**Transgender Children and the Right to Transition**

*Medical Ethics when Parents Mean Well but Cause Harm*

**1. Introduction**

Most of us that live in liberal democracies agree that parents have the right to raise their own children. Most, however, also agree that there are limits to parental authority. Arguably, these limits have grown stronger and more expansive throughout the 20th century.[[1]](#footnote-1) Consider, for instance, that several states and counties have outlawed programs which attempt to change the sexual orientation of homosexual youth.[[2]](#footnote-2) Not too long ago, it would have been unimaginable that a religious program which threatens no physical harm to children would be legally prohibited.

Outlawing the above mentioned, “gay reform camps” suggests not only that we are taking youth rights more seriously, but that we are taking the notion of *psychological harm* more seriously. While we have long accepted that mental states arise from brain states, there remains a lingering tendency for experts and lay persons alike to think of psychological harm in a distinct and less important category than physical harm. This is despite the evidence that points to psychological abuse being every bit as harmful as physical and sexual abuse (Spinazzola et al., 2014).

Yet the tide is turning. Not only are gay reform camps now illegal in some states, but laws against bullying and harm via cyber space is increasingly becoming a matter or legislative prohibition. Along similar lines, therapy and psychiatric drugs are used much more frequently than ever before.[[3]](#footnote-3) Both of these moves suggest a growing concern with mental ailments that fall upon children and adolescents.

As we continue to move in the direction of seeing psychological harm in the same light as we see physical harm, we should expect to see an increase in the ways in which the state intervenes with parental authority. After all, for most of the history of liberal democratic societies, parents “psychologically” harming their children was not considered a matter for the state to deal with at all. There are hence large gaps in appropriate measures to protect those not of age to protect themselves. In the United Kingdom, for instance, new “Cinderella” legislation (formally, *Serious Crime Act of 2014*) was recently ratified and is aimed at protecting emotionally abused youth and punishing their perpetrators. Parliament member Robert Buckland had this to say about the legislation: “Our criminal law has never reflected the full range of emotional suffering experienced by children who are abused by their parents or caretakers. The sad truth is that, until now, the wicked stepmother would have got away scot free” (Chorley, 2014). Buckland’s statement well exemplifies the legal gap when it comes to protecting minors from non-physical forms of abuse.

 This paper discusses one area of psychological harm that is worthy of new attention: harm to transgender youth who have non-supportive parents (by “non-supportive” I do not mean parents who do not love or care for their children. I rather mean parents who do not support, aid, and/or approve of the transition process.) In particular, I will argue that transgender adolescents have a fundamental right to PBT (puberty-blocking treatment) *even if* their parents disapprove. The need for this type of state protection is serious. The World Professional Association of Transgender Health (WPATH) warns us that, “refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization” (Coleman et al., p.78, 2012). A child is transgender if he or she identifies with a gender other than their biological sex. A child has gender dysphoria if such atypical identification causes distress.[[4]](#footnote-4) Being transgender itself does not necessarily mean one suffers from gender dysphoria. Transgender youth who lack supportive families, for instance, are far more likely to experience gender dysphoria (Olson et al., 2016; Gorin‐Lazard et al., 2012; and De Vries et al., 2014.)

Sadly, youth suffering from gender dysphoria often face more than just psychological harm, but all too often the ultimate physical harm. Transgender youth are ten times as likely to attempt suicide when compared to their cisgender peers (Haas et al.: 2010). Even more, suicide has recently moved up the list from the third leading cause of death amongst teenagers to the second. From the words of the American Academy of Pediatrics, “With suicide rising to the second-leading cause of death among adolescents, the American Academy of Pediatrics (AAP) is publishing updated guidelines advising pediatricians how to identify and help teens at risk” (AAP, 2016). If suicide is already a serious risk amongst adolescents, and this risk is magnified by 10-fold when it comes to transgender youth, this is nothing other than a serious mental health crisis. These statistics suggest that not only should pediatricians be especially concerned with psychological harm that befalls marginalized youth such as transgender children, but arguably so should the state. The formal argument runs as follows:

1. The state has a duty to protect minors from serious harm inflicted by their caretakers.

2. Harm which leads to suicide is a serious harm.

3. Transgender youth with non-supportive parents are at a high risk of psychological harm leading to suicidal tendencies.

4. Therefore the state should pay special attention to, and has a duty to protect, transgender minors from psychological harm inflicted via their caretakers.

Admittedly, the above argument, even if persuasive, leaves much vague. The remainder of this paper will attempt to fill in those details.

 My strategy for defending the formal argument above revolves around arguing in favor of two normative claims:

 (1) Transgender youth should have access to treatment which is not dependent upon parental approval.

(2) There should be state-sponsored publically-available information regarding gender dysphoria, transgender identification, and means of appropriate treatment.

The next section offers an overview of gender dysphoria and the use of PBT. Section 3 describes the particular *psychiatric* problems that befall transgender youth in the absence of PBT. Section 4 focuses on the *physical* harms that result from the absence of PBT. Section 5 argues that the harms described in Sections 3 and 4 indeed justify state intervention into the life of transgender minors and their families. Section 6 argues that the state has not only a role to play in legally mandating the right to PBT, but also in using government institutions to educate the public about transgender issues and treatment. In Section 7 I respond to potential objections. Section 8 reviews the paper’s main argument and offers concluding remarks.

**2. Gender Dysphoria and Treatment for Transgender Youth**

*2.1 Gender dysphoria and its consequences*

Gender dysphoria, the feeling of disconnect and unease at the difference between one’s biological gender and one’s sense of gender identity, often begins at a surprisingly young age.[[5]](#footnote-5) Many parents, knowing nothing about what it means to be transgender, are baffled by toddlers who insist that they are the gender opposite the one on their birth certificate. A dad might be horrified when his little boy comes down stairs in a tutu. A mother might be exasperated that her 6-year old daughter insists on calling herself a “big brother” rather than a big sister.[[6]](#footnote-6) And two Christian parents might cry themselves to sleep because their preschooler insists on playing with girl toys and has already been labeled “gay” by his peers.[[7]](#footnote-7) While all parents understandably feel stressed in such situations, different parents often handle these situations in polarizing fashions. Not only do some parents not accept their transgender children, but sadly more than a few have forced their children out of the home, leaving them homeless. Indeed, being transgender is one of the leading risk factors for homelessness.[[8]](#footnote-8)

While many parents are unaware of how to address their transgender child’s expressions of dysphoria, the earliest treatment requires neither medication nor any intervention that is irreversible. Rather, specialists recommend that parents of young transgender children offer support in at least two ways. First, because their child is likely to go through psychological stress unlike that of their gender conforming peers, counseling of some sort is often helpful. (Ettner et al., p.101, 2016, and Krieger, p.40, 2011). Or, to put things more starkly, “It is recommended that all transgender adolescents be involved in psychological therapy, even those who are functioning well, to ensure that they have the necessary support they need and a safe place to explore identities and consider the transitioning experience” (Levine, p.308, 2013). In addition, parents wishing to help their children maintain a healthy psychological state should be supportive and non-judgmental of their children’s gender expression (Olson et al., 2015). Indeed, perhaps nothing speaks to the importance of parental support more than the disparity in the suicide rate of transgender teens without supportive parents compared to those who do have support. A recent *Huffington Post* article notes the following,

Transgender people who are [rejected by their families or lack social support](http://www.tandfonline.com/doi/abs/10.1080/19361653.2014.910483#.Vkd78vlViko) are much more likely to both consider suicide, and to attempt it. Conversely, those with strong support were[82% less likely to attempt suicide](http://www.biomedcentral.com/1471-2458/15/525) than those without support, according to one recent study. Another study showed that transgender youth whose parents reject their gender identity are [13 times more likely to attempt suicide](http://transpulseproject.ca/wp-content/uploads/2012/10/Impacts-of-Strong-Parental-Support-for-Trans-Youth-vFINAL.pdf) than transgender youth who are supported by their parents. (Tannehill, 2016).[[9]](#footnote-9)

Parents who have mixed feelings about their children’s transgender expressions are wise to keep this statistic in mind. It is fine for parents to have internal questions, but parents who want to protect their kids should outwardly express support and love to young persons already prone to feelings of isolation and rejection.

The transgender child who cannot dress or express oneself genuinely will likely face an insufferable sense of gender dysphoria (Burgess 1999; De Vries et al., 2014 and 2012; Durso and Gates, 2012; Frisch 2017; Garofalo et al., 2006; and Watson et al., 2017). When a child is accepted by their family and allowed to express their gender identity, they remain transgender but may experience little to no gender dysphoria.[[10]](#footnote-10) However, a child who is not accepted and not allowed to express their gender identity is likely to struggle with the mismatch between their physical body and their gender identity (Olson et al., 2016; Gorin‐Lazard et al., 2012; and De Vries et al., 2014).

*2.2 Do children own their bodies?*

Philosopher John Locke argued that our bodies are our property; in his words, "…every man has a Property in his own Person” (John Locke, *Second Treatise*, Ch. 5, book 27). This idea has been foundational to liberal democracies ever since: members of liberal democracies should have the liberty to do with their body what they want, when they want to, and with whom they choose. Yet for transgender youth approaching puberty, their bodies do not feel like their property at all. Indeed, such puberty induced changes create a body they would rather disown than own. In the words of Irwin Krieger, “When transgender kids reach puberty, their bodies begin to betray them. They develop the physical characteristics that are typical of their biological sex but not in accord with their deeply felt gender…. As puberty progresses, many begin to feel hopeless about their future” (p.20, 2011). If transgender youth are truly the owners of their bodies, they should have the right to prevent them from going through changes of which they disapprove. What these adolescents would like to do with their bodies is clear: they want to take steps to make the puberty induced changes stop. And indeed, the standard of care for transgender adolescents lines up with their wants. The recommendation for adolescents beginning puberty up until age 16 is to undergo PBT. According to the Standards of Care for transgender persons, “withholding puberty suppression and subsequent feminizing or masculinizing hormone-therapy is not a neutral option for adolescents” (Coleman et al., 2012). This does not mean every gender dysphoric child should go forward with PBT, but that those adolescents who (after an evaluation) are deemed good candidates should have the option available. PBT freeze the child in time physiologically. Hence, a transgender boy need not go through the horrors of developing breasts nor a transgender girl look in the mirror and see facial hair. With this treatment, the development of these secondary-sex characteristics is put on hold.

In spite of their children’s struggles, parents understandably might worry that their child, at such a young age, does not know what they want, especially not for the rest of their life. Indeed, these parents might point out that they (the parents) are the true owners of their children’s bodies, at least until they become legal adults. Before that time, it is the job of the parents to protect the bodies of their children in ways they see fit. Or so one might argue. However, even if parents are worried that their child might change their mind regarding their gender identity; the comforting news is that PBT is completely reversible. (Cohen-Kettenis et al., p.1894, 2008, and Delemarre-van de Waal and Cohen-Kettenis, 2006). Puberty-blockers give youth time to be sure that they really do identify with their non-biological gender. The WPATH makes a recommendation for puberty-suppressing treatment with the following justification:

Two goals justify intervention with puberty suppressing hormones: (i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment. Puberty suppression may continue for a few years, at which time a decision is made to either discontinue all hormone therapy or transition to a feminizing/masculinizing hormone regimen (Coleman et al., p. 177, 2012).

Most adolescents who use puberty-blockers do later choose to continue throughout life with a transgender identification (De Vries et al., 2014). However, it is always possible some will not, and for these youth it is a great relief that their body has not been changed permanently. Again, from the WPATH, “Pubertal suppression does not inevitably lead to social transition or to sex reassignment” (Coleman et al., p.177, 2012).

 Following treatment with puberty suppressants, the next step in care involves taking cross-sex hormones so the transgender youth might experience the puberty of their identified gender (to the closest extent possible.) According to Endocrine Society Guidelines, “We recommend treating transsexual adolescents (Tanner stage 2) by suppressing

puberty with GnRH analogues until age 16 years old, after which cross-sex hormones may

be given” (Hembree et al., p.3133, 2009). And as the WPATH notes, “Feminizing/masculinizing hormone therapy – the administration of exogenous endocrine agents to induce feminizing or masculinizing changes – is a medically necessary intervention for many transsexual, transgender, and gender nonconforming individuals with gender dysphoria” (Coleman et al., p.187, 2012, and Gorin-Lazard et al., 2011). At this stage of cross-sex hormone-treatment, unlike the stage of PBT some of the bodily changes enacted are irreversible (Ettner et al, p.201, 2016).

Although this stage of cross-sex hormone intervention is clearly important, it is not the focus of this paper. One reason is that I believe that the thesis *I am* arguing for (the need for PBT), is an issue worthy of a paper on its own. In addition, when youth reach the appropriate age for cross-sex hormone-treatment, in many countries they have already reached the age of medical consent or they are very close to doing so. In comparison, when youth reach the apt age for PBT most are too young to make legal medical decisions. Therefore, it seems that PBT is a more pressing issue than is cross-sex hormone-treatment.

*2.3 Persisting and desisting*

It is not only parents that might worry about transgender children simply going through a “phase.” There has also been a series of studies about “persisters” and “desisters” that suggest many transgender childrendo not become transgender adults (see Steensma et al., 2011 and 2013; Drummond et al., 2008, and Wallien & Cohen-Kettenis, 2008.) These studies label transgender children who maintain their transgender identity into adulthood “persisters”, and those who revert back to their natal gender as “desisters.” Taken as a whole, this literature suggests that most transgender children do not go on to become transgender adults, but rather cisgender homosexuals.

So why recommend PBT if evidence suggests that most seemingly transgender children are going to desist? Four points explain why PBT remains the best option:

1. The empirical work on persisters and desisters is controversial, leaving much room for doubt.

2.Most of the work on persisters and desisters focuses on childhood, however, the stage at which PBT is recommended is adolescence.

3.Regardless of the literature on persisters and desisters, and regardless of some disagreement among experts, PBT is the standard of care consistent with the opinion of the collective body of experts in the field of transgender medicine and endocrine studies.

4.Even assuming a significant number of youth who receive PBT do not go on to be transgender adults, this treatment risks far less harm than the absence of PBT.

Let us discuss each of the above in turn. A series of articles has offered compelling criticism of the literature on persisters and desisters (a non-exhaustive list includes Temple Newhook et al., 2018, Olson & Durwood, 2016; Olson 2016; Pyne, 2014; Serano, 2016; Winters, 2014, and Ehrensaft et al. 2018). It will be helpful to briefly summarize some of these criticisms here. One suggested difficulty with the desisting literature is that those who “desisted” might not have meet criteria for having gender dysphoria in the first place. The criteria used for diagnosing children with *gender identity disorder* (the diagnosable condition at the time) would not meet today’s standards for *gender dysphoria* (the revised diagnosable condition)*.* In the words of Temple et al.,

Due to such shifting diagnostic categories and inclusion criteria…these studies included children who, by current DSM-5 standards, would not likely have been categorized as transgender (i.e., they would not meet the criteria for gender dysphoria) and therefore, it is not surprising that they would not identify as transgender at follow-up. (p.4, 2018).

This (subjects not meeting criteria for gender dysphoria) is arguably the most serious problem for these studies, for it leaves open the possibility that children *who are* diagnosed with gender dysphoria indeed persist in their identities. Concerning still, as Temple et al. explain further, in one particular study 40% of the subjects did not even meet the criteria for gender identity disorder (p.5, 2018). Let us look at this piece by piece. In one study 40% of children did not meet standards for gender identity disorder. Of the remaining 60% of subjects who did meet gender identity disorder standards, many of these would not have meet the standards for gender dysphoria. Looking at those two statistics together, it is unclear what percentage of the subjects provide evidential relevance for today’s transgender youth diagnosed with gender dysphoria.

A different difficulty with the desisting studies was the high attrition rate of participates, and even in one case, classifying those who left the study as desisting, with the justification that, “…the Amsterdam Gender Identity Clinic for children and adolescents is the only one in the country, we assumed that their gender dysphoric feelings had desisted...” (Steensma et al., p.501, 2011) So in this case it was actually unknown whether subjects desisted, but simply assumed that they did. While it *might* be true that participants who did not return desisted, there are many other explanations for these participants not returning. Other criticisms of the studies include the fact that the numbers of children in the study were small and confined to two specific cultures (The Netherlands and Canada), the age at the follow-up was relatively young, and the fact that one of the clinics in the study actively worked to discourage persisting (Temple et al., 2018).

 When the above criticisms are taken into consideration, one is likely to walk away with considerable doubt over whether most transgender children are desisters. Moreover, even the desisting literature suggests that when children *explicitly state they are the gender opposite of their natal birth*, (as opposed to simply showing gender non-conforming behaviors or claiming they “wished” they were the other gender) we have strong reason to believe these children will be persisters. In the words of Steensma et al., “From Steensma et al, “Persisters indicated that they felt they were the ‘other’ sex and the desisters indicated they wished they were the ‘other’ sex… explicitly asking gender dysphoric children with which sex they identify seems to be of great value in predicting a future outcome for both gender dysphoric boys and girls” (p.588, 2013). Hence this criterion (openly stating their transgender identity) can be used to help diagnosis adolescents who are good candidates for PBT.

The most recent moves in the desisting literature are two published replies (Steensma and Cohen-Kettenis, 2018, and Zucker 2018) to Temple Newhook et al.’s 2018 critical commentary. While some of this discussion takes us off-track (given this particular paper’s aim), let me try to summarize the most relevant points, beginning with the Steensma and Cohen-Kettenis response, and then moving on to Zucker.

Steensma and Cohen-Kettenis acknowledge that, “As we have stated elsewhere (Hembree et al., 2017; Steensma,2013), we expect that future follow-up studies using the new diagnostic criteria may find higher persistence rates…” (Steensma and Cohen-Kettenis, p.226, 2018). However, the authors do defend their choice to classify those who did not return to the study as desisters, arguing that other possibilities are far-fetched (p.226). Steensma and Cohen-Kettenis took issue with the suggestion that they might be unsupportive of transgender children’s identities, reminding readers that “As we were the ﬁrst (in the world) to provide adolescents with puberty blocking treatment, it was important for us to know more about the lowest age for responsibly starting with this treatment… (228).” They continue, “We want to stress that we do not consider the methodology used in our studies as optimal…or that the terminology used in our communications is always ideal…” (229). Lastly, Steensma and Cohen-Kettenis conclude by defending themselves against accusations of unethical behavior, and call for clinicians to work together for the good of their patients (229).

Zucker (2018) seems less willing to admit possible limitations of past studies. He criticized Temple Newhook et al. for failing to include a discussion of some earlier studies on the one hand, and on the other hand for including some studies that Zucker thought should have been precluded (p.232, 2018). Zucker also criticizes the way Temple Newhook et al. summarize and interpret certain data from past studies (p.233, 2018). Zucker is skeptical that the changes in diagnostic criteria are as significant as Temple Newhook et al. think they are. He notes, “It is my clinical opinion that the similarities across the various iterations of the DSM are far greater than the differences…” (p.234, 2018). Zucker also claims that at points in their paper, Temple Newhook et al., “…have defaulted to rhetoric and dogma” (p.240,2018).

My paper is not the place to resolve the remaining disputes in the desisting literature. Interested scholars can check out the references themselves, and make their own judgements. My point in bringing up this discussion, is to make clear that the commonly heard claim that “most transgender children do not become transgender adults” is far from settled. Notwithstanding, as I will argue below, *even if* most transgender children *were* desisters, there remains strong reason to believe that gender dysphoric youth deserve access to PBT.

*2.4 PBT is the best route, regardless*

Suppose that for whatever reason a clinician is convinced by the desisting literature, and believes many transgender children do not become transgender adults. There are still three reasons to think PBT is the best medical route. The first is that much of the desisting and persisting literature concerns children. It is at *adolescence*, however, that PBT is recommended. As noted by Coleman et al., “In contrast (to childhood), the persistence of gender dysphoria into adulthood appears to be much higher for adolescents” (p.172,2012). While the field of transgender health is still emerging, and while there are many areas where researchers have disagreements, puberty suppression at early adolescence is suggested both by the World Professional Association of Transgender Health and the Endocrine Society. As stated earlier in the paper, “According to Endocrine Society Guidelines, “We recommend treating transsexual adolescents (Tanner stage 2) by suppressing puberty with GnRH analogues until age 16 years old, after which cross-sex hormones may be given” (Hembree et al., p.3133, 2009). And as the WPATH notes, “Feminizing/masculinizing hormone therapy – the administration of exogenous endocrine agents to induce feminizing or masculinizing changes – is a medically necessary intervention for many transsexual, transgender, and gender nonconforming individuals with gender dysphoria” (Coleman et al., p.187, 2012). As said in the abstract of the 7th edition of the Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, “The SOC are based on the best available science and expert professional consensus”(Coleman et al., 2012).

We can see that despite the controversy surrounding persisting and desisting literature, experts have managed to agree on standards of care for transgender youth, and such standards are consistent with PBT at early adolescence (Coleman 2012, pg. 177-179). Now this, of course, is not to say that every gender dysphoric child should receive PBT. There are a number of other criteria that make gender dysphoric adolescents good candidates for PBT, and an extensive medical evaluation by a medical and/or psychological professional is an important part of the process. This paper only contends that parental approval need not be an important part of this process.

 Some might still worry that over-ruling parental decisions is going too far. It is *possible*, after all, that any given transgender adolescent will not become a transgender adult. No medical test guarantees that a youth who claims to be transgender will carry that identity into adulthood. Said differently, there is no way to know that any given transgender youth will turn out to be a “persister” rather than a “desister.” With other types of medical treatment, one might argue, we have blood tests or X-rays which can confirm a diagnosis. This is not so with gender dysphoria.

 It is true that PBT comes with risks. However, let us recall that there are risks on both sides. The risks of *not treating* with PBT are very serious: gender dysphoric youth forced to go through puberty of their natal gender are likely to suffer from especially strong dysphoric feelings. They are also unlikely to feel a sense of support from their families or physicians. Such factors put transgender minors at high risk for mental health problems and potentially suicide (Burgess 1999; De Vries et al., 2014 and 2012; Durso and Gates, 2012; Frisch 2017; Garofalo et al., 2006; and Watson et al., 2017). Even more, those transgender adolescents who *do* persist in their identities, and have not been given PBT, enter adulthood with a body they reject. Their first years as an independent autonomous agent might be spent worrying about physical features which are either impossible, expensive, or dangerous to change (Taylor, 2015 ).Let us compare this to an adolescent who takes PBT but then desists. Fortunately for these young persons, PBT is reversible and hence desisters can experience the normal (albeit delayed) puberty process with little physical risk, resulting in the adult body the desister desires (Cohen-Kettenis et al., 2011). When we compare these risks against each other, the risker, more dangerous, and more permeant option *is not* the option of using PBT and desisting. It is rather bypassing PBT and persisting.

**3. Psychological Harm and Epistemic Barriers**

In spite of the serious harms facing transgender youth, one reason society, parents, and clinicians might be disinclined to take this harm seriously is that much of the harm is psychological. Ethically speaking, this distinction is irrelevant: we are psychological selves every bit as much as we are physical selves, and harm to either one of these parts is real and ethically significant. Yet one (perhaps legitimate) reason that to be less inclined to take action against psychological harm (in comparison to physical harm) is that we frequently lack the evidential manifestations present with physical harm.

Psychological harm leaves no visible bruises. Even when *we can* identify the presence of extreme psychological harm, we rarely can be sure that harm was caused by the parent rather than siblings or the stress of school, sports, or other stress points. These epistemic difficulties in establishing the cause and true consequence of psychological ailments explains and justifies hesitancy in state meddling. While these reasons are perhaps justified, they have nothing to do with psychological harm being *intrinsically* less wrong or damaging than physical harm. Given that such justifications are epistemic, when we DO have an epistemic hold over certain kinds of mental ailments, there is every bit as much reason for the state to intervene as in cases of *physical* abuse.

The harm transgender youth suffer is importantly different from typical instances of psychological harm, and for at least three reasons. First, we have clear and specific evidence that going through puberty of their natal gender imposes serious psychological harm on a transgender child. Second, we have evidence that this harm is often long-term and potentially irreversible. Third, we know exactly what causes this harm (the distressing experience of going through puberty of the “wrong” gender) (Colemman et al., 2012; Tannehill 2016; Olson et al., 2014 and 2016; Gorin‐Lazard et al., 2012; and De Vries et al., 2012, 2014, and 2016; Murad et al., 2010, and Kids Pay the Price, 2017). In all these ways, harm to transgender children is unlike other kinds of psychological harms where important variables are epistemically suspect. Thus, whatever epistemic concerns we may have about psychological harms in other contexts, these should not factor into the topic of consideration in this paper.

**4. The Physical Risks**

Although many of the notable harms that a transgender child suffers are psychological, there also are risks of physical harm. The increased risk of the ultimate physical harm: death by suicide, has already been stated. But in addition, we should consider the physical realities of what happens when a transgender child is forced to go through the puberty process of their natal sex. This process will result in the secondary-sex physical characteristics that the transgender child so dearly wants to avoid, i.e. breasts, hips, and feminized voice and face for transgender men and facial hair, height, muscle development, and masculine voice and face transgender women. While it is possible to change many of these features through surgery as an adult, this is anything but a simple process. It is important to note that if the youth was denied recommended treatment according to the WPATH transition stages, the surgical operations needed to fully transition as an adult are much more expensive and complex (Taylor, 2015).

 A second physical risk of avoiding recommended puberty-blocking treatment is that transgender children sometimes seek to self-medicate ( Garofalo et al., 2006; Clark et al., 2008; Schmid et al., 2008, and Rosioreanu et al., 2004).Let us remember that many transgender youths are homeless, having been abandoned by their family for their identity ( Burgess, 1999; Seaton, 2017, Keuroghlian et al., 2014, and Durso and Gates, 2012). Homelessness is of course a physical risk on its own. But whether the transgender child is homeless or not, they might seek puberty-blockers that can be found on the street or via questionable internet websites. Some transgender adolescents attempt to access this treatment after they are denied it through sanctioned means. Not only is the child not under medical supervision—and hence more at risk of dosage errors--but the medication can be counterfeit, i.e., either not really puberty-blockers at all, or synthetic PBT mixed with dangerous substances. This can, in turn, lead to infection and sadly even death (Garofalo et al., 2006; Clark et al., 2008; Schmid et al., 2008, and Rosioreanu et al., 2004).

Transgender children seeking puberty-blockers via their own means is clearly not an outcome any decent parent would want, even parents who disapprove of puberty-blockers in general. We might compare this to parents who disapprove of their children having sex but would never wish that their children contract an STD if they did. Indeed, one of the justifications behind having sexual education in school is that even if it is “best” for adolescents to wait, many will have sex anyway. This puts teens in grave risk if not taught to take proper precautions. Currently, many teens not only receive sexual education in school, but have access to both private and public health clinics to get access to sexually related treatment (Much like sexual education, minors’ access to sexual healthcare via public clinics varies by state and jurisdiction. See Goodwin et al., 2012, for an in-depth look at a state law in Arizona that afforded minors special rights related to sexual health).

I propose that we expand traditional sexual preventative health education to cover transgender health. We should include education relevant to transgender persons and transgender care, as well as have such care available at public and private health clinics. Admittedly, this wish might have better chances of becoming a reality in some parts of the United States than in other parts. Sexual education is not uniform throughout the US, and schools that insist on abstinence only education are unlikely to implement curriculum concerning transgender health. Notwithstanding, we should work toward implementing transgender health education where possible, and further work toward expanding these programs as conditions permit.

**5. Justifying Intervention**

*5.1 A child’s right to their body*

The first stages of puberty (and hence the approximate time to begin puberty-blockers) begins far younger than the age of legal majority ( Selva, 2017). Hence, we run into a dilemma if parents are insistent against such treatment. One potential solution, at least in the United States, is to appeal to what is known as *the mature minor doctrine*. This doctrine recognizes that some adolescents are wise beyond their years, and hence leaves room for these precocious children to make their own medical decisions when deemed sufficiently mature by the courts (Coleman and Rosoff, 2013). However, this is not the solution I want to defend. While I have no issue with using this justification in some cases, I believe that transgender children have a right to treatment apart from any use of the mature minor doctrine, a right that is both universal and not dependent on the transgender child possessing a specific level of maturity. After all, not all transgender youth meet the requirements of a mature minor. Hence if *all* transgender youth deserve access to PBT, it is best that we do so on different grounds. The justifying principles fit for this task are similar to principles used in the following two types of cases:

(1) Principles that justify taking a neglected child away from the home.

(2) Principles that justify performing a blood transfusion on children of Jehovah’s Witnesses.

Notice that in neither of the cases above is the mature minor doctrine the justification for state action. And while the justifications for these two interventions are not identical, the relevance of each is important. The comparison to negligence explains why the state must help even if the parents have no intention to harm their child. Just as is the case with negligent parents, transgender children should not suffer due to their parents’ unintentional mistakes.

 Sometimes parental decisions against PBT might be motivated from religious belief, i.e., parents might believe that God made people biologically the gender that they were “meant” to be. While there is a strong presumption supporting parental rights to raise their child according to the parents’ religious values, like most rights, this one is limited. As bioethical cases concerning Jehovah’s Witnesses have taught us, children should not be destined to suffer because of the religious beliefs of their parents(Guichon and Mitchell, 2008; Woolley, 2005, and Press Association, 2014). Children’s future autonomy, autonomy which includes making their own religious choices as adults, is arguably as important as a parent’s right to religion and hence must be preserved. While most religious choices made by parents do not interfere with a child making different choices when they reach adulthood, some do. Religious choices which prevent a child from ever reaching adulthood, or reaching adulthood in a healthy state, are problematic. And whether the parents fully understand or not, transgender children going through puberty of the “wrong” gender is harmful in this way. As we have seen, refusing PBT first presents immediate and intense psychological harm. And second, it causes lasting and *irreversible* physical harm(Bauer et al., 2015; Brill and Pepper, 2008; Burgess 1999; Cohen‐Kettenis et a., 2008; De Vries et al., 2012 and 2014; Delemarre-van de Waal et a., 2006 and Krieger 2011 and Zucker 2012).

 We can compare the parents of transgender children opposed to physician-recommended treatment to “naturalist” parents, i.e., parents who mistrust traditional Western medicine. Regardless of whether these parents have good intentions, these children are often at risk of harm. In various cases the courts have ruled that not only are these “naturalist” parents required to treat their children with Western medicine, but also that they are criminally liable if their children are harmed due to lack of treatment.

Just as it is the state’s duty to step in when naturalist parents are refusing insulin to their diabetic son or antibiotics to their daughter sick with meningitis, so is it the state’s duty to step in when the parents of gender dysphoric children are avoiding medically-recommended treatment. Whatever genuine mistrust parents might have of traditional treatment for gender dysphoria, as soon as their behavior threatens serious and irreversible harm to their child (and we can reliably identify as much), the state has a duty to intervene and protect the child. In this circumstance, this duty entails legally mandating that transgender children have a right to puberty-blockers.

 Let us consider what would happen if my criteria that justifies state action regarding transgender children and PBT would have implications for other cases. There are a number of conditions and activities, after all, that might put a child at risk of serious and irreversible harm. A few examples are refusing to give children certain vaccinations (consider HPV) or even refusing to spend quality-time with a child. There are two replies to those worried about the implications of my view. The first is that I am only advocating that the state take action if there is clear evidence that a youth faces a high risk of irreversible, serious, harm. Depending on what potential harm is at issue, the risk might be low, or we might lack proper evidence, or the harm might not be serious. Any one of the aforementioned (low risk, lack of evidence, lack of seriousness) justify the state staying out of parental affairs. However, supposing all of these conditions are meet (serious harm, high likelihood, evidence), state intervention seems a blessing rather than a curse. Why would anyone want children to be at serious risk of irreversible harm? While state intervention into parental authority must be justified, when it is justified, it is an ethically positive rather than negative state of affairs.

*5.2 Putting rights into practice*

For the sake of argument, suppose we have determined that transgender children have a right to PBT and the state has a duty to help enforce this right. How exactly, one might wonder, should the state intervene? Given that we are indeed entering new terrain when it comes to the state protecting children from psychological harm, it is important that the state not be perceived to be overstepping certain boundaries. If this interference is viewed as an unreasonable government intrusion, it might negatively influence the chances that the state could ever play a role in psychologically protecting minor children. For these reasons, the children themselves have an important part to play as a self-advocate.

The first step is for transgender children to seek help outside of the home. This could be possible to facilitate at school (as the next section argues), privately funded public health clinics like Planned Parenthood, or publically funded health clinics. A healthcare worker can then counsel the child through the process of applying for PBT, a process which adolescents should be allowed to conduct without parental permission. At some point in the process, perhaps the parents would be notified that their child is seeking this type of treatment and has a right to receive it. Parental notification has its pluses and minuses. In this particular situation, not notifying might result in confusion from parents who notice their child is not going through the normal puberty process. Notification would also open the door to therapy for child and parents together. Lastly, notification would likely make mandatory PBT easier to pass by legislatures. On the other hand, some children might face serious harm if parents are notified, and the risk of harm might be a reason to have an exception to any notification demands, if we are to have them at all.

There are many variations of the scenario I just described, and it requires a separate paper to discuss the specific details at length. Notwithstanding, what matters is that transgender children may apply for PBT in a way that makes them feel safe and empowered. One way to make the process easier is to have a state-sponsored website where a transgender child could apply for both a health mentor and puberty-blocking treatment. Another way is to have applicable services available in public schools. And this is the topic of the next section.

**6. Spreading the Word and the Role of Schools**

Even if we come to agreement regarding the right of transgender children to receive PBT, that is just one step of the process. The other is some sort of collective effort to articulate and publicize a public conception of transgender identity and the relevant recommended treatment for those seeking to transition. There are many moral reasons, of course, to support this second step of the process. But for the purposes of this essay, the primary reason is to facilitate transgender adolescents understanding of who they are and what medical interventions are available to help. It is only once adolescents understand this that they can seek PBT. Moreover, the less supportive their parents, the less likely the youth fully understands what it means to be transgender. Because of religious beliefs, parents might not allow their children to express their gender identity. Given the harm that can befall transgender young persons without proper information, there is a moral duty for all of us to help communicate the issue and a duty for the state to make efforts to protect this vulnerable population.

 The best place to provide information about gender identity and treatment for transgender adolescents is public schools. The reasons are both pragmatic and moral. The pragmatic justification is that there is perhaps no other place where such a large number of children are gathered together. It has already been accepted that schools have a role to play in youth healthcare. Schools are commonly where children are screened for eye problems, scoliosis, and hearing issues. In addition, schools are places of learning: what it means to be transgender and potential treatment is just one more thing to learn. The most obvious place to include this lesson is part of sex education. Earlier lessons are also a good idea. But a refresher course that begins around the same time as sexual education is the perfect place to teach about PBT. Sexual education, after all, usually occurs right before most children start puberty.

 For children who lack supportive homes, a lesson at school is not enough. If these adolescents asked their parents for PBT, the parents would likely refuse. Thus, each school should have a trusted counselor, with whom students know they can discuss gender dysphoria issues (and schools already should have a counselor trained to assist with the various psychological problems that arise with adolescents) (Levine, p.308, 2013).Lastly, whether it be directly connected to the school or not, advocates for transgender children should be publicly provided. Adolescents are unlikely to be resourceful enough to confront and negotiate with unsupportive parents themselves. They need help, not only with receiving the puberty-blockers, but with counseling and emotional support. These children, after all, will likely be experiencing a tough situation at home going against their parents’ wishes. Hence, for children who do proceed with PBT sans parental approval, a support system should be in place to help these children through an emotionally difficult situation.

Obviously, not all minors attend public school. In fact, one might argue that children with less supportive parents are more likely to attend a private religious school. As such, much of the effort to inform other families will need to be performed by private persons and organizations, perhaps through websites, videos, and testimonials from transgender youth and their families. Indeed, these types of activities are already fostering greater public awareness (Craig et al., 20014; Mehra et al., 2004, and Land, 2016). We should hope that transgender children will take initiative and search for information online. Yet there still remains a small but important role for the state. Large cities with sufficient budgets could and should fund either healthcare centers for transgender youth, or to integrate healthcare services at existing community health centers. Such healthcare services can offer free information about PBT and other issues relevant to transgender healthcare. Counselors could be available to talk to those who need help. Public service announcements can broadcast over the internet, television, and radio. Consider that today very few people are unaware of the dangers of smoking. Public service information campaigns played an important role in public awareness and helping smokers quit (Siegel and Biener, 2000; Warner, 1977; Wakefield et al., 2008, and Brook, 2004). Young persons are often savvier than we think, and many (but not all) are likely to find their way. It is impossible to inform everyone, but the state has an obligation to make reasonable efforts to help those minors who are not yet of age to fully help themselves.

**7. Objections and How to Answer Them**

Here I respond in detail to two objections that I suspect will be common lines of argument against my proposal. (Such suspicions are based on discussions with academics, physicians, therapists, and lay persons.)

*7.1 Parental rights to raise their children*

One objection to my proposal is simply a concern about the intrusion it imposes on the autonomy of the family. Imagine that parents have religious values against children expressing transgender dress and behavior. Are not parents allowed to raise their kids according to their own religious values? And if so, how can I argue that parents must be forced not only to accept, but to facilitate, transition?

The mistake here is in thinking that parents have rights to raise their children according to their religious values, *full stop*. Like nearly all rights, the right of parents to raise children according to their own values is not absolute. Rather, parents have such authority up and until the point at which a given decision or practice threatens serious harm. According to some religious sects, after all, girls who are raped should be put to death. Obviously, parents have no right to do this regardless of whether doing so accords with their religion. Requiring that transgender adolescents have access to PBT is simply an instance of preventing parents from imposing harmful values against their children’s will. The reason we may be disinclined to see things this way is that (1) much of the harm is psychological, and (2) some of the harm will occur in the future. But when we think about it, neither of these are sufficient grounds. The first reverts back to our bias that physical harm is worse than psychological (even though the latter often leads to death via suicide), while the second is ethically irrelevant. A parent who encouraged their toddler to smoke would be abusing the child, even if the harmful effects would not be present for decades to come.

*7.2 Funding issues*

The legal right to PBT is not the only barrier that transgender youth face in accessing PBT. How to pay for it is another issue (Khan 2011; Reisner et al., 2015 and 2014; Macapagal et al.; 2016, and Shipherd et al., 2010). Some transgender adolescents with non-supportive parents have insurance that would cover PBT, others do not( Baker 2015; Stevens et al., 2015; Khan 2011 and Stroumsa 2014). Some reside in states where PBT treatment would be covered via state-sponsored healthcare schemes, others do not (Green, 2014; Sheets 2014; Reisner et al., 2015). Still other transgender teens would have access to charitable sources to pay for PBT while others would lack this option ( Wylie, 2016).Regardless, even if transgender adolescents have the legal right to seek PBT without parental permission, it does not follow that they would be able to access PBT. It might sadly be the case that a transgender adolescent has no means of funding expensive PBT treatment.

 While I acknowledge funding PBT is an important issue, it is simply a separate issue from the one addressed in this paper. If funding was available to all transgender youth who desired PBT, transgender youth without supportive parents would still lack the treatment they need. Parental permission and funding are two separate obstacles that transgender youth face in receiving PBT. Because they are separate obstacles, (i.e. these obstacles are not conceptually linked: adolescents can run into one obstacle but not the other) they require distinct scholarly investigations. This paper attempts to fill a distinct gap in the literature while in no way minimizing the importance of tackling healthcare funding for transgender youth.

*7.3 Why not take it further?*

I have argued for a rather narrow proposition – namely, that transgender adolescents have a right to PBT without parental approval. I have also argued that the state should play a role in providing information to transgender youth who might not have supportive families. Some might think I should go further and argue, for instance, that transgender youth should be able to get cross-sex hormone-treatment without parental approval or that young children should be able to dress in accordance with their gender identification. Let me start with the latter first. It is important to keep the reach of the law to what it can enforce. Having unenforceable laws creates a false sense of security. It is also important to not overuse the power of the state since laws that help a just cause can quickly lead to other laws which work against it. I worry that trying to legally enforce how parents allow transgender children to dress is unenforceable, or if enforced, would stretch the appropriate powers of the state. Another concern with such regulation is that the harms imposed do not threaten the same irreversibility as the absence of PBT. Once an adolescent turns 18, they may dress as they wish. Being forced to dress a certain way as a youth does not impair their ability to dress as one wants as an adult. With PBT, however, the absence of this treatment not only has consequences for the youth’s body while they are a youth, but also when they are an adult. The feasibility concerns, alongside the lack of permanent harm, explains why it is a mistake for the state to enforce a dress code, but apt to enforce PBT. There remains the potential, of course, for scholars to argue otherwise. Yet for the purposes of this paper, the ethical reach is constrained to a few issues that can currently be advocated with confidence.

 Unlike enforcing dress requirements, requiring that underage transgender teens have a right to cross-sex treatment is plausibly enforceable. Yet I restrain my paper to arguing only for PBT latter for a few reasons. I want to make the strongest argument I can in favor of something that can have a real impact in the life of marginalized young persons. My argument for PBT is stronger than any argument for cross-sex hormones might be. Hence, I want to devote a paper entirely to making this strong case, without the risk that other issues bring my whole argument into doubt.

The case for PBT is stronger than cross-sex hormones for a few reasons. First, cross-sex hormones (unlike PBT) induce irreversible changes (Coleman et al., 2017). It is more plausible to argue that minors should have access to reversible treatment than treatment that causes permanent changes. Second, as mentioned, in many parts of the world, minors reach the medical age of consent, or even the full age of majority, at 16 or younger, which is already the recommended age to begin cross-sex hormone-treatment (De Vries and Cohen-Kettenis, 2016, and Hembree, 2009).

**8. Review and Concluding Remarks**

This paper argued that (1): transgender adolescents should have the legal right to access puberty-blocking treatment (PBT) without parental approval; and (2), the state has a role to play in publicizing information about gender dysphoria, appropriate treatment, and leading gender dysphoric youth to appropriate healthcare resources. First let me review my main argument for the former. There is now well-documented evidence that transgender youth who lack access to PBT suffer both physically and emotionally (Coleman et al., p.178, 2012; Olson et al., 2016; Gorin‐Lazard et al., 2012; and De Vries et al., 2014). Emotional harm can be long term, and might even result in suicide (Haas et al., 2010). Certain physical changes which transgender youth experience during puberty are irreversible ( Bauer et al., 2015; Brill and Pepper, 2008; Burgess 1999; Cohen‐Kettenis et a., 2008; De Vries et al., 2012 and 2014; Delemarre-van de Waal et a., 2006 and Krieger 2011 and Zucker 2012). For the transgender person these permanent physical changes are harms that prevent one from living a satisfying life ( Burgress 1999; Cohen-Kettenis et al., 2011; De Vries et al. and 2014; Frisch 2014). In addition, transgender youth who lack support in the home are at an unusually high risk of homelessness, and might even end up seeking PBT through non-medically secure fashions (Burgess, 1999; Seaton, 2017, Keuroghlian et al., 2014, and Durso and Gates, 2012 ; Garofalo et al., 2006; Clark et al., 2008; Schmid et al., 2008, and Rosioreanu et al., 2004).

 Not only are transgender youth harmed psychologically and physically via lack of access to PBT, but PBT is an established standard of care. Given that we generally think that parental authority should not go so far as to, (1) severely and permanently harm a child, and (2) prevent a child from access to standard physical care, then it follows that parental authority should not encompass denying gender dysphoric children access to PBT.

 Implementing the above policy only is half the battle. Transgender youth without supportive parents are not helped unless they access healthcare clinics and counseling that will help with the transition. Hence there is an additional duty of the state to help facilitate sharing this information with vulnerable youths. I argued that one of the first places this should be done is in public schools. In addition, information should be available at publicly funded health clinics.

While it is implausible that the state will stop all forms of parental abuse, especially all forms of psychological abuse, transgender youth seeking puberty-blocking treatment is a special case. It is special because the need for the treatment and the treatment itself are identifiable and accessible, respectively. As such, it is sensible and legitimate for the state to take action via legislation. More specifically, the law should clearly state that transgender youth (after having meet appropriate diagnostic criteria) have a legal right to PBT regardless of parental approval. In addition to these legal parameters, the state should play a role in publicizing information about gender dysphoria and treatment via public schools, government sponsored websites, and public service announcements.

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1. One landmark case that comes to mind is Prince vs. Massachusetts where the court ruled that a child’s welfare can justify overruling parental rights, even parental rights regarding a child being raised according to parental religious beliefs (https://www.law.cornell.edu/supremecourt/text/321/158 ).But what is a child’s welfare? Generally, we have seen this ruling bear out in laws against neglect and abuse which generally (but not exclusively) override parental authority in cases in which a child faces *physical* harm. [↑](#footnote-ref-1)
2. States and counties which have laws prohibiting “conversation therapy” include Pima County, AZ; Westminster, CO ; Bay Harbor Islands, FL ; Boynton Beach, FL ;Delray Beach, FL ;El Portal, FL ;Greenacres, FL ;Key West, FL ;Lake Worth, FL; Miami, FL ;Miami Beach, FL ;Riviera Beach, FL ;Tampa, FL ;Wellington, FL ;West Palm Beach, FL ;Wilton Manors, FL ;Athens, OH; Cincinnati, OH  Columbus, OH ;Dayton, OH ;Toledo, OH ;Allentown, PA ;Philadelphia, PA ;Pittsburgh, PA and Seattle, WA. (See, Kids Pay the Price: 2017). [↑](#footnote-ref-2)
3. Every US state now has a law against bullying. Admittedly, the definition of “bullying” varies by district. The extent of the penalty for violating bullying laws also varies. Notwithstanding, the fact that these laws are common place speaks to a growing concern for the psychological health of adolescents (“Specific State Laws Against Bullying”, 2017). Another sign that we are taking psychological harm more seriously is the increasing use of psychiatric medication. According to a 2013 report from the CDC, “Approximately 6.0% of U.S. adolescents aged 12–19 reported psychotropic drug use in the past month” (See Jonas et al.:2013). Please note this is in reference to all youth, not just transgender youth. We are taking psychological harm more seriously across the board, and transgender youth deserve special attention in this regard, for they face increased risk of these mental harms. [↑](#footnote-ref-3)
4. “Gender dysphoria is usually experienced from childhood on, and it is not based on any cultural preference but on a person’s innate sense of self: it is characterized by persistent discomfort and distress about one’s assigned sex or gender…” (Brill and Pepper: 200: 2008). And similarly, “…*gender dysphoria* refers to discomfort or distress that is caused by a discrepancy between a person’s gender identity and that person’s sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)” (Coleman et al.: 2017). [↑](#footnote-ref-4)
5. “During the last decade, more children have made a social gender role transition, sometimes as early as 4 or 5 years of age” (de Vries and Cohen-Kettenis 2016). And similarly, “Children as young as age two may show features that could indicate gender dysphoria” (Coleman et al., 2017). See also, Brill and Pepper, 2008. [↑](#footnote-ref-5)
6. These examples are taken from the experience of real families. The first can be found in Nutt, 2017 and the second in Whittington and Gasbarre, 2016. [↑](#footnote-ref-6)
7. Of course, gender nonconforming behavior does not alone mean that a child is transgender (nor does its absence mean a child is cisgender.) Plenty of cisgender children enjoy games and dress that is traditionally considered typical of the opposite gender. Nonetheless, gender nonconforming behavior is often listed as one of the many “signs” that a child might be transgender. For example, in *Principles of Transgender Medicine and Surgery*, Walter Bockting (Professor of Medical Psychology) and Eli Coleman (Professor of Family Medicine and Community Health) describe one “vignette” in the early stages of the coming-out process (coming out as transgender) in the following fashion, “His parents expressed concern about Ben’s gender nonconformity. People regularly mistook him for a girl. Ben identified with Dorothy from The Wizard of Oz. At Christmas, he asked for ruby slippers” (Ettner, et al.: 140:2016). [↑](#footnote-ref-7)
8. For information on transgender youth and homelessness, see Burgess, 1999; Seaton, 2017, Keuroghlian et al., 2014, and Durso and Gates, 2012. Seaton and Durso and Gates contain specific information about the risk factors for transgender homelessness. [↑](#footnote-ref-8)
9. The studies mentioned include Bauer et al., 2015 and Travers et al, 2012. In addition, Olson et al., 2016 show that transgender children who do have supportive parents have average levels of depression. In these studies support was measured via surveys where transgender teens described the level of support they received from their parents. [↑](#footnote-ref-9)
10. Throughout this paper, I will use the term “they” as a singular gender-neutral pronoun. The term “they” is becoming increasingly used (and advocated) as a singular gender-neutral pronoun, especially amongst the LGBT community. For instance, see Dembroff and Wodak 2018, and McKenzie and Dembroff, 2018. [↑](#footnote-ref-10)