

IN THE
Supreme Court of the United States

INTERNATIONAL PARTNERS FOR
ETHICAL CARE, INC., *et al.*,

Petitioners,

v.

BOB FERGUSON, GOVERNOR OF
WASHINGTON, *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE NINTH CIRCUIT

**BRIEF OF *AMICI CURIAE* GLOBAL ALLIANCE
FOR BEHAVIORAL HEALTH AND SOCIAL
JUSTICE, ET AL. IN SUPPORT OF RESPONDENTS**

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INTERESTS OF *AMICI CURIAE*¹

The Global Alliance for Behavioral Health and Social Justice is a global interdisciplinary organization that informs policy, practice and research at the intersection of human rights, social justice and behavioral health. Global Alliance members include researchers, scholars, and practitioners in their fields.

The Society for the Psychological Study of Social Issues promotes research and education on psychological aspects of critical social issues, bringing science and evidence to human problems of the group, the community, the nation, and those that have no national boundaries.

The Association of LGBTQ+ Psychiatrists educates and advocates on LGBTQ+ mental health issues and strives to be a recognized expert on LGBTQ+ mental health issues.

The Society for Sexual, Affectional, Intersex, and Gender Expansive Identities (SAIGE) advocates for the voice, equity, and inclusion of LGBTQEQIAP+ persons within the counseling profession and beyond and promotes the professional development of counselors and related professionals so that all LGBTQEQIAP+ individuals receive ethical, inclusive, and liberating services that attend to all

¹ Pursuant to Rule 37.6, *Amici* affirm that no counsel for any party authored this brief in whole or in part, and no person or entity other than *Amici*, their members and their counsel has made a monetary contribution to support the brief's preparation or submission.

aspects of their intersectional identities.

Physicians for Reproductive Health organizes, mobilizes, and amplifies the voices of medical providers to advance sexual and reproductive health, rights, and justice, working towards a just and equitable world where all people are free to make their own decisions about their bodies, families, and futures.

Amici, professionals in the fields of medicine, psychology, and the sciences, submit this brief to inform the Court of research on identity formation in transgender youth; the positive outcomes associated with social transition and age-appropriate medical care; and the factors that reduce family conflict that lead transgender youth to run away.

SUMMARY OF ARGUMENT

Gender identity development is a normal part of human development. Petitioners and their supporting *amici* paint a picture of transgender youth that scientific evidence does not support. In this brief, *Amici* offer the Court scientific research and clinical experience that Petitioners leave out.

Petitioners cast the experience of raising and supporting a transgender or gender expansive child as a cognizable harm, but neither science nor common sense supports the premise that there is any injury to the parents in this case. As this brief demonstrates, Petitioners' claims are belied by scientific evidence that when transgender youth are supported at home, they experience positive outcomes.

Nothing in Washington law prevents Petitioners from disagreeing with the medical consensus or from parenting their children according

to their convictions. Petitioners' disagreement with their children's gender identity, and with the availability of gender-affirming care generally, does not constitute a cognizable injury in this case. The disagreement is speculative because, as Washington construes its laws, youth can only access a referral to outpatient mental health services. Resp't Br. at 12–14. Nor have Petitioners alleged their children have run away or plan to run away to a licensed shelter since Washington amended its laws. *Id.* at 16; Pet. App. at 14a–15a. Petitioners' allegations that they have altered their parenting choices because they are afraid their children might run away and access medically necessary health care while at a licensed shelter are the precise kind of speculative, self-imposed “injuries” the Court rejected in *Clapper v. Amnesty International USA*, 568 U.S. 398, 416 (2013). As this Court has held, Petitioners “cannot manufacture standing merely by inflicting harm on themselves based on their fears of hypothetical future harm that is not certainly impending.” *Ibid.*

This brief demonstrates there is no causal connection between Petitioners' hypothetical fears and Washington's laws, making Petitioners' alleged harms neither fairly traceable to the statutes at issue nor redressable by their challenge. There is no evidence that the existence of Washington's statutes will encourage or “lure” children to run away or to transition. Conversely, significant evidence suggests that transgender youth have strongly held, persistent self-knowledge about their gender. Any breakdown in the parent-child relationship in the hypotheticals posited by Petitioners would be the result of Petitioners' disapproval of their transgender child, not Washington's laws. No research supports Petitioners'

proposition that transgender youth are more likely to run away when laws such as Washington's are in place; such risk is only redressable through Petitioners' own choices, not Washington's statutes.

Petitioners' standing theory rests on assumptions about gender identity development and predictions about how their children would respond to Washington's laws that science contradicts. Without those premises, Petitioners lack Article III standing to challenge Washington's laws.

ARGUMENT

I. Transgender youth have a strong and stable understanding of who they are.

Like all young people, transgender youth typically develop a consistent, persistent, and insistent sense of their gender identity as part of childhood and adolescent development. Research shows transgender and cisgender (i.e., non-transgender) youth both develop a comparably strong and persistent sense of self. No research suggests Washington's laws have any impact on young people's understanding or development of their identities.

A. Gender identity development is a typical part of childhood and adolescence.

Despite Petitioners' and their *amici*'s claims, the available research does not support the suggestion that respecting a young person's gender identity, social transition, or puberty-delaying interventions cause or "lock in" transgender identity.²

² Benjamin E. deMayo et al., *Stability and Change in Gender Identity and Sexual Orientation Across Childhood and*

Most people have an awareness of their “gender identity”— a well-established concept in psychology and medicine, referring to a person’s internal or psychological sense of being male, female, both, or neither.³ Gender identity development is a typical part of child and adolescent development for both transgender and cisgender youth.⁴ Transgender children and adolescents experience a pervasive, consistent, persistent, and insistent sense that their gender identity is different from the sex assigned to them at birth.⁵ Transgender people differ from cisgender individuals, whose gender identity aligns with their sex assigned at birth.⁶ People explore and develop their understanding of their gender identity throughout their life, beginning as early as age three.⁷

Research suggests transgender youth experience similar stability in their gender identities compared to their cisgender peers. In a retrospective chart review of transgender adolescents receiving

Adolescence, 90 Monographs Soc’y Rsch. Child. Dev. 7, 7–8 (2025).

³ Am. Psych. Ass’n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70 Am. Psych. 832, 832, 834, 862 (2015).

⁴ See generally deMayo et al., *supra* note 2.

⁵ Am. Psych. Ass’n, *supra* note 3, at 834; see also, e.g., Kristina R. Olson et al., *Gender Cognition in Transgender Children*, 26 Psych. Sci. 467, 473 (2015); Am. Acad. Pediatrics, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 Pediatrics 1, 2 (2018).

⁶ Am. Psych. Ass’n, *supra* note 3, at 861.

⁷ Philip Graham, *Transgender children and young people: how the evidence can point the way forward*, 47 BJPsych Bull. 98, 98 (2023).

gender-affirming care at four pediatric clinics in Canada between 2012 and 2017, high levels of gender identity stability were observed over the course of the study.⁸ At the end of the follow-up period, 94.6% of adolescents continued with the gender identity they reported at the initial visit.⁹ Of those who reported changes in gender identity, 2.9% returned to the gender identity aligned with their sex assigned at birth.¹⁰ A recent longitudinal study following 317 transgender youth who had socially transitioned, a sample of 218 siblings of the transgender group, and a sample of 377 cisgender youth, matched by age and gender, found a pattern of gender identity stability across all groups.¹¹ Overall, all groups showed stability in gender identity over a period of 6.2 years.¹² Most parents (89.3%) and youth (83.1%) reported stability in their child's gender identity across all waves of the study.¹³ A study that explored the question of gender cognition in transgender and cisgender children found that, when matched on the basis of gender identity, there were no distinguishable differences between the transgender and cisgender groups in terms of viewing themselves in alignment

⁸ Daniel L. Metzger et al., *Stability of Transgender Identity in Adolescents Seen in Multidisciplinary Specialized Gender Centers: A Multicenter Study in Canada*, 79 J. Adolescent Health 242, 246 (2026).

⁹ *Id.* at 245–46.

¹⁰ *Id.* at 246.

¹¹ deMayo et al., *supra* note 2, at 69–72.

¹² *Id.* at 14, 83.

¹³ *Id.* at 79.

with their expressed gender.¹⁴

Skeptics of the existence of transgender people offer explanations for transgender people's understanding of themselves that are unsupported by evidence. For example, the concept of so-called “rapid onset gender dysphoria” described by several *amici* has not been clinically validated.¹⁵ These claims made by Lisa Littman (2018) and others are derived solely from parent reports of their child's gender identity development and have been criticized on methodological grounds.¹⁶ Many children who do not believe their parents will be supportive of their identity will wait longer to disclose their identity and

¹⁴ Olson et al., *supra* note 5, at 472; Selin Gülgöz et al., *Similarity in transgender and cisgender children's gender development*, 116 *Proceedings Nat'l Acad. Scis.* 24480, 24482–83 (2019).

¹⁵ See Jack L. Turban et al., *Age of Realization and Disclosure of Gender Identity Among Transgender Adults*, 72 *J. Adolescent Health* 852, 852–58 (2023).

¹⁶ It is important to note that Littman's initial paper, which introduced the term “rapid onset gender dysphoria,” relied solely on online survey responses from parents, recruited through websites frequented by parents skeptical of their children's gender identity, and has since been subject to correction after additional review identified serious methodological flaws, inappropriate interpretation of data, and overstatement of findings. The hypothesis has not been clinically validated, and subsequent studies using clinical data have not found support for it. See Greta R. Bauer et al., *Do Clinical Data from Transgender Adolescents Support the Phenomenon of “Rapid Onset Gender Dysphoria”?*, 243 *J. Pediatrics* 224, 225–26 (2022); André Leonhardt et al., *Gender dysphoria in adolescence: examining the rapid-onset hypothesis*, 39 *Neuropsychiatrie* 1, 6–7 (2025); Arjee Javellana Restar, *Methodological Critique of Littman's (2018) Parental-Respondents Accounts of “Rapid-Onset Gender Dysphoria”*, 49 *Archives Sexual Behav.* 61, 62–63 (2020).

may not express gender nonconformity to avoid parental rejection, causing their parents to perceive their transgender identity as “sudden.”¹⁷

Similarly, claims that transgender identity is caused by “social contagion” or peer influence have not been clinically validated. Transgender children who are allowed to live in accordance with their gender identity understand and express their gender identity similarly to cisgender children, indicating transgender identity is part of typical human variation and, when allowed to be expressed, does not differ from developmental processes observed in cisgender children.¹⁸ Other related claims of a causal relationship between social media use and the emergence of transgender identity are unsupported by evidence. Research finds that transgender youth use social media to find peer support after they come out as transgender, not before.¹⁹

¹⁷ Florence Ashley, *A critical commentary on ‘rapid-onset gender dysphoria,’* 68 Socio. Rev. 779, 782 (2020).

¹⁸ Olson et al., *supra* note 5, at 467, 473; Gülgöz et al., *supra* note 14, at 24482–83.

¹⁹ Oliver L. Haimson & Tiffany C. Veinot, *Coming Out to Doctors, Coming Out to “Everyone”: Understanding the Average Sequence of Transgender Identity Disclosures Using Social Media Data*, 5 Transgender Health 158, 158–65 (2020); Claire A. Coyne et al., *Gender Dysphoria: Optimizing Healthcare for Transgender and Gender Diverse Youth with a Multidisciplinary Approach*, 19 Neuropsychiatric Disease & Treatment 479, 479–93 (2023); Lena Herrmann et al., *How social is social media for transgender and gender-diverse youth? Association of online social experiences with internalizing mental health problems*, 33 Eur. Child & Adolescent Psychiatry 3503, 3509 (2024).

B. What it means for transgender youth to experience gender dysphoria.

Some transgender youth are diagnosed with gender dysphoria, the psychiatric diagnosis for the clinically significant distress associated with the incongruence between gender identity and birth-assigned sex.²⁰ In the chart review by Metzger and colleagues, on average, adolescents reported they started to experience gender dysphoria at 9.5 years of age.²¹ Those results align with Zaliznyak and colleagues' findings that, among a sample of adults between the ages of 20 and 60 years old, the average reported age for onset of gender dysphoria was around six years old.²² This is around the same age children typically begin to appreciate the concept of gender.²³

Under the DSM-5-TR (APA, 2022), there are two criteria for diagnosing gender dysphoria in adults and adolescents (F64.0). The symptoms under Criterion A for identifying gender dysphoria include a marked incongruence between one's experienced/expressed gender and one's assigned gender of at least six months. Criterion B requires a finding of clinically significant distress or impairment in social, occupational, educational, or other

²⁰ Am. Psych. Ass'n, *Gender Dysphoria, in Diagnostic and Statistical Manual of Mental Disorders, Text Revision* 511, 515–16 (5th ed. 2022) [hereinafter “DSM-5-TR”].

²¹ Metzger et al., *supra* note 8, at 244.

²² Michael Zaliznyak et al., *How Early in Life do Transgender Adults Begin to Experience Gender Dysphoria? Why This Matters for Patients, Providers, and for Our Healthcare System* 3, Int'l Soc'y Sexual Med. (Sep. 17, 2021), <https://tinyurl.com/5asdr2mf>.

²³ *Id.* at 5.

important areas of functioning.²⁴

Before a patient receives a gender dysphoria diagnosis, a qualified medical or mental health provider conducts an intake and health history, where the provider asks the patient questions focused on the diagnostic criteria for gender dysphoria.²⁵ The diagnosis is most often provided based on a diagnostic interview where a highly trained clinician asks questions derived from a diagnostic manual. Some providers may also use psychological assessment tools focused on gender dysphoria.²⁶

People, including children and adolescents, who are diagnosed with gender dysphoria can experience a number of different symptoms.²⁷ When transgender people are unable to live consistently with their gender identity, including being unable to socially transition or access medically necessary treatment when clinically indicated, those symptoms can become exacerbated and debilitating.²⁸ Recent

²⁴ DSM-5-TR, *supra* note 20, at 512.

²⁵ Eli Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 Int'l J. Transgender Health S1, S31–S36 (2022); *see generally* Joseph H. Bonifacio et al., *Management of gender dysphoria in adolescents in primary care*, 191 Canadian Med. Ass'n J. E69, E69–E75 (2019).

²⁶ Coyne et al., *supra* note 19, at 479, 484, 486.

²⁷ Nat'l Acads. Scis., Eng'g & Med., *Common Co-occurring Conditions and Impacts of Gender-Affirming Care on Chronic Conditions in Transgender and Gender Diverse Populations, in Sex and Gender Identification and Implications for Disability Evaluation* 197, 200–05 (Hortensia de los Angeles Amaro & Mary-Beth Malcarney eds. 2024).

²⁸ *See, e.g.*, Brae Anne McArthur et al., *Suicidality and*

studies demonstrate significant relationships between gender dysphoria and psychological distress among youth. For example, studies note associations between gender dysphoria and disordered eating,²⁹ suicidal attempts,³⁰ and depression and anxiety.³¹ A systematic review of 21 studies found youth with gender dysphoria had higher rates of self-injurious behavior than their cisgender peers and almost one third attempted suicide.³²

Systematic reviews show significant mental health disparities for transgender youth who experience gender dysphoria, especially when untreated, as compared to their cisgender peers.³³

Nonsuicidal Self-Injury in Transgender and Gender Diverse Youth: A Systematic Review and Meta-Analysis, 180 JAMA Pediatrics 144, 149 (2026); Jaclyn M. White Hughto et al., *Social and Medical Gender Affirmation Experiences Are Inversely Associated with Mental Health Problems in a U.S. Non-Probability Sample of Transgender Adults*, 49 Archives Sexual Behav. 2635, 2638, 2642–43 (2020).

²⁹ Liz Abernathey et al., *Associations Between Gender Dysphoria, Eating Disorders, and Mental Health Diagnoses Among Adolescents*, 75 J. Adolescent Health 780, 782 (2024).

³⁰ Marissa Nunes-Moreno et al., *Mental Health Diagnoses and Suicidality Among Transgender Youth in Hospital Settings*, 12 LGBT Health 20, 24–25 (2025); McArthur et al., *supra* note 28, at 144–51.

³¹ Jiaqi Li et al., *The influence of the severity of gender dysphoria on anxiety, depression, suicidal ideation, and non-suicidal self-injury in Chinese transgender, nonbinary, and gender-diverse youth*, 25 Int'l J. Transgender Health 456, 462–66 (2024).

³² Elisa Marconi et al., *A systematic review on gender dysphoria in adolescents and young adults: focus on suicidal and self-harming ideation and behaviours*, 17 Child & Adolescent Psychiatry & Mental Health 110, 126 (2023).

³³ Tabitha Frew et al., *Gender dysphoria and psychiatric*

Like other minority groups, transgender individuals are frequently subjected to prejudice and discrimination in multiple areas (*e.g.*, school, employment, housing, health care), which exacerbates these negative health outcomes and makes access to appropriate care even more important.³⁴

II. Transgender youth experience positive outcomes when their gender identity is supported and respected.

Transgender youth fare better when their gender identity is respected. Research shows youth are capable of considered decision-making, including whether to seek medically necessary mental health care. Parental support promotes positive outcomes and reduces the very harms Petitioners seek to avoid, including family discord and the risk of their child running away from home.

A. Like all youth, transgender youth are capable of considered decision-making in certain contexts.

There is no evidence to support Petitioners' claim that the mere existence of Washington's runaway youth laws will influence a transgender young person's decision to go to a licensed shelter and seek an outpatient mental health referral. Evidence suggests young people demonstrate deliberative decision-making in medical contexts, and no evidence

comorbidities in childhood: a systematic review, 73 *Austl. J. Psych.* 255, 259 (2021); Marconi et al., *supra* note 32, at 16.

³⁴ See, *e.g.*, Michael L. Hendricks & Rylan J. Testa, *A Conceptual Framework for Clinical Work with Transgender and Gender Nonconforming Clients: An Adaptation of the Minority Stress Model*, 43 *Pro. Psych.: Rsch. & Prac.* 460, 465–66 (2012).

suggests they are swayed or “lured” into seeking certain care by Washington’s laws.

Decision-making is a multifactorial process, which includes, but is not limited to, the evaluation of risk and reward.³⁵ Contemporary neurodevelopmental literature indicates highly specific circumstances where adolescents are more likely to overvalue reward and underestimate risk, such as when peers are present or when decisions must be made quickly (known as “hot” contexts).³⁶ However, adolescents demonstrate deliberative and appropriate consideration of reward and risk in the absence of peers and in the presence of adults, such as healthcare providers, and when decisions are made over time, so-called “cold” contexts.³⁷ Medical decision-making is distinct from the contexts that promote “hot” cognitive function, especially given the staged, contemplative, and rigorously overseen nature

³⁵ Christopher G. Coutlee & Scott A. Huettel, *The functional neuroanatomy of decision making: Prefrontal control of thought and action*, 1428 Brain Rsch. 3, 4 (2012).

³⁶ Douglas S. Diekema, *Adolescent Brain Development and Medical Decision-making*, 146 Pediatrics S18, S21 (2020).

³⁷ James P. Byrnes, *The Development of Decision-making*, 31 J. Adolescent Health 208, 211–13 (2022); Bernd Figner et al., *Affective and Deliberative Processes in Risky Choice: Age Differences in Risk Taking in the Columbia Card Task*, 35 J. Experimental Psych.: Learning, Memory, and Cognition 709, 719, 725 (2009); Jennifer M. Wolff & Lisa J. Crockett, *The Role of Deliberative Decision Making, Parenting, and Friends in Adolescent Risk Behaviors*, 40 Empirical Rsch. 1607, 1607–09 (2011); Grace Icenogle & Elizabeth Cauffman, *Adolescent decision making: A decade in review*, 31 J. Rsch. Adolescence 1006, 1007–09 (2021).

of the care.³⁸ This important difference in the contextual nature of decision-making in adolescence is well-established in scientific literature.³⁹ Indeed, a literature review from leading experts in adolescent

³⁸ The brain-development research cited by Petitioners and their *amici* misreads the science by failing to account for this distinction and does not answer the question before the Court. The brain's development is not so simple as having a singular controlling pathway that switches on a certain age. Different neural pathways develop at different rates. While pathways that govern impulse control and emotional regulation in high-pressure, emotionally charged moments continue to develop into early adulthood, the capacity that drives deliberative reasoning develops well before adulthood. Medical decisions about gender-affirming care unfold over months or years, and these decisions rely on the deliberate reasoning that youth develop at earlier stages. Orma Ravindranath et al., *Adolescent neurocognitive development and decision-making abilities regarding gender-affirming care*, 67 Developmental Cognitive Neurosci., art. 101351, 4 (2024).

³⁹ Jason Chein et al., *Peers increase adolescent risk taking by enhancing activity in the brain's reward circuitry*, 14 Developmental Sci. F1, F1–F10 (2011); Lia O'Brien et al., *Adolescents Prefer More Immediate Rewards When in the Presence of their Peers*, 21 J. Rsch. Adolescence 747, 747–53 (2011); Bruce G. Simons-Morton et al., *The Effect of Passengers and Risk-Taking Friends on Risky Driving and Crashes/Near Crashes Among Novice Teenagers*, 49 J. Adolescent Health 587, 587–93 (2011); Ashley R. Smith et al., *Peers Increase Adolescent Risk Taking Even When the Probabilities of Negative Outcomes Are Known*, 50 Developmental Psych. 1564, 1564–68 (2014); Alexander Weigard et al., *Effects of anonymous peer observation on adolescents' preference for immediate rewards*, 17 Developmental Sci. 71, 71–78 (2014); Catherine A. Hartley & Leah H. Somerville, *The neuroscience of adolescent decision-making*, 5 Current Op. Behav. Scis. 108, 108–15 (2015); João F. Guassi Moreira & Eva H. Telzer, *Mother still knows best: Maternal influence uniquely modulates adolescent reward sensitivity during risk taking*, 21 Developmental Sci. 1, 1 (2018).

development and decision-making explicitly states adolescents demonstrate adult decision-making abilities in cold contexts.⁴⁰

Evidence suggests adolescents are capable of considered medical decision-making, including accessing outpatient mental health care, as these decisions are typically made in cold contexts.⁴¹ Although access to gender-affirming medical care is not at issue in this case, decisions about this care are also made in cold contexts because the process of receiving an assessment for care after an adolescent discloses their identity typically takes months and for some, even years.⁴² Data suggest that the typical time between an adolescent realizing they are transgender and coming out to an adult is three years,⁴³ and such

⁴⁰ Sarah-Jayne Blakemore & Trevor W. Robbins, *Decision-making in the adolescent brain*, 15 *Nature Neurosci.* 1184, 1187–88 (2012); see also Beatriz Luna et al., *An Integrative Model of the Maturation of Cognitive Control*, 38 *Ann. Rev. Neurosci.* 151, 151–70 (2015).

⁴¹ Georgia Chaplyn et al., *Experiences of parents of trans young people accessing Australian health services for their child: Findings from Trans Pathways*, 25 *Int'l J. Transgender Health* 19, 19, 26 (2024); Kacie M. Kidd et al., “*Difficult to Find, Stressful to Navigate*”: Parents’ Experiences Accessing Affirming Care for Gender-Diverse Youth, 10 *LGBT Health* 496, 502 (2023); Diana M. Tordoff et al., *Factors Associated with Time to Receiving Gender-Affirming Hormones and Puberty Blockers at a Pediatric Clinic Serving Transgender and Nonbinary Youth*, 8 *Transgender Health* 420, 427 (2023); Jessica Wilson et al., *Healthcare experiences of gender diverse youth: a scoping review of youth and caregiver perspectives*, *BMC Pub. Health* (Sep. 5, 2026), <https://tinyurl.com/5c7rh3pr>.

⁴² *Ibid.*

⁴³ Bauer et al., *supra* note 16, at 225–26.

disclosure follows significant periods of reflection and deliberation. Multiple studies show youth seeking gender-affirming medical interventions are certain about their identity and their desire to access care, a certainty reached through careful consideration over time.⁴⁴ This type of decision-making process is not unique to youth seeking gender-affirming care, but typical of non-emergency medical care more broadly.⁴⁵

B. Youth experience positive outcomes following accepted standards of care for treating gender dysphoria.

Transgender youth experience positive outcomes from following accepted standards of care for treating gender dysphoria. For transgender youth, social transition is important to reduce symptoms of gender dysphoria.⁴⁶ Social transition includes aspects

⁴⁴ Diane Chen et al., *Factors Affecting Fertility Decision-Making Among Transgender Adolescents and Young Adults*, 6 *LGBT Health* 107, 113 (2019); Thomas Daley et al., *"I Couldn't See a Downside": Decision-Making About Gender-Affirming Hormone Therapy*, 65 *J. Adolescent Health* 274, 276 (2019); Drew B. A. Clark et al., *Conditions for shared decision making in the care of transgender youth in Canada*, 36 *Health Promotion Int'l* 570, 574–75 (2020); Drew B. A. Clark & Alice Virani, *"This Wasn't a Split-Second Decision": An Empirical Ethical Analysis of Transgender Youth Capacity, Rights, and Authority to Consent to Hormone Therapy*, 18 *J. Bioethical Inquiry* 151, 160 (2021); Hayley K. Baines et al., *Fertility related knowledge, attitudes, and decision-making among gender diverse youth – A narrative review*, 168 *Reprod. e240032* (2024); Loren G. Marino et al., *Capacity to consent: A scoping review of youth decision-making capacity for gender-affirming care*, 25 *BMC Med. Ethics*, art. 108, 6–8 (2024).

⁴⁵ Ravindranath et al., *supra* note 38, at 4; Icenogle & Cauffman, *supra* note 37, at 1008.

⁴⁶ Aidan Key, *Transition Considerations for Children, in Trans*

of expressing one's gender, such as using a name and pronouns congruent with their gender identity, and dressing and presenting in a manner typically associated with their gender identity. Youth whose identities are respected and supported at home experience substantial improvement in the parent-child relationship and improved mental health outcomes.⁴⁷

Many transgender youth will undergo some type of social transition as part of their gender transition. Current evidence-based treatment protocols indicate that when a transgender young person socially transitions, mental health providers, medical providers, and social supports should acknowledge and respect the young person's gender identity in all aspects of their lives.⁴⁸ This

Children in Today's Schools 141–86 (Oxford U. Press 2023).

⁴⁷ Antonia Dangaltcheva et al., *Transforming Connections: A Trauma-Informed and Attachment-Based Program to Promote Sensitive Parenting of Trans and Gender Non-conforming Youth*, 12 *Frontiers in Psych.*, art. 643823, 1 (2021); Arnold H. Grossman et al., *Parental Responses to Transgender and Gender Nonconforming Youth: Associations with Parent Support, Parental Abuse, and Youths' Psychological Adjustment*, 68 *J. Homosexuality* 1260, 1269–70, 1272 (2021); Jody Russon et al., *Demonstrating Attachment-Based Family Therapy for Transgender and Gender Diverse Youth with Suicidal Thoughts and Behavior: A Case Study*, 61 *Fam. Process* 230, 230 (2021); Caitlin Ryan et al., *Family-Based Psychosocial Care for Transgender and Gender Diverse Children and Youth Who Experience Trauma*, 32 *Child & Adolescent Psychiatric Clinics N. Am.* 775, 779, 782 (2023).

⁴⁸ *Gender-Affirming Therapy*, in *A Guide for Working With Transgender and Gender Nonconforming Patients*, Am. Psych. Ass'n, <https://tinyurl.com/4nvnz7s8> (last visited Oct. 28, 2026); Terrence Z. Huit et al., *State of the Science: Gender-Affirming*

acknowledgment and respect assists children and adolescents in successfully integrating their internal identity into their life and allows them to function in accordance with that identity and without shame. When youth do not move forward with social transition or medical care, it is often due to external factors, such as unsupportive caregivers or lack of safety, rather than changes in identity.⁴⁹

Psychotherapy can also be an important form of support for transgender individuals of any age with gender dysphoria to reduce the harmful effects of stigma and improve resiliency. While psychotherapy may be a useful support tool,⁵⁰ it is not a substitute for social transition or clinically indicated medical interventions to reduce gender dysphoria.⁵¹ Transgender youth often have complex mental health

Care for Transgender and Gender Diverse Youth, 55 *Behav. Therapy* 1335, 1338 (2024); Stanley R. Vance et al., *Community-Derived Recommendations for Improving Gender Affirmation of Black and Latine Transgender/Nonbinary Youth*, 58 *Annals Behav. Med.* 517, 524 (2024).

⁴⁹ See Diane Ehrensaft et al., *Prepubertal social gender transitions: What we know; what we can learn—A view from a gender affirmative lens*, 19 *Int'l J. Transgenderism* 251, 251–68 (2018); Pip Buckingham et al., *Social transition in young trans people accessing gender-affirming care*, 27 *Int'l J. Transgender Health* 2332, 2332 (2026).

⁵⁰ Claire Heathcote et al., *Psychosocial support interventions for children and adolescents experiencing gender dysphoria or incongruence: a systematic review*, 109 *Archives Disease Childhood* s19, s20 (2024).

⁵¹ Terri A. Croteau et al., *Psychological and Physical Health Outcomes Associated with Gender-Affirming Medical Care for Transgender and Gender-Diverse Youth: A Critical Review*, 13 *Healthcare* 1, 4 (2025).

needs and require targeted resources to reduce health care disparities.⁵² These disparities are exacerbated by lack of support and unfair treatment compared to their cisgender peers, highlighting the need for mental health treatment tailored to their needs.⁵³

Post-pubertal transgender youth may sometimes pursue medical transition, when clinically indicated. Medical interventions seek to align a transgender youth's body with their gender identity (e.g., pubertal suspension, hormone therapy). Recent peer-reviewed research suggests the effectiveness of pharmacological interventions for improving mental health and reducing gender dysphoria in transgender adolescents.⁵⁴

Overall, parental acceptance of transgender

⁵² See generally Natalie M. Wittlin et al., *Mental Health of Transgender and Gender Diverse Youth*, 19 Ann. Revs. 207, 207–24 (2023); Stephanie L. Budge, *Interpersonal Psychotherapy With Transgender Clients*, 50 Psychotherapy 356, 356 (2013); Stephanie L. Budge et al., *Longitudinal Effects of Psychotherapy With Transgender and Nonbinary Clients: A Randomized Controlled Pilot Trial*, 58 Psychotherapy 1, 8–9 (2021).

⁵³ Wittlin et al., *supra* note 52, at 219–20.

⁵⁴ Several longitudinal studies that tracked youth outcomes over time reveal the potential effectiveness of gender-affirming care in addressing youth's mental health concerns. See, e.g., Johanna Olson-Kennedy et al., *Emotional Health of Transgender Youth 24 Months After Initiating Gender-Affirming Hormone Therapy*, 77 J. Adolescent Health 41, 41–50 (2025); Luke R. Allen et al., *Changes in Suicidality among Transgender Adolescents Following Hormone Therapy: An Extended Study*, 289 J. Pediatrics, art. 114883, 1–7 (2025); Priya Chelliah et al., *Changes in Gender Dysphoria, Interpersonal Minority Stress, and Mental Health Among Transgender Youth After One Year of Hormone Therapy*, 74 J. Adolescent Health 1106, 1106–11 (2024); Croteau et al., *supra* note 51, at 584–85.

identity and secure attachment to caregivers are associated with improved mental and physical health⁵⁵ and improved parent-child relationships.⁵⁶ Parental acceptance is one of the best predictors of lower rates of past-year suicide attempts among transgender youth.⁵⁷ Parental acceptance is consistently associated with better mental health outcomes, and early intervention studies suggest that programs promoting acceptance may improve family relationships.⁵⁸

⁵⁵ Caitlin Ryan et al., *Family Acceptance in Adolescence and the Health of LGBT Young Adults*, 23 J. Child & Adolescent Psychiatric Nursing 205, 210 (2010); Lisa Simons et al., *Parental Support and Mental Health Among Transgender Adolescents*, 53 J. Adolescent Health 791, 793 (2013); K. Marie Sizemore et al., *Attachment buffers against the association between childhood sexual abuse, depression, and substance use problems among transgender women: a moderated-mediation model*, 13 Psych. & Sexuality 1319, 1319–20 (2021).

⁵⁶ Jordon D. Bosse et al., *Transgender and nonbinary young adults' perception of sibling and parental support for gender identity*, 45 Resch. in Nursing & Health 569, 573 (2022).

⁵⁷ Myesha N. Price et al., *Association of Gender Identity Acceptance with Fewer Suicide Attempts Among Transgender and Nonbinary Youth*, 8 Transgender Health 56, 59 (2023).

⁵⁸ See e.g., Anna L. Olsavsky et al., *Associations Among Gender-Affirming Hormonal Interventions, Social Support, and Transgender Adolescents' Mental Health*, 72 J. Adolescent Health 860, 860, 867 (2023); Jordon D. Bosse et al., *Transgender and nonbinary young adults' depression and suicidality is associated with sibling and parental acceptance-rejection*, 56 J. Nursing Scholarship 87, 87–102 (2024); Kerry McGregor et al., *Understanding Family Support for Transgender Youth: Impact of Support on Psychosocial Functioning*, 75 J. Adolescent Health 261, 261–66 (2024).

C. Transgender youth experience low regret, low discontinuation, and high satisfaction from social and medical transition.

Contrary to the claims of Petitioners and supporting *amici*, the evidence does not show that social transition causes harm, and studies of medical transition report low rates of regret and high satisfaction. Most transgender youth experience positive outcomes from social support and medically necessary care. Recent studies found low rates of treatment discontinuation and regret among youth receiving gender-affirming care.⁵⁹ Furthermore, where discontinuation does occur, however infrequent compared to the dominant trend of continuity, such discontinuation occurs for many reasons and does not necessarily mean a person's gender identity has changed or that treatment is regretted.⁶⁰

Olson and colleagues (2024) found that among transgender youth in North America receiving either puberty blockers or gender-affirming hormone therapy, 97% continued care.⁶¹ In another study

⁵⁹ Kristina R. Olson et al., *Levels of Satisfaction and Regret With Gender-Affirming Medical Care in Adolescence*, 178 JAMA Pediatrics 1354, 1357 (2024); Maria ATC van der Loos et al., *Children and adolescents in the Amsterdam Cohort of Gender Dysphoria: trends in diagnostic- and treatment trajectories during the first 20 years of the Dutch Protocol*, 20 J. Sexual Med. 398, 407 (2023).

⁶⁰ Daniel Wright et al., *Rates of discontinuation and regret in trans and gender diverse adolescents receiving puberty blockers and hormone therapy: a systematic review* 9, Int'l J. Transgender Health (2026), <https://tinyurl.com/2wanar3p>.

⁶¹ Olson et al., *supra* note 59, at 1357.

including a large sample of adolescents receiving care in the oldest pediatric gender identity clinic in the Netherlands over a period of 17 years, 98.4% of adolescents continued treatment.⁶² Similarly, in a sample of youth receiving gender-affirming care in England, 86.8% were discharged to adult gender care clinics.⁶³ In a retrospective study of a community sample of 731 sexual and gender minority young adults who had received gender care at some point in their life in the United States and Canada, most participants (83.2%) did not stop medical care at any point, of those who stopped treatment (16.4%), 37.2% later wished they had not stopped.⁶⁴ A retrospective study of a large cohort of 1050 youth receiving care in a pediatric clinic examined rates of continuation of hormone therapy treatment. Over the course of follow-up, most youth (92.67%) received continuous hormone therapy treatment, 2% discontinued hormones for over 3 months but then restarted, 4% discontinued hormones, and hormone status at follow-up was unknown for 2% of the sample.⁶⁵

⁶² van der Loos et al., *supra* note 59, at 407.

⁶³ Gary Butler et al., *Discharge outcome analysis of 1089 transgender young people referred to paediatric endocrine clinics in England 2008-2021*, 107 *Archives Disease Childhood* 1018, 1018 (2022).

⁶⁴ Kinnon R. MacKinnon et al., *Discontinuation of Gender-Affirming Medical Treatments: Prevalence and Associated Features in a Nonprobabilistic Sample of Transgender and Gender-Diverse Adolescents and Young Adults in Canada and the United States*, 75 *J. Adolescent Health* 569, 572–74 (2024).

⁶⁵ Elizabeth R. Boskey et al., *A Retrospective Cohort Study of Transgender Adolescents' Gender-Affirming Hormone Discontinuation*, 76 *J. Adolescent Health* 584, 587–88 (2025).

Of the small percentage of youth who do discontinue treatment, and do so permanently, the majority do not regret having received treatment and continue to identify as transgender. In the Boskey et al. study, among those who discontinued hormone treatment, the most common reason for discontinuation was achieving their gender expression or embodiment goals. Among those who stopped hormone therapy for at least three months but then restarted, the most common reasons for pausing treatment were difficulty accessing or taking their medication. Most individuals who discontinued hormone therapy, either temporarily or permanently, continued to identify as transgender. It is important to note that only 0.5% reported they no longer identified as transgender.⁶⁶

Crabtree and colleagues conducted an anonymous electronic survey with patients at a gender clinic diagnosed with gender dysphoria and found patients who received gender-affirming care continued treatment, and treatment regret was uncommon.⁶⁷ About one third of respondents accessed puberty blockers, and among those who did not receive blockers, 80.6% wished they had.⁶⁸ Only 6% had never received gender-affirming hormones, and within that group, for those who wished they had received hormones, the most common reason for not

⁶⁶ *Id.* at 587.

⁶⁷ Luca Crabtree et al., *A More Nuanced Story: Pediatric Gender-Affirming Healthcare is Associated With Satisfaction and Confidence*, 75 J. Adolescent Health 772, 773–74 (2024).

⁶⁸ *Id.* at 775.

receiving care was lack of family support.⁶⁹ Among those who received hormones, 88% were satisfied and 86.7% expressed confidence in their gender-affirming care. Notably, only 2% expressed regret with receiving care.⁷⁰ The most common reasons for discontinuation were difficulty with injections, difficulty with adherence, and other barriers accessing hormones.⁷¹ The authors concluded that researchers and clinicians should distinguish between treatment discontinuation and regret, and that, similar to prior studies, regret is rare and often involves both positive and negative feelings about treatment.⁷²

In their longitudinal survey study of transgender youth, Olson and colleagues (2024) found 94% of adolescents were satisfied with treatment involving puberty blockers and 96.6% were satisfied with hormones. Only 4% of participants expressed regret related to either pubertal suspension, hormone therapy, or both. Eighteen percent of participants wished they had initiated pubertal suspension sooner and 34% wished they had been able to initiate hormone therapy sooner. These findings suggest delays in access to care were a much more significant concern than regret among their sample.⁷³ The authors did not assess reasons for the small number that reported regret; however, some participants reported regret about some aspects of the care process, such as adverse effects of treatment or developmental

⁶⁹ *Id.* at 775, 778.

⁷⁰ *Id.* at 776.

⁷¹ *Id.* at 775.

⁷² *Id.* at 778.

⁷³ Olson et al., *supra* note 59, at 1357.

delay compared to their peers. Similarly, 94.4% of parents were satisfied with puberty blockers and 100% were satisfied with hormones.⁷⁴

A qualitative study by Kidd and colleagues interviewed 227 parents of gender diverse youth about their experiences accessing gender-affirming care. Overall, nearly all the parents talked about the positive impact of gender-affirming care on their child’s mental health, with some referring to it as “lifesaving.”⁷⁵

Taken together, the literature suggests continuation of treatment is the norm for most adolescents receiving gender-affirming care, and the process of discontinuation is complex and does not necessarily mean youth stop identifying as transgender or regret treatment.⁷⁶

III. Any alleged harms to Petitioners stem from self-imposed parenting choices, not Washington’s laws or the scientific realities of youth development.

Article III of the United States Constitution confers jurisdiction to federal courts over “cases” and “controversies.” Standing is a “bedrock constitutional requirement that this Court has applied to all manner of important disputes.” *FDA v. All. for Hippocratic Med.*, 602 U.S. 367, 378 (2024) (quoting *United States*

⁷⁴ *Ibid.*

⁷⁵ Kidd et al., *supra* note 41, at 499.

⁷⁶ Annie Pullen Sansfaçon et al., *A nuanced look into youth journeys of gender transition and detransition*, 32 *Infant & Child Dev.* e2402, e2418–19 (2023); Wright et al., *supra* note 60, at 9–11.

v. Texas, 599 U.S. 670, 675 (2023)). To establish standing a plaintiff must demonstrate: “(i) that she has suffered or likely will suffer an injury in fact, (ii) that the injury likely was caused or will be caused by the defendant, and (iii) that the injury likely would be redressed by the requested judicial relief.” *Id.* at 367 (citing *Summers v. Earth Island Inst.*, 555 U.S. 488, 493 (2009); *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560–61 (1992)). To constitute an injury-in-fact, the injury must be “certainly impending,” not speculative. *Clapper*, 568 U.S. at 409 (alteration in original) (quoting *Lujan*, 504 U.S. at 565). “The party invoking federal jurisdiction bears the burden of establishing these elements.” *Lujan*, 504 U.S. at 561. Here, Petitioners have neither an injury-in-fact nor a causal connection to Washington’s laws, and their alleged harms are not redressable by this challenge.

A. Harms alleged by Petitioners are self-imposed and do not constitute an injury-in-fact.

The Ninth Circuit in its straightforward application of this Court’s standing jurisprudence properly concluded Petitioners have not demonstrated an injury-in-fact because their alleged injuries are “self-inflicted” and a voluntary response to Washington’s statutes, not a requirement the laws impose. *Int’l Partners for Ethical Care Inc. v. Ferguson*, 146 F.4th 841, 849 (9th Cir. 2025), *cert. granted sub nom. Int’l Partners for Ethical Care, Inc. v. Ferguson*, 146 S. Ct. 2804 (2026).

Petitioners’ claims of harm include alleged changes they made to their parenting styles around discussions of gender, use of their children’s names and pronouns, and disciplinary choices, to attempt to

avoid a breakdown in the parent-child relationship that might cause their children to run away from home. Pet. Br. at 3–4. As the Ninth Circuit panel properly concluded, these are independent choices parents are free to make, none of which are the subject or result of Washington’s laws. Washington’s laws do not regulate parental speech and “have no bearing on whether and to what extent Plaintiffs are permitted to speak about topics, such as gender, with or around their children.” *Ferguson*, 146 F.4th at 849. This is the precise kind of speculative, self-imposed injury this Court has repeatedly rejected as insufficient under Article III. *See, e.g., Pennsylvania v. New Jersey*, 426 U.S. 660, 664 (1976) (per curiam) (“[n]o [plaintiff] can be heard to complain about damage inflicted by its own hand”); *Clapper*, 568 U.S. at 416 (“respondents cannot manufacture standing merely by inflicting harm on themselves based on their fears of hypothetical future harm that is not certainly impending”).

As this brief and its review of the scientific literature have shown, there is nothing objectively harmful about having a transgender child, including a transgender child who is socially respected or receives mental or medical health services in accordance with accepted standards of care. Petitioners are free to disagree with those standards and parent their children as they see fit—which Washington’s laws do not regulate or prohibit—but that disagreement does not constitute an injury-in-fact for Article III standing. *See Hollingsworth v. Perry*, 570 U.S. 693, 704 (2013) (“[t]he presence of a disagreement, however sharp and acrimonious it may be, is insufficient by itself to meet Art. III’s requirements” (quoting *Diamond v. Charles*, 476 U.S.

54, 62 (1986))).

Petitioners’ objections to Washington’s laws reflect the precise kind of “legal, moral, ideological, or policy objection” that this Court recently rejected in *Alliance for Hippocratic Medicine*, 602 U.S. at 381; *see also Nat’l Park Serv. v. Nat’l Tr. for Historic Pres. in the U.S.*, 609 U.S. ----, 2026 WL 2564318, at *2 (2026) (per curiam) (“we have repeatedly held that mere offense, disagreement, or distaste does not qualify as a concrete and particularized injury under Article III”). Like the plaintiffs in *Alliance for Hippocratic Medicine*, Petitioners cannot turn their disagreement with their children’s gender identity into an injury-in-fact, much less use that disagreement to restrict access to outpatient mental health services that protect young people who have run away from home. 602 U.S. at 374 (“[A] plaintiff’s desire to make a drug less available *for others* does not establish standing to sue.” (emphasis in original)). Whatever the state of the evidence on gender-affirming medical care, even if there were scientific uncertainty, that does not make a parent’s injury concrete, particularized, or imminent. Parental rights also belong to parents in Washington who support their children’s identities and want them to be able to consent to medically necessary outpatient mental health services, including parents whose teens do not feel comfortable coming to their parents about that decision or who are, for whatever reason, in a shelter.

Psychological research demonstrates the harms alleged by the parents in this case, even if viewed as well-intentioned from their perspectives, are self-imposed. Petitioners remain free to parent and instruct their children according to their own

beliefs, and Washington’s laws do not stand in their way.

B. Petitioners’ alleged harms are not caused by Washington’s laws and cannot be redressed by this challenge.

Causation and redressability—the second and third standing requirements—are often “flip sides of the same coin.” *All. for Hippocratic Med.*, 602 U.S. at 380 (quoting *Sprint Commc’ns Co. v. APCC Servs., Inc.*, 554 U.S. 269, 288 (2008)). As reflected in this brief’s discussion of the scientific literature on adolescent identity development, Petitioners’ alleged harms have no causal connection to Washington’s runaway youth statutes, and therefore also fail the second and third prongs of the standing test.

Petitioners make the wholly unsupported claim that Washington’s laws will “lure” children to run away or transition. Pet. Br. at 41. Petitioners cite no evidence to support this claim and instead rely solely on what they claim are “commonsense inferences about child behavior,” *id.* at 39 (citations omitted). The scientific evidence does not support Petitioners’ claim that Washington’s statutes have any influence on a young person’s understanding of their gender identity, choice to seek medical care, or decision to run away from home (i.e., luring effect).

As this brief has shown, gender identity development is a typical psychological process that both transgender and cisgender youth experience.⁷⁷ Transgender youth typically have a strong and stable understanding of their gender identities from an early

⁷⁷ See generally deMayo et al., *supra* note 2.

age.⁷⁸

On the factors that go into a young person's decision to seek medical care, cognitive development research shows that from late childhood into adolescence, a youth's decision-making capacity is informed by an ability to systematically examine information and reason through alternatives and consequences.⁷⁹ As youth age, they become more likely to seek out independent sources of information to help inform their decisions to seek medical care.⁸⁰ Studies have shown that youth's decision to seek medical care, including gender-affirming care, consists of thoughtful reflection and deliberation.⁸¹

Research demonstrates that parental support among transgender adolescents is associated with higher life satisfaction, fewer depressive symptoms, lower perceived burden about being transgender,⁸² and lower risk of suicidality.⁸³ An increase in parental acceptance of their children's gender identity is associated with greater closeness as well as reductions in familial conflict and relational stress.⁸⁴

⁷⁸ Graham, *supra* note 7, at 98.

⁷⁹ Tara L. Kuther, *Medical Decision-Making and Minors: Issues of Consent and Assent*, 38 *Adolescence* 343, 348 (2003).

⁸⁰ *Id.* at 349.

⁸¹ Clark & Virani, *supra* note 44, at 157–59; Charles-Antoine Thibeault et al., “*I have been thinking about this for a long time*”: *Navigating gender affirming medical care decisions for trans and nonbinary youth and their families in six countries*, 27 *Int'l J. Transgender Health* 408, 408–22 (2025).

⁸² Simons et al., *supra* note 55, at 792.

⁸³ Price et al., *supra* note 57, at 59.

⁸⁴ Nina Bhattacharya et al., *Conceptualizing Relationships*

Family acceptance can also serve as a protective factor by promoting adolescent health and well-being even in the face of societal discrimination and victimization.⁸⁵

To the extent Petitioners allege they are harmed by the risk of their children running away from home, data shows transgender youth may run away when they are not supported at home, while no data shows youth are any more likely to run away because of laws like Washington’s. As Petitioners themselves acknowledge, transgender youth “run away more frequently” than their cisgender peers. Pet. Br. at 41 n.17 (citing Max Ferguson et al., *Health and Healthcare Service Use: The Experiences of Runaway Trans Adolescents Compared to Their Peers*, 69 J. Homosexuality 821, 821 (2022)). Unsupportive households are a contributing factor to the risk of transgender youth running away,⁸⁶ a finding which remains true regardless of Washington’s runaway youth laws.

Research consistently associates family non-acceptance with the outcomes Petitioners say they fear, including family conflict and youth running

Among Transgender and Gender Diverse Youth and Their Caregivers, 35 J. Fam. Psych. 595, 600 (2021).

⁸⁵ Roger Mills-Koonce et al., *The Significance of Parenting and Parent–Child Relationships for Sexual and Gender Minority Adolescents*, 28 J. Rsch. Adolescence 637, 644 (2018).

⁸⁶ See, e.g., Travis Campbell et al., *Mental Health of Transgender Youth Following Gender Identity Milestones by Level of Family Support*, 178 JAMA Pediatrics 870, 870, 874–76 (2024); Travis Campbell & Yana van der Meulen Rodgers, *Conversion therapy, suicidality, and running away: An analysis of transgender youth in the U.S.*, 89 J. Health Econ. 102750, 102750 (2023).

away. No research suggests that laws like Washington's increase those risks. Any such harms therefore are not fairly traceable to the challenged statutes. The parent-child conflicts Petitioners name predate Washington's amendments to its runaway youth laws, and Petitioners cite nothing to support the assertion that the risks they fear from this conflict are connected to these new laws.

Amici do not doubt Petitioners sincerely hold their beliefs. But at bottom, Petitioners' quarrel is not with Washington. It is with a developmental process every child undergoes, one the State neither causes nor controls. Decades of research confirm that supporting a transgender child is not harmful. And the lack of causal connection between Petitioners' alleged harms and the statutes at issue in this case means their alleged injuries are not fairly traceable to Washington's statutes or redressable by their challenge. Because Petitioners have shown no injury, causation, or redressability, they lack standing to challenge Washington's laws.

CONCLUSION

For the foregoing reasons, *Amici* ask that the Court affirm the judgment of the Court of Appeals or dismiss the case as improvidently granted.

Respectfully submitted,

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