No. 25-952

United States Court of Appeals for the Second Circuit

JENNIFER VITSAXAKI,

Plaintiff-Appellant,

v.

SKANEATELES CENTRAL SCHOOL DISTRICT,
SKANEATELES CENTRAL SCHOOLS' BOARD OF EDUCATION,

Defendants-Appellees.

On Appeal from the United States District Court
for the Northern District of New York
No. 5:24-CV-00155-DNH-ML, Hon. David N. Hurd

BRIEF OF *AMICUS CURIAE*
THE AMERICAN COLLEGE OF PEDIATRICIANS
IN SUPPORT OF APPELLANT AND REVERSAL

Gene C. Schaerr
Edward H. Trent
Justin A. Miller
SCHAERR | JAFFE LLP
1717 K Street NW, Suite 900
Washington, DC 20006
Telephone: (202) 787-1060
gschaerr@schaerr-jaffe.com

Counsel for Amicus Curiae

JUNE 12, 2025

CORPORATE DISCLOSURE STATEMENT

In accordance with Federal Rule of Appellate Procedure 26.1, *amicus curiae* The American College of Pediatricians states that it is not publicly traded and has no parent corporations. No publicly traded corporation owns 10% or more of *amicus*.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Rule

Other Authorities

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

School policies that facilitate secret social gender transitioning of children unconstitutionally usurp parents' decision-making authority. As Judge Thapar of the Sixth Circuit recently explained, such policies are "beyond troubling" because they "strip[]" parents "of th[e] possibility" to "interven[e] and s[eek] medical help for their [child]." *Kaltenbach v. Hilliard City Schs.*, No. 24-3336, 2025 WL 1147577, at *1–2 (6th Cir. Mar. 27, 2025) (Thapar, J., concurring).

The rise in such misguided policies, like the Policy implemented by the Skaneateles Central School District here, is of great concern to *Amicus*, the American College of Pediatricians ("the College" or "ACPeds"), a national organization of nearly 500 board-certified pediatricians or related specialists with active practices in 46 different states, all dedicated to the health and well-being of children. Formed in 2002, the College is a scientific medical association committed to

[1] *Amicus curiae* has submitted a motion to file this brief because, while Appellant consented to the filing of the brief, Appellee declined. *See* Fed. R. App. P. 29(a)(3). 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.

producing policy recommendations based on the best available scientific research. The College strives to ensure that all children reach their optimal physical and emotional health and well-being.[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

[2] In keeping with these objectives, the American College of Pediatricians, 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://doctors protectingchildren.org/.

addressing the underlying mental health issues such children experience is critical. But social transitioning cannot address these co-occurring 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, 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. That 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, is dangerous. The district court's decision must be reversed.

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 potential effects. And the school district here does so based on blatantly political ideology untethered from biological reality and contrary to valid scientific

evidence. Here, the school district, upon being "apprised" 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 to the restrooms and locker rooms of the opposite sex, will require school personnel to use those alternate names and pronouns and permit access to those single-sex spaces. But the school will only notify the child's parents "as appropriate" in the eyes of the school—that is, only when requested or permitted by the student. JA078, JA080, JA082–084 (Dkt. 23). 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 dismiss Vitsaxaki's complaint should be reversed.

I. The School District's 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]

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.

---

[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/42u7yhm6; Nat'l Insts. of Health, Off. Rsch. on Women's Health, *How Sex and Gender Influence Health and Disease* (Jan. 28, 2015) [archived at https://tinyurl.com/889van4j (last accessed June 10, 2025)]; *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).

[4] Am. Coll. of Pediatricians (ACPeds), *Gender Dysphoria in Children* 1 (Nov. 2018), https://tinyurl.com/4rucnr76 ("ACPeds, *Gender Dysphoria*"). Indeed, "[f]or natal adult males, prevalence 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").

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]

As explained in detail below, efforts to "transition" a child using "gender-affirming care," is a misnomer—as such procedures are specifically designed to *entrench* a mental health condition of gender incongruence while leading to a child's permanent sterility, without providing relief from the underlying mental health issues that contributed to the dysphoria in the first place.

B. Gender Incongruence and Dysphoria are Mental Health Issues.

It follows that gender dysphoria, or equivalently, gender identity disorder, is a problem that resides in the mind, not in the body. As

---

[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/y4y93we2.

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]

Unsurprisingly, gender dysphoria is frequently comorbid with anxiety, depression, autism spectrum disorder, and trauma.[8] Accordingly, treating gender dysphoria, especially in children, as a mental health disorder is the appropriate focus for medical providers.

---

[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.

Further, 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 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.

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 GID will no longer experience a GID in

---

[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)).

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 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

---

[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), doi:10.3389/fpsyt.2021.632784 (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).

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

[14] *Id.* at 1818.

overwhelmingly express no gender discomfort after going through puberty.[15]

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] The same is true for children who are started on puberty blockers to address gender confusion.[18]

Accordingly, by pushing social transition, the Policy forces children onto a pathway that will result in life-long hormone interventions and sterilization, all without, in most cases, improved mental health. And inexplicably, the Policy places this monumental healthcare decision

---

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

[18] 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"); Hilary Cass for NHS England, *The Cass Review, Final Report* 176, §14.24 (as amended Dec. 2024), https://tinyurl.com/3mzfckv2 [hereinafter "Cass Review"].

exclusively in the hands of untrained school officials, which denies parents basic information about what is happening to their children.

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.[19] The Policy here does exactly the opposite and keeps it all hidden from the child's parents.

II. Social Transitioning is Medical Treatment.

Vitsaxaki's allegations that social transitioning is medical treatment are also well-founded. For example, 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) (cleaned up), *petition for cert. docketed*

[19] *See* Doctors Protecting Children Decl., *supra* note 2, ¶ 4; Cass Review, *supra* note 18, at 193, §16.8; 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").

sub nom. Peterson v. Doe, No. 24-449 (U.S. Oct. 22, 2024).[20] But the evidence shows that 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 recommended or implemented by untrained school officials behind parents' backs.

A. Pro "Gender-Affirming Care" Advocates Recognize Social Transitioning is a Medical Intervention.

In other contexts, social transitioning is actually promoted as a *medical* intervention for gender dysphoria by the very organizations and individuals who advocate it. For example, one prominent gender clinician and researcher concludes that social transitioning is a course of

[20] *See also Kadel v. Folwell*, 100 F.4th 122, 136, 157 (4th Cir. 2024) (relying on WPATH SOC8 [*see infra* note 25] to describe social transition as gender dysphoria treatment), *petition for cert. docketed,* No. 24-99 (U.S. July 30, 2024) *and docketed sub nom. Crouch v. Anderson*, No. 24-90 (U.S. July 29, 2024); *Fowler v. Stitt*, 104 F.4th 770, 778 (10th Cir. 2024) (recognizing that "treatment" for two plaintiffs, each with gender dysphoria, "includes 'hormone therapy and social transition to living openly" as male or female), *petition for cert. docketed,* No. 24-801 (U.S. Jan. 28, 2025); *Doe 2 v. Shanahan*, 917 F.3d 694, 696 (D.C. Cir. 2019) (Wilkins, J., concurring) (per DSM-5, gender dysphoria is treated with "psychotherapy, hormone therapy, surgery, and changes to gender expression and role," *i.e.*, social transitioning).

treatment.[21] The Cass Review, a comprehensive review of the scientific evidence of medical interventions 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."[22] And the American Academy of Pediatrics included social transitions as part of its guidelines on "Ensuring Comprehensive Care" for "Gender-Diverse" children in 2018.[23]

Even the World Professional Association for Transgender Health (WPATH), a "gender-affirming" advocacy organization,[24] recognizes social transitioning as a "[t]reatment option[]" for gender dysphoria.[25]

---

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

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

[23] *See* Jason Rafferty et al., *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 Pediatrics 72, 77 (2018), https://tinyurl.com/mvs3xfuh.

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

[25] 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*

This from an organization that has been exposed as suppressing results that conflict with its ideological treatment preferences.[26]

Such interventions are not benign but consequential and harmful. Even Dr. Erica Anderson, the first transgender president of USPATH and a former board member of WPATH, who recently resigned from those organizations, has condemned automatic approval of transition upon the request of a child or adolescent. Dr. Anderson noted that "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."[27] Dr. Anderson therefore urges that "a comprehensive bio-psychosocial evaluation" should proceed before allowing a child to transition.[28] Indeed, Dr.

Gender Diverse People: Version 8, 23 Int'l J. Transgender Health, Suppl. 1, S1, S60 (2022) ("WPATH SOC8") (emphasis added).

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

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

[28] *Id.*

Anderson has 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 intervention most children who suffer from gender dysphoria will accept their biological sex by late adolescence.[29]

While the Policy mandates secret "social transitioning," which is a central part of the "unquestioning affirmation" model rejected by both the Cass Review[30] and the recent report from the U.S. Department of Health and Human Services,[31] three other non-"affirming" models of treatment

---

[29] 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. Academy 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 et al., *supra* note 11, at 1895; 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. (2018)*, 19 Int'l J. of Transgenderism 231, 240–41 (2018) ("Zucker, *Myth*").

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

[31] Dep't Health & Hum. Servs., Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices 88–89 (as corrected 2025) [hereinafter "HHS Report"], https://tinyurl.com/2x4enzkn.

has been proposed. *First*, a "watchful waiting" model focuses on treating other psychological comorbidities. *Second*, the "hands-off" approach involves no treatment at all, except for regular follow-up appointments. *Third*, a psychotherapy model focuses on identifying and alleviating the causes of distress. The choice of which model to follow properly rests with a child's parents, not school personnel.

B. Social Transitioning is Controversial and Unproven.

The "unquestioning affirmation" model of treatment, and the use of social transitioning in particular, remain highly controversial among practitioners.[32] Social transitioning is an experimental therapy that has not been shown to improve mental or physical health outcomes in minors.[33] 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

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

[33] 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).

foreclosing this stage of (trans)gender identity development."[34] The Association added that social transition might be "challenging to reverse" even if the person is no longer gender dysphoric.[35] Moreover, no long-term control studies support the use of social transition as a treatment for gender dysphoria in children.[36] The only systematic review of evidence to date reports an "absence of robust evidence of the benefits or harms of social transition for children and adolescents."[37]

Prominent voices have emphasized the severe lack of scientific knowledge in this field. The American Academy of Child and Adolescent Psychiatry has recognized that "[d]ifferent clinical approaches have been advocated for childhood gender discordance," but "no randomized

---

[34] 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).

[35] *Id.* at 750.

[36] Adelson & AACAP, *supra* note 29, 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 29, at 240.

[37] Ruth Hall et al., *Impact of Social Transition in Relation to Gender for Children and Adolescents: A Systematic Review*, 109 Arch. Disease Childhood s12, s12 (2024).

controlled trials of any treatment" exist, so "the proposed benefits of treatment to eliminate gender discordance … must be carefully weighed against ... possible deleterious effects."[38] 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."[39] That is why, consistent with the Cass Review's findings, countries in Europe such as Sweden,[40] Norway,[41] Finland,[42] Germany,[43] Scotland,[44] and others have

---

[38] Adelson & AACAP, *supra* note 29, at 968–69.

[39] APA, *Guidelines*, *supra* note 36, at 842.

[40] 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/5349b4pk.

[41] Jennifer Block, *Norway's Guidance on Paediatric Gender Treatment is Unsafe, Says Review,* 380 BMJ 697, 697 (2023), https://tinyurl.com/yf7dsswu.

[42] 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/47vraxmh.

[43] Resolution Ic-048, Treatment of gender dysphoria in minors, 128th German Med. Assembly (passed May 2024), https://tinyurl.com/2jkrjazm.

[44] Mary McCool, *Scotland's under-18s gender clinic pauses puberty blockers*, BBC (Apr. 18, 2024), https://tinyurl.com/4fsyxmny.

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 Switzerland, New Zealand, Australia, Chile, Netherlands, France, Belgium, and Italy have called for stringent reviews of transgender protocols in their countries.[45] Yet the Policy gives that authority to untrained school personnel without any parental input, let alone input from a trained mental health professional.

C. Social Transitioning Causes Persistence and Long-term Poor Mental Health Outcomes.

Social transitioning, moreover, 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.[46] 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

---

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

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

persistence."[47] 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 adolescence—that is, achieved comfort identifying with his or her natal sex—instead persist in a transgender identity.[48]

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."[49] The fact is that these unproven mental health interventions are not just a kind of

---

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

[48] Zucker, *Myth*, *supra* note 29, at 237; *see also*, Cantor, *supra* note 29 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).

[49] 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).

"civility code," but are treatments with profound and harmful long-term effects on children.

D. 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, with its potential to cause persistence and other long-term poor mental health outcomes, 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. This exclusion of the parents from this medical decision is both alarming and contrary to sound medical practice.

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."[50] And staff without the appropriate clinical training cannot discuss the risks and benefits of social transition.[51] With respect to children, even

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

[51] *Id.* at 164.

WPATH "recommend[s] health care professionals discuss the potential benefits and risks of a social transition with *families* who are considering it."[52]

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. That social transition *can* be done without the involvement of a mental health professional does not mean that it *should* be done—especially without parental input.

III. The School District's Policy is Inconsistent with Sound Medical Practice.

The Policy needs to be evaluated against this backdrop. As shown below, the medical interventions used to socially and then physically "transition" a minor pose enormous risks, have not been shown to reduce other risks associated with gender dysphoria such as suicide, and cannot

[52] WPATH SOC8, *supra* note 25, at S77.

be ethically administered to a child who is incapable of making decisions that entrench a mental condition and lead to permanent, life-altering consequences such as permanent 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. Such subversion is significant as it leads to many other harms, including persistence in a transgender identity and pushing children on a path toward more invasive medical procedures. *See supra* I.C.

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%); 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.[53] They are also "substantially" more likely to abuse alcohol or other substances.[54] Social transitioning does not address these issues, but rather leaves them untreated behind the mask of a false identity.

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,

---

[53] 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).

[54] 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).

and suggesting it is acceptable or necessary to keep secrets from them.[55] Facilitating these behaviors can lead to catastrophe.[56] 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 Leads to More Invasive Medical Procedures.

Social transitioning also significantly increases the likelihood of more invasive medical intervention. As noted above, social transition makes a medical pathway of puberty blockers, cross-sex hormones, and even surgery almost guaranteed when the child would otherwise almost always desist without such efforts.[57] That is why courts have recognized that "no one disputes" that chemical and surgical transition procedures "carry risks" and that there is no conclusive "evidence supporting their

---

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

[56] *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 (Sept. 4, 2023), https://tinyurl.com/bc5ukh4f.

[57] Cass Review, *supra* note 18, at 31; 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.

use." *L.W. ex rel. Williams v. Skrmetti*, 83 F.4th 460, 489 (6th Cir. 2023), *cert. granted sub. nom United States v. Skrmetti,* 144 S. Ct. 2679 (2024) (mem.) (No. 23-477, argued Dec. 4, 2024); *accord Eknes-Tucker v. Gov't of Ala.*, 80 F.4th 1205, 1225 (11th Cir. 2023), *reh'g en banc denied,* 114 F.4th 1241 (11th Cir. 2024).

Regarding hormonal interventions, the first chemical intervention is typically puberty blockers, followed by cross-sex hormones which can lead to surgical alteration to a child's healthy body.[58] And the Cass Review noted that these interventions were *not* proven to be effective.[59] The Cass Review further observed that, "[t]he adoption of a treatment with uncertain benefits without further scrutiny is a significant departure from established practice."[60]

Even setting aside the extreme physical impacts of such treatments on fertility, bone density, and brain development, the impact on mental

---

[58] Maria van der Loos et al., *Children and Adolescents in the Amsterdam Cohort of Gender Dysphoria: Trends in Diagnostic- and Treatment Trajectories During the First 20 Years of the Dutch Protocol,* 20 J. Sexual Med. 398, 398–401 (2023), https://tinyurl.com/2pej8k7k.

[59] Cass Review, *supra* note 18, at 25,¶ 23; *see also* HHS Report, *supra* note 31, at 23, 126, 146.

[60] Cass Review, *supra* note 18, at 25,¶ 23; *see also*, HHS Report, *supra* note 31, at 172–75.

health is also significant. One recent "comprehensive data review of all 3,754 trans-identified adolescents in US military families over 8.5 years showed that cross-sex hormone treatment leads to increased use of me[n]tal health services and psychiatric medications, and increased suicidal ideation/attempted suicide."[61] If the child later elects to undergo surgical transition—including the removal of testes or ovaries—he or she must remain on synthetic hormones until death, even if he or she later detransitions.[62] And the health risks associated with chemical and surgical transition cannot be understated: shortened lifespan, sterility, infertility, loss of sexual function, increased risk of suicide, brain

[61] ACPeds, *Mental Health in Adolescents*, *supra* note 3, at 9, 16 & n.48 (discussing Elizabeth Hisle-Gorman et al., *Mental Healthcare Utilization of Transgender Youth Before and After Affirming Treatment*, 18 J. Sexual Med. 1444 (2021), https://doi.org/10.1016/j.jsxm.2021.05.014).

[62] Guy T'Sjoen et al., *Endocrinology of Transgender Medicine*, 40 Endocrine Reviews 97, 106 (2019) ("Androgen therapy will need to be continued lifelong…."); Deepshika Sudhakar et al., *Feminizing Gender-Affirming Hormone Therapy for the Transgender and Gender Diverse Population: An Overview of Treatment Modality, Monitoring, and Risks*, 42 Neurourology and Urodynamics 903, 904 (2023) ("E2 therapy is often lifelong.").

development issues, cancers, heart disease, heart attacks, strokes, and osteoporosis.[63]

The three mental health treatment models addressed above that do not encourage social transition do not pose these same harms to children. Nor are they subject to the oft-repeated threat that parents must choose between "a live son or a dead daughter." Such statements are both factually wrong and unethical. No studies show that social transition of children or adolescents reduces suicide, prevents suicidal ideation, or

---

[63] Robert Hart, *Transgender People Twice As Likely To Die As Cisgender People, Study Finds*, Forbes (May 16, 2022), https://tinyurl.com/3jwuzu67; Philip J. Cheng et al., *Fertility concerns of the transgender patient*, 8 Translational Andrology & Urology 209, 209 (2019), https://tinyurl.com/4byhevwu; Mauro E. Kerckhof et al., *Prevalence of Sexual Dysfunctions in Transgender Persons: Results from the ENIGI Follow-Up Study*, 16 J. Sexual Med. 2018, 2018, 2024 (2019), https://tinyurl.com/yv6sv4ed (Erratum 17 J. Sexual Med. 830 (2020), https://tinyurl.com/5649zfr9); Gabrielle M. Etzel, *New study finds 12-fold higher risk of suicide attempt for adult transgender patients*, Wash. Examiner (May 17, 2024), https://tinyurl.com/4yrczt7p; Sallie Baxendale, *The impact of suppressing puberty on neuropsychological function: A review*, 113 Acta Paediatrica 1156, 1156, 1163–64 (2024), https://tinyurl.com/m69mbny3; Darios Getahun et al., *Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons,* 169 Annals Internal Med. 205, 206 (2018); Michael Biggs, Letter to Editor, *Revisiting the effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria,* 34 J. Pediatric Endocrinology & Metabolism 937, 937 (2021); Mabel Yau et al., *Pubertal Status at the Time of Fertility Preservation in Transgender Girls*, 30 Endocrine Practice 356, 357–58 (2024).

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 review found that the studies did not support a claim that "gender-affirming treatment reduces suicide risk."[64]

This point was illustrated in a recent Finnish study among a population of 2,083 "gender-referred adolescents." That study revealed that the suicide rate in these adolescents was equal to the suicide rate in 16,643 controls when the groups were matched for underlying mental disorders.[65] In other words, the underlying mental disorder, not the gender dysphoria, was the cause of the suicide.[66] Indeed, while studies demonstrate that transgender adolescents and homosexually identified agemates have elevated rates of suicidal thoughts when compared to

---

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

[65] *Id.* at 96, §5.66.

[66] 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).

peers who are not transgender or homosexually identified,[67] this is not surprising given the higher incidents of co-occurring mental health issues in this population, as noted above. In fact, suicide rates are similar across all stages of transition from pretreatment assessment to post-transition follow-up.[68] Accordingly, proper mental health treatment is needed for gender dysphoric children, not secret social transitioning done by untrained school officials.

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'

---

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

[68] 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).

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.[69]

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."[70] It deters "high-risk behavior" and "generally leads to the best outcomes for teens."[71] 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); *Wisconsin*

---

[69] *See, e.g.*, Lisa Littman, *Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria*, 13 PLoS ONE 1, 16–18 (2018).

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

[71] *Id.* at 460.

v. Yoder, 406 U.S. 205, 232–33 (1972); *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.

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.

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.[72] 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. Indeed, as the Cass Review noted: "The duty of information disclosure is complicated by many 'unknown unknowns' about the long-term impacts of puberty blockers and/or masculinising/feminising hormone during a dynamic developmental period when gender identity may not be settled."[73]

Schools cannot avoid these serious ethical concerns by alleging that some parents will not support their child's decision. Indeed, the law presumes that parents "act in the best interests of their child[.]" *Parham*, 442 U.S. at 604. To override the presumption that parental decision-making is reasonable, there must be "clear and convincing" evidence of harm or abuse, *Troxel v. Granville*, 530 U.S. 57, 69–70 (2000) (citation

---

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

[73] Cass Review, *supra* note 18, 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.

omitted), not a blanket policy like the School District's here. But here, the Policy "not only fail[s] to presume that the plaintiff parents would act in the best interest of their children, [but] assume[s] the exact opposite[.]" *Doe v. Heck*, 327 F.3d 492, 521 (7th Cir. 2003). Secretly socially transitioning a child and intentionally concealing that major psychological intervention is dangerous, unethical, and unconstitutional.

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 reversed.

June 12, 2025

Respectfully submitted,

/s/ Gene C. Schaerr
Gene C. Schaerr
Edward H. Trent
Justin A. Miller
SCHAERR | JAFFE LLP
1717 K Street NW, Suite 900
Washington, DC 20006
Telephone: (202) 787-1060
gschaerr@schaerr-jaffe.com

Counsel for Amicus Curiae
The American College of Pediatricians

CERTIFICATE OF COMPLIANCE

This brief contains 6,969 words excluding the parts of the brief exempted by Fed. R. App. P. 32(f), and complies with the type volume limitation of Fed. R. App. P. 29(a)(5) and Local Rule 29.1(c).

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

Dated: June 12, 2025

/s/ Gene C. Schaerr
Gene C. Schaerr