LIBERTY JUSTICE CENTER
Emily Rae (State Bar No. 308010)
erae@ljc.org
440 N. Wells Street, Unit 200
Chicago, Illinois 60654
Telephone: (312) 637-2280

ATKINSON, ANDELSON, LOYA, RUUD & ROMO
A Professional Law Corporation
Anthony P. De Marco (State Bar No. 217815)
ADeMarco@aalrr.com
William A. Diedrich (State Bar No. 233982)
WDiedrich@aalrr.com
20 Pacifica, Suite 1100
Irvine, California 92618
Telephone: (949) 453-4260
Fax: (949) 453-4264

Attorneys for Defendant
CHINO VALLEY UNIFIED SCHOOL DISTRICT

[Fee exempt Pursuant to Govt. Code § 6103]

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN BERNARDINO

THE PEOPLE OF THE STATE OF CALIFORNIA, EX REL. ROB BONTA, ATTORNEY GENERAL OF THE STATE OF CALIFORNIA,,

Plaintiff,

v.

CHINO VALLEY UNIFIED SCHOOL DISTRICT,

Defendant.

Case No. CIVSB2317301

DECLARATION OF DR. ERICA E. ANDERSON, PHD, IN SUPPORT OF DEFENDANT'S OPPOSITION TO PLAINTIFF'S APPLICATION FOR A PRELIMINARY INJUNCTION

Judge: Hon. Michael A. Sachs
Date: October 13, 2023
Time: 8:30 a.m.
Dept.: S28

Complaint Filed: August 28, 2023

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I, Dr. Erica E. Anderson, declare and state as follows:

1. I am a clinical psychologist currently practicing in Berkeley, California. I received a Ph.D. in clinical psychology from Fuller Theological Seminary in 1978. I have been actively working as a clinical psychologist for over 40 years, with extensive experience working with clients of all ages. I am licensed in California, Minnesota, and formerly Pennsylvania (no longer active there).

2. I have been retained by Defendant to provide an expert medical opinion in this matter regarding the Chino Valley Unified School District's parental notification policy as related to Board Policy 5020.1, which requires school administrators to notify parents if their child requests to be "identified or treated as a gender other than the student's biological sex or gender listed on the student's birth certificate or any other official records." I have reviewed the Plaintiff's complaint filed in this matter, including its exhibits, and the memorandum of points and authorities in support of Plaintiff's ex parte application for a temporary restraining order and order to show cause regarding a preliminary injunction. My opinions are below. They are based on my own personal knowledge, as applied to the facts of this case, and I could and would testify to them in court if called upon to do so.

I. CREDENTIALS & SUMMARY OF OPINIONS

3. For the past seven years, my work has focused primarily on children and adolescents dealing with gender-identity related issues. Between 2016 and 2021, I served as a clinical psychologist and member of the medical staff with a behavioral pediatrics appointment at the Child and Adolescent Gender Clinic at Benioff Children's Hospital at the University of California, San Francisco. From 2016 to the present, I have also operated a private consulting and clinical psychology practice serving children and adolescents and their parents, as well as adults and couples. During the past seven years, I estimate that I have seen hundreds of children and adolescents for gender-identity-related issues. Many, though not all, have transitioned—either socially, medically, or both—to a gender identity that differs from their natal sex, with my guidance and support.

4. I am a life member of the American Psychological Association and a member of the World Professional Association for Transgender Health (WPATH). I served as the President of the United

States Professional Association for Transgender Health (USPATH) and as a board member for WPATH between 2019 and 2021.

5. I myself am a transgender woman. I was born a natal male, but transitioned to living openly in a female identity in 2011. As a result, I have a unique perspective and shared experience with those exploring their gender identity.

6. A more thorough overview of my professional experience, publications, and list of prior cases I have testified in is provided in my curriculum vitae, a copy of which is attached as Exhibit A.

7. I am being compensated for my time spent in connection with this case at a rate of $500.00 per hour/$750.00 per hour for depositions and time in court.

8. A summary of my opinions is as follows:

a. A child or adolescent who exhibits a desire to change name and pronouns should receive a careful professional assessment prior to transitioning. (Section III).

b. A request to change name and pronouns may be the first visible sign that the child or adolescent may be dealing with gender dysphoria or related coexisting mental-health issues. (Section III.A).

c. A child or adolescent's experience of gender incongruence may be influenced by societal or cultural factors and may or may not persist. (Sections III.B, III.C).

d. A careful assessment by professionals prior to transitioning is critical to understand the causes of the child's or adolescent's feelings of gender incongruence, the likelihood that those feelings will persist, to provide guidance about the implications of any kind of transition, to diagnose and treat any gender dysphoria or coexisting conditions, and to provide ongoing support to both youth and parents during any transition. (Section III.D).

e. Social transition itself is an impactful psychotherapeutic intervention that has the potential to increase the likelihood of persistence of gender incongruence. Transitioning socially can also be psychologically hard to reverse for a child or adolescent. (Section IV).

f. For some children experiencing gender incongruence, social transition is not the best approach. Some cease desiring to transition after an exploratory process and/or therapy to understand the source of their feelings, and some who do transition later come to regret it. (Sections V.A, V.B).

g. Social transition often leads to other medical interventions later in life, some of which are irreversible. (Section V.C).

h. No professional medical association that I am aware of recommends social transition of children and adolescents without a careful assessment and treatment plan. (Section V.D).

i. Parental involvement is necessary to obtain professional assistance for a child or adolescent experiencing gender incongruence, to provide accurate diagnosis, and to treat any gender dysphoria or other coexisting conditions. (Sections VI.A, VI.B, VI.C).

j. A school-facilitated transition without parental consent interferes with parents' ability to pursue a careful assessment and/or therapeutic approach prior to transitioning, prevents parents from making the decision about whether a transition will be best for their child, and creates unnecessary tension in the parent-child relationship. Nor is facilitating a double life for some children, in which they present as transgender in some contexts but cisgender in other contexts, in their best interests. (Sections VI.D, VI.E).

k. No professional medical association that I am aware of recommends that school officials facilitate the social transition of a child or adolescent without parental knowledge and consent. (Section VI.F).

l. The Chino Valley Unified School District's BP 5020.1 parental notification policy is consistent with the best practices of all leading mental health professional associations with respect to parental notification when their children ask to be socially transitioned at school and is more likely to lead to student safety than harm. (Section VII).

II. BACKGROUND ON TERMS AND SOURCES

9. Throughout this report, I use the term "social transition" (and variations) to refer primarily to adopting a new name and/or pronouns that differ from one's natal sex. A social transition can include more than just name-and-pronoun changes—individuals adopting a transgender identity

sometimes change their hairstyle, clothing, or their appearance in other ways, begin using opposite-sex facilities, and/or make other social changes. In the literature, however, the phrase "social transition" is primarily used to refer to name-and-pronoun changes. "Social transition" is used as a contrast to medical transition, which refers to various medical interventions to bring one's physical appearance closer into alignment with one's asserted gender identity, such as puberty blockers, cross-sex hormone therapy, and various surgical interventions. The primary purpose of social transitioning is to relieve the psychological distress associated with having a mismatch between one's natal sex and gender identity.

10. The term "gender dysphoria," as defined in the American Psychiatric Association's current *Diagnostic and Statistical Manual of Mental Disorders* ("DSM-5"), refers to "clinically significant distress or impairment related to gender incongruence" (i.e., a mismatch between one's natal sex and one's felt, perceived, or desired gender identity). I use the phrases "gender incongruence" or "gender variance" as broad catch-all terms for those who experience, perceive, or desire a gender identity that differs from their natal sex. As the DSM-5 notes, not everyone who is gender variant experiences gender dysphoria, in the sense of clinically significant distress. Gender Dysphoria as a psychiatric diagnosis should be appropriately evaluated by a qualified mental health professional.

11. WPATH is a scientific, professional, and educational organization that, among other things, produces a set of recommendations for transgender health care. Its "Standards of Care" document ("SOC") is one of the more widely known and cited set of guidelines for transgender care, though its recommendations are not universally agreed upon by professionals in the field. As noted above, I recently served as the president of USPATH (the United States arm of WPATH) and on the board of WPATH. In late 2021, however, I resigned from my offices within USPATH and WPATH because I disagreed in important respects with some of the directions the organization was going. Until September last year (2022), the latest version of WPATH's SOC was its 7th version, released

in 2012 ("SOC7").[1] The 8th version was released publicly on September 6, 2022 ("SOC8").[2] How the SOC8 will be received by the wider mental health community beyond the WPATH membership remains to be seen. For this reason, and given how recently SOC8 was released, its size, and the time it will take to fully process and consider its recommendations, I rely more heavily in this report on SOC7, though I quote from SOC8 as well.

III. A CHILD OR ADOLESCENT WHO EXHIBITS A DESIRE TO CHANGE NAME AND PRONOUNS SHOULD RECEIVE A CAREFUL PROFESSIONAL ASSESSMENT BEFORE TRANSITIONING

a. A child's or adolescent's request or desire to go by a different name and pronouns is a sign that may indicate the presence of gender dysphoria—and may be the first specific sign.

12. As WPATH notes, "many adolescents and adults presenting with gender dysphoria do not report a history of childhood gender nonconforming behaviors," so "it may come as a surprise to others (parents, other family members, friends, and community members) when a youth's gender dysphoria first becomes evident in adolescence."[3]

13. As WPATH's more recent SOC8 acknowledges, a recent "phenomenon occurring in clinical practice is the increased number of adolescents seeking care who have not seemingly experienced, expressed (or experienced and expressed) gender diversity during their childhood years."[4] Such "late-onset gender dysphoria and [transgender] identification may come as a significant surprise" to parents and others.[5]

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[1] The World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (Version 7, 2012), *available at* https://www.wpath.org/publications/soc ("WPATH SOC7").

[2] *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, WPATH, International J. Trans. Health 2022, Vol. 23, No. S1, S1–S258 (2022), *available at* https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644 ("WPATH SOC8").

[3] WPATH SOC7 at 12.

[4] WPATH SOC8 at S45.

[5] American Psychological Association, *Guidelines for Psychological Practice With Transgender*
(continued)

b. The recent surge of children and adolescents reporting a transgender identity suggests that social and cultural factors may play a significant role.

14. Recent surveys indicate that the number of children and adolescents asserting a transgender identity has dramatically increased in recent years. As WPATH's SOC8 notes, there has been a "sharp increase in the number of adolescents requesting gender care" recently, both in the United States and internationally.[6]

15. Recent surveys also show a significantly higher percentage of young people asserting a transgender identity than older adults. A recent survey by the Pew Research Center reported that 5.1% of adults ages 18–29 identify as transgender or non-binary, whereas only 1.6% of adults ages 30–49 identify as transgender or non-binary.[7] Similarly, a 2021 Gallup poll reported that 2.1% of Gen Z adults (born 1997-2003) identify as transgender (up from 1.8% in 2020), while only 1% of Millenials (born 1981-1996), .6% of Gen X adults (born 1965-1980), and .1% of Baby Boomers (born 1946-1964) reported a transgender identity.[8]

16. These changes are consistent with what I have seen in my clinical practice in recent years. While I have not attempted to quantify this, the number of youth and parents of youth contacting me for assistance with gender-identity issues has increased in recent years, and continues to increase year after year.

17. Various surveys and studies have also shown an increase in the ratio of natal female adolescents reporting gender incongruence. Until recently, more natal male children and adolescents

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and Gender Nonconforming People, APA 70(9):832–64, at 843 (2015) ("APA Guidelines").

[6] WPATH SOC8 at S43.

[7] 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/fact-tank/2022/06/07/about-5-of-young-adults-in-the-u-s-say-their-gender-is-different-from-their-sex-assigned-at-birth/.

[8] Jeffrey M. Jones, *LGBT Identification in U.S. Ticks Up to 7.1%*, Gallup (Feb. 17, 2022), https://news.gallup.com/poll/389792/lgbt-identification-ticks-up.aspx; Jeffrey M. Jones, *LGBT Identification Rises to 5.6% in Latest U.S. Estimate*, Gallup (Feb. 24, 2021), https://news.gallup.com/poll/329708/lgbt-identification-rises-latest-estimate.aspx.

have presented with gender incongruence than natal females, but that ratio has flipped in recent years, with far more adolescent girls experiencing gender incongruence than adolescent boys.[9] WPATH's SOC8, for example, notes that gender clinics in recent years have reported natal female adolescents "initiating care 2.5-7.1 times more frequently as compared to" natal male adolescents.[10]

18. That change in the sex ratios of children and adolescents asserting a transgender identity is consistent with my experience in my clinical practice. In the last few years, I estimate that I see roughly twice as many natal female adolescents for gender-identity-related issues than natal male adolescents. I also conduct parent consultations for gender-related issues much more often for natal female youth.

19. To my knowledge, to date these dramatic changes in the population of children and adolescents reporting a transgender identity and the differences between age cohorts have not been adequately studied or explained, but these statistics suggest that cultural and/or societal factors may contribute—even substantially—to a young person's experience of gender variance.[11] Indeed, WPATH SOC8 acknowledges that the recent phenomenon of "adolescents seeking care who have not seemingly experienced, expressed (or experienced and expressed) gender diversity during their childhood years" suggests that for some young people, "susceptibility to social influence impacting gender may be an important differential to consider."[12]

c. A child's or adolescent's experience or perception of a transgender identity may or may not persist.

20. Multiple studies across different groups and times have reported that, for the vast majority of children, gender incongruence does not persist (most of these studies involved children who did

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[9] *E.g.*, Kenneth J. Zucker, *Adolescents with Gender Dysphoria: Refections on Some Contemporary Clinical and Research Issues*, Archives of Sexual Behavior 48(7) at 1983–1992 (2019).

[10] WPATH SOC8 at S43.

[11] *See* WPATH SOC8 at S44 (noting that "research [has] demonstrated [that] psychosocial and social factors also play a role").

[12] WPATH SOC8 at S45.

not transition). As WPATH notes, these studies show a persistence rate between 6% and 27%.[13] One researcher summarized these studies as follows: "every follow-up study of [gender diverse] children, without exception, found the same thing: Over puberty, the majority of [gender diverse] children [identifying before puberty] cease to want to transition."[14]

21. In my clinical practice, I have worked with youth who, after a period of exploration and therapy as appropriate, ultimately conclude that they no longer desire to transition to a different gender identity.

d. When children or adolescents begin to experience gender incongruence, they should receive a careful evaluation and assessment by a professional mental health provider before transitioning, for a variety of reasons.

22. Given the broad variety of factors that can contribute to a child's or adolescent's experience of gender incongruence and the reality that those feelings may be transitory, a mental health provider's first job is a careful evaluative process to understand the causes of the child's or adolescent's gender incongruence, assess the likelihood that those feelings will persist, and to help the child or adolescent and their parents process those feelings and make decisions about next steps.[15]

23. WPATH's SOC7, for example, recommends a "thorough assessment" of "gender dysphoria and mental health" to "explore the nature and characteristics of a child's or adolescent's gender identity," as well as a "psychodiagnostic and psychiatric assessment" that covers "areas of emotional functioning, peer and other social relationships, and intellectual functioning/school achievement," "an evaluation of the strengths and weaknesses of family functioning," any "emotional or behavioral problems," and any "unresolved issues in a child's or youth's environment."[16] Similarly, the

[13] WPATH SOC7 at 11.

[14] James M. Cantor, *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, Journal of Sex & Marital Therapy, 46(4), 307–313 (2019).

[15] *See* WPATH SOC8 at S45 ("Since it is impossible to definitively delineate the contribution of various factors contributing to gender identity development for any given young person, a comprehensive clinical approach is important and necessary.").

[16] WPATH SOC7 at 15.

Endocrine Society recommends "a complete psychodiagnostic assessment" including "an assessment of the decision-making capability of the youth."[17] Endocrinology is the subspecialty in medicine having to do with hormones. Pediatric endocrinologists are the physicians who prescribe puberty blockers or cross-sex hormones in the gender clinics.

24. While young people sometimes "self-transition," responsible mental health practice requires that this assessment should occur *before* a child or adolescent socially transitions. WPATH SOC7 notes that mental health professionals "should strive to maintain a therapeutic relationship with gender nonconforming children/adolescents and their families throughout any *subsequent* social changes," (i.e., after the diagnostic process it recommends), which "ensures that decisions about gender expression and the treatment of gender dysphoria are thoughtfully and recurrently considered."[18] Similarly, the Endocrine Society's Guidelines "advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of [a mental health provider] or another experienced professional."[19]

25. In my practice, consistent with WPATH's recommendations, I employ a comprehensive evaluative and exploratory process before recommending any form of transition, including a social transition, and I certainly would never recommend any kind of medical interventions before a careful assessment. My clients often find this process helpful—and many of them seek it out—even if they ultimately transition, which many do.

26. Another reason for a comprehensive assessment by a mental health professional is to determine whether and to what extent the child or adolescent is experiencing gender dysphoria (i.e., clinically significant distress associated with their experience of gender incongruence). As noted above, not every child or adolescent who exhibits gender variance experiences distress about that variance, but many do, and, as WPATH notes and I have personally encountered in my practice,

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[17] Wylie C. Hembree, et al., *Endocrine Treatment of Gender-Dyshporic/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, Endocrine Society, J Clin Endocrinol Metab, 102(11):3869–3903 at 3877 (Nov. 2017) ("Endocrine Society Guidelines").

[18] WPATH SOC7 at 16.

[19] Endocrine Society Guidelines at 3870.

children and adolescents can be "intensely distressed about it" and require professional support.[20]

27. Yet another reason for a professional assessment is to identify and address any coexisting mental health concerns. Gender incongruence is often accompanied by other mental health issues, like anxiety, depression, self-harm, and others. WPATH's SOC8, for example, notes studies showing that transgender youth have higher rates of depression, emotional and behavioral problems, suicide attempts and ideation, self-harm, eating disorders, autism spectrum disorders/characteristics, and other mental health challenges than the general population.[21] Thus, WPATH and other professional associations recommend screening children and adolescents presenting with gender incongruence for coexisting mental health issues and treating those as necessary.[22]

28. The assistance of a mental-health professional can also be critically important *during* any social transition. As the Endocrine Society's Guidelines note, a social transition "may test the person's resolve, the capacity to function in the affirmed gender, and the adequacy of social, economic, and psychological supports," and processing the transition is often "a major focus of the counseling" during the transition.[23] I have seen firsthand the benefits of having professional support during a social transition. In my experience, youth are not always prepared for all of the challenges associated with transitioning.

IV. SOCIAL TRANSITION IS AN IMPORTANT PSYCHOTHERAPEUTIC INTERVENTION THAT CAN CHANGE OUTCOMES IN CHILDREN AND ADOLESCENTS

a. Multiple respected voices agree that social transition does or may affect gender identity outcomes, increasing the likelihood that identification with a transgender identity will persist.

29. As noted above, numerous studies prior to the widespread adoption of social transition reported that gender incongruence did not persist through adolescence for a majority of children

[20] WPATH SOC7 at 12.

[21] WPATH SOC8 at S62.

[22] WPATH SOC7 at 24–25; Endocrine Society Guidelines at 3876; APA Guidelines at 845.

[23] Endocrine Society Guidelines at 3877.

who experience it.

30. By contrast, a recent study of 317 transgender youth found that, 5 years after transitioning, 94% continued to identify as transgender, whereas only 6% had retransitioned back to a cisgender or nonbinary identity.[24] A significant difference between this study and the prior studies is that all of the children in this study had already socially transitioned. The dramatic difference in persistence rates reported in prior studies and this and similar studies of children who have transitioned demands an explanation and raises multiple questions. While there are a variety of possible explanations for this difference in persistence rates, one possible explanation that cannot yet be ruled out is that social transition itself has a causal effect on persistence rates by reinforcing a child's or adolescent's beliefs about their identity.

31. Indeed, multiple well-respected researchers in this area have raised this concern. A study in 2013, which reported higher persistence rates among children who had transitioned, noted that "[c]hildhood social transitions were important predictors of persistence, especially among natal boys. Social transitions were associated with more intense GD in childhood, but have never been independently studied regarding the *possible impact of the social transition itself on cognitive representation of gender identity or persistence*."[25] The authors went on to note that "the hypothesized link between social transitioning and the cognitive representation of the self" may "influence the future rates of persistence."[26] "Until there is more knowledge about this mechanism," the authors wrote, they endorsed the approach in WPATH SOC7 of deferring to parents and helping them "weigh the potential benefits and challenges" and "make decisions regarding the timing and process of any gender role changes for their young children."[27]

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[24] Kristina R. Olson, *Gender Identity 5 Years After Social Transition*, Pediatrics 2022;150(2):e2021056082 (Aug. 2022), https://doi.org/10.1542/peds.2021-056082.

[25] Steensma, T. D., at al., *Factors Associated with Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study*. Journal of the American Academy of Child & Adolescent Psychiatry, 52(6), 582–590, at 588 (2013).

[26] *Id*. at 589.

[27] *Id*. (quoting WPATH SOC7 at 17).

32. Another well-known researcher and long-time practitioner in this field, Dr. Kenneth J. Zucker, commented on this study as follows: "With the emergence in the last 10–15 years of a pre-pubertal gender social transition as a type of psychosocial treatment [citations omitted]—initiated by parents on their own (without formal clinical consultation) or with the support/advice of professional input—it is not clear if the desistance rates reported in the four core studies will be 'replicated' in contemporary samples. Indeed, the data for birth-assigned males in Steensma et al. (2013a) already suggest this: of the 23 birth-assigned males classified as persisters, 10 (43%) had made a partial or complete social transition prior to puberty compared to only 2 (3.6%) of the 56 birth-assigned males classified as desisters. Thus, *I would hypothesize that when more follow-up data of children who socially transition prior to puberty become available, the persistence rate will be extremely high*."[28] Dr. Zucker then adds that, in his view, "parents who support, implement, or encourage a gender social transition (and clinicians who recommend one) are implementing a psychosocial treatment that will increase the odds of long-term persistence."

33. The Endocrine Society Guidelines also recognize that "[s]ocial transition is associated with the persistence of GD/gender incongruence as a child progresses into adolescence. It may be that the presence of GD/gender incongruence in prepubertal children is the earliest sign that a child is destined to be transgender as an adolescent/adult (20). However, social transition (in addition to GD/gender incongruence) has been found to contribute to the likelihood of persistence."[29]

34. A recent, comprehensive review by Dr. Hillary Cass of the U.K.'s model of transgender care, notes that "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. There are different views on the benefits versus the harms of early social transition. Whatever position one takes, it is important to acknowledge that it is not a neutral act, and better information is needed

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[28] Zucker, K., *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.*, International Journal of Transgenderism 19(2) 231–245 (2018).

[29] Endocrine Society Guidelines at 3879.

about outcomes."[30]

35. I share the concerns of these researchers and writers that transitioning may affect the likelihood of persistence, *especially* transitions without a careful assessment by a mental health professional prior to transitioning.

36. Again, the effects of social transition on a child's or adolescent's psychological development are still open to conjecture and hypothesis, since, to my knowledge, there have not yet been adequate long-term studies of social transitions during childhood or adolescence, as this is a relatively recent phenomenon. Indeed, WPATH's SOC8, released last year acknowledges that "there is a dearth of empirical literature regarding best practices related to the social transition process."[31]

37. WPATH and others have acknowledged that, in light of the paucity of long-term evidence about the effects, social transitions during childhood and adolescence are a controversial issue among mental-health professionals in this field. WPATH's SOC7, for example, notes that "[Social transition in early childhood] is a controversial issue," that "divergent views are held by health professionals," and that "[t]he current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood."[32] Another group of researchers that is attempting to study this recently wrote: "Relatively unheard-of 10 years ago, early childhood social transitions are a contentious issue within the clinical, scientific, and broader public communities. [citations omitted]. Despite the increasing occurrence of such transitions, we know little about who does and does not transition, the predictors of social transitions, and *whether transitions impact children's views of their own gender*."[33]

38. Thus, while social transition is too often described as nothing more than a harmless "exploration" of gender and identity, at this time we cannot rule out that a social transition may have

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[30] Cass, H., *Independent review of gender identity services for children and young people: Interim report* (2022), https://cass.independent-review.uk/publications/interim-report/.

[31] WPATH SOC8 at S76.

[32] *See* WPATH SOC7 at 17.

[33] James R. Rae, *Predicting Early-Childhood Gender Transitions*, Psychological Science Vol. 30(5) 669–681 at 669–70 (2019).

a causal effect on a child's or adolescent's future development of their internal sense of identity. On the contrary, the early research we have is consistent with the hypothesis that social transition causes some children to persist who otherwise might have desisted from experiencing gender dysphoria and transgender identification.

b. Social transition erects psychosocial barriers to potential desistence.

39. One way in which social transition may *decrease desistence* is the psychological difficulty children and adolescents may face in transitioning back to an identity aligned with their natal sex after publicly transitioning to a transgender identity.

40. One group of researchers, in a qualitative study of 25 gender variant youth, found that "some girls, who were almost (but not even entirely) living as boys in their childhood years, experienced great trouble when they wanted to return to the female gender role."[34] In light of that possibility, they "suggest[ed] a cautious attitude towards the moment of transitioning." I agree.

41. WPATH also recognizes that "[a] change back to the original gender role can be highly distressing and even result in postponement of this second social transition on the child's part."[35] So does the Endocrine Society: "If children have completely socially transitioned, they may have great difficulty in returning to the original gender role upon entering puberty."[36]

42. In short, a social transition represents one of the most difficult psychological changes a person can experience. For all these reasons embarking upon a social transition based solely upon the self-attestation of the youth without consultation with parents and appropriate professionals is unwise.

43. Further to place teachers in the position of accepting without question the preference of a minor and further direct such teachers to withhold the information from parents concerning their

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[34] Steensma, T. D., et al., *Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study*, Clin. Child. Psychol. Psychiatry (Jan. 7, 2011), http://ccp.sagepub.com/content/early/2011/01/06/1359104510378303.

[35] WPATH SOC7 at 17; *see also* WPATH SOC8 at S78 ("Another often identified social transition concern is that a child may suffer negative sequelae if they revert to the former gender identity that matches their sex designated at birth.").

[36] Endocrine Society Guidelines at 3879.

minor children is hugely problematic.

V. SOCIAL TRANSITION IS NOT ALWAYS THE BEST OPTION FOR A CHILD OR ADOLESCENT

a. Some children and adolescents stop wanting to transition after an exploratory process to understand the cause of their feelings and self-perceptions.

44. As discussed above, multiple studies have reported that many children who experience gender incongruence ultimately revert to identifying with their natal sex. I personally have worked with youth, who, after an exploratory and therapeutic process, ultimately decided that transitioning was not the best approach for them.

45. WPATH's SOC8 argues that "recognition that a child's gender may be fluid and develop over time [citations omitted] is not sufficient justification to negate or deter social transition for a pre-pubescent child when it would be beneficial."[37] I understand the SOC8's caveat, "when it would be beneficial," as an implicit recognition that a social transition is not *always* beneficial for every child or adolescent experiencing gender incongruence. Indeed, SOC8 repeatedly "emphasizes the importance of a nuanced and individualized clinical approach to gender assessment,"[38] both for children and for adolescents.[39] While SOC8's focus is on medical interventions, the same is true for social transitions.

46. WPATH's SOC8 asserts that the fluidity of gender variance during youth is not a reason to "negate or deter social transition," however, the reality that gender variant feelings can be fluid for many young people warrants caution before making any significant changes, including a social transition. Part of a mental-health provider's role is to counsel patients to exercise caution and

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[37] WPATH SOC8 at S76.

[38] WPATH SOC8 at S68.

[39] WPATH SOC8 at S45 ("Given the emerging nature of knowledge regarding adolescent gender identity development, an individualized approach to clinical care is considered both ethical and necessary.").

explore what they are feeling before making major changes.[40]

b. We are becoming more aware of cases in which young people have transitioned and later desist or are detransitioning.

47. Yet another reason for caution is the growing awareness of "detransitioners"—youth who previously transitioned to a transgender identity but later decide to revert to an identity that aligns with their natal sex. Many of these youth express regret about their prior transition.[41] Some go further and express anger at providers who they feel gave them an inadequate evaluation.[42]

48. This population has not yet been adequately studied or quantified—indeed it has only recently been acknowledged in the literature—but the existence of this population is undeniable at this point.[43] WPATH's SOC8 recognizes that "detransitioning may occur in young transgender adolescents and health care professionals should be aware of this."[44]

49. In a recent survey of 237 detransitioners (92% of which were natal females), 70% reported that one reason for their detransition was the realization that their "gender dysphoria was related to other issues."[45] Half reported that transition did not help with the dysphoria, and 34% reported that their dysphoria "resolved itself over time." Nearly half of those surveyed (45%) reported "not feeling properly informed about the health implications of the accessed treatments and interventions before undergoing them." And 60% listed "learning to cope with feelings of regret" as one of their

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[40] *E.g.*, APA Guidelines at 843 (noting that, for adolescents in which "late-onset gender-dysphoria and TGNC identification [ ] come[s] as a significant surprise," "[m]oving more slowly and cautiously in these cases is often advisable.").

[41] WPATH SOC8 at S47.

[42] *E.g.*, Grace Lidinsky-Smith, *There's No Standard for Care When it Comes to Trans Medicine*, Newsweek (June 25, 2021), https://www.newsweek.com/theres-no-standard-care-when-it-comes-trans-medicine-opinion-1603450.

[43] *E.g.*, Irwig, M.S., *Detransition Among Transgender and Gender-Diverse People—An Increasing and Increasingly Complex Phenomenon*, J. Clin. Endocrinology & Metab. (June 9, 2022), https://doi.org/10.1210/clinem/dgac356.

[44] WPATH SOC8 at S47.

[45] Vandenbussche, E., *Detransition-Related Needs and Support: A Cross-Sectional Online Survey*, Journal of Homosexuality, 69:9, 1602–1620 (2022).

psychological needs during the detransitioning process.

50. The recent and dramatic increase in the number of natal female adolescents who assert a transgender identity, and the reality reflected in the study above that a subset of these later detransition and regret transitioning, also warrants caution before rushing into a social transition. As WPATH acknowledges, this recent trend among adolescent girls may be driven in part by "excessive peer and social media influence."[46] A number of recent surveys have documented a significant deterioration in the health of adolescents in recent years, especially during the pandemic and among adolescent girls.[47] We are also becoming increasingly aware of the effect of social media on adolescent girls in particular—that population appears to be uniquely susceptible to negative mental health outcomes and imitations of behavior related to heavy social media use.[48]

51. I regularly monitor an online community of detransitioners on reddit (/r/detrans), and have observed many similar stories reported in that online community.

52. The potential for a difficult detransition process in the future and regret over a prior transition are important considerations that a mental-health provider should help a child or adolescent and their parents understand before they decide to undertake a social transition.

c. Social transition sets children down a path that often leads to medical interventions.

53. Yet another reason for caution is that social transition often leads to medical interventions, many of which have permanent, long-term effects (or the effects are not yet fully known).[49] Not everyone who socially transitions goes on to pursue medical interventions, but many do.

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[46] WPATH SOC8 at S58.

[47] *E.g.*, CDC, *Adolescent Behaviors and Experiences Survey* (Mar. 31, 2022), https://www.cdc.gov/healthyyouth/data/abes.htm

[48] *E.g.*, Amy Orben, *Windows of development sensitivity to social media*, Nature Communications 13, 1649 (2022); Robert H. Shmerling, *Tics and TikTok: Can social media trigger illness?*, Harvard Health Publishing, Harvard Medical School (Jan. 18, 2022), https://www.health.harvard.edu/blog/tics-and-tiktok-can-social-media-trigger-illness-202201182670.

[49] *E.g.*, WPATH SOC8 at S46 (noting the "lifelong implications of medical treatment").

54. In the Olson study discussed above, only 37 of the 317 participants (11.7%) had started puberty blockers when the study began. By the end of the study (five years later), 190 of the 317 participants (59.9%) had started either puberty blockers and/or cross-sex hormones.[50]

55. The fact that a high percentage of children who socially transition later feel the need to undergo medical interventions to maintain or further align their appearance with the identity adopted during a social transition further highlights the fact that social transition is itself a major health and mental health decision that may lead to important long-term consequences in the life of the child, for good or ill. This is itself an important consideration that children and adolescents, and their parents, should understand and weigh when deciding whether to undertake a social transition. Without the involvement of a mental health professional, they are unlikely to obtain the information and counsel necessary to make an informed decision.

d. Social transition upon request without assessment and a treatment plan is not endorsed by *any* medical or mental health organization.

56. For the reasons I have explained above, an assessment process and plan can be critically important *before* a child or adolescent transitions. I recognize that some children and adolescents do socially transition before meeting with a mental-health professional. But the fact that some individuals and families disregard sound practice is a problem that mental health professionals and schools should work to address, not a reason to ignore sound practice.

57. As far as I am aware, no medical or mental health organization recommends that adults facilitate a social transition upon a child or adolescent's request without a careful evaluation by an appropriately trained mental health professional. WPATH's SOC7 recommends a careful, psychological assessment and guidance from a mental health professional to help parents "weigh the potential benefits and challenges" of a social transition.[51] The Endocrine Society's Guidelines "advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional" (the

[50] Olson (2022) at 2, 4.

[51] WPATH SOC7 at 14–15, 17.

guidelines do not say anything different about adolescents).[52] The American Psychological Association recommends that "[p]sychologists are encouraged to complete a comprehensive evaluation and ensure the adolescent's and family's readiness to progress," to discuss "the advantages and disadvantages of social transition during childhood and adolescence" with parents and their children, and to assist parents and their children with "developmentally appropriate decision-making about their education, health care, and peer networks, as these relate to children's and adolescent's gender identity and gender expression."[53]

58. While its recommendations focus on medical interventions, WPATH's SOC8 likewise recognizes that "a comprehensive clinical approach is important and necessary" and recommends "a comprehensive biopsychosocial assessment of adolescents who present with gender-identity concerns."[54] SOC8 even emphasizes that "[t]reatment in this context (e.g., with limited or no assessment) has no empirical support and therefore carries the risk that the decision to start gender-affirming medical interventions may not be in the long-term best interest of the young person at that time."[55]

59. In a few places, although it is not entirely clear about this, certain statements in SOC8 could be read to suggest that social transition should be implemented immediately upon the request of a child or adolescent. SOC8 says that "social transition should originate from the child and reflect the child's wishes in the process of making the decision to initiate a social transition process,"[56] and that any "efforts at blocking reversible social expression or transition [like] choosing not to use the youth's identified name and pronouns" are "disaffirming behaviors" that are always inappropriate

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[52] Endocrine Society Guidelines at 3870.

[53] APA Guidelines at 843.

[54] WPATH SOC8 at S45, S50; *see also id.* ("Given the emerging nature of knowledge regarding adolescent gender identity development, an individualized approach to clinical care is considered both ethical and necessary.").

[55] WPATH SOC8 at S51.

[56] WPATH SOC8 at S76.

and equivalent to conversion therapy.[57]

60. To the extent that one reads these statements as an endorsement of the view that children and adolescents should always immediately be allowed to socially transition upon request, this goes too far. As I have noted above, social transition may not in fact be easily "reversible." As a result, it can be appropriate for parents to say "no" to a social transition (whether at school or elsewhere) to, among other things, allow time for assessment and exploration with the help of a mental health professional before making such a significant change. Part of parents' job is to help their children avoid making bad decisions. That ordinary parental role is not remotely comparable to or properly characterized as "conversion therapy." As WPATH's SOC7 recognizes, it is appropriate for parents to decide whether to "allow" a social transition for their children.[58] Neither SOC 7 nor SOC 8 suggest that school personnel should decide whether a minor should socially transition, let alone doing so and hiding this information from parents.

VI. PARENTAL INVOLVEMENT IS ESSENTIAL AT EVERY STAGE IN THE PROCESS

a. Parental involvement is essential as a practical matter in order for a child or adolescent to be seen by a mental-health provider.

61. Aside from a few limited exceptions, medical and mental-health providers generally cannot see or treat a minor without informed consent from the parent(s)/legal guardian(s), both as a matter of state laws and as a matter of medical ethics.[59]

62. As WPATH's section on adolescents recognizes, many adolescents lack the "skills for future thinking, planning, big picture thinking, and self-reflection" that are necessary for informed decision-making.[60] Adolescents' decisions are often influenced by factors that are unrelated to their

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[57] WPATH SOC8 at S53.

[58] WPATH SOC7 at 17.

[59] *E.g.*, WPATH SOC8 at S61 ("In most settings, for minors, the legal guardian is integral to the informed consent process: if a treatment is to be given, the legal guardian (often the parent[s]/caregiver[s]) provides the informed consent to do so.").

[60] WPATH SOC8 at S62.

long-term best interests, like "a sense of urgency that stems from hypersensitivity to reward," a "heightened focus on peer relationships," and "increased risk-taking behaviors."[61] In light of the ongoing and unfinished development of emotional and cognitive maturity during adolescence, "[i]n most settings, for minors, the legal guardian is integral to the informed consent process."[62]

63. Parental involvement is also necessary as a practical matter. Many children and adolescents could not get to any appointments with a mental-health provider without their parents' assistance. And most children and adolescents do not have their own health insurance and would have no way to pay for those appointments.

64. For these and other reasons, in my practice, I will not (nor have I ever, that I can recall) see a minor child or adolescent without informed consent from a parent/legal guardian. During my years at the Child and Adolescent Gender Clinic at UCSF, we routinely would decline to see minors without a parent present. And our standard practice was to obtain an informed consent form from a parent prior to initiating any form of treatment. If a minor presented for treatment without a parent present or if there were questions about which parent had decision-making authority, we would cease further contact until we could confirm that we had proper informed consent from the parent or parents with decision-making authority.

b. Parental involvement is important for accurate diagnosis, as parents often have a critical perspective on the history and likely causes of a child's or adolescent's gender questioning feelings.

65. Parents are often the only people who have frequently and regularly interacted with a child or adolescent throughout the child's or adolescent's entire life, and therefore they have a unique view of the child's development over time. Indeed, parents often have more knowledge than even the child or adolescent does of whether their child or adolescent exhibited any signs of gender incongruence or gender dysphoria during the earliest years of life.

66. Thus, parental involvement is a critical part of the diagnostic process to evaluate how long

[61] WPATH SOC8 at S44.

[62] WPATH SOC8 at S61.

the child or adolescent has been experiencing gender incongruence, whether there might be any external cause of those feelings, and a prediction of how likely those feelings are to persist.

67. WPATH, for example, notes that "parent(s)/caregiver(s) may provide key information for the clinical team, such as the young person's gender and overall developmental, medical, and mental health history as well as insights into the young person's level of current support, general functioning, and well-being."[63]

68. And, as WPATH notes, "a parent/caregiver report may provide critical context in situations in which a young person experiences very recent or sudden self-awareness of gender diversity and a corresponding gender treatment request, or when there is concern for possible excessive peer and social media influence on a young person's current self-gender concept."[64] In my practice, it is a common occurrence that the reconstructed history from a child or adolescent does not match the reported history from the parent. Likewise, children and adolescents often acknowledge that they have consumed many hours of social media from other transgender youth and have absorbed these experiences in some personal way.

69. Indeed, WPATH's SOC8 recommends "involving parent(s) or primary caregiver(s) in the assessment process … in almost all situations," and adds that "including parent(s)/caregiver(s) in the assessment process to encourage and facilitate increased parental understanding and support of the adolescent may be one of the most helpful practices available."[65] In my practice, I find it critical that I, the parents, and the child come to consensus about the truth about each individual child.

70. In assessing an individual child or adolescent, it is my own practice to meet with the parent(s) before seeing a child or adolescent, to get their perspective on when, where, and how their child's feelings began, and I will often meet with parents throughout the assessment process as well, as necessary.

[63] WPATH SOC8 at S58.

[64] WPATH SOC8 at S58.

[65] WPATH SOC8 at S58.

c. Parental involvement is necessary for treatment of gender dysphoria and/or other diagnosed coexisting conditions.

71. Given the need for informed consent, as explained above, parental involvement is a necessary prerequisite for any kind of treatment by a medical professional, whether for gender dysphoria or any coexisting mental-health condition. For example, a child experiencing depression/anxiety related to gender incongruence ordinarily could not receive counseling or medication to treat the depression/anxiety without the informed consent of a parent/guardian.

72. Parents should also be involved to make important decisions about next steps for their minor child or adolescent, especially given the somewhat complicated risk-benefit calculus in this context and the limited knowledge about long-term effects and outcomes. WPATH's SOC7, for example, recommends that mental health professionals "help *families* to make decisions regarding the timing and process of any gender role changes for their young children," and to provide "counsel and support" even "[i]f parents do not allow their young child to make a gender role transition."[66] Similarly, WPATH's SOC8 recommends that mental health providers "should provide guidance *to parents/caregivers* and supports to a child when a social gender transition is being considered" and to "facilitate the parents/caregivers' success in making informed decisions about the advisability and/or parameters of a social transition for their child."[67]

73. In my practice, I always contact the parent(s) at the end of the assessment process to share my thoughts and recommendations so that they can ultimately make the decision about what is best for their child.

d. A school-facilitated transition without parental consent and buy-in interferes with the parents' ability to pursue a careful, investigative assessment before undergoing a gender identity transition.

74. If a school facilitates a social transition at school without parental consent and buy-in, it necessarily interferes with the parents' ability to take a cautious approach and pursue an evaluation and assessment before allowing their child or adolescent to make significant changes to their identity.

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[66] WPATH SOC7 at 17.

[67] WPATH SOC8 at S78.

75. A school-facilitated transition without parental consent also interferes with parents' ability to pursue a treatment approach that does not involve an immediate transition—such as an exploratory process to understand the cause of the feelings or self-perceptions of gender incongruence.

76. Finally, a school-facilitated transition without parental consent necessarily interferes with the parent(s') ability to say "no" to a social transition, which can be appropriate in some circumstances.

e. A school-facilitated transition without parental consent and buy-in creates unnecessary and additional tension in the parent-child relationship.

77. A school-facilitated transition over the objection of parents (or possibly worse, without their knowledge) necessarily creates tension in the parent-child relationship. A common principle in the training for psychotherapists who work with children and adolescents is to never create or aggravate any tensions in the parent-child relationship. By facilitating a social transition at school over the parents' objection or without their knowledge, a school would drive a wedge between the parent and child.

78. Similarly, facilitating a double life for some children, in which they present as transgender in some contexts but cisgender in other contexts, is not in their best interest.

79. WPATH recognizes that "social transition for children typically can only take place with the support and acceptance of parents/caregivers."[68] Likewise, "adolescents are typically dependent on their caregivers/parents for guidance in numerous ways," including as they "navigate[ ] through the process of deciding about treatment options."[69]

80. As WPATH notes elsewhere, "[p]arent and family support of TGD youth is a primary predictor of youth well-being."[70] Circumventing, bypassing, or excluding parents from decisions about a social transition undermines the main support structure for a child or adolescent who

[68] WPATH SOC8 at S77.

[69] WPATH SOC8 at S49.

[70] WPATH SOC8 at S58.

desperately needs support.

f. No professional body that I am aware of has endorsed school-facilitated social transition of minors without parental knowledge and consent.

81. I am not aware of any professional body that has endorsed school-facilitated social transitions without parental consent. As noted above, WPATH's SOC7 recommends that *mental-health professionals* advise, but ultimately defer to, parents whether or not they "allow their young children to make a social transition to another gender role."[71] The Endocrine Society's Guidelines "advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional" (which would require the informed consent of the parents).[72] And the American Psychological Association advises psychologists to discuss "the advantages and disadvantages of social transition during childhood and adolescence" with parents and their children, to promote discussion between parents and their children about "developmentally appropriate decision making."[73]

VII. CONCLUDING SUMMATION OF OPINIONS

82. In light of the above, it is my expert opinion that Chino Valley Unified School District's policies encouraging and facilitating parental involvement and decision-making regarding the care of their gender incongruent or gender dysphoric children are consistent with widely accepted mental health principles and practice relating to parental notification when their child or adolescent expresses a desire to be socially transitioned at school. Specifically, I am not aware of any professional body that would endorse the State of California's position, which encourages policies that envision adult personnel socially transitioning a child or adolescent without evaluation of mental health professionals and without parental involvement.

83. When a child presents with a desire to use a new name or pronouns, the very first step should be to notify parents and involve them in the process of considering whether the child should undergo

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[71] WPATH SOC7 at 17.

[72] Endocrine Society Guidelines at 3870.

[73] APA Guidelines at 843.

a careful professional assessment by a mental health professional with expertise in child gender incongruence.

84. Social transition is an impactful psychotherapeutic intervention. It may or may not be the best therapeutic approach for any specific child. Parents must be notified and involved in the process to determine whether social transition is appropriate. Chino Valley Unified School District's BP 5020.1 facilitates this process. Any contrary policies that may require immediate social transition of children who request it may increase persistence among children who may have desisted had they received evaluation by a competent mental health professional. Persistence for such children is not in their best long-term interest.

85. Finally, Chino Valley Unified School District's policies are consistent with best practices relating to parental notification when their child or adolescent expresses a desire to be socially transitioned at school insofar as they encourage and facilitate maintaining the relationship between parents and their children. Best mental health practices abhor activity that maintains secrets between children and their parents, which create distrust and tension. In all cases, parental consent is required to provide medical and psychological treatment to minors. In part, this is because the science of mental health recognizes that the best evidence regarding a minor's mental and emotional well-being comes from first-hand accounts by parents, rather than potentially biased accounts from immature children.

86. In sum, the Chino Valley Unified School District's policies, which include parental involvement and decision-making regarding the care of their children, are consistent with best mental health practices relating to parental notification when their child or adolescent expresses a desire to be socially transitioned at school.

I declare under penalty of perjury under the State of California that the foregoing is true and correct.

Executed on October 2, 2023, in Berkeley, California.

Dr. Erica Anderson

Erica E. Anderson, PhD