25-952

In the 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
Case No. 5:24-cv-155

AMICUS BRIEF OF DR. ERICA E. ANDERSON, PhD, SUPPORTING APPELLANT AND REVERSAL

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Dr. Erica E. Anderson, PhD, is a clinical psychologist practicing in California and Minnesota with over 45 years of experience and is transgender. Between 2019 and 2021, Dr. Anderson served as a board member for the World Professional Association for Transgender Health (WPATH) and as the President of USPATH (the United States arm of WPATH). Since 2016, Dr. Anderson's work has focused primarily on children and adolescents dealing with gender-identity-related issues, at the Child and Adolescent Gender Clinic at Benioff Children's Hospital at the University of California, San Francisco (2016 to 2021), and at a private consulting and clinical psychology practice (2016 to present). She has seen hundreds of children and adolescents for gender-identity-related issues in that time, many of whom transition, with her guidance and support.

As a practitioner serving children and adolescents experiencing gender incongruence, Dr. Anderson has a strong interest in ensuring that

[1] No party's counsel authored this brief in whole or in part. No party or party's counsel contributed money that was intended to fund preparing or submitting this brief. No person—other than the amicus curiae, its members, or its counsel—contributed money that was intended to fund preparing or submitting this brief.

such children receive the best possible support and assistance (whether or not they ultimately transition), which, in her view, requires involving their parents.

INTRODUCTION

The Skaneateles Central School District, like other school districts around the country, maintained a policy allowing minor children to secretly adopt a new gender identity at school, requiring all staff to treat them as though they were the opposite sex, without parental notice or consent. Numerous mental health professionals believe that a gender-identity transition during childhood is a profound and difficult treatment decision and that parental involvement is critical for many reasons: to properly assess the underlying sources of the child's feelings; to evaluate the risks and benefits of a transition; to identify and address any coexisting issues; to provide ongoing support; and ultimately, to decide whether a transition will be in their child's best interests.

Yet the District Court held that this is not a healthcare decision, but merely a decision related to the "manner of instruction" that school districts may not only exclude parents from but also hide from them. And it held this on a motion to dismiss, contrary to the allegations in the

complaint and the opinions of many well-respected mental health professionals in the field. This Court should reverse.

ARGUMENT

I. Whether a Minor Experiencing Gender Incongruence Should Transition Socially Is a Major and Potentially Life-Altering Health-Related Decision That Requires Parental Involvement, for Many Reasons.

When children and adolescents express a desire to socially transition to a different gender identity (to change their name and pronouns to ones at odds with their natal sex), there is a major fork in the road. Questions arise about whether a transition will be in the youth's best interests, especially considering this decision comes with potentially lifelong implications. Parents must be involved in this decision, for many reasons.

First, there is an ongoing debate in the mental health community about how quickly and under what conditions children and adolescents who experience gender incongruence (a mismatch between their natal sex and perceived or desired gender identity) should transition socially. Childhood social transitions were "[r]elatively unheard-of 10 years ago"

but have become far more frequent in recent years.[2] Before the recent trend in some circles to immediately "affirm" every child's and adolescent's expression of a desire for an alternate gender identity, a robust body of research had found that, for the vast majority of children (roughly 80 to 90 percent), gender incongruence does not persist.[3] As one researcher summarized, "*every* follow-up study of GD [gender diverse] children, without exception, found the same thing: Over puberty, the majority of GD children cease to want to transition."[4]

These studies were conducted before the recent trend to quickly transition, whereas some newer studies of youth who *have* socially transitioned show much higher rates of persistence. A study in 2013 found that "[c]hildhood social transitions were important predictors of

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[2] James R. Rae, et al., *Predicting Early-Childhood Gender Transitions*, 30(5) Psychological Science 669–681, at 669–70 (2019), https://doi.org/10.1177/0956797619830649.

[3] *See*, *e.g.*, The World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* ("WPATH SOC7") at 11 (Version 7, 2012), *available at* https://gendergp.s3.eu-west-2.amazonaws.com/media/Standards-of-Care-V7-2011-WPATH.pdf.

[4] James M. Cantor, *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, 46(4) Journal of Sex & Marital Therapy 307–313 (2019), https://doi.org/10.1080/0092623X.2019.1698481.

persistence, especially among natal boys."[5] Another recent study of 317 transgender youth found that 94% continued to identify as transgender five years after transitioning.[6]

Considering the vastly different rates of persistence between youth who transition and those who do not, many experts in the field are concerned that a social transition may affect the likelihood that a child's or adolescent's experience of gender incongruence will persist.

In the UK, for example, a recent, comprehensive review of the evidence by the National Health Service concluded that "social transition in childhood may change the trajectory of gender identity development for children with early gender incongruence."[7] This review also found that "those who had socially transitioned at an earlier age and/or prior to being seen in clinic were more likely to proceed to a medical pathway,"

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[5] T. D. Steensma, et al., *Factors Associated with Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study*, 52(6) Journal of the American Academy of Child & Adolescent Psychiatry 582–590, at 588 (2013), https://doi.org/10.1016/j.jaac.2013.03.016.

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

[7] Hilary Cass, *Independent review of gender identity services for children and young people: Final report* at 31–32 (April 2024), https://cass.independent-review.uk/home/publications/final-report/.

with all the associated risks and complications. In view of this evidence, the report concluded that "parents should be actively involved in decision making" about a social transition.[8]

Dr. Kenneth Zucker, who for decades led "one of the most well-known clinics in the world for children and adolescents with gender dysphoria," has argued that a social transition can "become[ ] self-reinforcing" because "messages from family, peers, and society do a huge amount of the work of helping form, reinforce, and solidify gender identities."[9] He has also written that "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."[10]

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[8] *Id.* at 163.

[9] Jesse Singal, *How the Fight Over Transgender Kids Got a Leading Sex Researcher Fired*, The Cut (Feb. 7, 2016), https://www.thecut.com/2016/02/fight-over-trans-kids-got-a-researcher-fired.html.

[10] Kenneth J. Zucker, *The myth of persistence: Response to "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender non-conforming children" by Temple Newhook et al.*, 19(2) International Journal of Transgenderism 231–245 (2018), available at https://www.researchgate.net/publication/325443416.

The authors of the 2013 study referenced above expressed concern that "the hypothesized link between social transitioning and the cognitive representation of the self" may "influence the future rates of persistence," while noting that this "possible impact of the social transition itself on cognitive representation of gender identity or persistence" had "never been independently studied," Steensma (2013), *supra* n.5, at 588–89.

Another group of researchers recently wrote that "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*." Rae (2019), *supra* n.2, at 669–70 (emphasis added).

The Endocrine Society's guidelines similarly 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."[11]

The World Professional Association for Transgender Health (WPATH), which takes a decidedly pro-transitioning stance, has acknowledged that "[s]ocial transitions in early childhood" are "controversial," that "health professionals" have "divergent views," that "[f]amilies vary in the extent to which they *allow* their young children to make a social transition to another gender role," and that there is insufficient evidence "to predict the long-term outcomes of completing a gender role transition during early childhood." WPATH SOC7, *supra* n.3, at 17.[12]

In short, when a child or adolescent expresses a desire to change name and pronouns to another gender identity, mental health

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[11] Wylie C. Hembree, et al., *Endocrine Treatment of Gender-Dyshporic/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, Endocrine Society, 102(11) J Clin. Endocrinol. Metab. 3869–3903, at 3879 (2017), https://doi.org/10.1210/jc.2017-01658.

[12] The latest version of WPATH's standards of care guidelines (version 8) continues to acknowledge that "there is a dearth of empirical literature regarding best practices related to the social transition process." *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, WPATH, 23 International J. Trans. Health 2022 S1–S258, at S76 (2022), *available at* https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644.

professionals do not universally agree that the best decision, for *every* such child or adolescent, is to immediately "affirm" their desire and begin treating that child or adolescent as the opposite sex. And whether transitioning will be helpful or harmful likely depends on the individual child or adolescent. As WPATH emphasizes, "an individualized approach to clinical care is considered both ethical and necessary." WPATH SOC8, *supra* n.12, at S45.

While the mental health community continues to debate whether socially transitioning is generally beneficial or not, it is beyond dispute that there is currently little solid evidence about who is right, given how recent a trend this is. *See supra* n.12.

Even setting aside the debate about socially transitioning, there is near universal agreement that, when a child or adolescent exhibits signs of gender incongruence (and a request to change name/pronouns would qualify), each should be considered separately and individually and can benefit from the assistance of a mental health professional, for multiple reasons.

Every major professional association recommends a thorough professional evaluation to assess, among other things, the underlying

causes of the child's or adolescent's feelings and consider whether a transition will be beneficial. The American Psychological Association, for example, recommends a "comprehensive evaluation" and consultation with the parents and youth to discuss, among other things, "the advantages and disadvantages of social transition during childhood and adolescence."[13] The Endocrine Society likewise recommends "a complete psychodiagnostic assessment." *Supra* n.11, at 3877. WPATH, too, recommends a comprehensive "psychodiagnostic and psychiatric assessment," covering "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." WPATH SOC7, *supra* n.3, at 15.[14] WPATH also recommends that mental health professionals "discuss the

[13] American Psychological Association, *Guidelines for Psychological Practice With Transgender and Gender Nonconforming People*, 70(9) APA 832–64, at 843 (2015), https://www.apa.org/practice/guidelines/transgender.pdf.

[14] WPATH SOC8, *supra* n. 12, at S45, likewise states that "a comprehensive clinical approach is important and necessary," "[s]ince it is impossible to definitively delineate the contribution of various factors contributing to gender identity development for any given young person."

potential benefits and risks of a social transition with families who are considering it." WPATH SOC8, *supra* n.12, at S69.

A professional assessment is especially important given the "sharp increase in the number of adolescents requesting gender care" recently, particularly among adolescent girls ("2.5-7.1 times" adolescent boys). WPATH SOC8, *supra* n.12, at S43. As WPATH acknowledges, an increasing number of "adolescents [are] seeking care who have not seemingly experienced, expressed (or experienced and expressed) gender diversity during their childhood years," indicating that "social factors also play a role," including "susceptibility to social influence." *Id.* at S44–S45.

There is also growing awareness of adolescents who come to "regret gender-affirming decisions made during adolescence" and later "detransition," which many find to be a "difficult[ ]" and "isolating experience." *Id.* at S47. In one recent survey of 237 detransitioners (over 90% of which were natal females), 70% said they realized their "gender

dysphoria was related to other issues," and half reported that transitioning did not help.[15]

Another reason for professional involvement is to assess whether the child or adolescent needs mental health support. Many experience dysphoria—psychological distress—associated with the mismatch between their natal sex and perceived or desired gender identity. Indeed, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders' (DSM-V) official diagnosis for "gender dysphoria" is *defined by* "clinically significant distress." *See What Is Gender Dysphoria?*, American Psychiatric Association.[16]

Gender incongruence is also frequently associated with other mental health issues. WPATH's SOC8 surveys studies showing that transgender youth have higher rates of depression, anxiety, self-harm, suicide attempts, eating disorders, autism spectrum disorders, and other emotional and behavioral problems than the general population. *Supra*

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[15] Elie Vandenbussche, *Detransition-Related Needs and Support: A Cross-Sectional Online Survey*, 69(9) Journal of Homosexuality 1602–1620, at 1606 (2022), https://doi.org/10.1080/00918369.2021.1919479.

[16] American Psychiatric Association, *What is Gender Dysphoria?* https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria.

n.12, at S62–63. All major professional organizations recommend screening for these coexisting issues and treating them if needed. *Id.*; APA Guidelines, *supra* n.13, at 845; Endocrine Society Guidelines, *supra* n.11, at 3876.

Finally, professional support can be vital *during* any transition. A transition can "test [a young] person's resolve, the capacity to function in the affirmed gender, and the adequacy of social, economic, and psychological supports," and "[d]uring social transitioning, the person's feelings about the social transformation (including coping with the responses of others) is a major focus of [ ] counseling." Endocrine Society Guidelines, *supra* n.11, at 3877.

It should go without saying, but parents cannot obtain a professional evaluation, screen for dysphoria and other coexisting issues, or provide professional mental health support for their children, if their school hides from them what is happening at school.

To summarize, no professional association recommends that teachers and school officials, who have no expertise whatsoever in these issues, should facilitate a social transition while at school, treating minors as if they are really the opposite sex, in secret from their parents.

II. Parental Decision-Making Authority Over Their Minor Children Includes the Right to be Involved in How School Staff Refer to Their Child While at School.

A long line of cases from the United States Supreme Court establishes that parents have a constitutional right "to direct the upbringing and education of children under their control." *Troxel v. Granville*, 530 U.S. 57, 65 (2000) (plurality op.) (quoting *Pierce v. Society of Sisters*, 268 U.S. 510, 534–35 (1925)). This is "perhaps the oldest of the fundamental liberty interests recognized by [the Supreme] Court," *Troxel*, 530 U.S. at 65 (plurality op.), and is "established beyond debate as an enduring American tradition," *Wisconsin v. Yoder*, 406 U.S. 205, 232 (1972). It is a "basic civil right[ ] of man," *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942), "far more precious … than property rights," *May v. Anderson*, 345 U.S. 528, 533 (1953).

This line of cases establishes four important principles with respect to parents' rights.

First, parents are the primary decision-makers with respect to their minor children—not their school, or even the children themselves. *Parham v. J. R.*, 442 U.S. 584, 602 (1979) ("Our jurisprudence historically has reflected … broad parental authority over minor children."); *Troxel*,

530 U.S. at 66 (plurality op.) ("[W]e have recognized the fundamental right of parents to *make decisions* concerning the care, custody, and control of their children.") (emphasis added); *Yoder*, 406 U.S. at 232 (emphasizing the "primary role of the parents in the upbringing of their children"). Parental decision-making authority rests on two core presumptions: "that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions," *Parham*, 442 U.S. at 602, and that "natural bonds of affection lead parents to act in the best interests of their children," far more than anyone else. *Parham*, 442 U.S. at 602; *Yoder*, 406 U.S. at 232 ("The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children.").

Second, parental rights reach their peak, and thus receive the greatest constitutional protection, on "matters of the greatest importance." *See C.N. v. Ridgewood Bd. of Educ.*, 430 F.3d 159, 184 (3d Cir. 2005) (calling this "the heart of parental decision-making authority"); *Yoder*, 406 U.S. at 233–34. One such area traditionally reserved for parents is medical and health-related decisions. As the United States Supreme Court recognized long ago: "Most children, even

in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment. Parents can and must make those judgments." *Parham*, 442 U.S. at 603.

Third, a child's disagreement with a parent's decision "does not diminish the parents' authority to decide what is best for the child." *Parham*, 442 U.S. at 603–04. *Parham* illustrates how far this principle goes. That case involved a Georgia statute that allowed parents to voluntarily commit their minor children to a mental hospital (subject to review by medical professionals). *Id.* at 591–92. A committed minor argued that the statute violated his due process rights by failing to provide him with an adversarial hearing, instead giving his parents substantial authority over the commitment decision. *Id.* at 587. The Court rejected the minor's argument, confirming that parents "retain a substantial, if not the dominant, role in the [commitment] decision." *Id.* at 603–04. "The fact that a child may balk at hospitalization or complain about a parental refusal to provide cosmetic surgery does not diminish the parents' authority." *Id.* at 604.

Fourth, the fact that "the decision of a parent is not agreeable to a child or … involves risks does not automatically transfer the power to

make that decision from the parents to some agency or officer of the state." *Parham*, 442 U.S. at 603. Likewise, the unfortunate reality that some parents "act[ ] against the interests of their children" does not justify "discard[ing] wholesale those pages of human experience that teach that parents generally do act in the child's best interests." *Id.* at 602–03. The "notion that governmental power should supersede parental authority in *all* cases because *some* parents abuse and neglect children" is "statist" and "repugnant to American tradition." *Id.* at 603 (emphasis in original). Thus, as long as a parent is fit, "there will normally be no reason for the State to inject itself into the private realm of the family to further question the ability of that parent to make the best decisions concerning the rearing of that parent's children." *Troxel*, 530 U.S. at 68–69 (plurality op.).

In accordance with these principles, courts have recognized that a school violates parents' constitutional rights if it attempts to usurp their role in significant decisions. In *Gruenke v. Seip*, 225 F.3d 290 (3d Cir. 2000), for example, a high school swim coach suspected that a team member was pregnant, and, rather than notifying her parents, discussed the matter with other coaches, guidance counselors, and teammates, and

eventually pressured her into taking a pregnancy test. *Id.* at 295–97, 306. The mother sued the coach for a violation of parental rights, explaining that, had she been notified, she would have "quietly withdrawn [her daughter] from school" and sent her to live with her sister until the baby was born. *Id.* at 306. "[M]anagement of this teenage pregnancy was a family crisis," she argued, and the coach's "failure to notify her" "obstruct[ed] the parental right to choose the proper method of resolution." *Id.* at 306. The court found that the mother had "sufficiently alleged a constitutional violation" against the coach and condemned his "arrogation of the parental role": "It is not educators, but parents who have primary rights in the upbringing of children. School officials have only a secondary responsibility and must respect these rights." *Id.* at 306–07.

The school district's policy violates parents' decision-making authority in at least three different ways.

First, the policy violates parents' constitutional right to make the decision about whether a social transition is in their child's best interest. When children or adolescents experience gender dysphoria, the decision whether they should socially transition is a significant and impactful

health-related decision that falls squarely within "the heart of parental decision-making authority," *C.N.*, 430 F.3d at 184; *Parham*, 442 U.S. at 603. As described in more detail above, there is an ongoing debate among mental health professionals over how to respond when a child experiences gender incongruence, and, in particular, whether and when children should socially transition by being addressed as though they were the opposite sex.

The District's policy takes this life-altering decision out of parents' hands and places it with educators and young children, who lack the "maturity, experience, and capacity for judgment required for making life's difficult decisions." *Parham*, 442 U.S. at 602. By enabling children to transition at school, in secret from parents, without parental involvement, the District is effectively making a treatment decision without the legal authority to do so and without informed consent from the parents. Given the significance of changing gender identity, especially at a young age, parents "can and must" make this decision. *Parham*, 442 U.S. at 603.

A child's fear that his or her parents might not support a transition is not sufficient to override their decision-making authority. Parents' role

is sometimes to say "no" to protect their children from decisions against their long-term interests.

Second, the District's policy also violates parental rights by concealing a serious mental health issue from parents, circumventing their involvement altogether on this sensitive issue. *See H. L. v. Matheson*, 450 U.S. 398, 410 (1981) (parents' rights "presumptively include[ ] counseling [their children] on important decisions"); *Arnold v. Bd. of Educ. of Escambia Cnty., Ala.*, 880 F.2d 305, 313 (11th Cir. 1989). Parents cannot guide their children through difficult decisions without knowing what their children are facing. By allowing secrecy from parents about this one issue, the District's policy effectively substitutes school staff for parents as the primary source of input for children navigating difficult decisions, with long-term implications. *See Gruenke*, 225 F.3d at 306–07.

Third, the policy interferes with parents' ability to provide professional assistance that their children may urgently need. As explained above, gender dysphoria can be a serious psychological issue that requires support from mental health professionals. And gender incongruent children often present other psychiatric co-morbidities,

including depression, anxiety, suicidal ideation and attempts, and self-harm. Teachers and staff do not have the training and experience necessary to properly diagnose children with gender dysphoria or to opine and advise on the treatment options. They cannot provide professional assistance for children dealing with these issues, and parents cannot obtain it either for their child if they are kept in the dark. Thus, parents must be notified and involved not only to make the decision about whether a social transition is in their child's best interest, but also to obtain professional support for their child.

Other courts and judges are beginning to recognize that policies to exclude parents from gender transitions at school violate parents' constitutional rights. In Wisconsin, parents were forced to remove their 12-year-old daughter, who was struggling with various mental health issues, from a school that refused to respect their decision about how their daughter should be addressed. After being removed from that environment, the daughter changed her mind about wanting to transition, realizing that her struggle with her gender was related to

other issues.[17] The parents sued their school district, and a Wisconsin court held that the district violated their parental rights. *T.F. v. Kettle Moraine Sch. Dist.*, No. 21-CV-1650, 2023 WL 6544917 (Wis. Cir. Ct. Oct. 3, 2023).[18] As the Court put it, "The School District could not administer medicine to a student without parental consent. The School District could not require or allow a student to participate in a sport without parental consent. Likewise, the School District [cannot] change the pronoun of a student without parental consent without impinging on a fundamental liberty interest of the parents." *Id.* The Court enjoined the District from "allowing or requiring staff to refer to students using a name or pronouns at odds with the student's biological sex, while at school, without express parental consent." *Id.*

The District Court for the Southern District of California denied a motion to dismiss in a similar case, holding that parents "have a

[17] She shares part of her story here (starting at 2:30): https://www.youtube.com/watch?v=PJJdq3vW21w&t=265s.

[18] Although the parents in this case raised claims under the Wisconsin Constitution, the Wisconsin Supreme Court has long held that the Wisconsin Constitution provides "the same equal protection and due process rights afforded by the Fourteenth Amendment to the United States Constitution." *E.g.*, *Mayo v. Wisconsin Injured Patients & Families Comp. Fund*, 2018 WI 78, ¶ 35, 383 Wis. 2d 1, 914 N.W.2d 678. Thus, the Circuit Court's opinion relied heavily on federal parental rights cases.

constitutional right to be accurately informed by public school teachers about their student's gender incongruity that could progress to gender dysphoria, depression, or suicidal ideation, because it is a matter of health." *Mirabelli v. Olson*, 761 F. Supp. 3d 1317, 1332 (S.D. Cal. 2025). Another district court granted a preliminary injunction against such a policy, after which the case settled. As that court put it, a parent's "constitutional right includes the right … to have an opinion and to have a say in what a minor child is called and by what pronouns they are referred." *Ricard v. USD 475 Geary Cnty., KS Sch. Bd.*, No. 5:22-cv-4015, 2022 WL 1471372 (D. Kan. May 9, 2022).

There is also a growing chorus of appellate judges who have commented critically on similar policies in cases where the majority resolved the case on some ground other than the merits. Judge Niemeyer, for example, wrote that a similar policy was "effectively a nullification of the constitutionally protected parental rights," by "granting the school the prerogative to decide what kinds of attitudes are not sufficiently supportive for parents to be permitted to have a say in a matter of central importance in their child's upbringing." *John & Jane Parents 1 v. Montgomery Cnty. Bd. of Educ.*, 78 F.4th 622, 646 (4th Cir. 2023)

(Niemeyer, J., dissenting) (the majority concluded the parents lacked standing). Judge Thapar, in an appeal dismissed solely for lack of a final, appealable order, called a similar policy "beyond troubling." *Kaltenbach v. Hilliard City Schs.*, No. 24-3336, 2025 WL 1147577, at *1 (6th Cir. Mar. 27, 2025) (Thapar, J., concurring).

Judge McHugh wrote that a school policy "to help students conceal their gender identities from their parents" "impedes parents' longstanding, fundamental right." *Lee v. Poudre Sch. Dist. R-1*, 135 F.4th 924, 936–38 (10th Cir. 2025) (McHugh, J., concurring). "While the district may disagree with how some parents may react when they learn about their children's gender identities, the district may not seize control of a child's upbringing based on a 'simple disagreement' about what is in the child's best interests." *Id.* (Judge McHugh concurred with the majority, however, that the policy was not a sufficient cause of the plaintiff's injuries to support a *Monell* claim).

Three Justices of the Wisconsin Supreme Court, in yet another case similar to this one, reasoned that "social transitioning is a healthcare choice for parents to make," and that putting a school district "in charge of enabling healthcare choices without parental consent" deprives

parents of their constitutionally protected "decision-making [authority] for their children." *Doe 1 v. Madison Metro. Sch. Dist.*, 2022 WI 65, ¶¶ 89, 92, 94, 403 Wis. 2d 369, 976 N.W.2d 584 (Roggensack, J., dissenting) (again, the majority did not reach or discuss the merits).

III. None of the District Court's Reasons Justify Excluding Parents from This Decision.

The District Court made multiple errors in its analysis. First, the Court erroneously framed this case as a challenge to "the manner of instruction employed by the district." J.A. 110. Appellant's claim has nothing at all to do with the "manner of instruction." Parents of course cannot dictate a school's curriculum, but they retain decision-making authority over their minor children. When a major decision-point arises—like whether staff will treat their child as the opposite sex—schools must defer to parents, even if the issue surfaces at school. Indeed, the Third Circuit has drawn this exact distinction, emphasizing that exposing children to an objectionable survey is not "of comparable gravity" to "depriv[ing] [parents] of their right to make decisions concerning their child." *C.N.*, 430 F.3d at 184. That is what is at stake here. Schools cannot give children a Tylenol without parental consent. A social transition is far more serious; parents must be involved.

Second, the District Court erroneously held that treating a child as the opposite sex is not a "healthcare decision." J.A. 112. Many professionals disagree and view a social transition during childhood as a form of "psychosocial treatment." *Supra* Part I. Even WPATH lists "[c]hanges in gender expression and role" *first* among "[t]reatment options" for gender dysphoria. WPATH SOC7, *supra* n.3, at 9. Regardless, it does not ultimately matter whether treating a child as the opposite sex is characterized as "mental health treatment" or not. The Constitution protects parents' authority to make all kinds of decisions with respect to their minor children, *supra* Part II, which sometimes includes saying "no." And a gender-identity transition during childhood is a major decision with long-term implications.

Finally, the District Court suggested that the policy is justified "to maintain a *safe* learning environment." J.A. 114 (emphasis added). But here that can only mean protecting children *from their own parents*. That rationale flies directly in the face of the "traditional *presumption*"—constitutionally mandated, by the way—that parents act in their children's best interests. *Troxel*, 530 U.S. at 69; *Doe v. Heck*, 327 F.3d 492, 521 (7th Cir. 2003) (finding a violation of parents' rights where state

actors "not only failed to presume that the plaintiff parents would act in the best interest of their children, they assumed the exact opposite").

It is never constitutionally permissible to usurp parental authority solely at the say-so of a minor, without requiring any evidence or allegation of harm, or providing any process or opportunity for the parents to respond or defend themselves. *See Santosky v. Kramer*, 455 U.S. 745 (1982). School districts do not have the power to act as ad hoc family courts, litigating family law issues or deciding on their own, independent of any court process, which parents will be included in which decisions.

* * * * *

At bottom, the District simply disagrees with parents who might say "no" to an immediate transition. That is not sufficient to override their parental role. Schools cannot and should not exclude parents from decisions involving their own children solely based on a school's assessment of how supportive parents are of a transition. The District's policy, and others like it around the country, are a stunning deviation from what parents expect when they send their minor children to school. If this Court affirms the District Court, parents in this Circuit will have

no choice but to withdraw their children from public school to preserve their parental role and prevent harm to their children. Some do not have that option. Parents should not have to cede their decision-making authority merely by sending their children to public school.

CONCLUSION

This Court should reverse the judgment of the District Court.

Dated: June 12, 2025

Respectfully Submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 29(a)(4)(G), I certify the following:

This brief complies with the type-volume limitation of Local Rule 29.1(c) because this brief contains 5,275 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(f).

This brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5), and the type-style requirements of Federal Rule of Appellate Procedure 32(a)(6), because this brief has been prepared in a proportionately spaced typeface using Microsoft Word in 14-point Century Schoolbook font.

Dated: June 12, 2025

/s/ Luke N. Berg
LUKE N. BERG

CERTIFICATE OF SERVICE

I hereby certify that on June 12, 2025, I filed the foregoing Amicus Brief with the Clerk of the Court for the United States Court of Appeals for the Second Circuit through the Court's ACMS system. I certify that all participants in the case who are registered ACMS users will be served by the appellate ACMS system.

Dated: June 12, 2025

/s/ Luke N. Berg
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