Nos. 25-8056 & 26-2337

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ELIZABETH MIRABELLI, AN INDIVIDUAL, ET AL.,

Plaintiffs-Appellees,

v.

ROB BONTA, IN HIS OFFICIAL CAPACITY AS ATTORNEY GENERAL OF CALIFORNIA, ET AL.,

Defendants-Appellants

On Appeal from the United States District Court
for the Southern District of California
No. 3:23-CV-00768-BEN-VET, Hon. Roger T. Benitez

BRIEF OF *AMICUS CURIAE* THE AMERICAN COLLEGE OF PEDIATRICIANS IN SUPPORT OF APPELLEES AND AFFIRMANCE

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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9th Cir. Case Number(s) 25-8056, 26-2337

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INTRODUCTION, INTEREST OF *AMICUS CURIAE* AND SOURCE OF AUTHORITY TO FILE[1]

School policies that require a child's social gender transitioning at school be kept from the child's parents unconstitutionally usurp parents' decision-making authority. As the Supreme Court has made clear, "those policies cut out the primary protectors of children's best interests: their parents." *Mirabelli v. Bonta*, 607 U.S. 492, 496–97 (2026) (per curiam). In doing so, these policies violate the constitution, *id.*, and as set out below, harm the very students the school claims they are protecting.

The rise in such harmful policies, like the "Parental Exclusion Policies" (the "Policy") implemented by various California School Districts consistent with California law as directed by the California State Board of Education here, is of great concern to *Amicus*, the American College of Pediatricians ("the College" or "ACPeds"), a medical membership organization of pediatricians and healthcare professionals who care for children across 47 states and 5 countries working to promote

[1] No party or counsel for a party authored this brief in whole or in part and no entity or person, aside from *amicus curiae,* its members, or its counsel, made any monetary contribution intended to fund the preparation or submission of the brief. All parties have consented to the filing of this brief. *See* Fed. R. App. P. 29(a)(2), (a)(4)(E).

the optimal health and well-being of all children through evidence-based medicine.[2]

The College's members provide high-quality medical services to children and all patients without discrimination. In doing so, *Amicus*'s members cannot harm or lie to their patients. Based on the Hippocratic Oath and on science, *Amicus* categorically excludes providing medical interventions or referrals for "gender transition" procedures, including the "social transitioning" of minors, because such interventions inherently harm children. *Amicus* has a direct interest in the outcome of this case because it affects the vulnerable population *Amicus* serves.

SUMMARY OF ARGUMENT

Treatment of children and adolescents with gender incongruity and dysphoria should be based on sound scientific evidence. Properly addressing the underlying mental health issues such children experience is critical. But social transitioning cannot address these co-occurring

[2] In keeping with these objectives, ACPeds, other medical organizations representing over 75,000 physicians and healthcare providers, and over 5,600 individual signatories, recently issued a declaration—the Doctors Protecting Children Declaration—stating that "Medical decision making should respect biological reality and the dignity of the person by compassionately addressing the whole person." Doctors Protecting Children Decl. (2024), https://doctorsprotectingchildren.org/.

conditions because it is a controversial and unproven social experiment masquerading as medical mental health treatment. While the overwhelming majority of gender distressed children naturally desist in their dysphoria and accept their sex when allowed to go through puberty, social transition efforts lead children and adolescents to persist in their transgender identities. This often results in hormonal treatments and even surgery that permanently alters the patients' bodies, causing sterility and a host of other physical and psychological problems. Yet the Policy mandates social transition of gender confused children on a uniform basis, without parental input or consent, and at the whim of untrained school officials, which is dangerous. The district court's decision striking down the Policy must be affirmed.

ARGUMENT

School policies that facilitate the secret social gender transition of children, as the Policy does here, improperly usurp the role of parents in what is fundamentally a medical decision with wide-ranging primarily harmful effects. And California requires school districts to do so based on blatant political ideology untethered from biological reality and contrary to valid scientific evidence. Here, school districts, upon learning of a

student's desire to be called by a different name, be referred to by pronouns inconsistent with the child's sex or be permitted to access the restrooms and locker rooms of the opposite sex, require school personnel to use those alternate names and pronouns and permit access to those single-sex spaces, no questions asked and no debate. But the school will only notify the child's parents if authorized to do so by the child, even one as young as two years old. *Mirabelli v. Olson*, 820 F. Supp. 3d 1123, 1133 (S.D. Cal. 2025), *appeal docketed,* No. 25-8056 (9th Cir. Dec. 23, 2025), *stay granted*, No. 25-8056, 2026 WL 44874 (9th Cir. Jan. 5, 2026) (per curiam), *and stay partially vacated,* 607 U.S. 492 (2026) (per curiam) *and* No. 25-8056, 2026 WL 622693 (9th Cir. Mar. 3, 2026). Teachers are forbidden from sharing information about a child's gender incongruity with the parents under threat of punishment for harassment and bullying of the child. *Id.* at 1133, 1156 n.13. Such a policy creates significant and life-long harms to children subjected to such efforts to change their sex while denying the parents their basic rights to raise and care for their children. The district court's decision to enjoin such policies in California should be affirmed.

I. The School Districts' Policy Misunderstands Gender Incongruence and Dysphoria in Children.

To understand why social transitioning is a controversial medical intervention, even when performed by professionals, it is helpful to briefly review what is known about gender incongruence in children.

A. "Transitioning" to a different sex is biologically impossible.

First, sex is a biological, immutable characteristic—a scientific fact, not a social construct. Sex is "almost always easily identifiable at birth (if not before) based upon phenotypic expression of chromosomal complement [XX for female, and XY for male]. … To describe sex as 'assigned at birth' is inaccurate and misleading."[3]

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[3] Am. Coll. of Pediatricians (ACPeds), *Mental Health in Adolescents with Incongruence of Gender Identity and Biological Sex* 2 (2024) [hereinafter, "ACPeds, *Mental Health in Adolescents*"] (citing extensive scientific research), https://tinyurl.com/u5wrbak8; *6,500 Genes Expressed Differently in Men and Women*, Weizmann Inst. (May 7, 2017), https://tinyurl.com/4w5h9ypn (reporting on Moran Gershoni & Shmuel Pietrokovski, *The Landscape of Sex-differential Transcriptome and its Consequent Selection in Human Adults*, 15 BMC Biology 1, 2 (2017), https://tinyurl.com/4pzkmfp2); Tracy E. Madsen et al., *Sex- and Gender-Based Medicine: The Need for Precise Terminology*, 1 Gender & Genome 122, 123 (2017).

While rare,[4] some children suffer from a condition where their mental state cannot accept or feels discomfort with their biological sex. This condition, recognized by almost every psychological association, is known as gender dysphoria. It is defined as "a psychological condition in which [affected persons] experience marked incongruence between their experienced gender and the gender associated with their biological sex. They often express the belief that they are the opposite sex."[5] Crucially, gender identity is *psychological* while sex is *biological*. As one leading medical expert puts it,

> *[G]ender identity* is psychological, made up of expectations and self-perceptions. Gender does not exist in the body or in any bodily structure or process. This is in contrast to *sex*, which is determined exclusively by bodily data: genitals and chromosomes.[6]

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[4] Am. Coll. of Pediatricians (ACPeds), *Gender Dysphoria in Children* 1 (Nov. 2018), https://tinyurl.com/2pdfku3v ("ACPeds, *Gender Dysphoria*"). Indeed, "[f]or natal adult males, prevalence [of gender dysphoria] ranges from 0.005% to 0.014%, and for natal females, from 0.002% to 0.003%." Am. Psych. Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 454 (5th ed. 2013) ("DSM-5").

[5] ACPeds, *Gender Dysphoria, supra* note 4, at 1 (citing DSM-5, *supra* note 4, at 451–59).

[6] David Schwartz, *Clinical and Ethical Considerations in the Treatment of Gender Dysphoric Children and Adolescents: When Doing Less Is Helping More*, 20 J. Infant, Child & Adolescent Psych. 439, 439 (2021), https://tinyurl.com/3eftvke6.

As explained in detail below, efforts to "transition" a child, even socially with the use of a new name, opposite sex pronouns, dress, restroom access, and otherwise treating the child as if the child were of the sex other than their biological sex, do nothing to address the child's mental distress. Rather, such efforts are specifically designed to *entrench* a child's gender incongruence which often leads to hormonal and potentially surgical interventions resulting in permanent sterility among other physical and psychological harms. So instead of helping a child, the Policy harms them while denying parents valuable information they need to properly care for their child.

B. Gender incongruence and dysphoria are mental health issues.

As noted, gender dysphoria, or equivalently, gender identity disorder, is a problem that resides in the mind, not in the body. As ACPeds has elsewhere explained, "Children with GD [gender dysphoria] do not have a disordered body—even though they feel as if they do. Similarly, a child's distress over developing secondary sex characteristics does not mean that puberty should be treated as a disease to be halted,

because puberty is not, in fact, a disease."[7] Accordingly, treating gender dysphoria, especially in children, as a mental health disorder is the appropriate focus for medical providers.

Unsurprisingly, gender dysphoria is frequently comorbid with anxiety, depression, autism spectrum disorder, and trauma.[8] Children experiencing gender incongruity are two to three times more likely to have suffered from an adverse childhood event such as sexual abuse, emotional neglect, emotional abuse, or having a family member with

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[7] ACPeds, *Gender Dysphoria*, *supra* note 4, at 9.

[8] Pien Rawee et al., *Development of Gender Non-Contentedness During Adolescence and Early Adulthood*, 53 Archives of Sexual Behav. 1813, 1822 (2024) (internal citations omitted), doi.org/10.1007/s10508-024-02817-5; *see also* ACPeds, *Mental Health in Adolescents*, *supra* note 3, at 3 ("transgender and gender-diverse individuals have, on average, higher rates of autism, other neurodevelopmental and psychiatric diagnoses"); Riittakerttu Kaltiala-Heino et al., *Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development*, 9 Child & Adolescent Psych. & Mental Health 1, 5 (2015) (75% of adolescents seen for gender identity services were or had undergone psychiatric treatment for reasons other than GD); Tracy A. Becerra-Culqui et al., *Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers*, 141 Pediatrics e20173845 (2018) (study finding teens with gender non-conformity significantly more likely to have underlying psychiatric disorders, psychiatric hospitalizations, and suicidal ideation than peers), https://tinyurl.com/kmtxydph.

mental illness.[9] Additionally, "studies suggest that social reinforcement, parental psychopathology, family dynamics, and social contagion–facilitated by mainstream and social media, all contribute to the development and/or persistence of GD in some vulnerable children."[10]

Accordingly, gender dysphoria is a mental health condition that requires proper diagnosis and treatment. This is evident in the examples given by the district court—examples even Defendants' experts accept—where children whose parents are given the opportunity to have the child properly treated find their children desist from the notion of being the opposite sex and relief from their mental health concerns. But when the school keeps information about a child's gender confusion from the parents, the child suffers because the parents were prevented from

[9] ACPeds, *Mental Health in Adolescents*, *supra* note 3, at 5 (citing, among others, Anna Austin et al., *Adverse Childhood Experiences Related to Poor Adult Health Among Lesbian, Gay, and Bisexual Individuals*, 106 Am. J. Pub. Health 314 (2016); Shelley L. Craig et al., *Frequencies and patterns of adverse childhood events in LGBTQ+ youth*, 107 Child Abuse & Neglect 104623 (2020)).

[10] ACPeds, *Gender Dysphoria*, *supra* note 4, at 6 (citing, among others, Kenneth J. Zucker & Susan J. Bradley, *Gender Identity and Psychosexual Disorders*, 3 Focus 598 (2005)).

properly addressing the child's mental health distress. *Mirabelli*, 820 F. Supp. 3d at 1139–41.

C. In natural puberty, gender dysphoria generally desists on its own, without intervention.

Fortunately, it has long been recognized that "80–95% of the prepubertal children with [Gender Identity Disorder] will no longer experience a GID in adolescence."[11] The American Psychiatric Association observed that "only a minority" of those diagnosed with childhood gender identity disorder "will identify as transsexual or transgender in adulthood (a phenomena termed *persistence*), while the majority will become comfortable with their natal gender over time (a phenomena called *desistance*)."[12]

In a recent study, for example, researchers found that, while "children and adolescents referred for gender dysphoric feelings had a more negative self-concept compared to the standardization sample of the

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[11] Peggy T. Cohen-Kettenis et al., *The Treatment of Adolescent Transsexuals: Changing Insights*, 5 J. Sexual Med. 1892, 1893, 1895 (2008); Devita Singh et al., *A Follow-Up Study of Boys With Gender Identity Disorder*, 12 Frontiers in Psych. 632784, at 1, 8 (2021), https://tinyurl.com/3je5hp89 (finding 87.8% desistance in "largest sample to date of boys clinic-referred for gender dysphoria").

[12] William Byne et al., *Report of the APA Task Force on Treatment of Gender Identity Disorder*, 169 Am. J. Psych., Suppl., 1, 4 (2012).

questionnaire,"[13] such "gender non-contentedness … decreased with age."[14] Indeed, the scientific evidence confirms that the vast majority of children who express discomfort with their sex at the start of puberty overwhelmingly express no gender discomfort after going through puberty.[15] Parents are in the best position to help their child struggling with the challenges of growing up but the Policy excludes the parents when the issue the child is struggling with relates to gender identity.

Equally important, while natural desistance predominates, children who socially "transitioned"[16] in early childhood were more likely (often between 96% and 100% of the time) to have persistent feelings of gender dysphoria.[17] By pushing social transition, California places this monumental healthcare decision exclusively in the hands of untrained school officials at the whim of the gender confused child, while denying

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[13] Rawee, *supra* note 8, at 1814.

[14] *Id.* at 1818.

[15] *Id.*

[16] Social transitioning "consists of first affirming the child's false self-concept by instituting name and pronoun changes, and facilitating the impersonation of the opposite sex within and outside of the home." ACPeds, *Gender Dysphoria*, *supra* note 4, at 11.

[17] Rawee, *supra* note 8, at 1814 (citation omitted); *see also* ACPeds, *Mental Health in Adolescents*, *supra* note 3, at 7.

parents basic information of what is happening to their children and conscripting teachers into their deception.

A sound evidence-based approach is to simply allow a child to grow up without being "affirmed" in an incongruent gender identity. This approach is critical since no test can determine which small minority of children experiencing gender incongruence will persist in such feelings into adulthood unless forced onto that path by medical intervention or social affirmation.[18] The Policy here does exactly the opposite of a sound medical and reality based approach to a child's distress and keeps it all hidden from the child's parents.

II. Social Transitioning is Medical Treatment.

The Ninth Circuit has recognized that "social transition, including adopting a new name, pronouns, appearance, and clothing, and correcting identity documents" is a "medical treatment for gender dysphoria." *Doe v. Horne*, 115 F.4th 1083, 1107 n.13 (9th Cir. 2024)

[18] *See* Doctors Protecting Children Decl., *supra* note 2, ¶ 4; Hilary Cass for NHS England, *The Cass Review, Final Report* 193, §16.8 (as amended Dec. 2024), https://tinyurl.com/3mzfckv2 [hereinafter "Cass Review"], https://tinyurl.com/yt62vk3e (amendments); ACPeds, *Gender Dysphoria*, *supra* note 4, at 11–12 ("puberty is suppressed … as early as age 11 years, and then finally, patients may graduate to cross-sex hormones at age 16 in preparation for sex-reassignment surgery").

(cleaned up), *vacated and remanded sub nom. Peterson v. Doe,* --S.Ct.--, 2026 WL 1871306 (U.S. June 30, 2026) (mem.), *and appeals dismissed as moot*, No. 23-16026 (9th Cir. Aug. 26, 2026), ECF No. 136, *following voluntary dismissal*, No. 4:23-cv-00185-JGZ (D. Ariz. July 13, 2026), ECF No. 350.[19] But it is not actual "treatment." Rather, social transitioning is a controversial and unproven social experiment masquerading as medical intervention that greatly increases rates of persistence in a transgender identity, with all the accompanying negative mental and physical health outcomes. It certainly should not be done by untrained school officials behind parents' backs.

A. Pro "gender-affirming care" advocates recognize social transitioning is a medical intervention.

The very organizations and individuals who advocate it promote social transitioning as a medical intervention.[20] The Cass Review, a comprehensive review of the scientific evidence of medical interventions

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[19] *See also Kadel v. Folwell*, 100 F.4th 122, 136–37, 157 (4th Cir. 2024) (en banc) (relying on WPATH SOC8 [*see infra* note 23] to describe social transition as gender dysphoria treatment), *vacated and remanded*, 145 S.Ct. 2838 (2025).

[20] *See, e.g.*, Kenneth J. Zucker, *Different Strokes for Different Folks*, 25 Child & Adolescent Mental Health 36, 36–37 (2020), https://tinyurl.com/bdtr3fpy.

used to address gender dysphoria in children conducted by Dr. Hillary Cass for the National Health Services England, notes that social transition is "an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning and longer-term outcomes."[21] Even the World Professional Association for Transgender Health (WPATH), a "gender-affirming" advocacy organization,[22] recognizes social transitioning as a "[t]reatment option[]" for gender dysphoria.[23] This from an organization that has been exposed as suppressing results that conflict with its ideological treatment preferences.[24]

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[21] Cass Review, *supra* note 18, at 158.

[22] *See* Mia Hughes, *The WPATH Files* 36 (2024) (WPATH's model is "gender-affirming care"), https://tinyurl.com/bdzeax3n.

[23] WPATH, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* 9–10 (7th ver. 2011); Eli Coleman et al., *Standards of Care for the Health of Transgender and Gender Divers People: Version 8,* 23 Int'l J. Transgender Health, Suppl. 1, S1, S60 (2022) ("WPATH SOC8").

[24] Azeen Ghorayshi, *Biden Officials Pushed to Remove Age Limits for Trans Surgery, Documents Show*, N.Y. Times (June 25, 2024), https://tinyurl.com/3m59adwx; Brief of Amici Curiae State of Alabama and 23 Other States in Support of Jurisdiction at 5–10, *Moe v. Yost*, No. 2025-0472 (Ohio May 16, 2025), https://tinyurl.com/2nvvtcbn (explaining evidence found in discovery).

B. Social transitioning is controversial and unproven.

The unquestioning affirmation model of treatment mandated by California's "Parental Exclusion Policies," *Mirabelli*, 820 F. Supp. 3d at 1133, 1141, and the use of social transitioning in particular, remain highly controversial among practitioners.[25] Social transitioning is an experimental therapy that has not been shown to improve mental or physical health outcomes in minors.[26] In 2014, the American Psychological Association warned: "[P]remature labeling of gender identity should be avoided" and "[e]arly social transition … should be approached with caution to avoid foreclosing this stage of (trans)gender identity development."[27] The Association added that social transition might be "challenging to reverse" even if the person is no longer gender dysphoric.[28] Even Dr. Erica Anderson, the first transgender president of

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[25] Cass Review, *supra* note 18, at 158.

[26] Maja Drobnič Radobuljac et al., *ESCAP Statement on the Care for Children and Adolescents with Gender Dysphoria: An Urgent Need for Safeguarding Clinical, Scientific, and Ethical Standards*, 33 Eur. Child & Adolescent Psych. 2011, 2013–14 (2024).

[27] Walter O. Bockting, *Chapter 24: Transgender Identity Development in*, Am. Psych. Ass'n, *APA Handbook of Sexuality and Psychology* 744 (Deborah L. Tolman & Lisa M. Diamond eds. 2014) (citations omitted).

[28] *Id.* at 750.

USPATH and a former board member of WPATH, who testified before the district court, has condemned automatic approval of transition upon the request of a child or adolescent. This is because, as Dr. Anderson noted, "adolescents ... are notoriously susceptible to peer influence," that gender transition "doesn't cure depression, doesn't cure anxiety disorders, doesn't cure autism-spectrum disorder, [and] doesn't cure ADHD."[29] Dr. Anderson therefore urges that "a comprehensive bio-psychosocial evaluation" should proceed before allowing a child to transition,[30] something the Policy prohibits. Indeed, at an earlier hearing before the district court, Plaintiffs' expert Dr. Anderson called social transitioning "one of the most difficult psychological changes a person can experience." *Mirabelli v. Olson*, 691 F. Supp. 3d 1197, 1208 (S.D. Cal. 2023). There is no justification for schools to push children to endure that trauma when, as noted above, without affirmation of an incongruent

[29] Lisa Davis, *A Trans Pioneer Explains Her Resignation from the US Professional Association for Transgender Health*, Quillette (Jan. 6, 2022), https://tinyurl.com/22nd38aa.

[30] *Id.*

gender identity, most children who suffer from gender dysphoria will accept their biological sex by late adolescence.[31]

Moreover, no long-term control studies support the use of social transition as a treatment for gender dysphoria in children.[32] The only systematic review of evidence to date reports at best an "absence of robust evidence of the benefits or harms of social transition for children and adolescents."[33] This makes California's Policy rank experimentation on California's children all without parental notice or consent.

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[31] James M. Cantor, *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, 46 J. Sex & Marital Therapy 307, 307 (2019); Stewart L. Adelson & Am. Acad. of Child & Adolescent Psych. (AACAP), *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, 51 J. Am. Acad. Child & Adolescent Psych. 957, 963 (2012); Cohen-Kettenis, *supra* note 11, at 1895; Kenneth Zucker, *The Myth of Persistence: Response to "A Critical Commentary on Follow-up Studies and 'Desistance' Theories About Transgender and Gender Non-conforming Children" by Temple Newhook et al. (2018)*, 19 Int'l J. Transgenderism 231, 240–41 (2018) (hereinafter "Zucker, *Myth*").

[32] Adelson & AACAP, *supra* note 31, at 968–69; Am. Psych. Ass'n (APA), *Guidelines for Psychological Practice With Transgender and Gender Nonconforming People*, 70 Am. Psych. 832, 842 (2015) ["APA, *Guidelines*"] (no "empirically validated, consensus … exist[s] regarding best practice with prepubertal children"); Zucker, *Myth*, *supra* note 31, at 240.

[33] Ruth Hall et al., *Impact of Social Transition in Relation to Gender for Children and Adolescents: A Systematic Review*, 109 Arch. Disease

That is why, consistent with the Cass Review's findings, numerous European countries[34] have determined in recent years that there is no solid evidence to support many of these interventions on minors. Additionally, professional groups and governing agencies in eight other nations have called for stringent reviews of transgender protocols in their countries.[35] Yet the Policy gives that authority to untrained school

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Childhood s12, s12 (2024). The American Academy of Child and Adolescent Psychiatry has recognized that "no randomized controlled trials of any treatment" for gender dysphoria exist. Adelson & AACAP, *supra* note 31, at 968–69. Similarly, the American Psychological Association has acknowledged that, "because no approach to working with [transgender and gender nonconforming] children has been adequately, empirically validated, consensus does not exist regarding best practice with prepubertal children." APA, *Guidelines*, *supra* note 32, at 842.

[34] Socialstyrelsen, Swedish Nat'l Bd. of Health & Welfare, *Care of Children and Adolescents with Gender Dysphoria: Summary of National Guidelines* 3–4 (Dec. 2022), https://tinyurl.com/59vpb43x; Jennifer Block, *Norway's Guidance on Paediatric Gender Treatment is Unsafe, Says Review,* 380 BMJ 697, 697 (2023), https://tinyurl.com/yf7dsswu; Council for Choices in Health Care [Finland], *Summary of a Recommendation by Council for Choices in Health Care in Finland: Medical treatment methods for dysphoria associated with variations in gender identity in minors—recommendation* 2 (June 16, 2020), https://tinyurl.com/mpax9cke; Resolution Ic-048, Treatment of gender dysphoria in minors, 128th German Med. Assembly (passed May 2024), https://tinyurl.com/2jkrjazm; Mary McCool, *Scotland's under-18s gender clinic pauses puberty blockers*, BBC (Apr. 18, 2024), https://tinyurl.com/54bayw73.

[35] *See* Christina Buttons, *The Global Response to the Cass Review: June 2024 Update*, buttonslives (May 13, 2024), https://tinyurl.com/y67b8e8k.

personnel without any parental input, or even input from a trained mental health professional.

C. Social transitioning causes persistence and long-term poor mental health outcomes.

Social transitioning, therefore, is not a low-risk treatment, but rather a psychotherapeutic intervention that dramatically changes outcomes. As noted above, without affirmation, up to 95% of children with gender dysphoria naturally desist by the time they become adults, with the exact opposite being true if a child is socially transitioned.[36] So much so that one researcher observed that a partial or complete gender social transition prior to puberty "proved to be a unique predictor of persistence."[37] Similarly, a comparison of recent and older studies suggests that when an "affirming" methodology is used with children, a substantial proportion of children who would otherwise have desisted by

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[36] Carly Guss et al., *Transgender and Gender Nonconforming Adolescent Care: Psychosocial and Medical Considerations*, 26 Current Op. in Pediatrics 421, 422 (2015) ("The gender identity affirmed during puberty appears to predict the gender identity that will persist into adulthood.").

[37] Singh, *supra* note 11, at 14.

adolescence—that is, achieved comfort identifying with his or her natal sex—instead persist in a transgender identity.[38]

Even voices supportive of unqualified affirmation and social transition acknowledge a causal connection between social transition and this change in outcomes. The Endocrine Society recognized that "[i]f children have completely socially transitioned, they may have great difficulty in returning to the original gender role upon entering puberty.... [S]ocial transition (in addition to GD/gender incongruence) has been found to contribute to the likelihood of persistence."[39] The fact is that this unproven mental health intervention is not just a kind of "polite social courtesy," *Mirabelli*, 820 F. Supp. 3d at 1141, but a psychological intervention with profound and harmful long-term effects on children.

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[38] Zucker, *Myth*, *supra* note 31, at 237; *see also* Cantor, *supra* note 31, at 307, 311–12; Kristina R. Olson, *Gender Identity 5 Years After Social Transition*, 150 Pediatrics 1, 3–6 (2022); James R. Rae et al., *Predicting Early-Childhood Gender Transitions*, 30 Psych. Sci. 669, 671 (2019).

[39] Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. Clinical Endocrinology & Metabolism 3869, 3879 (2017).

D. Children with gender dysphoria need proper counseling, not "affirmation" or social transition.

Social transition is not benign but consequential and harmful. While the Policy mandates secret "social transitioning," which is a central part of the "unquestioning affirmation" model rejected by both the Cass Review[40] and the recent report from the U.S. Department of Health and Human Services,[41] there are talk therapy treatments that actually help a child struggling with gender dysphoria to address their underlying mental health concerns. The selection of a trustworthy therapist or other treatment properly rests with a child's parents, not school personnel.

Because gender dysphoria is a psychiatric condition, not a disorder of the body, treatment should be psychological, often through exploratory talk therapy designed to alleviate feelings of gender incongruence and the associated distress associated with such feelings. Adequate treatment requires acknowledging this fact, along with the fact that gender dysphoria is frequently comorbid with anxiety, depression,

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[40] Cass Review, *supra* note 18, at 30.

[41] Dep't Health & Hum. Servs., Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices 93–94 (as corrected 2025) [hereinafter "HHS Report"], https://tinyurl.com/2x4enzkn.

autism spectrum disorder, and trauma.[42] And youth presenting with gender dysphoria can have their co-morbid mental health conditions treated as "many psychological therapies have a good evidence base for the treatment in the general population of conditions that are common in this group, such as depression and anxiety."[43] Therefore, best practices for a mental health practitioner will often involve treating a youth with gender dysphoria for his or her underlying anxiety or depression.

Indeed, there is robust evidence that youth with gender dysphoria benefit when their other underlying mental conditions are treated through exploratory talk therapy. A recent report shows "there is available evidence to support the role of psychotherapy in treating children and adolescents with other mental health problems, including depression, anxiety, eating disorders, self-harm, and suicidality."[44] But the Policy requires schools to "affirm" an incongruent gender identity, no questions asked, all while keeping parents in the dark and the child from

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[42] *See supra* note 8; *see also* Lisa Littman, *Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria,* 13 PLoS ONE e0202330, at 13 (2018), *correction*, 14 PLoS ONE e0214157 (2019).

[43] Cass Review, *supra* note 18, at 30, ¶ 68.

[44] HHS Report, *supra* note 41, at 94.

getting the proper care he or she needs. *See, e.g.*, *Mirabelli*, 820 F. Supp. 3d at 1139–41. Thus, the Policy prevents the child from receiving treatment for the child's underlying mental health concerns that will often assist in resolving a child's gender dysphoria.[45] As the district court recognized here, parents must be notified and involved if the child is to get such treatment. *Id*. at 1140, 1142.

E. Social transitioning should not be attempted by untrained persons.

Even well-documented medical treatments should only be performed by a trained professional. Yet the Policy's mandate for *untrained school officials* to blindly implement controversial social transitioning interventions is astounding. And the Policy mandates that these officials do so by simply taking a child's word for it without any communication with the parents. By excluding the parents, not to mention a mental health professional, the Policy is contrary to sound

[45] Tatiana Brandsma et al., *A Pilot Study on the Effect of Peer Support on Quality of Life of Adolescents with Autism Spectrum Disorder and Gender Dysphoria*, 54 J. Autism Dev. Disorders 997, 1006 (2024) (study on such treatment of youth with gender dysphoria "found that participating in a specific peer support group increased psychological well-being and decreased psychological complaints in these adolescents with [Autism Spectrum Disorder] and [Gender Dysphoria], thereby increasing their quality of life").

medical practice and basic constitutional protections. *Wisconsin v. Yoder*, 406 U.S. 205, 232–33 (1972); *Mirabelli*, 607 U.S. at 497.

For example, the Cass Review emphasized that *families* making decisions about social transition of pre-pubertal children must be seen "as early as possible by a clinical professional with relevant experience."[46] And staff without the appropriate clinical training cannot discuss the risks (there are many) and benefits (dubious at best) of social transition.[47]

Educators, moreover, are not qualified to second-guess or displace parental judgments. They lack the training to perform mental health evaluations; grasp the complexity of gender dysphoria; diagnose autism, anxiety, trauma, and other mental health conditions associated with gender dysphoria; recognize when a student's health and well-being are at risk; or determine the best response to a child's identity confusion. Social transitioning is not a preferred style of dress or preferred nickname, but a suggestion that the child is not the same sex as the child's biological reality which has significant psychological ramifications. School officials have no business pushing this on a child

[46] Cass Review, *supra* note 18, at 32, 165.

[47] *Id.* at 164.

suffering from gender dysphoria and then keeping the information from the parents.

III. California's Parental Exclusion Policy Is Inconsistent with Sound Medical Practice.

The Policy needs to be evaluated against this backdrop. As shown below, "social transitioning" a minor poses enormous risks and has not been shown to reduce other risks associated with gender dysphoria such as suicide. Further, such an intervention cannot be ethically administered to a minor who is incapable of making decisions that entrench a mental health condition that often leads to permanent, life-altering consequences such as sterility.

A. Social transitioning harms children.

In the school setting, social transitioning poses many potential harms to children, including subverting biological reality, concealing comorbidities, and putting children at risk for grooming.

1. Young people look to adults to understand reality: what's real and unreal, possible and impossible. Parents and other adults should be honest and consistent with children and stay grounded in biological reality. When adults, especially those in positions of authority such as teachers and school officials, abdicate that responsibility, they cause

immeasurable harm to young people and their families. For example, using a boy's name and male pronouns to refer to a girl endorses the girl's false belief, perpetuates an impossibility, and is no favor or kindness.

2. Social transitioning also often conceals comorbidities that require treatment. This was demonstrated in a cohort study by authors from Harvard and Boston Children's Hospital who found that youth and young adults (ages 12–29) who self-identified as transgender had an elevated risk of depression (50.6% vs. 20.6%) and anxiety (26.7% vs. 10.0%) and a higher risk of suicidal ideation (31.1% vs. 11.1%), suicide attempts (17.2% vs. 6.1%), and self-harm without lethal intent (16.7% vs. 4.4%) relative to the matched controls.[48] They are also "substantially" more likely to abuse alcohol or other substances.[49] Social transitioning does not address these issues, or the co-morbidities described above, but rather leaves them untreated behind the mask of a false identity.

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[48] Sari L. Reisner et al., *Mental Health of Transgender Youth in Care at an Adolescent Urban Community Health Center: A Matched Retrospective Cohort Study*, 56 J. Adolescent Health 274, 276–77 & tbl. 2 (2015).

[49] Michael E. Newscomb et al., *High Burden of Mental Health Problems, Substance Use, Violence, and Related Psychosocial Factors in Transgender, Non-Binary, and Gender Diverse Youth and Young Adults*, 49 Arch. Sexual Behav. 645, 655 (2020).

3. Further, secret social transitioning by school officials can cover up grooming behaviors, such as singling out children for special treatment, breaking down boundaries, portraying parents as threats, and suggesting it is acceptable or necessary to keep secrets from them.[50] Facilitating these behaviors can lead to catastrophe.[51] Encouraging a minor to keep issues from his/her parents, especially something as significant as gender dysphoria, would never be acceptable concerning any other non-sexual topic.

B. Social transitioning does not help the child but often leads to more invasive medical procedures.

Initially, no studies show that social transition of children or adolescents reduces suicide, prevents suicidal ideation, or improves long-term outcomes in those who suffer from gender dysphoria. Rather, in addressing this very issue, the Cass Review did a detailed analysis of studies on the relationship between gender dysphoria and suicide. The

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[50] Georgia M. Winters et al., *Validation of the Sexual Grooming Model of Child Sexual Abusers*, 29 J. Child Sexual Abuse 855, 856 (2020).

[51] *See* Emmanuel A. Rondón, *Virginia girl ran away from home and was a victim of sex trafficking after her school hid her gender transition from her family*, Voz Media (Sep. 4, 2023), https://tinyurl.com/bc5ukh4f.

review found that the studies did not support a claim that "gender-affirming treatment reduces suicide risk."[52]

This point was illustrated in a recent Finnish study that revealed the suicide rate in "gender-referred adolescents" was equal to the suicide rate in non-gender-confused peers when the groups were matched for underlying mental disorders.[53] In other words, the underlying mental disorder, not the gender dysphoria, was the cause of the suicide.[54] While studies demonstrate that transgender adolescents have elevated rates of suicidal thoughts when compared to peers who are not transgender,[55] this is not surprising given the higher rates of co-occurring mental health issues in this population, as noted above. Further, the suicide rates are similar across all stages of transition from pretreatment assessment to

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[52] Cass Review, *supra* note 18, at 186, §15.43; *see generally id.* at 186–87, §§15.36–15.43.

[53] *Id.* at 96, §5.66.

[54] Sami-Matti Ruuska et al., *All-cause and Suicide Mortalities Among Adolescents and Young Adults Who Contacted Specialised Gender Identity Services In Finland In 1996-2019: A Register Study*, 27 BMJ Mental Health 1, 3 & tbl. 1 (2024).

[55] Silvia S. Canetto et al., *Suicidal as Normal–A Lesbian, Gay, and Bisexual Youth Script?,* 42 Crisis 292, 292–93 (2021).

post-transition follow-up.[56] Accordingly, proper mental health treatment is needed for gender dysphoric children, not secret social transitioning done by untrained school officials.

Equally troubling, social transitioning significantly increases the likelihood of more invasive medical intervention such as puberty blockers, cross-sex hormones, and even surgery when the child would otherwise almost always desist without such efforts.[57] And the medical evidence shows that such procedures pose significant life-long harms such as sterility, bone loss, and diminished brain function along with increased mental health concerns.[58] So allowing a child to present as the

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[56] Chantal M. Wiepjes et al., *Trends in Suicide Death Risk in Transgender People: Results from the Amsterdam Cohort of Gender Dysphoria Study (1972–2017)*, 141 Acta Psychiatrica Scandinavica 486, 488–90 & tbl. 2 (2020).

[57] ACPeds, *Gender Dysphoria*, *supra* note 4, at 12 (study of 70 pre-pubertal candidates to receive puberty suppression showed that every child "eventually embraced a transgender identity and requested cross-sex hormones"); Cass Review, *supra* note 18, at 31, 176 (§14.24); Annelou L.C. de Vries et al., *Puberty Suppression in Adolescents With Gender Identity Disorder: A Prospective Follow-Up Study*, 8 J. Sexual Med. 2276, 2280–81 (2011), https://tinyurl.com/25cahzah.

[58] *See generally United States v. Skrmetti*, 605 U.S. 495, 505 (2025); *id.* at 532–36 (Thomas, J., concurring) (detailing medical concerns from such interventions); Brief of *Amici Curiae* American College of Pediatricians et al. at 15–36, *id.* (No. 23-477), https://tinyurl.com/ymj6n6m8; *accord Eknes-Tucker v. Governor of Ala.*, 80 F.4th 1205, 1225 (11th Cir. 2023).

opposite sex at school behind his or her parents' backs is not a benign social politeness, but a serious psychological intervention that has the potential for significant harmful consequences. Yet the Policy does all of this through untrained school personnel while intentionally keeping this critical information from parents.

C. Social transitioning harms others, including children's families.

The harms from secret, social transitioning policies are not limited to the child. The Policy here harms *all* students at the school by presenting an unscientific and destabilizing ideology—that sex is determined by feelings; male and female are "assigned" at birth; and identity might be at odds with material reality. Under the Policy, authority figures encourage students to reject the truth they have always known by proclaiming "he" is now "she" and "she" will now use girls' spaces—no objections allowed. The Policy thus calls into question the core aspect of students' humanity, being male or female, and celebrates body dissociation. These children are also placed at significantly elevated risk of developing gender dysphoria via social contagion.[59]

[59] *See, e.g.*, Littman, *supra* note 42, 13 PLoS One e0202330, at 16–19.

The Policy also harms parents. To raise children successfully, parents must have authority. Indeed, the scientific literature shows that "[a]uthoritative parenting, which is characterized by a high degree of parental warmth and support, firm limit setting, open communication, and high levels of supervision, has long been believed to be the ideal parenting style."[60] It deters "high-risk behavior" and "generally leads to the best outcomes for teens."[61] It is therefore dangerous to strip parents of their constitutional right to exercise authority over their minor children, make decisions, and direct their upbringing, education, and mental health care. *Parham v. J.R.*, 442 U.S. 584, 603 (1979); *Yoder*, 406 U.S. at 232–33; *Pierce v. Soc'y of Sisters*, 268 U.S. 510, 534–35 (1925). Instead, parents must be given vital mental health information about their children—as that is information they must have to guide and support their child. Yet, Defendants automatically label parents as uncaring and dangerous, telling children to hide information from their

[60] Elise R. DeVore & Kenneth R. Ginsburg, *The protective effects of good parenting on adolescents*, 17 Current Op. Pediatrics 460, 460–61 (2005), https://tinyurl.com/mr3w3d3y.

[61] *Id.* at 460.

parents, because their parents, by not "affirming" an incongruous gender identity, do not really love their child.

Finally, the secret social transition of a student places siblings in a wrenching quandary: Do they tell their parents that their sibling is living a double life, or do they remain complicit in the deception? They are forced to take a side, and neither feels right. It is an impossible dilemma created entirely by the Policy.

D. Concerns over parental involvement do not justify the policy.

Not only is social transitioning inherently harmful and dubiously beneficial, but alleged risks from informing parents are illusory. If there are specific concerns that a parent has abused or neglected a child, the school is required to contact state child protective services. A parent's disapproval of an incongruent gender identity does not justify a school making healthcare decisions for the child behind the parent's back and is not, in and of itself, evidence or even a suggestion of abuse or neglect. *See Mirabelli*, 820 F. Supp. 3d at 1142–43 (quoting *Parham*, 442 U.S. at 603). Indeed, the law presumes that parents "act in the best interests of their child[.]" *Parham*, 442 U.S. at 604. As the Supreme Court has held, "so long as a parent adequately cares for his or her children (*i.e.,* is fit), there

will normally be no reason for the State to inject itself into the private realm of the family to further question the ability of that parent to make the best decisions concerning the rearing of that parent's children." *Troxel v. Granville*, 530 U.S. 57, 68–69 (2000). The blanket Policy here violates this fundamental principle.

Ironically, because doctors do not know the long-term effects of social transitioning and the near-inevitable drugs and surgeries that follow, they cannot even provide the necessary information for a child or their parents to give informed consent to such intervention.[62] Yet the Policy allows the school to make that decision without any input from the parents and without any psychological evaluation of the child, clearly falling short of informed consent for a medical intervention that has such serious consequences on the child's mental and physical health.[63]

Secretly socially transitioning a child and intentionally concealing that major psychological intervention from the child's parents is

[62] Cass Review, *supra* note 18, at 194, §§16.15–16.18.

[63] *Id.* at 194, §16.18; *see also id.* at 195–96, §§16.25–16.31; *id.* at 196, §16.34. *See also* Doctors Protecting Children Decl., *supra* note 2, ¶ 2.

dangerous, unethical, and unconstitutional. Accordingly, the district court's judgment should be affirmed.

CONCLUSION

The Policy requires untrained school officials to employ a controversial medical intervention for gender dysphoria, without even a proper diagnosis, and without notice to the parents. Employing this treatment by untrained school personnel, especially in secret, is unethical because it harms children, their peers, and their families. The district court's judgment should be affirmed.

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Respectfully submitted,

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This brief complies with the type-volume limitation of Fed. R. App. P. 29(a)(5) because this brief contains 6,827 words excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

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