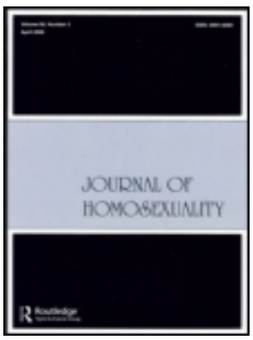

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Supporting Transgender Children: New Legal, Social, and Medical Approaches

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The author, a lawyer who advocates for transgender children and youth, explores how clinical approaches to transgender children and youth are keeping pace with social and legal changes affecting these young people and with recent evidence suggesting that children are harmed by family and societal rejection as well as by attempts to change their gender identity or gender expression. The author urges providers and legal advocates to work with policymakers and the families of transgender children and youth to create a future in which these young people can reach their full potential and be embraced as fully equal, respected, and participating members of society.

KEYWORDS gender, gender identity, gender identity disorder, gender identity disorder of childhood, gender identity disorder of adolescence, gender variance, legal rights, transgender, transsexual, treatment

As a lawyer who advocates for transgender children and youth, I appreciate the opportunity to comment on the important articles submitted by some of the leading clinicians and mental health professionals who work with this unique population. Although we approach these young people from the perspective of different disciplines, we share a deep commitment to their best interests and long-term health and wellbeing. In this article, I explore how clinical approaches to transgender children and youth are keeping pace with social and legal changes affecting these young people and with recent evidence suggesting that children are harmed by family and societal rejection and by attempts to change their gender identity or gender expression. I end by urging providers and legal advocates to work with policymakers and the

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families of transgender children and youth to create a future in which these young people can reach their full potential and be embraced as fully equal, respected, and participating members of society.

During the past 15 years, public awareness and acceptance of transgender children and youth in the United States have increased at breathtaking speed. In 1997, the Belgian film *Ma Vie En Rose* [*My Life in Pink*] portrayed a family's journey from rejection to acceptance of a transgender child who was born male but identifies as a girl. Despite receiving an R rating solely because it dealt with transgender issues, the film played to popular audiences in the United States and received a Golden Globe award for best foreign film. Two years later, Hilary Swank won an Oscar for her portrayal of the murdered transgender youth Brandon Teena in *Boys Don't Cry,* a major Hollywood film that portrayed Brandon with compassion and humanity.

In 2002, Gwen Araujo, a transgender teenager, was murdered by four young men in Newark, California. Gwen's death attracted national attention and shined a spotlight on the terrible vulnerability of many transgender youth. The subsequent trial was one of the first in which prosecutors brought hate crimes charges in a case involving a transgender victim. Gwen's mother, Sylvia Guerrero, expressed wholehearted acceptance of her deceased daughter and became one of the first public role models for other parents of transgender youth.

In the wake of this growing public awareness, more parents have begun to recognize that their gender variant children may be transgender and to seek out information and support. Informal networks for families of transgender children have begun to proliferate. In 2002, the influential national group Parents, Family, and Friends of Lesbians and Gays (PFLAG) launched a special affiliate, called the Transgender Network (TNET), for parents of transgender children and youth. Around the same time, nonprofit organizations dedicated to supporting parents and advocating for transgender children, such as Gender Spectrum and TransYouth Family Allies also emerged. In 2008, Stephanie Brill and Rachel Pepper published the first mainstream book for parents of transgender children: *The Transgender Child: A Handbook for Families and Professionals.*

In 2007, the popular television show *20/20* aired an hour-long special on families raising young transgender children, and cited research on family rejection from Ryan, Huebner, Diaz, and Sanchez's (2009) study of lesbian, gay, bisexual, and transgender (LGBT) young people and their families. Hosted by Barbara Walters, the show provided the mainstream public with its first intimate glimpse into the lives and psyches of these children and the challenges faced by their parents, portraying both with great insight and nuance. A year later, National Public Radio taped interviews with a number of parents and children attending an annual conference for families of transgender children. The segment focused on the benefits to children

of being permitted to express their gender identities and of having parental support ("The Conversation," 2007; "All Things Considered," 2008).

Also during the past decade, states and localities began to enact legal protections for transgender children and youth in schools. California was the first to do so in 1999, followed by New Jersey (2002), Washington and the District of Columbia (2006), Iowa and Vermont (2007), Oregon (2008), Colorado, North Carolina, and Hawaii (2009), New Hampshire and Illinois (2010), and Arkansas, Connecticut, and New York (2011). These laws generally protect transgender children and youth against discrimination and bullying in schools. In addition, some school districts have adopted detailed policies requiring that schools use appropriate names and pronouns for transgender students, permit them to dress according to their gender identity, and provide them with access to restrooms and locker rooms based on their gender identity (see, e.g., L.A. Unified School District, 2011; San Francisco Unified School District, 2004).

In 2000, a state court in Massachusetts became the first to hold that a public high school had to accommodate a male-to-female transgender teenager by permitting her to wear female clothing to school and, generally, to be treated like any other girl. The court based its decision in part on testimony from the girl's therapist, finding that "plaintiff's ability to express herself and her gender identity through dress is important to her health and well-being, as attested to by her treating therapist. Therefore, plaintiff's expression is not merely a personal preference but a necessary symbol of her very identity" (Doe ex rel. Doe v. Yunits, 2000). The court held that "Defendants are essentially prohibiting the plaintiff from expressing her gender identity, and thus her quintessence, at school" and concluded that it could not "allow the stifling of plaintiff's selfhood merely because it causes some members of the community discomfort" (Doe ex rel. Doe v. Yunits, 2000).

In 2008, the Washington Association of High Schools adopted the nation's first policy for high school transgender athletes. The policy requires that schools accommodate transgender students and permit them to play on the teams that correspond to the student's gender identity regardless of the student's biological gender or the sex designated on the student's official identity documents or records. In 2009, the National Center for Lesbian Rights and the Women's Sports Foundation, with participation from the National Collegiate Athletic Association (NCAA), hosted a think tank on transgender athletes in high school and intercollegiate sports. The think tank—which included high school and college administrators and coaches, athletes, and medical and legal experts—resulted in the publication of the first recommended national guidelines for the inclusion of transgender athletes on high school and college teams ("On the Team," 2000). In 2011, the NCAA adopted an official policy based on those guidelines ("NCAA Adopts New Policy," 2011). The Transgender Law & Policy Institute (2009) has

issued similar national recommendations for the inclusion of younger transgender children in recreational sports.

In 2010, Kye Allums, a basketball player for the George Washington University Colonials, became the first openly transgender student to play on an NCAA team. He was strongly supported by his teammates and coaches, and his story received national attention (Orton, 2010). In 2011, the students at Mona Shores High School in Muskagon, Michigan, elected a transgender boy, Oak Marshall, to be their prom king (see Melloy, 2010). Since 2010, the popular television series *Degrassi* has featured a recurring transgender character, Adam, played by young actress Jordon Todosey (see, e.g., Jancelewicz, 2011).

As social and legal support for transgender children and youth have grown, youth are disclosing their identities at younger ages, and the demand for information and supportive care from physicians and mental health providers is increasing dramatically. In response, a number of children's hospitals have created or expanded programs for transgender children and youth, including facilities in Boston, Denver, Los Angeles, Minneapolis, Oakland, Seattle, and Washington, DC. Not coincidentally, most of the articles in this special issue are authored by clinicians affiliated with one of these programs, which have played a leading role in developing contemporary approaches and protocols for treating transgender children and adolescents. In addition, private practitioners who work outside these hospital clinics are also treating growing numbers of transgender children and youth, as evidenced in this issue by the valuable contribution of psychologist Diane Ehrensaft (2011), whose recent publication of *Gender Born, Gender Made: Raising Health Gender Non-Conforming Children* marks the first book length study of this topic by a clinical psychologist. Generally, the number of scholarly and professional articles on how to recognize and provide appropriate care to transgender children and youth is burgeoning.

The new scholarship being generated by clinicians who work with these young people and their families is remarkably consistent and points to a strong emerging consensus about the best ways to work with this population. In their article in this issue, Edwards-Leeper and Spack (this issue) aptly note that "[w]e are in a transitional period regarding the treatment of transgender youth," citing in particular a marked decrease in the age at which gender variant children disclose their identities and the corresponding need for practitioners to "reexamine the framework from which we understand Gender Identity Disorder (GID)" to protect these young people from the harmful consequences of "delaying proper diagnosis" (pp. 321–322). As more youth seek treatment and more practitioners gain experience working with these young people and their families, the benefits of a supportive, nonpathologizing approach are becoming increasingly clear—as are the dangers of pathologizing these identities. Many mainstream

practitioners have shifted from a pathologizing model that locates the problem within an individual child whose gender variance must be altered to avoid external social disapproval, to a supportive model that seeks to help the child self-actualize. This is a major shift from early clinical responses to transgender and gender variant children and youth.

As the contributions to this special issue reflect, many of the leading practitioners working in this field agree on a number of key points—first, and perhaps most important, that transgender children exist. As fundamental as this premise may seem, it marks an important milestone. As recently as the 1960s and 1970s and even early 1980s, many mental health professionals would have considered a child who insisted that he or she was "really" the other gender to be psychotic or, at the least, deeply disturbed. The treatments meted out to those children were often damaging and cruel, albeit motivated by a sincere belief that the child's gender variance could be eliminated and that doing so would benefit the child.

When I first began to advocate for transgender people in the early 1990s, I was shaken by meeting older transgender people who shared painful stories of being confined in psychiatric hospitals, subjected to electro-shock, and given debilitating drugs—not only as adults, but as teenagers and in some cases even children. One woman described being taken to a psychiatric facility by her parents when she was five years old. After a few initial visits, she never saw her parents again. Over the years, she was repeatedly sexually abused by other patients and staff and endured multiple exposures to electro-shock therapy and a variety of psychotropic drugs (including Thorazine, which left her with tardive dyskinesia). She remained institutionalized until her early 20s, when she walked in paper slippers through the woods adjacent to the hospital until she came to a road and hitchhiked to freedom. She soon made her way to San Francisco, where she worked in drag shows and eventually had sex-reassignment surgery in the basement of a house on Van Ness Street, because at that time, in the 1980s, no hospitals in San Francisco would permit sex-reassignment surgeries to be performed. As an adult, she is a fierce advocate for transgender children, and surprisingly forgiving of her own family. She tells me that she often dreams of her father, and believes that her parents loved her and simply did not have the information to understand her identity.

Today, the dominant clinical response to cross-gender identified children has changed dramatically. In this era, few if any children are likely to be subjected to such extreme efforts to change their identity by reputable therapists, although some parents continue to punish gender nonconformity in their children severely, and there still are religion-based programs that encourage this punitive approach. Increasingly, clinicians recognize that transgender children exist and that, at least for some children, "GID in children represents a normal developmental variation" (Menvielle, this issue, p. 363). Accordingly, they recognize that while a child's cross-gender

identification may be symptomatic of other issues, it may also represent a child's authentic core identity.

Once clinicians accept that transgender children and youth are part of the normative spectrum of gender expression and presentation, the goals of therapy change. In the past, therapeutic interventions with these children were focused on trying to prevent the child from growing up to be gay or transgender. With near unanimity, however, the clinicians contributing to this issue recognize that efforts to change or suppress a child's gender identity or gender expression to alter the child's adult identity are ineffective and damaging. Rather than attempting to eliminate or reduce a child's cross-gender behavior or identity, the goal of therapy, in Ehrensaft's (this issue) phrase, is "to facilitate the child's authentic gender journey" (p. 339). Menvielle similarly notes that "[a] premise of the program [at the Children's National Medical Center in Washington, DC] is that the development of children with cross-gender behaviors, interests, and characteristics is not to be interfered with, anymore than with children who are conventional in their gender" (p. 363).

This does not mean that every child who exhibits cross-gender behaviors or identity is presumed to be transgender. One of the most striking features of recent scholarship, including the articles submitted for this issue, is the growing sensitivity of practitioners to the differences between children who are simply tomboys or gender nonconforming boys, children for whom gender variance is limited to a particular developmental stage (de Vries & Cohen-Kettenis, this issue), children for whom gender variance or a stated wish to be the other gender is a transient symptom of their struggle with other issues (such as dealing with a traumatic death or separation),[1] and children who are developing a genuine aspect of their identity. As Menvielle (this issue) notes, "[s]ome children present with gender variant behaviors and interests, but their expressed wishes to be the other gender or assertions about being a member of the other gender are not pervasive and do not suggest or represent deep and persistent convictions" (p. 364). Ehrensaft (this issue) similarly explains that adopting a nonpathologizing view of transgender children "does not mean that gender can never be a symptom of some other underlying disorder rather than an expression of self." Rather, she explains, "the most challenging task for the child clinician is to differentiate those symptomatic situations from the albeit complicated but healthy developmental journey of children who are reaching to establish their true gender identity and authentic gender expressions" (p. 339).

Even when a child's developing identity appears to be clear, practitioners emphasize the need to avoid prematurely labeling the child or assuming the inevitability of any particular outcome. For example, Edwards-Leeper and Spack (this issue) "support the use of early individual and family therapy that encourages acceptance of the child's budding gender development while simultaneously emphasizing the importance of remaining open to the

fluidity of his or her gender identity and sexual orientation" (p. 330). Even when social transition is the right step for a particular child, they stress the need to emphasize to parents "the importance of remaining open to the possibility of the child's gender shifting back at some point" (p. 331). Ehrensaft (this issue) similarly stresses that "we must be modest enough to say that we can never know with absolute certainty if a child who says s/he is transgender is expressing a stable, permanent lifelong identity or just on a temporary stepping stone" (p. 347).

At the same time, contemporary practitioners increasingly acknowledge that prepubertal gender transition is appropriate for children who cannot live in their assigned gender without intense suffering and for whom social transition offers clear relief. As Menvielle (this issue) explains, "[t]here are some children who are so assertive in this regard, that refusing to accommodate to their wish is at face value inappropriate. Their life in their assigned gender is very distressing and the relief they get from switching their gender presentation very palpable" (p. 361). Edwards-Leeper and Spack (this issue) present a particularly thoughtful discussion of the factors that clinicians should consider when dealing with younger children who express a desire to socially transition, including the child's wishes and desires, how the social transition will affect the child's siblings, and the safety of the child and the child's family in light of the surrounding community.

In addition to this growing consensus (particularly among U.S.-based practitioners) that social transition is appropriate for some younger children who are not approaching puberty,[2] there is an even stronger consensus that as youth enter the first stages of puberty, the best practice for dealing with significantly gender dysphoric adolescents is to prescribe hormone blockers that suppress puberty.[3] This treatment usually coincides with the youth living in (or continuing) to live in the social role of his or her desired gender. Suppressing puberty provides these youth with an opportunity to explore their identities without the distress of developing the permanent, unwanted physical characteristics of their biological sex. For example, hormone blockers prevent a female-to-male transgender youth from the trauma of growing breasts, starting to menstruate, and developing typically female patterns of fat distribution around hips and thighs. They prevent a male-to-female transgender youth from developing unwanted facial and body hair, roughening of skin texture, muscle mass, a deep voice, a masculine facial structure, and other unwanted secondary sex characteristics. The relief provided by this intervention can be enormous and gives a transgender youth the opportunity to develop a strong, positive sense of self.

Credit for breaking new ground on this issue must go to Cohen-Kettenis and her colleagues at the Amsterdam Clinic, who have treated over 100 adolescent patients with puberty blocking medication and carefully tracked their outcomes. The article, contributed by deVries and Cohen-Kettenis to this issue, provides the first comprehensive description of what has come to

be known as the "Dutch protocol" for treating gender dysphoria in adolescents, which two studies have now shown to produce extremely positive results for the young people who have received this treatment. As they note, while "[m]any studies in gender dysphoric adults have demonstrated that gender reassignment treatment is effective," their "initial results demonstrate that this is also the case in young people who have received [hormone blockers] to suppress puberty at an early age, followed by the actual gender reassignment" (p. 315).

Edwards-Leeper and Spack (this issue) helpfully identify four psychological benefits of suppressing puberty for transgender adolescents. First, it "can prevent needless emotional and psychological suffering, which can be severe for some adolescents" (p. 329). As Edwards-Leeper and Spack elsewhere note, the psychological problems and symptoms that many transgender youth experience— often as a result of social isolation and rejection, in addition to gender dysphoria—frequently "decrease and even disappear once the adolescent begins a social and/or physical transition" (p. 327). Second, it buys time for the youth to continue exploring his or her identity and to make a more informed and less pressured decision about whether to pursue a full physical transition. Third, it provides an opportunity to see whether suppressing the unwanted secondary sex characteristics has a positive impact on how the youth functions, thereby confirming or disconfirming that the youth's distress was likely caused by gender dysphoria. Finally, for youth who go on to physically transition, it "allows for a much easier full transition to the other gender at a later time because the individual's body remains in a neutral, early pubertal state" (p. 329).

Contemporary experts also recognize, however, that there are a wide range of transgender identities, and medical interventions such as hormone blockers may not be appropriate for all transgender-identified youth.[4] For example, some children and youth may strongly identify as the other gender, but may be comfortable with their bodies. Others may identify as neither a boy nor a girl, or may identify as some combination of the two—and may or may not experience distress about their bodies. In every case, it is important to give children and young people the space to discover and determine who they are and to respect their emerging identities.

The contributors to this special issue and other practitioners also stress the therapeutic importance of providing transgender youth and their parents with tools to navigate societal discrimination and hostility. Here again, there is a marked break with past approaches, which often sought to justify efforts to prevent children from being transgender as a means of protecting them from social rejection and mistreatment as well as the potential need for medical transition with its limitations and risks. Zucker, Wood, Singh, and Bradley (this issue) continue to defend this approach[5]; however, many contemporary experts believe that seeking to alter a child's identity in order to avoid social discrimination is neither effective nor appropriate, and that

"the problem is not located within the child" (Menvielle, this issue, p. 367). Instead, they seek to provide these young people and their families with support, resources, and strategies for dealing with external discrimination and stigma. These include participation in support groups with other parents and youth, "helping a child build 'gender resilience' and explore his or her authentic gender identity while acknowledging social constraints that may work against its full expression," (Ehrensaft, this issue, p. 343) and practical advice for addressing "homophobia and transphobia among family members, schools, and the broader communities (neighbors, religious affiliations)" (Edwards-Leeper & Spack, this issue, p. 330). The goal, as Ehrensaft (this issue) notes, is to provide "a psychological tool kit that will allow a child to internalize a positive self-identity while recognizing situations in which that identity may be in need of protection from an unwelcome or hostile environment" (p. 344).

Research by Ryan and colleagues (Ryan, Huebner et al., 2009; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010) at the Family Acceptance Project at San Francisco State's Marian Wright Edelman Institute for the Study of Children, Youth, and Families lends support to this approach by showing the compelling relationship between family acceptance and rejection of transgender and gay children and their health and wellbeing as young adults. This work provides an empirical framework for helping families support their children's gender identity. For example, Ryan et al.'s research shows that transgender and gay young people who are supported by their families have significantly higher levels of self-esteem, social support and general health in adulthood, compared to peers with low levels of family acceptance. In particular, this research has found that specific parental and caregiver behaviors—such as advocating for their children when they are mistreated because of their LGBT identity or supporting their gender expression—protect against depression, substance abuse, suicidal thoughts and suicide attempts in early adulthood. Moreover, supporting a child's gender expression is among the most important protective factors for supporting a gay or transgender child's long-term health and wellbeing. Conversely, this research has found that parental or caregiver behaviors such as making a child keep his or her identity secret from other family members, pressuring a child to be more or less masculine or feminine, or telling a child that how he or she acts or looks will shame or embarrass the family dramatically increases the child's risk for depression, substance abuse, unprotected sex, and suicidality in adulthood (Ryan, 2009).[6] Other researchers (Crocket, Brown, Russell, & Shen, 2007) are finding similar results.

In light of this suggestive research, as well as the growing body of data being generated by therapists and doctors working with transgender and gender nonconforming youth, legislators, policymakers, and courts are becoming more aware of the need for laws and policies that protect these youth.

Similarly, medical practitioners are increasingly united in the view that one of their most important roles is "serv[ing] as advocates for the transgender population in the broader culture and community," recognizing that "a societal shift must occur in order for these patients to truly be able to live without increased risk of psychological distress and potential physical harm by self or others caused by intolerance and discrimination" (Edwards-Leeper & Spack, this issue, p. 334–335). Historically, medical practitioners such as Harry Benjamin and many others have shown tremendous foresight and courage in advocating for increased social and legal acceptance of transgender people. In the courts, individual therapists have supplied critical expert testimony on behalf of transgender youth and adults that has helped courts understand the reality of transgender identity and the need to treat transgender individuals with dignity and respect. In many important legal cases, the World Professional Association for Transgender Health (WPATH) has filed friend-of-the-court briefs on behalf of transgender plaintiffs, explaining why legal recognition and protection is essential to the health and wellbeing of transgender people. This legacy of collaboration between providers and legal advocates bodes well for the future and lays a strong foundation for clinicians, lawyers, policymakers, and families to work together to create a better future for transgender children and youth.

NOTES

1. Zucker et al. (this issue) describe various scenarios in which gender variance appears to be symptomatic rather than indicative of a child's authentic identity; Ehrensaft (this issue) describes scenarios in which children manifest gender variance "in an attempt to solve some other life or emotional problem" (p. 345).

2. In contrast to the U.S.-based clinicians represented in this volume, the Amsterdam Clinic currently "recommend[s] that young children not yet make a complete social transition (different clothing, a different given name, referring to a boy as "her" instead of "him") before the very early stages of puberty" (de Vries & Cohen-Kettenis, this issue, p. 307–308).

3. This strong consensus is based in part on a near-universal recognition that "gender dysphoria rarely changes or desists in adolescents who had been gender dysphoric since childhood and remained so after puberty" (de Vries & Cohen-Kettenis, this issue, p. 306). See also Zucker et al. (this issue): "there is much less evidence that GID can remit in adolescents than in children" (p. 392).

4. See, for example, Edwards-Leeper and Spack (this issue) noting the prevalence of "gender fluidity even in our clinic of severely gender dysphoric individuals in terms of the extent which patients feel it necessary to alter their physical bodies in order to feel comfortable in their affirmed gender" (p. 334).

5. See Zucker et al. (this issue) arguing that treatments designed to reduce cross-gender behavior and identification in children are justified in part by avoiding "the attendant social ostracism that can ensue from GID persistence" (p. 390).

6. In addition to this empirical research, there is growing anecdotal evidence that many of the young people touted as success stories by clinicians who claimed to successfully treat GID in children were in fact harmed by those treatments. See, for example, Burroway, 2011.

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