community — and the futures of countless young people — depend on it.

The Need for Mental Health Safeguards for Young Adults (Ages 18–26)

The period between ages 18 and 26 represents a critical developmental window often referred to as emerging adulthood**.** During this time, young adults are navigating profound transitions: leaving pediatric systems of care, moving away from home, attending college or entering the workforce, and assuming legal autonomy for medical decision-making. Brain development research demonstrates that the prefrontal cortex — responsible for executive function, impulse control, and risk assessment — continues to mature into the mid-20s**.**

For individuals with mental health vulnerabilities, these transitions can be destabilizing. This cohort has higher rates of depression, anxiety, substance use, and suicidal **i**deation than any other adult group. When these challenges intersect with gender dysphoria, the risks compound. Many young adults who present for gender-related medical interventions are navigating:

- **Unresolved trauma**, including childhood abuse or neglect.
- **Co-occurring mental health diagnoses**, such as depression, anxiety disorders, PTSD, OCD, or eating disorders.
- **Substance use issues**, particularly marijuana, which has been repeatedly associated with psychosis and impaired judgment in this age group.
- **Use of Hormones,** which is associated with changes in mood, emotional lability, and aggression.

Despite these vulnerabilities, young adults in this age range are routinely fast-tracked into irreversible medical interventions — including cross-sex hormones and surgeries — without adequate evaluation or long-term planning. This lack of oversight mirrors the same systemic failures seen in pediatric care but with fewer safeguards, as these individuals are now considered "adults" under the law.

Concerns About NAMI's Policy Influence

The National Alliance on Mental Illness (NAMI) is one of the most influential advocacy organizations in the United States, shaping public policy on mental health care, insurance coverage, and treatment standards. NAMI's stated values include:

- Accessible and comprehensive health care for all people with mental health conditions.
- Policies informed by credible, evidence-based research**.**
- Minimizing justice system interactions while preserving dignity and well-being.
- Avoiding practices that cause or worsen mental health symptoms.

While these principles are laudable, in practice NAMI has aligned itself with an affirmation-only model of care for individuals with gender dysphoria**,** including those in the 18–26 age group. This stance has several consequences:

1. **Lack of Specialized Mental Health Services:**
   NAMI has not meaningfully advocated for specialized therapeutic approaches to help young adults explore the underlying causes of gender distress. Instead, medicalization is often framed as the default "treatment," even when complex trauma, sexual orientation, or other mental health factors are present.
2. **Silencing Families and Detransitioners:**
   Families and detransitioned individuals who express concerns about rushed medical interventions frequently report feeling dismissed or stigmatized in NAMI spaces. This creates an environment where critical feedback and caution are framed as hostility**,** rather than as essential components of informed decision-making.
3. **Undermining Evidence-Based Policy:**
   Despite its stated commitment to evidence, NAMI has supported policies that lack rigorous scientific backing, particularly regarding irreversible medical interventions for young adults. This is inconsistent with its pledge to promote practices that "do no harm" and avoid worsening mental health symptoms.

By embracing these positions, NAMI inadvertently increases the likelihood of harm to vulnerable young adults. When the default pathway is medical transition rather than careful evaluation and mental health support, young people may later regret their decisions or experience worsened mental health outcomes.

Recommendations for the FTC and Policymakers

The FTC should recognize the unique vulnerabilities of the 18–26 age group and the outsized influence of national organizations like NAMI on treatment pathways. The following steps are recommended:

1. **Mandate Comprehensive Mental Health Evaluation:**
   Require that young adults seeking gender-related medical interventions receive thorough mental health assessments that include trauma history, co-occurring diagnoses, and substance use screening.

2. **Promote Access to Specialized Care:**
   Expand funding for non-medical therapeutic supports**,** such as trauma-informed counseling and family-based interventions, to give young adults alternatives to immediate medicalization.
3. **Ensure Informed Consent Standards Reflect Developmental Science:**
   Recognize that emerging adults may lack full cognitive maturity for high-stakes medical decisions. Require informed consent processes that account for this developmental reality, including cooling-off periods and access to neutral counseling.
4. **Encourage Transparency and Accountability from Advocacy Organizations:**
   Organizations like NAMI should be held accountable for the accuracy of their policy positions and the evidence base behind them. FTC oversight should discourage the promotion of medical interventions that lack strong empirical support.

Summary

The transition to adulthood is challenging under the best of circumstances. For young adults struggling with gender dysphoria and mental health conditions, the risks are profound. National organizations like NAMI wield significant influence over public policy and public perception, yet their affirmation-only stance leaves young people without adequate safeguards or alternatives.

By addressing these gaps and ensuring that policies are grounded in evidence and developmental science, the FTC can protect a generation of emerging adults from preventable harm — and promote pathways to genuine mental wellness rather than irreversible medicalization.

Recommendations Closing:

The LGB Courage Coalition will distribute this report directly to leading ASD advocacy groups, LGB organizations, and NAMI leadership. In addition to sharing our findings, we will invite open dialogue and collaboration to strengthen safeguards for youth and young adults impacted by gender-related medical interventions.

We are prepared to offer specialized training and resources for clinicians, advocates, and policymakers to help implement these recommendations effectively. By working together, we can protect vulnerable individuals, uphold scientific integrity, and create a system of care that prioritizes long-term mental health and well-being over ideology or expediency.

Families' Voices, Scale, and Impact

These sixteen case reports represent only a tiny fraction of American families who describe being affected by the marketing and delivery of so-called "gender-affirming care." The stories

collected here echo themes we have heard repeatedly from other parents and siblings across the country: grief, confusion, isolation, and a sense that basic safeguards and honesty were absent.

Sibling: *"One day I'm going to tell her what this did to our family."*
Parent: *"She went from the captain of the cross-country team to fat, balding, and has no friends or partner."*

Again and again, families recount being confronted with the ultimatum: "Would you rather have a dead son or a live daughter?" Parents report that this messaging has led their children to genuinely believe they will die without cross-sex hormones, while also believing that "no doctors tell them the truth."

Parent: *"My child's bedroom looks like the pharmacy in a nursing home."*
Parent: *"instead of being enlisted into the Army my child was duped into the state sponsored experimental trans regime"*

Across these narratives, common consequences emerge:

- Educational derailment: Many were gifted, high-performing students who have since left college or cannot sustain coursework.
- Medicalization without resolution: Families describe polypharmacy and ongoing mental-health struggles despite treatment; "pharmacy in a nursing home" captures the scale of prescriptions some teens and young adults now carry.
- Fear-based dependency: Repeated crisis framing (e.g., suicide ultimatums) cultivates a belief that hormones are singularly lifesaving, closing off discussion of alternatives.
- Family strain and isolation: Parents describe feeling "it is just us against the world," shut out of decision-making even while supplying medical history and paying for services.

These are consumer experiences, not isolated anecdotes. They point to patterns of coercive messaging, incomplete disclosure, and insufficient diagnostic rigor that frustrate informed choice and erode trust. The families who contributed to this record ask simply for what any consumer of medical services should be able to expect: clear information, honest risk-benefit discussion, consideration of alternatives, and respect for family input where appropriate.

Additional Realities Families Report

Many of the parents who stepped forward are still working to keep their children close—maintaining contact, providing practical support, and trying to preserve a pathway back to care that considers the whole person. They describe the following, repeatedly:

- Barriers to mainstream supports. Families who seek help from national ASD organizations or NAMI report an unexpected barrier: institutional environments they perceive as captured by a single narrative in which trans identity overrides all other clinical considerations. Parents say this stance effectively blocks access to otherwise

appropriate supports for autism, ADHD, mood disorders, psychosis, trauma, or substance use.
- Insurance dilemmas. Parents struggle with whether to keep their young adults on family insurance—knowing that this coverage can be used to access interventions the parents believe are harmful. They report feeling trapped between financial duty and the fear of financing iatrogenic harm.
- From welcomed partners to "conflicts." Families describe a stark shift: systems that once welcomed parental input (schools, colleges, clinics) now cold-shoulder them when parents offer well-meaning information about their child's broader history and needs. Even where consent procedures allow family involvement, parents say they are treated as adversarial rather than as critical informants and payers.
- Whole-person care sidelined. Parents emphasize that their contributions often include decades of medical history, educational records, and observations about sleep, nutrition, substance use (especially marijuana), trauma, ASD/ADHD traits, and social stressors—yet they find these data points discounted when they conflict with a narrow, identity-first lens.
- Continuing the fight with compassion. Despite deep frustration, these families persist in non-punitive, relationship-preserving approaches—supporting employment or schooling, coordinating primary care, advocating for diagnostic clarity, and encouraging evidence-based treatment of co-occurring conditions.

Clinical Climate & Cohort Context

Parents consistently describe a combative clinical climate that made collaborative care difficult:

Parent: *"Psychiatrist even broke me and wore me down on that one."*

- Dialogue shut down by affirmation-only framing. When families raised alternative hypotheses, differential diagnoses, or staged/least-harm approaches, they encountered reasserted identity affirmation rather than exploration of clinical complexity (ASD/ADHD, trauma, mood disorders, psychosis, substance use, family history, sleep/nutrition).
- Research-literate, engaged parents. Many report they read the literature, asked for documented risks/benefits and comparative outcomes, and requested watchful waiting, SUD screening, or non-hormonal supports—yet their efforts were met with resistance or dismissal, not engagement.
- Disrupted developmental context. These youth navigated adolescence/early adulthood amid COVID isolation and school closures, pervasive social media, and shifting peer dynamics—context parents say was rarely integrated into treatment planning.
- Cannabis as a cohort stressor. Parents repeatedly observe that the legalization and normalization of cannabis coincide with increases in anxiety, paranoia, amotivation, and cognitive fog in this cohort; they report little systematic screening or counseling about cannabis within mental-health or hormone-prescribing workflows.

Bottom line: Families attempted good-faith, evidence-seeking dialogue with providers and systems, but encountered a one-path clinical posture that prioritized identity affirmation over diagnostic rigor, context, and substance-use assessment—further eroding trust and leaving parents to shoulder the burden of advocating for whole-person care.

Closing Request

Taken together, these reports depict families attempting to act as responsible consumers and caregivers inside medical and educational systems that too often treat them as obstacles. Their closing request is modest and broadly applicable to consumer protection: that institutions restore balanced, diagnostic rigor; end fear-based messaging; offer transparent, complete information about risks, benefits, and alternatives; and reinstate parents as appropriate partners in care for youth and young adults.

LGB Courage Coalition is honored that the participating families chose to work with us to produce this report. We hope this contribution helps advance truly evidence-based care—care that is transparent, balanced, and attentive to the whole person—and, in doing so, furthers our overarching mission to protect consumers, support families, and improve outcomes for vulnerable youth.