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Target Article

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Transgender Children and the Right to Transition: Medical Ethics When Parents Mean Well but Cause Harm

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In this article, I argue 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. Not only are transgender children harmed psychologically and physically via lack of access to PBT, but PBT is the established standard of care. Given that we generally think that parental authority should not go so far as to (1) severally 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. Moreover, transgender children without supportive parents cannot be helped without access to health care clinics and counseling to facilitate the transition. Hence there is an additional duty of the state to help facilitate sharing this information with vulnerable teens.

Keywords: gender/sexuality, disability, chronic conditions, and rehabilitation, mental health, mental illness, right to health care

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] Consider, for instance, that several states and counties have outlawed programs that attempt to change the sexual orientation of homosexual youth.[2] Not too long ago, it would have been unimaginable that a religious program that threatens no physical harm to children would be legally prohibited.

Outlawing the already-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 bullying and harm via cyberspace are increasingly becoming a matter of legislative prohibition. Along similar lines, therapy and

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.

2. States and counties that 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).

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psychiatric drugs are used much more frequently than ever before.[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 nonphysical forms of abuse.

This article discusses one area of psychological harm that is worthy of new attention: harm to transgender youth who have nonsupportive parents (by "nonsupportive" 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 argue that transgender adolescents have a fundamental right to puberty-blocking treatment (PBT) 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. 2012, 78). 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] 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 (De Vries et al. 2014; Gorin-Lazard et al. 2012; Olson et al. 2016).

Sadly, youth suffering from gender dysphoria often face more than just psychological harm, but all too often the ultimate physical harm. Transgender youth are 10 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 among teenagers to the second. In 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 among 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 that leads to suicide is a serious harm.
3. Transgender youth with nonsupportive 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 preceding argument, even if persuasive, leaves much vague. The remainder of this article attempts 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 that 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.

3. Every U.S. 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 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 Centers for Disease Control and Prevention (CDC), "Approximately 6.0% of U.S. adolescents aged 12–19 reported psychotropic drug use in the past month" (see Jonas et al. 2013). Note that 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.

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 2008, 200). 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. 2012).

The next section offers an overview of gender dysphoria and the use of PBT. The third section describes the particular psychiatric problems that befall transgender youth in the absence of PBT. The fourth section focuses on the physical harms that result from the absence of PBT. The fifth section argues that the harms described in the third and fourth sections indeed justify state intervention into the life of transgender minors and their families. The sixth section argues that the state has a role to play not only in legally mandating the right to PBT, but also in using government institutions to educate the public about transgender issues and treatment. In the seventh section I respond to potential objections. The eighth section reviews the article's main argument and offers concluding remarks.

GENDER DYSPHORIA AND TREATMENT FOR TRANSGENDER YOUTH

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] 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] 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] 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]

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. 2016, 101; Krieger 2011, 40). 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 2013, 308). In addition, parents wishing to help their children maintain a healthy psychological state should be supportive and nonjudgmental of their children's gender expression (Olson et al. 2016). 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 are much more likely to both consider suicide, and to attempt it. Conversely, those with strong support were 82% less likely to attempt suicide 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 than transgender youth who are supported by their parents. (Tannehill 2016)[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.

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). Similarly, "Children as young as age two may show features that could indicate gender dysphoria" (Coleman et al. 2012). See also Brill and Pepper (2008).

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).

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 are 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. 2016, 140).

8. For information on transgender youth and homelessness, see Burgess (1999), Durso and Gates (2012), Keuroghlian et al. (2014), and Seaton (2017). Seaton and Durso and Gates contain specific information about the risk factors for transgender homelessness.

9. The studies mentioned include Bauer et al. (2015) and Travers et al. (2012). In addition, Olson and colleagues (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.

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; De Vries and Cohen-Kettenis 2012; Durso and Gates 2012; Frisch 2017; Garofalo et al. 2006; Watson et al. 2017). When a child is accepted by their family and allowed to express their gender identity, the child remains transgender but may experience little to no gender dysphoria.[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 (De Vries et al. 2014; Gorin-Lazard et al. 2012; Olson et al. 2016).

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" (2011, 20). If transgender youth are truly the owners of their bodies, they should have the right to prevent their bodies 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. Indeed, the standard of care for transgender adolescents lines up with their wants. The recommendation for adolescents beginning puberty up until age 16 years 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 freezes 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. 2008, p.1894, and Delemarre-van de Waal and Cohen-Kettenis 2006). Puberty blockers give youth time to be sure that they really do identify with their nonbiological 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. 2012, 177)

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. 2012, 177).

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. 2009, 3133). 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. 2012, 187; Gorin-Lazard et al. 2012). At this stage of cross-sex hormone

10. Throughout this article, I 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 among the LGBT (lesbian, gay, bisexual, transgender) community. For instance, see Dembroff and Wodak (2018) and McKenzie and Dembroff (2018).

treatment, unlike the stage of PBT, some of the bodily changes enacted are irreversible (Ettner et al. 2016, 201).

Although this stage of cross-sex hormone intervention is clearly important, it is not the focus of this article. One reason is that I believe that the thesis I am arguing for (the need for PBT) is an issue worthy of an article 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.

Persisting and Desisting

It is not only parents who might worry about transgender children simply going through a "phase." There has also been a series of studies about "persisters" and "desisters" that suggests many transgender children do not become transgender adults (see Drummond et al. 2008; Steensma et al. 2011; 2013; 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 preceding in turn. A series of articles has offered compelling criticism of the literature on persisters and desisters (a nonexhaustive list includes Ehrensaft et al. 2018; Olson et al. 2016; Olson 2016; Pyne 2014; Serano 2016; Temple Newhook et al. 2018; Winters 2014). 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 Newhook and colleagues:

> 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. (Temple Newhook et al. 2018, 4)

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 Newhook et al. explain further, in one particular study 40% of the subjects did not even meet the criteria for gender identity disorder (Temple Newhook et al. 2018, 5). 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 participants, and even in one case classifying those who left the study as desisting, with the justification that because "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. 2011, 501) So in this case it was actually unknown whether subjects desisted, but it was 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 follow-up was relatively young, and the fact that one of the clinics in the study actively worked to discourage persisting (Temple Newhook et al. 2018).

When the preceding 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 nonconforming 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 and colleagues (Steensma et al. 2013), "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" (588). Hence this criterion (openly stating their transgender identity) can be used to help diagnose adolescents who are good candidates for PBT.

The most recent moves in the desisting literature are two published replies (Steensma and Cohen-Kettenis 2018; Zucker 2018) to Temple Newhook and colleagues' 2018 critical commentary. While some of this discussion takes us off track (given this particular article's aim), let me 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. 2009; Steensma 2013), we expect that future follow-up studies using the new diagnostic criteria may find higher persistence rates" (Steensma and Cohen-Kettenis 2018, 226). However, the authors defend their choice to classify those who did not return to the study as desisters, arguing that other possibilities are far-fetched (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 and colleagues 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 (Zucker 2018, 232). Zucker also criticizes the way Temple Newhook and colleagues summarize and interpret certain data from past studies (233). Zucker is skeptical that the changes in diagnostic criteria are as significant as Temple Newhook and colleagues 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" (2018, 234). Zucker also claims that at points in their paper, Temple Newhook and colleagues "have defaulted to rhetoric and dogma" (2018, 240; Temple Newhook et al. 2018).

My article 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 judgments. 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 argue in the following, even if most transgender children were desisters, there remains strong reason to believe that gender dysphoric youth deserve access to PBT.

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 and colleagues, "In contrast (to childhood), the persistence of gender dysphoria into adulthood appears to be much higher for adolescents" (Coleman et al. 2012, 172). 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 article, "According to Endocrine Society Guidelines, we recommend treating transsexual adolescents (Tanner stage 2) by suppressing puberty with GnRH [gonadotropin releaseding hormone] analogues until age 16 years old, after which cross-sex hormones may be given" (Hembree et al. 2009, 3133). 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. 2012, 187). As said in the abstract of the 7th edition of the Standards of Care (SOC) 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 et al. 2012, 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 article only contends that parental approval need not be an important part of this process.

Some might still worry that overruling 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 and Cohen-Kettenis 2012; De Vries et al. 2014; Durso and Gates 2012; Frisch 2017; Garofalo et al. 2006; 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 that 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 riskier, more dangerous, and more permeant option is not the option of using PBT and desisting. It is rather bypassing PBT and persisting.

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 explain and justify 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; De Vries and Cohen-Kettenis 2012; De Vries et al. 2014; De Vries and Cohen-Kettenis 2016; Gorin-Lazard et al. 2012; Olson et al. 2016; Murad et al. 2010; Kids Pay the Price 2017; Tannehill 2016). 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 article.

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, namely, breasts, hips, and feminized voice and face for transgender men and facial hair, height, muscle development, and masculine voice and face for 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 (Clark et al. 2008;

Garofalo et al. 2006; Rosioreanu et al. 2004; Schmid et al. 2005). Let us remember that many transgender youths are homeless, having been abandoned by their family for their identity (Burgess 1999; 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, that is, 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 (Clark et al. 2008; Garofalo et al. 2006; Rosioreanu et al. 2004; Schmid et al. 2005).

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 a sexually transmitted disease (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 health care via public clinics varies by state and jurisdiction.)

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 United States, 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.

JUSTIFYING INTERVENTION

A Child's Right to Their Body

The first stage 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 these cases 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; that is, 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 2006; Press Association 2017; Woolley 2005). Children's future autonomy, autonomy that 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 that prevent a child from ever reaching adulthood, or from 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. Second, it causes lasting and irreversible physical harm (Bauer et al. 2015; Brill and Pepper 2008; Burgess 1999;

Cohen-Kettenis et al. 2008; De Vries and Cohen-Kettenis 2012; De Vries et al. 2014; Delemarre-van de Waal and Cohen-Kettenis 2006; Krieger 2011; Zucker et al. 2012).

We can compare the parents of transgender children opposed to physician-recommended treatment to "naturalist" parents, that is, parents who mistrust traditional Western medicine. Regardless of whether these parents have good intentions, their children are often at risk of harm. In various cases the courts have ruled not only that these "naturalist" parents are 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 it 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 justify state action regarding transgender children and PBT were to 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 human papillomavirus, 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) justifies 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.

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 publicly funded health clinics. A health care worker can then counsel the child through the process of applying for PBT, a process that 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 article 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. This is the topic of the next section.

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 it is that 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 health care. 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 way to include this lesson is as 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 2013, 308). 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. 2015; Land 2016; Mehra et al. 2004). 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 either fund health care centers for transgender youth, or integrate health care services at existing community health centers. Such health care services can offer free information about PBT and other issues relevant to transgender health care. 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 (Brook 2004; Siegel and Biener 2000; Warner 1977; Wakefield et al. 2008). 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.

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.)

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 to 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 reasons we may be disinclined to see things this way are 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 is 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.

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; Macapagal et al. 2016 Reisner et al. 2014, 2015; Shipherd et al. 2010). Some transgender adolescents with nonsupportive parents have insurance that would cover PBT; others do not (Baker 2017; Khan 2011; Stevens et al. 2015; Stroumsa 2014). Some reside in states where PBT treatment would be covered via state-sponsored health care 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 and 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 that funding PBT is an important issue, it is simply a separate issue from the one addressed in this article. If funding were 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 article attempts to fill a distinct gap in the literature, while in no way minimizing the importance of tackling health care funding for transgender youth.

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 that 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 reaches 18 years, they may dress as they wish. Being forced to dress a certain way as a youth does not impair their ability to dress as they want as an adult. With PBT, however, the absence of this treatment has consequences for the youth's body not only while they are a youth, but also when they are an adult. The feasibility concerns, alongside the lack of permanent harm, explain 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 article, 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 article to arguing only for PBT 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 an article 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 the case for cross-sex hormones for a few reasons. First, cross-sex hormones (unlike PBT) induce irreversible changes (Coleman et al. 2012). It is more plausible to argue that minors should have access to reversible treatment than access to 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 years or younger, which is already the recommended age to begin cross-sex hormone-treatment (De Vries and Cohen-Kettenis 2016; Hembree et al. 2009).

REVIEW AND CONCLUDING REMARKS

This article 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 and appropriate treatment, and leading gender dysphoric youth to appropriate health care 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. 2012, p. 178; Olson et al. 2016; Gorin-Lazard et al. 2012; De Vries et al. 2014). Emotional harm can be long term, and might even result in suicide (Haas et al. 2010). Certain physical changes that transgender youth experience during

puberty are irreversible (Bauer et al. 2015; Brill and Pepper 2008; Burgess 1999; Cohen-Kettenis et al. 2008; De Vries and Cohen-Kettenis 2012; De Vries et al. 2014; Delemarre-van de Waal and Cohen-Kettenis 2006; Krieger 2011; Zucker et al. 2012). For the transgender person these permanent physical changes are harms that prevent one from living a satisfying life (Burgess 1999; Cohen-Kettenis et al. 2011; De Vries et al. 2014; Frisch 2017). 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 in ways that are not medically secure (Burgess 1999; Clark et al. 2008; Durso and Gates 2012; Garofalo et al. 2006; Keuroghlian et al. 2014; Rosioreanu et al. 2004; Seaton 2017; Schmid et al. 2005).

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 this policy only is half the battle. Transgender youth without supportive parents are not helped unless they access health care 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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