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I Am Whoever You Say I Am: How the Custodial Decisions of Parents Can Affect and Limit a Transgender Child's Freedom and State of Mind

*By Kasia Szczerbinski**

I. INTRODUCTION

What were your favorite things to do as a child? Perhaps you had make-believe tea parties, played catch, or jumped rope. What did your favorite game say about you as a person? Maybe it showed your creative side or a propensity for athleticism. Was your favorite game an activity accepted by your peers? Was it something you could tell your friends and family members about, prompting praise and excited pictures to capture the moment?

For Coy Mathis, whose sex at birth was male and now enjoys her life as a transgender girl, his favorite thing to do was play dress-up.¹ But it was never the fireman or knight costumes that interested him—it was the frilly tutus, butterfly wings, and princess dresses that caught his eye.² For Coy's parents, Jeremy and Kathryn Mathis, this was merely a toddler engaging in harmless play, still unaware of the social constructions of gender norms.³ They assumed it was just a phase their child was going through or that he might be gay until January 2010.⁴ Kathryn was putting Coy to bed and noticed her toddler seemed upset.⁵ When she asked what was wrong, Coy's response would change the Mathis family forever.⁶ Quickly going from quivering his chin to crying, Coy responded, "When are we going to go to the doctor to have me fixed? To get my girl parts?"⁷ This was not just a phase Jeremy and Kathryn's child was going through—this was their child struggling with his gender identity, believing he was born in the wrong body.

Coy is far from alone in her struggles with gender identity. Today, expressions of gender nonconforming behavior are becoming more common and there is an increased presence of openly transgender persons in the media and our everyday lives. This has led to an enhanced public understanding of gender identity as well as a public debate regarding the legitimacy of an individual claiming to be a gender different than their assigned gender. A child's gender identity is their internal sense of self as a boy or girl.⁸ A child's internal sense of gender where there is a discrepancy between a person's gender identity and that person's assigned sex at birth, causing discomfort or distress, can result in a gender dysphoria diagnosis.⁹

Outside of gender experts, few professionals, even within the medical community, understand childhood identity issues.¹⁰ This leads to professionals, who oftentimes lack useful

* B.A. 2013, Albion College; J.D. 2016, Loyola University Chicago School of Law.

¹ Sabrina Rubin Erdely, *About a Girl: Coy Mathis' Fight to Change Gender*, ROLLING STONE (Oct. 28, 2013), <http://www.rollingstone.com/culture/news/about-a-girl-coy-mathis-fight-to-change-change-gender-20131028>.

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

⁷ *Id.*

⁸ Erika Skougard, *The Best Interests of Transgender Children*, UTAH L. REV. 1161, 1165 (2011).

⁹ Coleman et. al., *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People*, Version 7, 13 INT'L J. OF TRANSGENDERISM 165, 168, 172 (2012).

¹⁰ Skougard, *supra* note 8, at 1164.

information or proper training in addressing childhood identity problems, becoming shocked and automatically assuming a parent permitting their child to violate gender norms is irresponsible, if not negligent.¹¹ Because of the lack of relevant research and studies, it is unclear what causes gender dysphoria and how many children have this disorder.¹² Even after a diagnosis is made, viewpoints on the best treatment method for gender dysphoria widely differ. This failure to be educated or trained in regards to gender dysphoria goes from the doctor's office to the courts, where judges have a great deal of discretion in custody determinations. This discretion can lead to parents who are supportive of their child's gender dysphoria losing custody to the non-supportive parent and disregarding children's rights.¹³

Modern academic literature has been pushing on an international level for judges to take children's rights as a whole more seriously, even before adding children with gender dysphoria to the equation.¹⁴ The theories regarding where children's rights originate and what rights children have are greatly disputed, making it difficult to create any clear standard. For example, children can be deemed competent enough to access contraceptive advice and abortions but incompetent to refuse life-saving treatment.¹⁵

Beyond the concept of children's rights, courts struggle to develop best practices when determining custody arrangements involving a transgender child. The role of the parent, the debate over the proper application of the "best interests of the child" principle, and the judge's discretion in custody cases have created an environment where parents who are supportive of their child's self-identification run a high risk of losing custody if the treatment of the child's gender dysphoria is debated among the parents.

A best practices standard must be created and added to the policies regarding custody proceedings in order to better protect children's rights. These revisions may help standardize this type of court proceeding and enable courts to make decisions focused more on empirical evidence and the wishes of the child rather than basing their decisions on their personal biases and conceptions of gender norms. While there is still a great deal of research to be done on this topic, I have created a recommendation advocating the utilization of advisory councils in court proceedings and an adherence to more uniform treatment options.

In Section II, this Article will first discuss background information about gender dysphoria—usage of the term "transgender" in this Article, social perceptions of transgenderism, and treatment of this issue compared to other issues related to minors. Section III will discuss the gender dysphoria diagnosis will be introduced in Section III, as well as treatment options available. Section IV will explore how a minor's identification as transgender affects major aspects of that

¹¹ *Id.*

¹² J. Lauren Turner, *From the Inside Out: Calling on States to Provide Medically Necessary Care to Transgender Youth in Foster Care*, 47 FAM. CT. REV. 552, 553–54 (2009) ("There are a number of reasons for the lack of statistical data representing the number of transgender youth . . ."); see also Barbara Fedders, *Coming Out for Kids: Recognizing, Respecting, and Representing LGBTQ Youth*, 6 NEV. L.J. 774, 779 (2006) ("To date no one has completed a study assessing the number of transgender youth.").

¹³ David Alan Perkiss, *Boy or Girl: Who Gets to Decide? Gender-Nonconforming Children in Child Custody Cases*, 25 HASTINGS WOMEN'S L. REV. 57, 74–75 (2014) (When courts determine whether a child has gender dysphoria, if no diagnosis is made, then treatment is not ordered. A consequence of the failure to make a diagnosis is that courts then find it harmful for a child to live with a parent supporting the child's nonconforming identity).

¹⁴ John W. Tobin, *Judging the Judges: Are They Adopting the Right Approach in Matters Involving Children?*, 27 MELBOURNE U. L. REV. 579, 581 (2009) (While the United States has not ratified the United Nations Convention on the Rights of Children, the author views this issue through an international lens); see also Fedders, *supra* note 12, at 778 ("Universal agreement on what 'transgender' means is . . . lacking.").

¹⁵ Tobin, *supra* note 14, at 600.

minor's life, from educational experiences to mental, social, and physical health. The current legal environment regarding the rights of the parents of transgender youth will be examined in Section V through the use of case law and consideration of critical factors that determine custody. This includes the concept of "parental rights," the "best interests" principle, and the judge's discretion in custody determinations. Finally, Section VI will introduce proposals for change, which includes both ideas for further research and a recommendation for an accepted practice of approaching gender dysphoria treatment in domestic relations cases involving custody determinations.

II. BACKGROUND

A. Usage of the Term "Transgender" Throughout this Article

"'Transgender' is an umbrella term used to describe a person who expresses gender in a way that does not conform to prevailing societal expectations."¹⁶ Transgender persons identify themselves in a variety of non-stereotypical manners, such as genderqueer, gender-nonconforming, or pre-operative/post-operative.¹⁷ "Not everyone who is transgender has [gender dysphoria] but . . . those who do have [gender dysphoria] should receive proper and necessary treatment."¹⁸ Throughout this Article, the term transgender will refer to someone with gender dysphoria unless indicated otherwise.

B. Social Perceptions of Transgenderism, Particularly Regarding Transgender Minors

Today's social landscape reflects a culture more willing than ever to support the transgender population.¹⁹ Transgender issues are readily found in the media and most of the attention has been positive.²⁰ Recently, the Indiana legislature promulgated a controversial religious objections law that drew mostly negative and widespread criticism from Democrats, liberal groups, as well as some businesses (such as the NCAA) and high-profile leaders (such as Hilary Clinton and the CEO of Apple).²¹ Even the current bill that attempts to repeal most of this law is still drawing criticism due to the lack of protections for transgender people.²² Transgender people can be easily found in popular culture and on social media: television programs such as

¹⁶ Julie Anne Howe, *Transgender Youth, the Non-Medicaid Reimbursable Policy, and Why the New York City Foster Care System Needs to Change*, 2012 THE DUKEMINIER AWARDS 1, 4 (2012).

¹⁷ *Id.*

¹⁸ *Id.* at 5 (Not everyone who feels and/or expresses gender nonconforming attitudes qualifies for a diagnosis of gender dysphoria. For those diagnosed with gender dysphoria, treatment is crucial.).

¹⁹ Susan Scutti, *Transgender Youth: Are Puberty-Blocking Drugs An Appropriate Medical Intervention?*, MEDICAL DAILY (June 24, 2013), <http://www.medicaldaily.com/transgender-youth-are-puberty-blocking-drugs-appropriate-medical-intervention-247082> ("Awareness of the condition appears to be increasing because of this greater social visibility and presumably social acceptance.").

²⁰ Margaret Talbot, *About a Boy*, NEW YORKER (Mar. 18, 2012), <http://www.newyorker.com/magazine/2013/03/18/about-a-boy-2>.

²¹ Brian Slodysko, *Panel OKs Gay Rights Bill but Leaves Out Transgender Rights*, THE ASSOCIATED PRESS (Jan. 27, 2016), <http://abcnews.go.com/Politics/wireStory/indiana-senate-poised-lgbt-rights-bills-36541017>; see also Jack Linshi, *What You Need to Know About Indiana's Controversial Religious Objections Law*, TIME (Mar. 29, 2015), <http://time.com/3762656/indiana-religious-objections-law/> (explaining that the religious objections law "prohibits any state law that would 'substantially burden' a person's ability to follow his or her religious beliefs.").

²² Slodysko, *supra* note 21.

*Glee*²³, featuring LGBT²⁴ youth; Tumblr accounts and YouTube videos following transitioning individuals on the internet; and books aimed towards youth, such as *Parrotfish* by Ellen Wittlinger²⁵, are readily accessible.²⁶ LGBT groups and school diversity clubs are more widely available to provide LGBT youth with guidance, support, and accurate information.²⁷

With this trend of growing acceptance, there has been a striking change in medical practices, which now offer transgender people the possibility of switching gender at younger ages.²⁸ The treatment of transgender children, where both medical and psychiatric opinions are in a state of incredible flux, has become a civil rights issue in the same way as homosexuals undergoing psychiatric treatment in the 1970s.²⁹

C. Treatment of this Issue Compared to Other Issues Relating to Minors

Many legal systems have seen a noticeably growing trend of examining children's issues in terms of their own rights, despite resentment and resistance in some circles.³⁰ One of the biggest issues facing children's rights is the absence of clear legal definitions and boundaries. This conceptual instability creates a complicated and often-contradictory landscape of case law related to children's rights. This makes it difficult to understand what rights have been established and which ones are still in flux. One of the best examples of contradictory decisions regarding children's rights can be found concerning the issue of reproductive health.

There have been positive steps forward for youth related to their reproductive health. The U.S. Supreme Court held that blanket laws requiring pregnant minors seeking an abortion to obtain parental consent are unconstitutional.³¹ This is because requiring a minor to obtain the consent of her parents or judicial approval following notification to her parents inflicts an undue burden on a pregnant minor seeking an abortion.³² However, the Court's decisions are both progressive and regressive. For example, states have the right to require parental notification in certain circumstances but states cannot restrict access to abortions necessary to preserve the health or life of the mother.³³ Further, state laws do not typically prohibit physicians from writing prescriptive

²³ Rubin Erdely, *supra* note 1.

²⁴ LGBT stands for Lesbian, Gay, Bisexual, and Transgender. UNIV. OF MICH., *LGBT Terms and Definitions*, <https://internationalspectrum.umich.edu/life/definitions> (last visited Apr. 22, 2016).

²⁵ ELLEN WHITTLINGER, *PARROTFISH*, (2015) (The story of a transgender teenager, searching for identity and acceptance).

²⁶ Talbot, *supra* note 20.

²⁷ CAITLYN RYAN, *HELPING FAMILIES SUPPORT THEIR LESBIAN, GAY, BISEXUAL, AND TRANSGENDER (LGBT) CHILDREN* 1 (2009), http://nccc.georgetown.edu/documents/LGBT_Brief.pdf.

²⁸ Talbot, *supra* note 20.

²⁹ Alex Spiegel, *Two Families Grapple with Sons' Gender Identity*, NPR (May 7, 2008), <http://www.npr.org/2008/05/07/90247842/two-families-grapple-with-sons-gender-preferences>.

³⁰ Tobin, *supra* note 14, at 583.

³¹ *Bellotti v. Baird*, 443 U.S. 622, 643 (1979). Unmarried, minor women were required under Massachusetts law to gain consent from both her parents prior to having an abortion. If the minor is unable to gain this consent, a superior judge may issue a consent order. *Id.* The Court held that there needs to be a balance between a parent's ability to make decisions for their minor and the minor's right to have an abortion. *Id.* So, as long as the State provides an alternate procedure, the minor's right to an abortion may be conditional upon parental consent. *Id.*

³² *Id.* at 651.

³³ *Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320, 326–27 (2006). A court chose to invalidate an entire statute because there would be unconstitutional results in a small percentage of cases. The statute was deemed unconstitutionally narrow as it allowed an exemption for parent notification when the abortion is necessary to prevent the death of the mother, but did not exempt abortions necessary to protect the mother's health. *Id.* at 325. In a

contraception for a minor but many permit the physician to breach confidentiality and inform the parent of the prescription.³⁴

Despite the numerous rulings on youth reproductive health, the standard for measuring youth competency remains unclear. It is not uncommon for courts to find children competent to have access to contraceptive advice and abortions, but when children refuse life-saving treatment, their competency has been routinely denied—even when the child in question is wholly aware of the consequences of their decision.³⁵ In *In re E.G.*, a seventeen-year-old girl developed leukemia and needed blood transfusions as part of her medical treatment.³⁶ Both E.G. and her mother refused to consent to the transfusions on the basis of their shared religious beliefs, resulting in the State filing a neglect petition.³⁷ In the trial court's order, a temporary guardian was appointed for E.G. who, acting on E.G.'s behalf, would consent to the transfusions.³⁸ Additional hearings regarding this matter took place and E.G. testified in court that her refusal to consent to blood transfusions was her own decision and that she understood her diagnosis and the consequences of her refusal.³⁹ She also testified that the court's decision, which led to her being forced to undergo the transfusions, greatly upset her – she said, “[I]t seems as if everything that I wanted or believe in was just being disregarded.” The trial court stated in their decision that they found E.G. to be a “‘mature 17-year-old individual,’ that E.G. reached her decision on an independent basis, and that she was ‘fully aware that death [was] assured absent treatment.’”⁴⁰ Despite this, the court held that the State's interest in valuing sanctity of life and exercising its *parens patriae* power to protect those unable to care for themselves was greater than E.G. and her mother's interests, though great weight was given to the wishes of E.G. because of her maturity and religious beliefs.⁴¹

Studies show that the standards applied to youth actually contradict research on the subject. To illustrate, some states require parental notification or parental consent, but this notification or consent fails to promote health precautions in prevention of unwanted pregnancies or unwanted diseases in youth.⁴² Nearly sixty percent of participants in a 2002 Planned Parenthood study said they would stop using healthcare services if parental consent was required, but 99% of these participants said they would continue having sex.⁴³ Empirical evidence should be weighed when determining policies or laws to help ensure laws are created that actually work toward their intended purpose.

III. GENDER DYSPHORIA

unanimous decision, the Court held that invalidation of the entire statute was unnecessary and lower courts may issue an injunction and declaratory judgment only prohibiting the statute's unconstitutional application. *Id.* at 331.

³⁴ Paul Arshagouni, “*But I’m an Adult Now... Sort Of*”: Adolescent Consent in Health Care Decision-Making and the Adolescent Brain, 9 J. HEALTH CARE L. POL’Y 315, 325 (2006).

³⁵ Tobin, *supra* note 14, at 600.

³⁶ *In re E.G., a Minor*, 549 N.E.2d 322, 323 (1990).

³⁷ *Id.* at 323.

³⁸ *Id.* at 324.

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ *Id.* at 324, 327.

⁴² Arshagouni, *supra* note 34, at 324.

⁴³ *Id.*; see also Melissa Weddle & Patricia K. Kokotailo, *Confidentiality and Consent in Adolescent Substance Abuse: An Update*, 7 VIRTUAL MENTOR ETHICS J. OF THE AM. MED. ASS’N, 2005, <http://journalofethics.ama-assn.org/2005/03/pdf/pfor1-0503.pdf> (“When adolescents perceive that health care services are not confidential, they report that they are less likely to seek care, particularly for reproductive health matters or substance abuse.”).

A. Defining the Term

In general terms, gender dysphoria describes individuals who believe they were born in the wrong biological body.⁴⁴ More specifically, the Diagnostic and Statistical Manual of Mental Disorders (“DSM”) explains that “[g]ender dysphoria refers to the distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender.”⁴⁵ Although not every individual diagnosed with gender dysphoria will be distressed as a result of the incongruence, the lack of availability of desired physical interventions by means of hormones and/or surgery is distressing to many.⁴⁶ Gender dysphoria is not only more descriptive than *gender identity disorder*, the previous DSM-IV term, but is also focuses less on identity and more on dysphoria as the clinical problem.⁴⁷

Currently, the diagnostic criteria for gender dysphoria in children requires:

- A. A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months’ duration, as manifested by at least six of the following (one of which must be Criterion A1):
 1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one’s assigned gender).
 2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
 3. A strong preference for cross-gender roles in make-believe play or fantasy play.
 4. A strong preference in toys, games, or activities stereotypically used or engaged in by the other gender.
 5. A strong preference for playmates of the other gender.
 6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or, in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
 7. A strong dislike of one’s sexual anatomy.
 8. A strong desire for the primary and/or secondary sex characteristics that match one’s experienced gender.
- B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.⁴⁸

The American Psychological Association uses the following definition for gender identity: “as a person’s deeply felt, inherent sense of being a girl, woman, or female; a boy, a man, or male; a blend of male or female; or an alternative gender.”⁴⁹ For gender nonconforming persons, their assigned sex at birth is not congruent with their gender identity, where there is a spectrum of the

⁴⁴ Spiegel, *supra* note 29.

⁴⁵ AM. PSYCHIATRIC ASS’N, *Gender Dysphoria*, in DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013), <http://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm14#CFHEJFCE>.

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ AM. PSYCHOLOGICAL ASS’N, GUIDELINES FOR PSYCHOLOGICAL PRACTICE WITH TRANSGENDER AND GENDER NONCONFORMING PEOPLE 832, 834 (2015).

extent a person's gender identity differs from their assigned sex.⁵⁰ The Association advocates for medical professionals (specifically, psychologists) to have a nonbinary understanding of gender and increased comprehension of the varying degrees of gender identities and gender expressions.⁵¹

Protocols exist for medical professionals that evaluate whether a youth has gender identity disorder can involve projective testing, cognitive testing, general emotional development, and observation of a variety of gender-specific tasks.⁵² For example, one protocol uses The Tanner Stages, which outline the stages of puberty, to determine when it is best to begin hormonal therapy.⁵³ Examining gender stereotypes requires caution, especially as expressions of masculinity and femininity are culturally⁵⁴ and historically specific, regardless of biology's influence.⁵⁵

B. Treatment Options—Finding an Approach to Treatment

Once gender dysphoria is properly diagnosed, determining the method of treatment can be problematic. When no agreed treatment plan exists, it can later lead to parental disagreements during custody arrangements because the parents' approaches to treatment can vary so widely that failure to abide by their method could be seen as abuse. The divide between approaches to treatment is intense and offers very little common ground, even in the conceptualization of the issue. The two dominant approaches either support the child's gender identification or reject that identification.⁵⁶

Under the *supportive approach*, parents allow their child diagnosed with gender dysphoria to self-identify and express their gender nonconforming behaviors and feelings.⁵⁷ A child psychologist or other qualified mental health professional with expertise in childhood gender-identity issues is required to guide treatment (which can involve, among other services, therapy, family counseling, and hormone treatment if deemed necessary).⁵⁸ The supportive view maintains that it is crucial to support and embrace the child's core identity, aiding the child's emotional well-being; conversely, parental attempts to change or suppress this core identity have been found to be both harmful and futile.⁵⁹ Some parents worry that giving their child permission to express their gender identity amounts to encouragement of the behavior,⁶⁰ and these worries result in the implementation of different (or nonexistent) treatment plans. Unfortunately, as a result, parents often take the supportive approach only after their child has suffered after living in psychologically harmful environments.⁶¹

The *non-supportive approach* seeks to prohibit a child from defining or expressing their gender identity if it goes against stereotypical, traditional gender standards. This approach often

⁵⁰ *Id.*

⁵¹ *Id.* at 835.

⁵² Alex Spiegel, *Q&A: Therapists on Gender Identity Issues in Kids*, NPR (May 7, 2008), <http://www.npr.org/templates/story/story.php?storyId=90229789>.

⁵³ STEPHANIE BRILL & RACHEL PEPPER, *THE TRANSGENDER CHILD: A HANDBOOK FOR PROFESSIONALS* 206 (2008).

⁵⁴ *Id.* at 9.

⁵⁵ Ruth Padawer, *What's So Bad About a Boy Who Wants to Wear a Dress?*, N.Y. TIMES MAG. (Aug. 8, 2012), <http://nyti.ms/NhPVaD>.

⁵⁶ Spiegel, *supra* note 29.

⁵⁷ Skougard, *supra* note 8, at 1172.

⁵⁸ *Id.* at 1173.

⁵⁹ *Id.*

⁶⁰ Jesse Green, *S/He*, N.Y. MAG. (May 27, 2012), <http://www.nymag.com/news/features/transgender-children-2012-6/>.

⁶¹ Skougard, *supra* note 8, at 1174.

advocates the use of “corrective therapy,” a treatment method that many parents and clinicians now reject,⁶² which aims to help a child diagnosed with gender dysphoria feel more comfortable in their biological sex by limiting the child’s play activities to conform closely to traditional gender stereotypes.⁶³ Parents fear that allowing their child to act in gender nonconforming ways encourages the child to choose their gender preference.

Some parents still use conversion therapy to change their child’s gender identity,⁶⁴ “a treatment model paralleling the now-discredited ‘reparative therapy’ aimed at ‘curing’ homosexuals.”⁶⁵ This practice has been outwardly condemned by every major medical and mental health organization in the United States as harmful and ineffective.⁶⁶ Both the American Psychological Association and the American Academy of Pediatrics reject the use of conversion therapy, saying that not only is this method ineffective, but it frequently inflicts great psychological distress.⁶⁷ Courts properly applying the best interests principle when determining custody arrangements ultimately reject the conversion therapy approach and promote placement of the youth with the supportive parent,⁶⁸ or, at the very least, require the State to take control under *parens patriae*⁶⁹ to determine the child’s best interests.

1. Physical interventions

Some courts have recently recognized that transgender-related healthcare, such as hormone therapy, is well-established and medically necessary for individuals with gender dysphoria.⁷⁰ Officially establishing gender dysphoria treatment as medically necessary would vest the state with a duty to consent in place of the minor to receive such treatment in appropriate cases.⁷¹ Researchers have observed that early intervention seems to lead to better psychological outcomes and a better physical appearance, making acceptance as a member of the new gender easier compared to individuals beginning treatment during adulthood.⁷²

⁶² Padawer, *supra* note 55.

⁶³ Skougard, *supra* note 8, at 1177.

⁶⁴ Padawer, *supra* note 55.

⁶⁵ Rubin Erdely, *supra* note 1.

⁶⁶ Eliana T. Baer, *Navigating the Murky Waters of Best Interests with a Transgender Child*, N.J. L. J. (2014), <http://www.foxrothschild.com/publications/navigating-the-murky-waters-of-best-interests-with-a-transgender-child/>; see also Perkiss, *supra* note 13, at 66 (“Generally, proponents of conversion therapy believe that gender nonconformity is morally wrong and that gender-nonconforming individuals can adjust their behavior and identity accordingly, based on tenets of conservative Judeo-Christian religions.”); Fedders, *supra* note 12, at 788 (“Some parents actively seek to change their children’s gender identity . . . by sending them to gender clinics or “reparative” therapy Despite the fact that every major mental health organization has condemned this therapy, its practice survives . . .”).

⁶⁷ Rubin Erdely, *supra* note 1.

⁶⁸ Matthew J. Hulstein, *Recognizing and Respecting the Rights of LGBT Youth in Child Custody Proceedings*, 27 BERKLEY J. GENDER L. & JUST. 171, 190 (2012).

⁶⁹ *Id.* at 178. *Parens patriae* is the government’s traditional power as the ultimate protector of a child’s welfare.

⁷⁰ Turner, *supra* note 12, at 557 (quoting *White v. Farrier*, 849 F.2d 322, 325 (8th Cir. 1998). Transsexualism constitutes serious medical need) (*White v. Farrier* recognizes this conclusion in the context of the Eighth Amendment and prisoners); see *Wolfe v. Horn*, 130 F.Supp.2d 648, 652 (E. D. Pa 2001) (considering transsexualism a “serious medical need” in the Eighth Amendment context); *Cuoco v. Moritsugu*, 222 F.3d 99, 106 (9th Cir. 2000) (Conceding for appeal purposes that transsexualism is a serious medical need); see also Scutti, *supra* note 19 (“Stopping puberty, advocates argue, provides psychological relief to a transgender child”) (“ . . . treatment with GnRH analogues makes certain forms of transsexual surgery either redundant or less invasive because many irreversible features (such as height) or surgically reversible features (such as breast and genital development) would not have formed.”) .

⁷¹ Turner, *supra* note 12, at 561.

⁷² Talbot, *supra* note 20.

Researchers in the Netherlands developed a treatment where a youth, before puberty starts, is given hormone-blocking medication, giving the child the opportunity to grow without the physical characteristics of their sex assigned at birth emerging.⁷³ This treatment is becoming increasingly accepted internationally.⁷⁴ Dr. Rob Garofalo, the Director of the Lurie Children's Hospital's Gender and Sex Development Program, stated, "[Pubertal blockers] allow [. . .] families the opportunity to hit the pause button, to prevent natal puberty . . . until we know that that's either the right or the wrong direction for their particular child."⁷⁵ The youth then has the flexibility to elect later to begin gender transition by taking the sex hormones of the opposite sex or to resume their natural puberty development.⁷⁶ Mounting medical evidence from researchers and practitioners indicates that puberty blocking hormones are the best options for youth aiming to avoid the angst of developing secondary sex characteristics.

Still, the question remains whether youth have the maturity to make such a life-altering decision, especially when the drugs' long-term effects are not fully known yet.⁷⁷ The stakes are higher for youth who want to continue their transition by taking cross-sex hormones. The physical changes these hormones bring may have potentially irreversible, long-term side effects including the risk of heart disease, diabetes, cancer, and reduced fertility.⁷⁸ When Kathryn Mathis first began realizing that Coy may be transgender, she was unsure what to do.⁷⁹ Seeking advice, Kathryn reached out on an online messaging board for parenting and a transgender parent told her he "knew when [he] was two or three."⁸⁰ This struck Kathryn, prompting her to reflect upon her child's behavior and Coy's disappointment when asking her, "I'm a girl – why are you calling me a 'he'?"⁸¹ It was then that she was able to begin discussing with Jeremy her theory that Coy was transgender, allowing the couple to begin looking for help.⁸²

There is a concern in allowing a youth to transition only to later decide to embrace their biological gender, which is not completely unfounded. Long-term studies have found that only about fifteen percent of young children with gender dysphoria continue to have these gender-nonconforming feelings as adolescents and adults.⁸³ However, there is no scientific data supporting the idea that the decision to allow a child to explore their gender-nonconforming feelings causes those youth to undergo serious or long-term emotional harm later in life.⁸⁴ On the contrary, children suppressing their inner gender identity or expression are at risk for serious emotional

⁷³ Alex Spiegel, *Q&A: Doctors on Puberty-Delaying Treatments*, NPR (May 8, 2008),

<http://www.npr.org/templates/story/story.php?storyId=90234780>; see also Scutti, *supra* note 19

("[T]he medication simply provides an adolescent more time to explore their identity as well as any desire they may have for gender reassignment.").

⁷⁴ BRILL & PEPPER, *supra* note 53, at 205.

⁷⁵ Priyanka Boghani, *When Transgender Kids Transition, Medical Risks are Both Known and Unknown*, P.B.S. (June 30, 2015), <http://www.pbs.org/wgbh/frontline/article/when-transgender-kids-transition-medical-risks-are-both-known-and-unknown/>.

⁷⁶ Spiegel, *supra* note 73.

⁷⁷ Boghani, *supra* note 75.

⁷⁸ *Id.*

⁷⁹ Rubin Erdely, *supra* note 1.

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² *Id.*

⁸³ Talbot, *supra* note 20; see also Alice Dreger, *Pink Boys: What's the Best Way to Raise Children Who Might Have Gender Identity Issues?*, PACIFIC STANDARD (July 18, 2013), <http://www.psmag.com/books-and-culture/pink-boys-gender-identity-disorder-62782>.

⁸⁴ Skougard, *supra* note 8, at 1174.

harm.⁸⁵ Further, it has been shown that a youth whose gender dysphoria continues past the onset of puberty is likely to retain these feelings into adulthood.⁸⁶ Fear of a child not adhering to their initial exploration of gender identities should not be a factor in determining whether to provide treatment to youth with gender dysphoria—not all children require the same treatment (where some will not continue to have gender dysphoria past puberty, and thus will not require further treatment⁸⁷) and it does much more harm than good to suppress inner gender identity and expression.⁸⁸

IV. HOW A MINOR'S IDENTIFICATION AS TRANSGENDER AFFECTS MAJOR ASPECTS OF THAT MINOR'S LIFE

Individualized needs for each child need to be assessed and carefully weighed; every youth is different and decisions can produce drastic effects that impact a child's life and his or her educational needs, mental outlook, socialization abilities, and physical attributes. Determining the right treatment plan for a youth enhances their ability to fully exercise their rights after reaching the age of majority. Accordingly, examining how the minor's identification affects major aspects of that minor's life is critical when finding an approach to treat their gender dysphoria.

A. Educational Experiences

The 2013 National School Climate Survey examined the experiences of transgender students to determine what their educational landscape resembled.⁸⁹ This research had some positive conclusions: a higher percentage of LGBT students reported having supportive school staff, gay-straight alliances, positive representations of LGBT people in history or curriculum events, access to LGBT-related content on the internet and in their textbooks, and anti-bullying/harassments policies in place than in all prior survey years.⁹⁰

Other findings, however, were less encouraging. Over half of the surveyed students reported being harassed for their gender expression, and 61.6% of students who reported incidents of harassment or assault said that school staff did nothing in response.⁹¹ Some school policies exist that particularly target transgender students: 42.2% have been prevented from using their preferred name, 59.2% were required to use the bathroom or locker room of their biological sex, and 31.6% have been prevented from wearing clothes considered inappropriate based on their legal sex.⁹²

Transgender students today are coping with school districts struggling to establish a best practice for accessing appropriate bathrooms and locker rooms. The controversy lies between balancing Title IX⁹³ gender equality interests with privacy concerns, and it has brought out strong

⁸⁵ *Id.*

⁸⁶ Talbot, *supra* note 20.

⁸⁷ Spiegel, *supra* note 73.

⁸⁸ Rubin Erdely, *supra* note 1 (“The American Psychological Association and the American Academy of Pediatrics have rejected the forced-conformity approach for gender-dysphoric patients, saying that not only are such efforts doomed to fail but that... they ‘often result in substantial psychological pain.’”).

⁸⁹ GLSEN, THE 2013 NATIONAL SCHOOL CLIMATE SURVEY: THE EXPERIENCES OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER YOUTH IN OUR NATION'S SCHOOLS 2, 3 (2013).

⁹⁰ *Id.* at 55.

⁹¹ *Id.* at xvii.

⁹² *Id.* at xvii–xviii.

⁹³ See *Title IX- Sex Discrimination in Education*, THE U.S. DEP'T OF JUST., (Aug. 7, 2015),

opinions from both supportive and non-supportive ideology.⁹⁴ Some schools offer access to private bathrooms and/or changing rooms, which can provide a sufficient alternative for students merely seeking enhanced privacy.⁹⁵ However, for those who seeking full access to the facilities reflecting their gender identity, these private facilities options – oftentimes far away from those their peers use, if they exist at all – only further stigmatize transgender youth.⁹⁶

For Coy Mathis, her days worrying about which bathroom she will have to use are over—her elementary school decided it was her right to use their female bathrooms.⁹⁷ Steven Chavez, the director of the Colorado Civil Rights Division, said that, “[b]y not allowing Coy to use the girls’ restroom, the Eagleside Elementary School in Fountain ‘creates an environment rife with harassment.’”⁹⁸ This is not the only recent victory for transgender students—a federal appeals court held that Gavin Grimm, identified at birth as a female and now a transgender boy, can sue his school board, which barred him from using the boys’ bathroom, on discrimination grounds.⁹⁹ The school’s policy required transgender students to use a separate unisex restroom. Supporting Grimm, the court relied on the U.S. Education Department’s position that, instead of transgender students being required to use restrooms matching their sex given at birth, they should be able to use the bathrooms that correspond to their gender identities.¹⁰⁰ “The department said that requiring transgender students to use a bathroom that corresponds with their biological sex amounts to a violation of Title IX, which prohibits sex discrimination at schools that receive federal funding.”¹⁰¹ There are different arguments which use various interpretations of federal discrimination policies, but the court insisted that politicians should be the ones interpreting these policies – here, the Education Department.¹⁰² While the use of bathrooms by transgender people is still a controversial issue, this ruling could help settle the debate for schools.

B. Mental Health

Mental health professions have historically noted the increased risk of suicide in children deviating from sexual and gender social norms.¹⁰³ Much too often, transgender children suffer

<http://www.justice.gov/crt/overview-title-ix-education-amendments-1972-20-usc-1681-et-seq> (discussing protection for persons from discrimination in educational programs and activities).

⁹⁴ Duaa Eldeib & Robert McCoppin, *Feds Reject School District’s Plan for Transgender Student, Locker room*, CHI. TRIB. (Oct. 13, 2015), <http://www.chicagotribune.com/news/local/breaking/ct-transgender-student-locker-room-palatine-met-20151012-story.html>.

⁹⁵ *Id.* Palatine, a Chicago suburb, is the first district in the country to be found in violation of civil rights laws on transgender issues. Public schools are still unsure how to handle gender specific facilities that address both privacy concerns as well as unrestricted access to facilities. Kelsey Harkness, *Why These High School Girls Don’t Want a Transgender Student in Their Locker Room*, THE DAILY SIGNAL (Dec 21, 2015) <http://dailysignal.com/2015/12/21/why-these-high-school-girls-dont-want-transgender-student-a-in-their-locker-room/>.

⁹⁶ *Id.*

⁹⁷ Scutti, *supra* note 19.

⁹⁸ *Id.*

⁹⁹ Moriah Balingit, *Federal Appeals Court Sides with Transgender Teen, Says Bathroom Case Can Go Forward*, WASH. POST (Apr. 19, 2016), https://www.washingtonpost.com/local/education/federal-appeals-court-sides-with-transgender-teen-says-bathroom-case-can-go-forward/2016/04/19/6a873b88-f76b-11e5-9804-537defcc3cf6_story.html.

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ Skougard, *supra* note 8, at 1175; Howe, *supra* note 16, at 2.

rejection and harassment at school and in the home (which causes considerable psychological stress) and they must confront feeling uncomfortable in their own bodies as they mature.¹⁰⁴ “These factors, among others, account for the disproportionate instances of anxiety, depression, and suicidal ideation among this population.”¹⁰⁵

Some studies estimate the rate transgender persons attempting suicide to be three times higher.¹⁰⁶ Other studies have noted that the transgender youth population is more than eight times as likely to have attempted suicide; nearly six times as likely to report high levels of depression; and more than three times as likely to use illegal drugs than LGBT youth who are not rejected or only a little rejected by their parents and caregivers.¹⁰⁷ Supportive behaviors—which can include talking to the youth about their identity and expressing affection for the youth, among many other acts—can help protect against these health risks.¹⁰⁸

While some family members are concerned that supporting a transgender youth opens the youth up to negative social and mental consequences, family rejection of a child’s gender expression or sexual orientation is more precisely linked to the increased risk of depression, anxiety, and suicide than the gender or sexual variance itself.¹⁰⁹ The significance of this realization is the suggestion that when support and acceptance are offered to a transgender youth by their family, a higher suicide risk is not triggered by internal psychological stress and external social rejection.¹¹⁰ It can be reasonably concluded that it is more effective for a parent to adopt the supportive approach and protect their child from risk of suicide, depression, or anxiety than to reject the child’s gender expression and pressure them into conforming to social gender norms.¹¹¹

Supporting a transgender youth is, unfortunately, not the norm for families today. At least half of all transgender youth face negative reactions after coming out to their families and approximately one third are physically abused.¹¹² When transgender youth are forcefully rejected by their families and caregivers, they are more prone to suffer from low self-esteem and run a high risk of facing mental health problems.¹¹³ For the Mathis family, while Kathryn and Jeremy support Coy, other family members generally do not offer support, which led the Mathis family to create their own community by talking to other parents of transgender children online.¹¹⁴ Taking initiatives such as this help foster a supportive community for transgender children and their families, giving these children the potential for improved mental health and better outcomes in the future.

C. Social and Physical Health

A transgender youth can suffer devastating effects not only on their mental health, but on their social and physical health as well when gender-affirming medical care is postponed or interrupted.¹¹⁵ Howe, a researcher on the topic of transgender youth in foster care, states that, “[a]t

¹⁰⁴ Howe, *supra* note 16, at 2.

¹⁰⁵ *Id.*

¹⁰⁶ Skougard, *supra* note 8, at 1175.

¹⁰⁷ RYAN, *supra* note 27, at 4.

¹⁰⁸ *Id.* at 5.

¹⁰⁹ Skougard, *supra* note 8, at 1175.

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² Hulstein, *supra* note 68, at 177.

¹¹³ RYAN, *supra* note 27, at 4.

¹¹⁴ Rubin Erdely, *supra* note 1.

¹¹⁵ Turner, *supra* note 12, at 555.

a time in their growth when young people most need the support of others as they explore their identities, transgender youth often are told that they cannot be who they are.”¹¹⁶

Transgender students are commonly victimized in social situations such as at schools. Transgender students who experienced higher levels of victimization due to their gender expression, as compared to their peers experiencing lower levels of harassment, were three times as likely to have missed school, and have lower GPAs.¹¹⁷ These students were twice as likely to report they did not plan on pursuing post-secondary education, had higher levels of depression and lower levels of self-esteem.¹¹⁸

Transgender youth without proper support have a higher risk of medical problems as well. They are over three times more likely to be at high risk for HIV and sexually transmitted infections than LGBT youth who are not rejected or feel only slight rejection by their parents and caregivers.¹¹⁹ Transgender youth also face a higher risk of engaging in risky sexual behaviors (such as failing to protect themselves from sexually transmitted diseases).¹²⁰ Failure to support transgender youth affects them on a number of levels, increasing their risk for poor mental health and engagement with risky behaviors, opening them up to medical problems that may follow them throughout their lives.

V. THE CURRENT LEGAL ENVIRONMENT REGARDING THE RIGHTS OF PARENTS OF TRANSGENDER YOUTH

For the most part, transgender youth seeking to transition lack the legal capacity to consent to the relevant medical treatments.¹²¹ An obligation should be placed on the State to guarantee the youth justice system is structured to ensure children's foundational rights are not permanently or irreparably harmed before legally becoming an adult.¹²² The legal profession, generally using a binary understanding of gender and lacking precedent, needs to catch up to the modern landscape of transgender issues.¹²³

“[T]he law should – and indeed does, in some circumstances—go further than simply aiming to secure for the child an adulthood where she enjoys agency; it should seek to provide the child with the capacities for full autonomy.”¹²⁴ Because no capacity exists for a legal representative to be appointed to act solely on a child's instructions, providing a child with the capacities for full autonomy can be difficult.¹²⁵ This results in a serious concern that a child will not have the opportunity to express their views to the court in a truly independent way.¹²⁶

¹¹⁶ Howe, *supra* note 16, at 2.

¹¹⁷ GLSEN, *supra* note 89, at 6.

¹¹⁸ *Id.*

¹¹⁹ RYAN, *supra* note 27, at 4.

¹²⁰ *Id.*

¹²¹ Arshagouni, *supra* note 34, at 331–32.

¹²² Kathryn Hollingsworth, *Theorizing Children's Rights in Youth Justice: The Significance of Autonomy and Foundational Rights*, 76 MOD. L. REV. 1046, 1049 (2013).

¹²³ Baer, *supra* note 66; *see also* Perkiss, *supra* note 13, at 78 (bias favors traditional gender norms, which may explain courts' tendencies to place children in the custody of the non-supportive parent).

¹²⁴ Hollingsworth, *supra* note 122, at 1060.

¹²⁵ Tobin, *supra* note 14, at 608.

¹²⁶ *Id.* at 604. (“Commenters have lamented that this trend has not been continued in the U.S. nor has it been embraced universally by judges in other jurisdictions . . .”).

A. Case Law

When looking at the case law cumulatively, it is clear that there are no parental or state interests sufficient enough to outweigh the youth's right to equal respect when determining custody.¹²⁷ The following cases describe ideas of liberty and children's rights, as well as some limitations to those rights.

In *Meyer v. Nebraska*, the Supreme Court ruled that the term 'liberty' in the Due Process Clause of the Fourteenth Amendment refers to more than just "freedom from bodily restraint"; instead, it includes other interests such as the right to marry, privacy, and other rights typically associated with the Bill of Rights.¹²⁸ "[L]iberty may not be interfered with, under the guise of protecting the public interest, by legislative action which is arbitrary or without reasonable relation to some purpose within the competency of the state to effect."¹²⁹ This is especially important in the context of making treatment decisions for transgender children—because since there is still a percentage of the population that does not accept or support the transgender community, some argue that it would be detrimental for a child to be allowed to express gender non-conforming behavior due to potential negative social implications.

In what has been described as the most important children's right's case, the Court held that "neither the Fourteenth Amendment nor the Bill of Rights is for adults alone."¹³⁰ Before this case, children who committed criminal offenses were denied due process rights in the American juvenile justice system.¹³¹ This failure to afford these children their due process rights severely diminished their capacity for liberty. The Court ruled in that case that a youth's rights may not be weighed against society's possible negative reaction to the youth's chosen gender identity/expression.¹³² "A core purpose of the Fourteenth Amendment was to do away with all governmentally imposed discrimination based on race."¹³³ The Constitution may be unable to control the existence of prejudices, but it is unable to tolerate them.¹³⁴ Some of the arguments against using the supportive approach for youth with gender dysphoria rely heavily on the social implications of expressing gender nonconformity, but failure to support a child on these grounds unjustly strips that child of their liberty. Kathryn and Jeremy Mathis originally allowed Coy to express her gender identity, but only in their home, fearing their neighbors would frown upon such behavior.¹³⁵ Eventually, they realized that this approach was causing more harm than good. The couple thought "If we give [Coy] a safe space to be who [she] is, that's our way of being supportive... [b]ut we were really sending the opposite message: 'It's not safe, but we'll give you a place to hide.'"¹³⁶ With this realization in mind, Kathryn and Jeremy decided to support Coy's decision all the way, regardless of what others might think.¹³⁷

¹²⁷ Hulstein, *supra* note 68, at 189.

¹²⁸ *Id.* at 182.

¹²⁹ *Meyer v. Nebraska*, 262 U.S. 390, 399–400 (1923).

¹³⁰ *In re Gault*, 387 U.S. 1, 13 (1967).

¹³¹ Tobin, *supra* note 14, at 604.

¹³² Hulstein, *supra* note 68, at 192.

¹³³ *Palmore v. Sidoti*, 466 U.S. 429, 432 (1984) (citing *Strauder v. West Virginia*, 100 U.S. 303, 307–08, 310 (1880)) (Strauder was abrogated because it upheld a state's right to bar women or classes from jury selection; however, its holding that it is unconstitutional to categorically exclude African American men from jury duty, on the grounds that this practice violates the Equal Protection clause, still remains).

¹³⁴ *Id.* at 433.

¹³⁵ Rubin Erdely, *supra* note 1.

¹³⁶ *Id.*

¹³⁷ *Id.*

This holding finds support in other cases: in *Watson v. Memphis*, the Court held that “constitutional rights may not be denied simply because of hostility to their assertion or exercise.”¹³⁸ Professional organizations such as the American Psychological Association have also echoed this holding by releasing statements promoting education of the community and tolerance above blind adherence to social prejudice.¹³⁹ The prejudices of people should not inhibit a transgender child to express the gendered behaviors of their choice, and thus these prejudices should not be weighed in the court’s decision-making process.

Troxel v. Granville holds that parents have substantive due process rights concerning how their children are raised, including the right to refuse certain medical care, instruct the child in religion, and exercise control over the child’s education.¹⁴⁰ “[I]t cannot be doubted that the Due Process Clause of the Fourteenth Amendment protects the fundamental rights of parents to make decisions concerning the care, custody, and control of their children.”¹⁴¹

States usually rely on a parent’s judgment, working under the presumption that the parent has the child’s best interests in mind.¹⁴² These rights, however, are limited, and in situations where that presumption does not apply, the state may exercise *parens patriae* and decide for itself what is in the best interests of the child.¹⁴³ When parents act with their own best interests in mind and in the process trample upon their child’s liberty, it is the state’s responsibility to step in and remedy the situation. In the context of custody cases where parents disagree on the treatment of their transgender child, this implies that courts, acting in the child’s best interests, should reject the non-supportive parent, making decisions based on their own personal biases, in favor of the supportive parent.

The *Lawrence v. Texas* holding offers the idea that liberty presumes autonomy of self that includes freedom of thought, belief, expression, and certain intimate conduct.¹⁴⁴ “Equality of treatment and the due process right to demand respect for conduct protected by the substantive guarantee of liberty are linked in important respects, and a decision on the latter point advances both interests.”¹⁴⁵

In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Court stated:

These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under the compulsion of the state.¹⁴⁶

The interest protected in *Lawrence* was the ability to define the concept of one’s existence, which is an interest with the potential for profound implications for both minor and adult transgender

¹³⁸ *Watson v. Memphis*, 373 U.S. 526, 535 (1963).

¹³⁹ David K. Flaks, *Gay and Lesbian Families: Judicial Assumptions, Scientific Realities*, 3 WM. & MARY BILL RTS. J. 345, 354 (1994).

¹⁴⁰ Hulstein, *supra* note 68, at 193.

¹⁴¹ *Troxel v. Granville*, 530 U.S. 57, 66 (2000).

¹⁴² Hulstein, *supra* note 68, at 193–94.

¹⁴³ *Id.* at 194.

¹⁴⁴ *Lawrence v. Texas*, 539 U.S. 558, 562 (2003).

¹⁴⁵ *Id.* at 575.

¹⁴⁶ *Id.* at 574 (citing *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 851 (1992)).

persons.¹⁴⁷ “LGBT youth, like straight and cisgender youth, possess the substantive due process rights protected by *Lawrence*: the right to their sexual orientation or gender identity/expression and the right to be free from state action primarily expressing animus against their sexual orientation or gender identity/expression.”¹⁴⁸ Ultimately, the *Lawrence* court ruled that even if beliefs regarding the concept of one’s own existence were formed by the State, they would be insufficient to define the characteristics of being a person.¹⁴⁹ In protecting a child’s substantive due process rights, the State should not be allowed to enforce their own preferences for gender identity and expression upon children. It follows, then, that when the court placing gender nonconforming children with a non-supportive parent rather than their supportive parent, the court is, essentially, forcing that child to live according to the State’s preferences for gender identity and expression.

In *State v. Limon*, the substantive due process and equal protection analysis were linked together¹⁵⁰ and the court recognized and affirmed (after a lengthy process of appeals and remands) that the State has broad powers to protect minors.¹⁵¹ This decision by the Kansas Supreme Court was heavily influenced by multiple cases, implying the substantive due process rights articulated in *Lawrence* applied to this case.¹⁵² *Limon* is the most authoritative case regarding a minor’s substantive due process rights, despite not being binding on other states.¹⁵³

To support their holding, the *Limon* court referred to the ruling in *Carey v. Population Services International*, which held that, “in the area of sexual mores, as in other areas, the scope of permissible state regulation is broader as to minors than as to adults.”¹⁵⁴ “[T]he right to equal protection of those laws is offended when legal classifications are drawn for the purpose of invoking moral disapproval with ‘the purpose of disadvantaging the group burdened by the law.’”¹⁵⁵

LGBT youth have their substantive due process rights protected by *Lawrence*, just as their straight and cisgender peers do: the right to their gender identity and expression, the right to determining their own sexual orientation, and the freedom from the State acting hostile towards their gender identity, gender expression, and sexual orientation.¹⁵⁶ When the courts decide to give custody of a gender nonconforming child to a non-supportive parent, they are in essence acting hostile towards a child’s gender identity and/or expression.

In summary, *Meyer* held that liberty is more than just freedom from bodily restraint¹⁵⁷ and extended that liberty to minors in *In re Gault* when the Court held that Bill of Rights and Fourteenth Amendment are extended to children.¹⁵⁸ While some arguments rely on the potential for social disapproval as a reason to reject a youth’s wishes, *Palmore*’s ruling demonstrated that a youth’s orientation should not be weighed against society’s potential for condemnation of the youth’s life choices in court.¹⁵⁹ *Troxel* defined and clarified the boundaries of parents’ substantive due process

¹⁴⁷ Hulstein, *supra* note 68, at 186.

¹⁴⁸ *Id.* at 188. Cisgender refers to a person who has a gender identity aligning to the one assigned at birth.

¹⁴⁹ *Lawrence*, 539 U.S. at 574 (quoting *Casey*, 505 U.S. at 851).

¹⁵⁰ *State v. Limon*, 122 P.3d 22, 34 (Kan. 2005).

¹⁵¹ *Id.* at 35.

¹⁵² Hulstein, *supra* note 68, at 188.

¹⁵³ *Id.* (State supreme court decisions are only binding within that particular state).

¹⁵⁴ *Limon*, 122 P.3d at 35 (quoting *Carey v. Population Serv. Int’l*, 431 U.S. 678, 694 n. 17 (1977)).

¹⁵⁵ *Id.* at 34 (quoting *Romer v. Evans*, 517 U.S. 620, 633 (1996)).

¹⁵⁶ Hulstein, *supra* note 68, at 188.

¹⁵⁷ *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923).

¹⁵⁸ *In re Gault*, 387 U.S. 1, 41 (1967).

¹⁵⁹ *Palmore v. Sidoti*, 466 U.S. 429, 433 (1984).

rights to bring up their child.¹⁶⁰ Under *Lawrence*, the court holds that even if people could choose their sexual orientation that the choice is completely personal and should not be influenced by the force of the state, implicitly saying that the state cannot see a person's sexual orientation as a negative outcome.¹⁶¹ Lastly, *Limon* holds that the enforcement of "traditional sexual development of a child" and preservation of "traditional sexual mores of society" are insufficient interests, further establishing that societal disapproval is not a valid reason to restrict liberty.¹⁶²

B. Critical Factors in Determining Custody

1. Parental Rights

Children's rights are neither limited in scope nor balanced against the rights of the parents or State; they are rights-in-trust.¹⁶³ The State delegates these rights-in-trust to parents and affords them wide discretion, assuming the parents act with the child's best interests at heart.¹⁶⁴ "[T]he child's custodians must provide conditions for the child to become an adult who is able freely and in an informed way to make choices."¹⁶⁵ The ability to express gender nonconforming behavior is part of a transgender child's autonomy and, accordingly, a parent acting with their child's best interests in mind should support these expressions.

Parents have a conditional—not absolute—deference over their children contingent on parental responsibilities being carried out in a way that routinely favors the children's rights.¹⁶⁶ Laurence D. Houlgate, co-founder of the Society for Philosophy and the Family, in *Children's Rights, State Intervention, Custody and Divorce*, states that, "any interference in the child's attempt to exercise his rights is justifiable only if it can be proved that this is necessary to protect his future autonomy."¹⁶⁷ It would then follow that, if giving support to a transgender child is the best practice and being non-supportive greatly raises the risks for negative, and even deadly, consequences, a parent being unsupportive of their child's gender nonconforming behavior would not be able to justify their actions.

Some non-supportive parents object on religious grounds to supporting their child, but parents cannot subject their child to harm on the basis of their religious beliefs.¹⁶⁸ The State, acting as *parens patriae*, does not have its authority nullified where the parent grounds their "claim to control the child's course of conduct on religion or conscience."¹⁶⁹ Consequently, failure to support a gender nonconforming child should be viewed as a parent trying to dictate that child's conscience.

¹⁶⁰ *Troxel v. Granville*, 530 U.S. 57, 58 (2000).

¹⁶¹ *Lawrence v. Texas*, 539 U.S. 558, 574 (2003).

¹⁶² *State v. Limon*, 122 P.3d 22, 34-35 (Kan. 2005).

¹⁶³ LAURENCE D. HOULGATE, *CHILDREN'S RIGHTS, STATE INTERVENTION, CUSTODY AND DIVORCE: CONTRADICTIONS IN ETHICS AND FAMILY LAW* 38, 45 (2005) (where rights-in-trust is defined as "rights which children possess but which, in some cases, they are justifiably prevented from enjoying.").

¹⁶⁴ Hulstein, *supra* note 68, at 184 (2012); see *Troxel*, 530 U.S. at 65–66.

¹⁶⁵ HOULGATE, *supra* note 163, at 45.

¹⁶⁶ Tobin, *supra* note 14, at 587 ("deference given to parents is far from absolute and remains conditional on the exercise of parental responsibility being directed to and undertaken in a manner that is consistent with the realization of a child's rights, including the recognition of their evolving capacity.").

¹⁶⁷ HOULGATE, *supra* note 163, at 45.

¹⁶⁸ Hulstein, *supra* note 68, at 194.

¹⁶⁹ *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944).

A child's right-in-trust to be treated as a person requires parents and the State to help children grow into fully autonomous adults, as their roles as trustees charge them with this duty.¹⁷⁰ The obligation to respect a child's choices and entrust a child with greater responsibility becomes stronger as the child gets older and develops more characteristics of a fully autonomous adult.¹⁷¹ In a court's role as a trustee, it must determine which parent carries out their duty best during custody disputes when parents disagree over what is in the child's best interests.¹⁷² "The parent to whom the court does not grant custody cannot object that her rights are violated because, as a trustee, her rights could only be used to secure the child's best interest – a fact the court has determined against her."¹⁷³ As a result, when a supportive parent loses custody of their gender nonconforming child, it is very difficult to regain custody.

In custody cases concerning a transgender child, parents should provide the court with credible information about gender variance and commonly recommended treatments for gender dysphoria, as well as involve a qualified therapist with experience in gender and development issues in the proceedings.¹⁷⁴ When asking the court to order a treatment plan, parents should ask that the plan involve thoughtful evaluation of the child's needs, ideally under the guidance of a qualified therapist, made in collaboration of both parents before a treatment strategy is solidified.¹⁷⁵

2. "Best Interests" Principle

When awarding custody, judges must rule in favor of the arrangement that is in the "best interests of the child."¹⁷⁶ Illinois law requires courts to contemplate all relevant factors, including a list of enumeration factors.¹⁷⁷ These fifteen factors to consider include the needs and wishes of the child (where more mature children who can express themselves independently, in reasoned statements have more weight placed on their interests), the wishes of the parents, the mental and physical health of all parties involved, and each parent's ability to work together to make decisions.¹⁷⁸ "Determining the 'best interests' of the child ultimately consists of two questions: first, what is the desirable long-term goal for the child; and second, what present arrangement is most conducive to the child reaching that goal?"¹⁷⁹ The goal of a best interests analysis is not to reinforce a particular cultural perspective or work out a social controversy, regardless of an individual's views regarding gender change.¹⁸⁰

In applying the medical model of transgenderism, the presence of bias in favor of traditional gender norms and negative stereotypes about parents who promote gender nonconformity may explain why courts favor custody with the rejecting parent in cases involving gender-nonconforming children, where one parent is supportive and the other is rejecting.¹⁸¹

¹⁷⁰ HOULGATE, *supra* note 163, at 46.

¹⁷¹ *Id.*

¹⁷² Hulstein, *supra* note 68, at 195.

¹⁷³ *Id.*

¹⁷⁴ Skougard, *supra* note 8, at 1198–99.

¹⁷⁵ *Id.* at 1199.

¹⁷⁶ Hulstein, *supra* note 68, at 178.

¹⁷⁷ Ill. Marriage and Dissolution of Marriage Act 750 ILL. COMP. STAT. ANN. § 5/602.5(c) (West 2016).

¹⁷⁸ 750 ILCS 5/602.(5)(c) (2016).

¹⁷⁹ Hulstein, *supra* note 68, at 179.

¹⁸⁰ Skougard, *supra* note 8, at 1193.

¹⁸¹ Perkiss, *supra* note 13, at 78.

Together, *Limon* and *Lawrence* create a new best practice for judges to use when considering custody arrangements made in the best interests of a child.¹⁸² On one hand, a judge may not seek to “control [the youth’s] destiny” and consider a youth’s emerging sexual orientation as an undesirable goal.¹⁸³ On the other hand, when granting custody, the youth’s rights weigh heavily in favor of the supportive parent.¹⁸⁴

When judges are hostile to nonconforming gender identities and expressions, the best interests principle is unable to protect the LGBT youth’s best interests.¹⁸⁵ Under the guise of protecting the child’s best interests, judges can make decisions based off their own personal biases. Some have argued that the best interests principle should give children the benefit of the doubt in situations where there is a risk of harm to a child and the exact consequences of an action or decision are unknown.¹⁸⁶ “Because the best interests of the child standard is highly subjective and deferential, it is insufficient to protect the rights of the LGBT youth. Instead, a court must move beyond its own conceptions of the child’s best interest, recognize the LGBT youth’s rights, and rule accordingly.”¹⁸⁷ Ultimately, the youth’s best interests, including the eventual realization of the child’s own rights, should trump parental rights.¹⁸⁸

3. The Judge’s Discretion

When determining custody arrangements, the judge, an agent of the State, in essence acts as *parens patriae*, and in their role as the ultimate trustee, they delegate the duty of trusteeship to the parent deemed most capable.¹⁸⁹ Issues arise when two parents’ views regarding how their child should be raised conflict, as the court is unable to advance the rights of one parent without violating the rights of the other.¹⁹⁰

In custody proceedings, courts generally do not consider First Amendment rights (such as the freedom of religion) as the court may neither advance nor inhibit religion and is obligated to maintain an attitude of neutrality.¹⁹¹ Courts should also aim to avoid considering separate social prejudices or personal disapproval when making best interests determinations.¹⁹² In all cases, a youth’s rights disallow the court from considering a youth’s sexuality or expression as an unfavorable result.¹⁹³ Matthew J. Hulstein, a graduate from the University of Iowa College of Law, in *Recognizing and Respecting the Rights of LGBT Youth in Child Custody Proceedings*, stated that, “in many, *though not all* cases, the youth’s rights may impose an affirmative duty upon the court to favor the supportive parent so that the youth may fully realize her sexuality or gender identity/expression.”¹⁹⁴ Advocates of LGBT youth rights, based off these general court standards and rooted in the *Lawrence* decision, find that if a judge grants custody to the non-supportive

¹⁸² Hulstein, *supra* note 68, at 189.

¹⁸³ *Id.* at 189.

¹⁸⁴ *Id.* at 189–90.

¹⁸⁵ *Id.* at 181.

¹⁸⁶ Tobin, *supra* note 14, at 607–8.

¹⁸⁷ *Id.* at 196.

¹⁸⁸ Hulstein, *supra* note 68, at 194.

¹⁸⁹ *Id.* at 188.

¹⁹⁰ *Id.* at 196.

¹⁹¹ *Id.*

¹⁹² Skougard, *supra* note 8, at 1197.

¹⁹³ Hulstein, *supra* note 68, at 189.

¹⁹⁴ *Id.*

parent in an attempt to deter the youth's emerging gender identity or expression, that judge would then be essentially imposing his or her own understandings of "the attributes of personhood" on the youth through the compulsive force of the state, resulting in a violation of the principles developed in *Lawrence*.¹⁹⁵

It is in the wide range of discretion a judge holds that potentiates the concerns that a judge may act in favor of their personal bias rather than truly examining the case. For example, "a judge cannot consider an LGBT youth's sexual orientation or gender expression as a harm to be avoided."¹⁹⁶ Yet, this does not stop the judge in many instances from considering it as such, whether consciously or unconsciously. Another example is whether a judge with little or no training in medicine or psychology has the ability to appropriately determine whether a minor is mature and capable of making their own medical decisions.¹⁹⁷

In today's legal landscape, courts are unlikely to award residential custody and medical decision-making authority to the parent supporting the child's gender identity and expression.¹⁹⁸ The best interests standard can unfortunately be unfairly applied due to judges' biases. The existence of bias in the application of the medical model of transgenderism favors traditional gender norms.¹⁹⁹ The negative stereotypes surrounding parents who promote or allow for gender nonconformity could explain why, where one parent is supportive and the other is rejecting of a gender-nonconforming child, the courts favor custody with the rejecting parent.²⁰⁰ It is of the utmost importance to present evidence favoring a gender non-conforming child's felt gender identity and to debunk evidence rejecting of that identity, as trial courts do have broad discretion in child custody cases regarding a parent's authority to make medical decisions to evaluate evidence, which appellate courts overwhelmingly defer to in making their subsequent decisions.

VI. PROPOSALS FOR CHANGE

¹⁹⁵ *Id.* at 190; see also Chai R. Feldblum, *The Right to Define One's Own Concept of Existence: What Lawrence Can Mean for Intersex and Transgender People*, 7 GEO. J. GENDER & L. 115, 133 (2006) ("At its core, what the [c]ourt decided [in *Lawrence*] was that 'at the heart of liberty is the right to define one's own concept of existence'" *Id.* at 123; ("The limitations on the applicability of *Lawrence* for intersex and transgender people exist only if one believes that the liberty interest explicated by the Court in *Lawrence* is solely a negative right against intrusion by the state.") *Id.* at 127; Feldblum asserts that the application of *Lawrence* results in a positive right) *Id.* at 128, 129.

¹⁹⁶ Hulstein, *supra* note 68, at 196–97.

¹⁹⁷ Andrew Newman, *Adolescent Consent to Routine Medical and Surgical Treatment*, 22 J. LEGAL MED. 501, 506–07 (2001) ("Just what standard should the courts and/or statutes adopt in determining the point at which a minor is mature enough to make his or her own medical decisions? A precise standard has never been articulated.") *Id.*

¹⁹⁸ Perkiss, *supra* note 13, at 75–78 ("In addition to probability, scholarship about legal issues surrounding gender-nonconforming individuals suggests that bias and stereotypes . . . play a role in the outcomes of these custody cases.") *Id.* at 77; ("encouraging or even permitting a child to be gender non-conforming reflects negatively upon a parent's fitness . . . [and courts] will take extreme measures, like placing children in unsupportive homes, to deter [a child from growing up transgender].") *Id.*; see also *Grzyb v. Grzyb*, 79 Va. Cir. 93 1 (2009) (Case where court awards custody of a child to the mother, who, despite her intention to not give her child routine vaccinations, played a larger role in making medical decisions for the child than the father) ("the court has concluded that the medical benefits of immunization outweigh the medical risks of immunization.") *Id.* at 5. Therefore, the question remains where a court concludes that the benefits of a medical treatment outweigh the risks, should the court be able to deny a minor that treatment, essentially overriding the best interests of the child in favor of another interest?

¹⁹⁹ Perkiss, *supra* note 13, at 78 ("in applying the medical model of transgenderism, the presence of bias in favor of traditional gender norms and negative stereotypes about parents who promote gender nonconformity may explain why courts favor custody with the rejecting parent in cases involving gender-nonconforming children, where one parent is supportive and the other is rejecting.")

²⁰⁰ *Id.*

A. Further Research: Gender Dysphoria, Medication, etc.

Research indicates that much is yet unknown about gender dysphoria; outcomes vary wildly and the effects of clinical interventions are not clear.²⁰¹ Treatment can be difficult to determine absent a test that can predict whether a child experiencing distress regarding their gender will grow up to be transgender.²⁰²

There is very limited research on supporting transgender youth and a child's gender identity—making it impossible to know how many children step outside gender bounds²⁰³—and most providers have little to no training on how to support these youth.²⁰⁴ Studies in the future should avoid requiring the subject to identify as male or female and offer additional options.²⁰⁵ The likelihood of serious adverse effects is dependent on numerous factors such as the medication itself, dose, route of administration, and a patient's clinical characteristics, thus making it impossible to predict whether a given adverse effect will happen in an individual patient. Lupron and other medications typically used to prevent puberty need to undergo further research to determine the long-term effects of using these drugs in the treatment of gender dysphoria.²⁰⁶ The long-term effects on bone density and brain development of stalling puberty with medication need further research as well.²⁰⁷

B. Recommendation for an Accepted Practice of Approaching Gender Dysphoria Treatment in Domestic Relations Courts

States should have a legitimate interest in guiding youth to make informed life decisions concerning their medical treatment.²⁰⁸ Accordingly, once this interest is recognized, it is in the State's best interests to adhere to a protocol when dealing with the custody of a transgender child to better ensure fairness in the decision-making process.²⁰⁹ While currently transition related care is not currently considered medically necessary (accordingly, there is no guarantee that it will be covered by insurance), this recommendation will operate under the assumption that, as gender dysphoria is recognized under DSM-V, appropriate treatment will be covered under insurance.²¹⁰

When parents disagree on the treatment of their transgender or gender-nonconforming child, the first step should be for the courts to suggest mediation by a social worker. Best practices indicate that social workers, in this case acting as mental health professionals, should help families

²⁰¹ Dreger, *supra* note 83.

²⁰² Boghani, *supra* note 75.

²⁰³ Padawer, *supra* note 55.

²⁰⁴ RYAN, *supra* note 27, at 2.

²⁰⁵ AM. PSYCHOLOGICAL ASS'N, *supra* note 49, at 835 ("the majority of research has required a forced choice between a man and a woman, thus failing to represent or depict those with different gender identities").

²⁰⁶ Dreger, *supra* note 83; *see also* Scutti, *supra* note 19 (While the use of drugs as treatment for conditions other than those the drug has FDA approval for is not uncommon, the long-term consequences of their use is unknown.).

²⁰⁷ Boghani, *supra* note 75.

²⁰⁸ Hulstein, *supra* note 68, at 189.

²⁰⁹ *Id.* at 189.

²¹⁰ Howe, *supra* note 16, at 10 ("Because of the significant benefits hormone therapy and sex-reassignment surgery offer transgender youth with [gender dysphoria] transition-related care is, or ought to be, considered medically necessary . . ."); *see also* FAQ on Access to Transition-Related Care, LAMBDA LEGAL, <http://www.lambdalegal.org/know-your-rights/transgender/transition-related-care-faq> (last visited Apr. 27, 2016) ("The myth that transition-related care is 'cosmetic' or 'experimental' is discriminatory and out of touch with current medical thinking. The [American Medical Association] and [World Professional Association for Transgender Health] have specifically rejected these arguments, and courts have affirmed their conclusion.").

to have an accepting and nurturing response to the concerns of their gender dysphoric child or adolescent without imposing a binary view of gender.²¹¹ These professionals should then provide information and help families weigh the potential benefits and challenges of decisions regarding the timing and process of any gender role change for their child.²¹² Families should also be informed that as the child nears puberty and options for physical interventions become relevant, further assessment may be needed.²¹³ Ultimately, the best option for the child is to find a solution that both parents can readily agree upon. If this does not happen, then the court will need to utilize other resources to make their decision.

During a custody proceeding, an independent advisory council should be convened with the exclusive intent of protecting the child's best interests. The council's goal should be to provide an impartial, educated recommendation to the court as to what the course of treatment should be. This council should consist of a psychologist, an appropriately experienced doctor possessing the ability to provide treatment, and legal counsel in the form of a child representative.²¹⁴ These advisors should both individually and jointly provide the court with recommendations after working with the child in order to suggest a preferred method of treatment. The council's recommendation should factor in, on a case-by-case basis, the minor's desires regarding their treatment. The older and more mature a minor is, the more deference the council will give to his or her wishes.

The concept of an advisory council is not unheard of in hospital settings. St. John Providence Health System, which is located in the Detroit/Metro-Detroit area, utilizes an ethics council to step in when conflicts arise between patients and/or parents not agreeing on a method of treatment.²¹⁵ Under St. John's policy, the Ethics Council makes recommendations and shares resources, ideas, and best practices regarding treatment decisions and issues.²¹⁶

While the judge would still hold discretionary power over the issues in the case, the involvement of a team of experts dedicated to the child's best interests will provide the court with better information. To minimize the potential for judges relying on their own subjective opinions, the recommended approach is to let the judge be guided in his decision-making by: (a) relevant empirical evidence, (b) the rights of the child, and (c) the child's own wishes.²¹⁷

A judge's ability to recognize a positive conception of children's rights is crucial. Courts should strive to identify the minor as a rights-bearer, whose interests are separate and apart from those of their parents.²¹⁸ "It also requires that judges must give careful attention to the precise way in which the content of a child's right is to be interpreted so as to ensure their effective

²¹¹ Coleman et al., *supra* note 9, at 175.

²¹² *Id.*

²¹³ *Id.* at 176.

²¹⁴ See CIRCUIT COURT OF COOK COUNTY, *Child Representative/Guardian Ad Litem*, www.cookcountycourt.org/ABOUTTHECOURT/CountyDepartment/DomesticRelationsDivision/ChildRepGuardianAdLitemGAL.aspx (last visited Apr. 22, 2016) ("A guardian ad litem (also known as a "GAL") is an attorney for the parties' child(ren) . . . the guardian ad litem may be called as a witness for purposes of cross-examination regarding the guardian ad litem's report or recommendations") ("A child representative is an attorney for the parties' child(ren) that advocates what the child representative finds to be in the best interests of the child(ren) after reviewing the facts and circumstances of the case . . . Unlike a guardian ad litem, the child representative cannot be called as a witness to testify.").

²¹⁵ See generally *Ethics Council Guidelines*, ST. JOHN PROVIDENCE HEALTH SYSTEM ETHICS COUNCIL 320, (2012).

²¹⁶ *Id.*

²¹⁷ Tobin, *supra* note 14, at 591–92.

²¹⁸ *Id.* at 586.

enjoyment.”²¹⁹ A judge, acting as a decision-maker, should give substantial weight to the child's best interests, which results in a heavy burden cast on the actor seeking to displace a child's best interests to justify their approach using legitimate, compelling reasons.²²⁰

Treatment options that the advisory council can offer will be based on established best practices. “Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization.”²²¹ Due to the youth's level of psychiatric distress and its strong association with the level of gender-related abuse, it is not a neutral option for youth to have puberty suppression and hormonal therapy withheld.²²² It is no longer considered ethical for treatment to aim at changing a youth's gender expression and identity to become more congruent with their sex assigned at birth.²²³

A youth may be eligible for puberty suppressing hormones as soon as that youth starts going through puberty, where early use may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would.²²⁴ Extensive exploration of psychological, familial, and social issues should be undertaken before considering any physical interventions.²²⁵ Intervention with puberty-suppressing hormones, which may continue for a few years, is justified by two goals: giving youth time to explore their gender nonconformity and other issues and facilitating transition by preventing development of sex characteristics that are difficult or impossible to reverse.²²⁶ The value of using hormone blockers lies in the time bought for youth without an overwhelming fear of their body progressing past puberty – within months of stopping the use of hormone blockers, youth return to genetic puberty.²²⁷

The Standards of Care developed by World Professional Association for Transgender Health state:

In order for adolescents to receive puberty-suppressing hormones, the following minimum criteria must be met:

- 1) The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);
- 2) Gender dysphoria emerged or worsened with the onset of puberty;
- 3) Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment;
- 4) The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent through the treatment process.²²⁸

²¹⁹ *Id.* at 586.

²²⁰ *Id.* at 589.

²²¹ Coleman, *supra* note 9, at 178.

²²² *Id.*

²²³ *Id.* at 175.

²²⁴ *Id.* at 177.

²²⁵ *Id.* at 182.

²²⁶ *Id.* at 191.

²²⁷ Spiegel, *supra* note 52.

²²⁸ Coleman et al., *supra* note 9, at 177.

Adolescents may be eligible to begin cross-sex hormones, where hormone regimens are adapted to account for the somatic, emotional, and mental development occurring throughout adulthood, to progress with their transition.²²⁹ Because irreversible physical changes can result from feminizing/masculinizing hormone therapy, “hormone therapy should be provided only to those who are legally able to provide informed consent.”²³⁰ This gives rise to the question of whether a minor is capable of giving consent for their own procedure.

While parental consent is preferred, many countries allow sixteen-year-olds to legally consent to medical decision-making.²³¹ Decisions regarding the youth’s capability of understanding the magnitude of the following treatment and regarding the timing and degree of care to be used must be made on a case-by-case basis.²³² When the court is approached with a cross-sex hormone treatment issue, a judge should examine the youth under the mature minor doctrine²³³ and determine whether that youth has the ability to legally consent even where one parent fails to support this type of treatment.

Gender reassignment surgery should not be carried out until patients have lived continuously for at least a year in the gender role congruent with their gender identity and have reached the legal age of majority to give consent, where the age threshold should be viewed as minimum criteria and not an indication in and of itself for active intervention.²³⁴

VII. CONCLUSION

The landscape of children’s rights may be complicated, but determining how to address a transgender minor’s rights during parental dispute over custody provisions should be simple – it should involve treatment based on best practices and be based on empirical evidence and the experience of trained professionals. Courts today are allowing too many custody decisions to be made based on subjective opinions—court protocol needs to be established to protect children’s interests.

It is ultimately the role of the state, acting as a trustee of a child’s rights, to ensure that the child in question is able to fully exercise his or her rights upon reaching the age of majority. When parents are unable to make decisions with the child’s best interests in mind, the court needs to step up and advance the rights of transgender youth by supporting their gender identification.

²²⁹ *Id.* at 178.

²³⁰ *Id.* at 187; *see also* Turner, *supra* note 12, at 561. (“As with most medical procedures, informed consent is required for medical treatment for [gender dysphoria].”).

²³¹ Coleman et al., *supra* note 9, at 178.

²³² Turner, *supra* note 12, at 561.

²³³ Arshagouni, *supra* note 34, at 336 (The mature minor doctrine involves youth, typically between fourteen and eighteen years of age, who show a sufficient level of maturity, but fail to satisfy the criteria for emancipation.).

²³⁴ Coleman et al., *supra* note 9, at 178.