No. 25-8056, 26-2337

United States Court of Appeals for the Ninth Circuit

ELIZABETH MIRABELLI, an individual; LORI ANN WEST, an individual; JANE ROE, an individual, on behalf of herself and all others similarly situated; JANE BOE, an individual, on behalf of herself and all others similarly situated; JOHN POE, an individual, on behalf of himself and all others similarly situated; JANE POE, an individual on behalf of herself and all others similarly situated; Dr JOHN DOE, an individual, on behalf of himself and all others similarly situated; Miss JANE DOE, an individual, on behalf of herself and all others similarly situated,

Plaintiffs-Appellees,

(For Continuation of Caption See Inside Cover)

ON APPEAL FROM AN ORDER OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF CALIFORNIA IN NO. 3:23-CV-00768-BEN-VET, HONORABLE ROGER T. BENITEZ, DISTRICT JUDGE

AMICUS CURIAE BRIEF OF DR. JENNIFER BAUWENS IN SUPPORT OF APPELLEES

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– v. –

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Defendants-Appellants,

MARK OLSON, in his official capacity as President of the EUSD Board of Education, FRANK HUSTON, in his official capacity as Vice President of the EUSD Board of Education, JOAN GARDNER, in her official capacity as a member of the EUSD Board of Education, DOUG PAULSON, in his official capacity as a member of the EUSD Board of Education, ZESTY HARPER, in her official capacity as a member of the EUSD Board of Education, LUIS RANKINS-IBARRA, in his official capacity as Superintendent of EUSD, JOHN ALBERT, both in his personal capacity and in his official capacity as Assistant Superintendent of EUSD, TRENT SMITH, both in his personal capacity and in his official capacity as Director of Integrated Student Services for EUSD, TRACY SCHMIDT, both in her personal capacity and in her official capacity as Director of Integrated Student Supports for EUSD, STEVE WHITE, both in his personal capacity and in his official capacity as Principal of Rincon Middle School at EUSD, NAOMI PORTER, in her official capacity as a member of the California State Board of Education, ESCONDIDO UNION SCHOOL DISTRICT, a local educational agency,

Defendants.

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INTEREST OF THE AMICA CURIAE[1]

Dr. Jennifer Bauwens is the Director of American Values at the America First Policy Institute (AFPI), which focuses on protecting parental rights as one of its three policy priorities. Dr. Bauwens is a recognized expert in psychology and child development, and her research has been published in premier academic publications such as the Journal of Marriage and Family, the Clinical Social Work Journal, and the Journal of Public Child Welfare. Dr. Bauwens also has a long history of using her expertise to shape public policy, previously providing research to state and federal authorities on matters concerning the mental health of children and families as Director of the Center for Family Studies at the Family Research Council.

Based on her extensive knowledge and experience, Dr. Bauwens believes gender dysphoria to be a serious psychological disorder that should be treated by mental health professionals for the welfare and benefit of the child in conjunction with the wishes of a child's parents.

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

She also recognizes social transitioning as a risky treatment protocol and believes non-professionals such as teachers and administrators are not qualified to prescribe or promote such treatment. Dr. Bauwens further maintains that protecting parental primacy in healthcare decisions is essential to protecting vital freedoms guaranteed by the Constitution.

SUMMARY OF THE ARGUMENT

Over the last decade, mental health practitioners have increasingly diagnosed minors with gender dysphoria, a psychological disorder used to describe a person's mental distress about their biological sex. Gender dysphoria was once considered to be a very rare, and often short-lived, psychological disorder. *See* Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 579 (4th ed. text rev. 2000). Today, the ideas contained in this diagnosis are used both formally and informally with much greater frequency than at any time in the history of the diagnostic construct, especially among young people. Recent polling shows that roughly 5% of young adults identify as something other than their biological sex. Anna Brown, *About 5% of Young Adults in the U.S. Say Their Gender Is Different from Their Sex*

Assigned at Birth, Pew Research Center (June 7, 2022), https://www.pewresearch.org/short-reads/2022/06/07/about-5-of-young-adults-in-the-u-s-say-their-gender-is-different-from-their-sex-assigned-at-birth/. What's more, these numbers translate to a rise in youth undergoing risky treatment protocols that have been repeatedly shown to be ineffective at best.

One such "treatment" is social transitioning. Social transitioning is part of the gender affirming care model (GAC), and it continues to be the primary intervention associated with gender dysphoria. While aimed at reducing psychological distress and preventing suicide, recent studies show that social transitions are often the first step down a path to the most physiologically damaging aspects of the GAC model such as cross-sex hormones and surgeries. Kristina R. Olson et al., *Gender Identity 5 Years After Social Transition*, 150 Pediatrics e2021056082 (2022); Kenneth J. 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.*, 19 Int'l J. Transgenderism 231 (2018).

If that were not concerning enough, state actors in states such as California have now taken it upon themselves to usurp the role of both parent and clinician by instituting policies prescribing social transitioning for schoolchildren under their care without consulting the children's parents. Escondido Union School District (EUSD) requires all teachers to unquestioningly affirm a child's assertion of their gender identity by facilitating their social transition. *See* Ex. 5, Complaint, *86, *Mirabelli v. Olson*, No. 3:23-cv-00768-BEN-WVG (S.D. Cal. Apr. 27, 2023) ("The student's assertion is enough. . .There's no requirement for parent or caretaker agreement or even for knowledge for us to begin treating that student consistent with their gender identity"). The EUSD policy and others like it do not require consultation with a clinician to determine the child's mental health status and create an appropriate treatment plan. Nor do they pay heed to the desires of parents. Rather, they rely solely on the stated preferences of the child, facilitated by sympathetic unrelated adults.

Such policies are both incredibly dangerous and in clear violation of the Constitution. Gender dysphoria is a mental health disorder treated through clinical interventions, such as those outlined by the

GAC model, that can have serious long-lasting effects. Moreover, recent research has called into question the efficacy of both social transitioning and the GAC model writ large, making its rampant use by non-clinicians dubious. Additionally, the Supreme Court has reaffirmed the idea that parents have "primary authority with respect to 'the upbringing and education of children.'" *Mirabelli v. Bonta*, 146 S. Ct. 797, 803 (2026) (quoting *Pierce v. Soc'y of Sisters*, 268 U.S. 510, 534-35 (1925)); *see also Meyer v. Nebraska*, 262 U.S. 390, 399-400 (1923). This parental primacy includes a guarantee for parents "not to be shut out of participation in decisions regarding their children's mental health." *See Mirabelli*, 146 S. Ct. at 803; *Parham v. J.R.*, 442 U.S. 584, 602 (1979). Therefore, even if the "benefits" of social transitioning were identifiable and documented – which they are not – state actors such as EUSD do not possess the power to mandate clinical interventions without parental consultation or consent.

ARGUMENT

I. California's social transitioning policies violate parents' fundamental right to be involved in health care decisions affecting their children.

a. Gender dysphoria is a mental health disorder treated through clinical interventions.

i. Gender dysphoria is a mental health disorder.

Psychological diagnoses contained in the Diagnostic and Statistical Manual for Mental Disorders (DSM) should be made by a qualified medical or mental health professional. National Alliance on Mental Illness, Types of Mental Health Professionals (Apr. 2020), https://www.nami.org/treatments-and-approaches/types-of-mental-health-professionals. When it comes to diagnosing gender dysphoria—or as it was previously referred to, "gender identity disorder" (*See infra*, p. 9), there has been much confusion over who determines the condition and the nature of the diagnosis itself.[2] Am. Psychiatric Ass'n,

[2] Some researchers and proponents of the transgender movement have argued that the gender dysphoria diagnosis should not be included in the DSM or should only be included for insurance purposes. *See* Dan J. Stein et al., *What Is a Mental Disorder? An Exemplar-Focused Approach*, 51 Psych. Med. 894 (2021); Berenice Bento, *The Review Process of the DSM 5: Is Gender a Cultural or Diagnostic Category?*, 2 Sociology Int'l Journal 205 (2018).

Diagnostic and Statistical Manual of Mental Disorders (3d ed. 1980). Despite stark opposition against its inclusion, the continued presence of gender dysphoria in the DSM speaks to its recognition as a health-related matter. After all, including gender dysphoria in the DSM necessarily associates the transgender phenomenon with pathology rather than an experience that is indicative of sound mental health.

Another indication that a gender dysphoria diagnosis is a mental health condition is that it is often present alongside other comorbidities and neurological conditions. For example, gender dysphoria often occurs together with other psychiatric symptoms, exposures to traumatic events, and autism.[3]

This deep-seated connection between gender dysphoria and other atypical neurological conditions is further evidenced by the commonly cited claim that minors will commit suicide if gender affirming care is

[3] Tabitha Frew et al., *Gender Dysphoria and Psychiatric Comorbidities in Childhood: A Systematic Review*, 73 Austl. J. Psychol. 255 (2021); Darren Glidden et al., *Gender Dysphoria and Autism Spectrum Disorder: A Systematic Review of the Literature*, 4 Sexual Med. Rev. 3 (2016); Anna I.R. Van Der Miesen et al., *Gender Dysphoria and Autism Spectrum Disorder: A Narrative Review*, 28 Int'l Rev. Psychiatry 70 (2016); Aimilia Kallitsounaki & David M. Williams, *Autism Spectrum Disorder and Gender Dysphoria/Incongruence: A Systematic Literature Review and Meta-Analysis*, 53 J. Autism & Dev. Disorders 3103 (2023).

not offered. Landon D. Hughes et al., *"These Laws Will Be Devastating": Provider Perspectives on Legislation Banning Gender-Affirming Care for Transgender Adolescents,* 69 J. Adolesc. Health 976 (2021). After all, ongoing expressions of suicidal ideation are often associated with psychiatric issues. Leo Sher, *Suicide in Individuals with No Psychiatric Disorders: What Makes You Vulnerable?,* 117 QJM 313 (May 2024). Notably, suicide risk has often been the primary impetus for initiating GAC, giving more evidence that gender dysphoria and its expressions are characteristic of mental health disorders. Jody L. Herman et al., *Suicide Thoughts and Attempts Among Transgender Adults: Findings from the 2015 U.S. Transgender Survey* (Williams Inst. at UCLA Sch. of L., Sept. 2019), https://williamsinstitute.law.ucla.edu/publications/suicidality-transgender-adults/.

It is true that throughout subsequent iterations of the DSM, the American Psychiatric Association aimed to lessen the pathology associated with the gender dysphoria diagnosis by making several notable changes. Am. Psychiatric Ass'n, *Gender Dysphoria Diagnosis*, https://www.psychiatry.org/psychiatrists/diversity/education/transgender-and-gender-nonconforming-patients/gender-dysphoria-diagnosis (last

accessed Apr. 22, 2026). However, conceptions of the diagnosis in earlier iterations of the DSM, in addition to its continued presence in current versions, demonstrate that gender dysphoria is still best understood as a maladaptive phenomenon.

Early indications of the gender dysphoria diagnosis were formalized in the second iteration of the DSM. At that time, the diagnosis was formulated based on the observations of mostly adult men who were sexually aroused by cross-dressing as women. Ray Blanchard, *The Concept of Autogynephilia and the Typology of Male Gender Dysphoria*, 177 J. Nervous & Mental Disease 616 (1989). The diagnosis was later named "gender identity disorder," where it was still considered a maladaptive disorder that affected both children and adults. Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* (3d ed. 1980). By the fifth iteration of the DSM, the diagnostic term was renamed to exclude the disorder terminology to destigmatize the condition. Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. text rev. 2022). This

change to the DSM happened rather quickly, and statements[4] surrounding this change demonstrate the new diagnostic parameters focus on destigmatizing gender dysphoria rather than determining best treatments.

ii. Social transitioning is a clinical intervention.

Social transition falls within the definition of a clinical intervention, further demonstrating gender dysphoria to be a mental health disorder. According to the American Psychological Association,

> "an intervention is an 'action on the part of a psychotherapist to deal with the issues and problems of a client. The selection of the intervention is guided by the nature of the problem, the orientation of the therapist, the setting, and the willingness and ability of the client to proceed with the treatment.'"

Am. Psych. Ass'n, *Intervention*, APA Dictionary of Psychology (Nov. 15, 2023), https://dictionary.apa.org/intervention. Therefore, there are three key features typical to a psychological intervention: 1) it is employed by

[4] The DSM-V version of gender identity disorder states that "gender non-conformity is not in itself a mental disorder." The American Psychiatric Association goes on to say in their statement about the newly minted diagnosis that "discussions continue among advocates and medical professionals about how best to preserve access to gender transition-related health care while also minimizing the degree to which such diagnostic categories stigmatize the very people that physicians are attempting to help."

the psychotherapist; 2) it is done to improve health; and 3) the results are dependent on the willingness of the client to proceed with treatment. *Id.*

As for the nature of social transition, two systematic reviews noted, "[E]ven though social transition is undertaken *outside* healthcare settings, it is important to view [social transition] as 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*." H. Cass, *Independent Review of Gender Identity Services* (Apr. 2024); U.S. Dep't of Health & Hum. Servs., *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices* (Nov. 19, 2025) (emphasis added).

Social transition is part of the GAC model, and it continues to be the primary intervention associated with gender dysphoria. While the model is not necessarily applied in an entirely linear fashion, the typical first step in this intervention is social support or social transition. World Professional Association for Transgender Health, *Standards of Care for Transgender and Gender Diverse People, Version 8 Frequently Asked Questions (FAQs)*, https://app.wpath.org/media/cms/

Documents/SOC%20v8/SOC-8%20FAQs%20- %20WEBSITE2.pdf (last accessed Feb. 11, 2026). This step is supposed to be the least physiologically invasive part of the broader model, which has been suggested by World Professional Association for Transgender Health's (WPATH) for children and adults alike. The purpose of the intervention has been described as a means for reducing psychological distress and preventing suicide. *Id*.

The WPATH standards of care (version 8) defines the social transition intervention as: 1) adopting a change that might include their name, pronouns, identification (e.g., birth certificate, identification cards, passport, school and medical documentation); 2) their participation in sex-segregated programs and spaces; 3) changing their hair and clothing style; and 4) communicating one's preferred gender to others. The WPATH guidelines also suggest that children as young as 18 months can have an awareness of their gender and benefit from support to use a different name, hairstyle, and clothing that aligns with their preferred gender. E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 Int'l J. Transgender Health S1 (2022). WPATH sees the social transition step

as one means to decide whether a person needs gender affirming surgery. *Id.*

Even though WPATH guidelines have come under increasing scrutiny, *see infra* pp. 23, the goals of the GAC model outlined in the WPATH guidelines, have been promoted by government health services nationwide, and are a part of the scientific discourse.[5] Its goals include preventing suicide, lowering negative mental health symptoms, and helping a person embrace a transgender identity.[6] The primary basis for these outcomes is driven by the theory that psychological distress is associated with being a part of a minority group. Megan Sutter & Paul B. Perrin, *Discrimination, Mental Health, and Suicidal Ideation*, 63 J.

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[5] Coleman, *Standards of Care for the Health of Transgender and Gender Diverse People*; U.S. Dep't of Health & Hum. Servs., Off. of the Assistant Sec'y for Health (@HHS_ASH), (Oct. 13, 2022), https://x.com/HHS_ASH/status/1580277406820012032?s=20&t=rhjfqkWimgmfM2dtaDVNXQ; Endocrine Society, *Endocrine Society Statement in Support of Gender-Affirming Care* (May 8, 2024), https://www.endocrine.org/news-and-advocacy/news-room/2024/statement-in-support-of-gender-affirming-care.

[6] Amy E. Green et al., *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth,* 70 J. Adolesc. Health 643 (2022); Teddy G. Goetz & Amanda C. Arcomano, *"Coming Home to My Body": A Qualitative Exploration of Gender-Affirming Care-Seeking and Mental Health*, 27 J. Gay Lesbian Ment. Health 380 (2023).

Counseling Psychol. 98 (2016). In this way, affirmation and support are thought to reduce negative psychological symptoms, including suicide.

Ultimately, social transition's similarities to other clinical interventions, its connection with the broader GAC model of care, and its presence in health and science discourse confirm it as being a clinical intervention. This, in turn, helps to demonstrate gender dysphoria is indeed a mental health disorder as it is treated initially and largely through clinical interventions.

b. It is not justified to grant protected class status to a mutable psychological diagnosis.

i. Gender dysphoria is a mutable psychological diagnosis.

Some who propose that the gender dysphoric experience is completely normal have advocated for those who identify as transgender to be classified as a federally protected class of people. Ariel Cohen et al., *Shifts in Gender-Related Medical Requests by Transgender and Gender-Diverse Adolescents,* 72 J. Adolesc. Health 428 (2023). The protected class designation gained much traction during the Biden Administration and was reflected in policy changes to § 1557 of the Affordable Care Act, Title IV, and foster care regulations.

The case for the protected class designation is based on how a person thinks and feels about their identity—but thoughts and feelings are mutable and should not be characterized as static traits. Jiska Ristori & Thomas D. Steensma, *Gender Dysphoria in Childhood*, 28 Int'l Rev. Psychiatry 13 (2016); Devendra Singh et al., *A Follow-Up Study of Boys with Gender Identity Disorder*, 12 Frontiers Psychiatry 632784 (2021). There is a mutable quality to all types of emotions associated with dysphoric symptoms as evidenced by the growing population of men and women who are desisting or detransitioning from a transgender identity (*e.g.*, "detrans" support websites like r/detrans). *See r/detrans*, Reddit, https://www.reddit.com/r/detrans/ (last visited Jul. 31, 2026).

To truly be part of a protected class is to suggest that gender dysphoria is a mental health problem that can be characterized as a disability. Yet Congress explicitly rejected this characterization when it excluded "gender identity disorders not resulting from physical impairments" from the Americans with Disabilities Act's (ADA) definition of disability. ADA Nat'l Network, *What Is the Definition of Disability Under the ADA?* (2019), https://adata.org/faq/what-definition-

disability-under-ada. When Congress enacted the ADA in 1990 and amended the Rehabilitation Act in 1992, it explicitly excluded "gender identity disorders not resulting from physical impairments" from the statutory definitions of "disability" and "individual with a disability." 29 U.S.C. § 705(20)(F)(i); 42 U.S.C. § 12211(b).

In December 2025, the Department of Health and Human Services proposed a rule reaffirming this exclusion, clarifying that "gender dysphoria not resulting from physical impairments" is not encompassed by the statutory language Congress enacted—regardless of the DSM's 2013 renaming of the diagnosis. Nondiscrimination on the Basis of Disability in Programs or Activities Receiving Federal Financial Assistance, 90 Fed. Reg. 59,478 (Dec. 19, 2025).

Moreover, for gender dysphoria to be a disability, it would mean that the person experiences a level of psychological distress that has impaired their ability to function and manage their life. ADA Nat'l Network, *Definition of Disability Under the ADA*. In this case, the aim of treatment should be to expand one's psychological capacity to function. This is the goal of clinical and case management work with those who are psychologically disabled. Am. Psych. Ass'n, *Intervention*.

Therefore, any intervention should work towards lessening the key features of the disorder and not to further advance the pathology. For example, psychological treatment would never entail withholding food from someone with anorexia nervosa or giving laxatives to someone suffering from bulimia.

In the same way, it is illogical to affirm a pathology through a treatment protocol that works to embed the cognitive distortions of the dysphoria or advance the condition in the wrong direction. Therefore, even if gender dysphoria was deserving of protected status, it would receive such protection as a disability and therefore remain a medical matter, affirming that the exclusion of parental input would be an egregious violation of parental rights.

ii. Turning gender dysphoria into a civil rights issue would encourage poor clinical practice.

Advocating for expressions of gender dysphoria to be a civil rights issue is detrimental to the patient because this argument conveys that the diagnosis is unchangeable. This argument is not only unsupported by the evidence but is poor clinical practice. When change through appropriate treatment is not only possible but common, that truth should be conveyed to the patient and their parents. Good clinical

practice should aim to resolve or at least ameliorate distress and/or bolster coping skills through proper treatment. To tell someone that their condition is fixed when it is not, is bad practice and can wed a person to their diagnosis, amplifying their suffering. In this way, a civil rights claim has the potential to further the person's belief that they are their diagnosis, rather than being a person with a condition that can be treated. Again, the civil rights proposition runs counter to the vast majority of research addressing gender dysphoria in minors, which has shown that the distress can be attenuated and even resolved. U.S. Dep't of Health & Hum. Servs., *Treatment for Pediatric Gender Dysphoria*.

There is also a commonly occurring phenomenon in the psychological fields in which patients incorporate their diagnosis into their identity. Some refer to this as a mental illness identity, and this can happen when the patient has difficulties separating themselves from a diagnosis. Kristen M. Eddington & E. Badillo-Winard, *Mental Illness Identity: A Scoping Review*, 25 Identity 412 (2024); Joel Paris, *Overdiagnosis in Psych.* (2021). Having clear and attainable treatment goals can help facilitate an understanding that a person's identity is not rooted in a diagnosis and that change is possible, whereas

characterizing the diagnosis as if the symptoms were fixed creates more opportunity for the diagnosis to become one's identity. Eddington & Badillo-Winard, *Mental Illness Identity*; Singh et al., *A Follow-Up Study of Boys*.

Moreover, turning a clinical issue into a civil rights issue could exacerbate the tendency for healthcare professionals to make diagnoses based on trends.[7] The proclivity for clients to take on a mental illness identity and for practitioners to overuse the gender dysphoria diagnosis are highly consequential factors as they can contribute to an inaccurate assessment, a misdiagnosis, and ultimately, a misguided treatment plan. Without an accurate assessment, intervention or treatment will not be properly constructed to target the right issue. Ann Catrine Eldh et al., *Clinical Interventions, Implementation Interventions, and the Potential Greyness in Between—A Discussion Paper*, 17 BMC Health Servs. Res. 16 (2017).

[7] There are numerous indications that the gender dysphoria diagnosis in particular is among the latest cluster of symptoms to be overdiagnosed by the clinical community. Christian J. Bachmann et al., *Gender Identity Disorders Among Young People in Germany: Prevalence and Trends, 2013–2022*, 121 Dtsch. Ärztebl. Int. 370 (2024).

For example, the harms that can follow a loose approach to diagnosis or poorly defined diagnostic criteria can be readily observed in the medical profession. An undiagnosed cardiovascular issue or misdiagnosed disease can result in a delay in treatment and the possibility that the disease is not effectively addressed. This is no less true when it comes to diagnosing and rightly treating a mental health condition. As with the medical profession, the usual practice in the psychological field is to conduct an assessment and determine a mental health diagnosis or a provisional one. Am. Psych. Ass'n, *Intervention*. This helps determine a clear treatment plan, including identifying the appropriate intervention(s) to treat a mental health condition. If professional clinicians are at serious risk of over- or misdiagnosing particularly "popular" disorders, such as gender dysphoria, then granting the power to non-clinician state actors, as EUSD has done here, to prescribe interventions without the necessary assessments or training needed to suggest such a remedy is all the more reason for concern. These concerns are compounded by the lack of sound research into the efficacy of interventions such as social transition. Ultimately, gender dysphoria should not be given protected status because it is a

mutable psychological diagnosis whose status could lead to an increased likelihood of long-term, negative health outcomes for the very people it seeks to protect.

II. California's social transitioning policies should not be enforced against parents' fundamental right to be involved in health care decisions affecting their children when gender dysphoria generally resolves on its own.

a. Healthcare professionals sometimes can make gender dysphoria diagnoses based on bad or partisan science.

Despite numerous scientific reviews of the literature, the intervention, known as "gender affirming care" (GAC), has recently been endorsed by major professional psychological and medical organizations (i.e., American Psychiatric Association; American Academy of Pediatrics; Endocrine Society) as the treatment of choice for gender dysphoria. *See* Am. Acad. of Pediatrics, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents* (2018). This is undoubtedly influenced by the recommendations of WPATH which are rooted in flawed science and political bias.

WPATH recommendations have long been considered the gold standard for treating gender dysphoria in children. However, a growing

body of evidence suggests that WPATH guidance is based on weak evidence and partisan politics rather than sound science. Despite WPATH guidelines emphasizing the importance of quality evidence in evaluating treatment plans, a contributor to the guidelines explained:

> "[o]ur concerns, echoed by the social justice lawyers we spoke with, is that evidence-based review reveals little or no evidence and puts us in an untenable position in terms of affecting policy or winning lawsuits."

United States v. Skrmetti, 605 U.S. 495, 544 (2025) (Thomas, J., concurring) (internal quotations omitted) (citing *Eknes-Tucker v. Governor of Alabama*, 114 F.4th 1241, 1261 (11th Cir. 2024) (Lagoa, J., concurring).

Despite these concerns, WPATH still promotes gender-affirming interventions such as social transitioning as "safe and effective treatments" rooted in "decades of clinical experience and research." *Skrmetti*, 605 U.S. at 544 (Thomas, J., concurring) (citing WPATH guidelines). In reality, these conclusions are the product of a self-referencing consensus where evidence is called insufficient in one breath and used to recommend courses of action in another, all in order to fall in line with other guidelines which make similar

recommendations. *Id.*; Cass, *Independent Review of Gender Identity Services for Children and Young People* 130.

There are also a number of troubling recent revelations that point to WPATH's emphasis on ideology over science. Despite touting gender-affirming treatments as "safe, effective, and well understood, particularly for minors," *Eknes-Tucker*, 114 F.4th at 1268 (Lagoa, J., concurring), an endocrinologist on a WPATH panel acknowledged that teenagers often fail to comprehend the long-lasting impacts of gender-affirming care, calling into question their ability to provide informed consent. *Id.* at 1268-69. Additionally, a recent case in Alabama has revealed that WPATH has a history of tailoring its guidance to achieve legal objectives and to acquiesce to political pressure.[8] These revelations point to what has been true for a long time: WPATH is not politically neutral. *See Kosilek v. Spencer*, 774 F.3d 63, 78 (1st Cir. 2014).

[8] *See* Appendix A to Supplemental Expert Report of James Cantor, PhD, *Boe v. Marshall*, No. 2:22–cv–00184 (MD Ala., June 24, 2024). *See also* Azeen Ghorayshi, *Biden Official Pushed to Remove Age Limits for Trans Surgery*, N.Y. Times, June 27, 2024, https://www.nytimes.com/2024/06/25/health/transgender-minors-surgeries.html.

b. Social transitioning is not a magical cure-all for gender dysphoria.

i. Social transitioning does not improve negative mental health outcomes.

According to the GAC model, the first step for those with gender dysphoria is to intervene by socially transitioning the person, thereby theoretically reducing psychological distress and helping the person embrace a transgender identity. This includes mostly non-medical interventions such as adopting new pronouns, changing identification cards, using sex-segregated spaces that differ from one's biological sex, and changing one's clothing and hair to a more stereotypical presentation that is more consistent with the sex or entity that is the object of their identification. But based on the literature, initiating the social transition part of the GAC model will lead most minors down a path to the most physiologically damaging aspects (*i.e.*, cross-sex hormones, surgeries) of the protocol. Kristina R. Olson et al., *Gender Identity 5 Years After Social Transition* (2022); Zucker, *The Myth of Persistence*. When these children are supported and left to mature without gender affirming care, the majority report a psychological understanding of their identity that matches their biological reality.

Jiska Ristori & Thomas D. Steensma, *Gender Dysphoria in Childhood*, 28 Int'l Rev. Psychiatry 13 (2016); Devendra Singh et al., *A Follow-Up Study of Boys with Gender Identity Disorder, 12 Frontiers Psychiatry* 632784 (2021).

To date, the research on the gender affirming care intervention has primarily focused on physiological procedures, including the use of puberty blockers, cross-sex hormones, and surgical procedures. There is very little data available on the first step of the GAC model. However, national and international governmental health services have recently conducted systematic reviews of the GAC model including social transitioning.[9] The findings from the two most recent reviews showed that the GAC model did little to improve negative mental health outcomes. U.S. Dep't of Health & Hum. Servs., *Treatment for Pediatric Gender Dysphoria.*

[9] Council for Choices in Health Care in Finland, *Recommendation of the Council for Choices in Health Care in Finland (PALKO/COHERE Finland)* (2020); U.S. Dep't of Health & Hum. Servs., *Treatment for Pediatric Gender Dysphoria;* Nat'l Inst. for Health & Care Excellence, *Evidence Review: Gender-Affirming Hormones for Children and Adolescents with Gender Dysphoria* (2020); Cass, *Independent Review of Gender Identity Services*.

Despite the lack of empirical evidence, the social transition step in the gender affirming process has been widely applied by clinicians, paraprofessionals, and school officials alike.[10] While it is the easiest and most accessible step to implement, it is an intervention that has potentially "significant effects." U.S. Dep't of Health & Hum. Servs., *Treatment for Pediatric Gender Dysphoria*; Cass, *Independent Review of Gender Identity Services*.

Studies have repeatedly found that children who are given basic support and/or are left alone (without intervention) to resolve distress about their biology mostly come to embrace their natal sex at a rate that ranges from 65-94%.[11] This means that there is a 65% to 94%

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[10] James S. Morandini et al., *Is Social Gender Transition Associated with Mental Health Status in Children and Adolescents with Gender Dysphoria?*, 52 Archives Sexual Behav. 1045 (2023); Olivia Land, *Calif. Teacher Helps Students Change Names, Pronouns Without Parents' Knowledge,* N.Y. Post (Aug. 29, 2023), https://nypost.com/2023/01/25/calif-teacher-helps-students-change-gender-identity-without-parents-knowledge/; Michael Foust, *'Deceitful': California School Launches 'Transition Closet' for Students Hiding Gender Identity from Parents*, Crosswalk (Mar. 8, 2022), https://www.crosswalk.com/headlines/contributors/michael-foust/deceitful-calif-school-launches-transition-closet-for-students-hiding-identity-from-parents.html.

[11] Jon Brooks, *The Controversial Research on 'Desistance' in Transgender Youth*, KQED (May 23, 2018), https://www.kqed.org/futureofyou/441784/the-controversial-research-on-desistance-in-

success rate when no intervention or a supportive model is applied. In other words, not only does non-intervention have a better success rate than the GAC model, but it is also more successful than most other psychological interventions associated with a DSM diagnosis, which, statistically, show small effect sizes and seem to be subject to ceiling effects.[12] Falk Leichsenring et al., *The Efficacy of Psychotherapies and Pharmacotherapies for Mental Disorders in Adults: An Umbrella Review and Meta-Analytic Evaluation of Recent Meta-Analyses*, 21 World Psychiatry 133 (2022). Unfortunately, those who are encouraged to socially transition tend to progress to the more dangerous and physiological aspects of the GAC model (*e.g.*, cross-sex hormones, surgeries) and often still suffer from dysphoric symptoms.

Therefore, in reality, the GAC model creates two primary outcomes: low to no reduction in pre-existing negative mental health

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transgender-youth; Pien Rawee et al., D*evelopment of Gender Non-Contentedness During Adolescence and Early Adulthood*, 53 Archives Sexual Behav. 1813 (2024); Ristori & Steensma, *Gender Dysphoria in Childhood*; Singh et al., *Follow-Up Study of Boys with Gender Identity Disorder*.

[12] A "small effect size" means a treatment has a weak impact on the underlying condition. A "ceiling effect" occurs when a measurement tool hits an upper limit too easily.

outcomes and the emergence of *new* negative mental health outcomes. The caveat is that negative mental health outcomes are only beginning to emerge in the literature. Some of these investigations have examined those who end GAC or attempt to reverse the social, chemical, and/or surgical procedures initiated by the intervention.[13] The initial findings from this new body of literature reveal that patients are reporting regret at every stage of the GAC model. *Id.* The full effects of this are yet to be seen.

In addition to the reviews of the literature and research on regret, developmental psychology can also highlight reasons why socially transitioning a minor warrants the utmost caution from the clinical and scientific community. In the early years of a child's life, their sense of self is still taking shape and remains particularly sensitive to adult feedback and to the social environment more broadly. S. Harter, *The Construction of the Self: Developmental and Sociocultural Foundations*

[13] Michael S. Irwig, *Detransition Among Transgender and Gender-Diverse People: An Increasing and Increasingly Complex Phenomenon*, 107 J. Clinical Endocrinology & Metabolism e4261 (2022); Kaisa Kettula et al., *Gender Dysphoria and Detransitioning in Adults: An Analysis of Nine Patients from a Gender Identity Clinic from Finland* (2025).

(2d ed. 2012). Decades of cognitive research shows that children in the preoperational and concrete operational stages think in immediate, concrete terms and lack the capacity to reason through long-range implications. Robert S. Siegler et al., *How Children Develop* (7th ed. 2025). This research has since been confirmed using f-MRI technology to scan the brain. The results show that some of the most important neurological strides pertaining to emotional and cognitive development are not achieved until most people are in their twenties. Ajay Nadig et al., *Morphological Integration of the Human Brain Across Adolescence and Adulthood*, 118 Proc. Nat'l Acad. Sci. U.S. e2023860118 (2021). This research reveals that children do not have the capacity to understand the long-term implications of the interventions that are reshaping their identity.

Early research on children's suggestibility adds another layer that reinforces the need for parental involvement: adult cues influence not just what children report, but how they come to understand themselves. Maggie Bruck & S. J. Ceci, *The Suggestibility of Children's Memory,* 50 Ann. Rev. Psych. 419 (1999). When a child adopts a new name, pronouns, and social role, the adults around that child inevitably

respond in ways that reinforce the new identity but is not a neutral reflection of inner certainty. The National Health Service commissioned Cass Review explicitly characterized social transition as "an active intervention" with potentially "significant effects on…psychological functioning." Cass, *Independent Review of Gender Identity Services*, at 158. Social transition is an intervention in the child's developmental environment at a point when identity is still highly unsettled.

The GAC model does not adequately consider other potentially potent etiological or comorbid factors that might best account for the symptoms of gender dysphoria. Lisa Littman, *Parent Reports of Adolescents and Young Adults Perceived to Show Signs of Rapid Onset of Gender Dysphoria*, 14 PLOS ONE e021415 (2019). Some of these factors might include traumatic experiences, psychiatric issues, and autism.[14] This area of research has been neglected despite a general awareness of these social, psychiatric, and medical factors. The Trevor Project, *Gender-Affirming Care for Youth* (Jan. 29, 2020),

[14] Ilan Meyer et al., *LGBTQ People in the United States: Select Findings from the Generations and TransPop Studies* (Williams Inst. 2021); Frew et al., *Gender Dysphoria and Psychiatric Comorbidities in Childhood*; Van der Miesen et al., *Gender Dysphoria and Autism Spectrum Disorder*.

https://www.thetrevorproject.org/research-briefs/gender-affirming-care-for-youth/.

While social transition has been mostly characterized as a psychological and behavioral intervention, there is growing concern that aspects of social transition are causing physiological harm. Thanapob Bumphenkiatikul et al., *Non-Medical Gender Affirming Practices Among Transgender Individuals: A Systematic Review on the Health Implications of Chest Binding and Genital Tucking*, Int'l J. Sexual Health 1, 5 (2025). In fact, in a study conducted by the Department of Health and Human Services, one reviewer noted that parts of social transition should also be considered as physiological interventions because of the potential damage that can occur to the body. U.S. Dep't of Health & Hum. Servs., *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices* (May 1, 2025), https://opa.hhs.gov/sites/default/files/2025-11/gender-dysphoria-report-pre-peer-review-exec-summary.pdf. This can be seen when a female who wants to appear as a male is encouraged to use a breast binder to flatten her chest. A male who wants to appear as a female may be encouraged to tuck his penis and scrotum to hide his genitalia. As

written in the HHS report, "a significant number of negative health implications have been reported [for chest binding], with rates as high as 97.2%", noting that social transition is not without physiological consequences. Bumphenkiatikul, *Non-Medical Gender Affirming Practices Among Transgender Individuals: A Systematic Review on the Health Implications of Chest Binding and Genital Tucking,* at 5.

ii. Social transitioning is especially dangerous when deployed by non-clinicians.

The lack of clarity about the nature of the gender dysphoria diagnosis and its treatment creates misunderstanding regarding who should be allowed to make determinations concerning gender dysphoria. This lack of clarity has created space for paraprofessionals and non-clinically trained and unlicensed individuals to employ the GAC model, which, again, is a clinical intervention. Although the intervention lacks empirical support, it nonetheless remains a model that is associated with a psychological diagnosis. U.S. Dep't of Health & Hum. Servs., *Treatment for Pediatric Gender Dysphoria*; Cass, *Independent Review of Gender Identity Services.* However, unlike California, many state actors are looking at taking steps toward preempting the harmful effects of

deploying the GAC model without due consideration for its long-term efficacy.

As of early 2026, 27 states have enacted legal protections for minors against the physiological steps of the GAC model. Since President Trump began his second term in January 2025, his administration has also pursued protections for minors from these procedures by withholding federal funding to hospitals and public institutions. Exec. Order No. 14,187, 90 Fed. Reg. 8,771 (Feb. 3, 2025). Most of the federal efforts and state-wide bans impact the distribution and administration of puberty blockers, cross-sex hormones, and gender-affirming surgeries for the purposes of engaging in social transition. Although the U.S. Food and Drug Administration (FDA) recently announced that warning letters were sent to 12 manufacturers and retailers for marketing breast binders to children for the purposes of engaging in social transition, little has been done to widely address social transition, and only a few states (such as South Carolina, Tennessee, and Texas) have enacted protections that address this first step to the GAC intervention. U.S. Dep't of Health & Hum. Servs., *HHS Acts to Bar Hospitals from Performing Sex-Rejecting Procedures on Children* (Dec. 18, 2025), https://www.hhs.gov/

press-room/hhs-acts-bar-hospitals-performing-sex-rejecting-procedures-children.html. This part of GAC has remained relatively untouched, and yet, this is where the onboarding process begins for the most notorious aspects of the intervention.

There are two groups that most often apply the social transition intervention to children. First, there are mental health professionals who are credentialed and, therefore, are allowed to use psychological interventions. While this is the appropriate group to employ an intervention, these professionals should stop applying social transition based on reviews of the currently available literature which do not lend support to the GAC model. The literature also demonstrates that the risks outweigh the benefits of treatment and offers no other path for health in both mind and body.[15]

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[15] Nor should clinicians use the intervention because of the numerous study questions that have not been asked about social transition, like, "What are the long-term psychological and sociological effects of engaging in social transition?" This question has serious implications for the developing minor and the coherence of his or her identity. There is also a lack of understanding about if and how known comorbidities contribute to gender dysphoria. Tabitha Frew et al., *Gender Dysphoria and Psychiatric Comorbidities in Childhood: A Systematic Review*, 73 Austl. J. Psychol. 255 (2021); Aimilia Kallitsounaki & David M. Williams, *Autism Spectrum Disorder and Gender Dysphoria/ Incongruence: A Systematic Literature Review and Meta-Analysis*, 53 J.

The second group commonly using social transition—but without clinical credentials—are educators, school employees, and paraprofessionals. Just as no mental health professional should use the social transition intervention on the basis of weak evidence, no one else should use the intervention either.

As mentioned in the previous section, confusion that surrounds a diagnosis of gender dysphoria has led to poorly crafted treatment assessment and goals. Although the potential ramifications of the social transition intervention are significant, such practice can be easily applied by anyone. Zucker, *The Myth of Persistence*. This fact, combined with the lack of enforcement around the treatment protocol, has resulted in widespread and non-clinical use of a psychological intervention intended to treat the disorder of gender dysphoria.

Social transition intervention has been instituted by schools across the country. This can be readily seen in what has been referred

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Autism & Dev. Disorders 3103 (2023). As previously mentioned, there is some evidence that shows how the practices surrounding social transition can be physiologically damaging, but this, too, has not been thoroughly evaluated. Ruth Hall et al., *Impact of Social Transition in Relation to Gender for Children and Adolescents: A Systematic Review*, 109 Archives Disease Childhood 12, 15 (2024).

to as the gender closets where children can change into the opposite sex's clothing while they are at school and do so without their parents' or caregiver's knowledge (*e.g.*, California, New Mexico, Washington, Texas). The educational system has also been used to promulgate the ideas that describe gender dysphoria. This is seen in school curricula, libraries, and social media platforms. Reading lists with books like Gender Queer and I Am Jazz are read in classrooms and are stocked in libraries with the aim to introduce and normalize the ideas of the gender dysphoria construct to children.[16] Furthermore, curricula and resources for teaching elementary school children about the transgender experience have also been instituted in classrooms. *Creating Safe and Welcoming Schools*, Welcoming Schools, https://welcomingschools.org (last accessed Apr. 22, 2026); GLSEN, *Elementary Resources: Why Begin in Elementary School?* (Feb. 6, 2026), https://www.glsen.org/elementary-resources. This has been done

[16] *Early Childhood: Learning About Gender Identity*, Social Justice Books, https://www.socialjusticebooks.org/booklists/early-childhood/gender (last accessed Apr. 22, 2026); Caitlin Giddings, *15 LGBTQ Books for Kids and Teens Recommended by Queer Librarians, Educators, and Independent Booksellers*, N.Y. Times (June 27, 2024), https://www.nytimes.com/wirecutter/reviews/15-lgbtq-books-for-kids-and-teens/.

without any empirical data on the long-term effects of introducing children to these concepts or the outcomes of implementing the social transition model, with or without parental consent.

CONCLUSION

Because gender-affirming care is coming under increasing scrutiny as currently practiced by clinicians and non-clinicians without parental involvement to the detriment of adolescents claiming gender dysphoria, *amicus curiae* respectfully requests that this Court uphold the permanent injunction.

Dated: August 26, 2026 Respectfully submitted,

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FOR THE NINTH CIRCUIT

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