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Title: Ethical Concerns Related to Treating Gender Nonconformity in Childhood and Adolescence: Lessons from the family court of Australia

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I. INTRODUCTION

Recently, a family court in Australia considered whether Alex, a thirteen year-old anatomical female diagnosed with “Gender Identity Disorder, transsexual type,” should undergo a staged course of treatment that would support the child’s desire to be treated as a male and to eventually undergo sex reassignment to male.¹ In addition to psychosocial support and counseling, physicians and psychiatrists treating Alex proposed to begin, as the first stage of medical treatment, the continuous administration of estrogen and progesterone to suppress Alex’s menses. The treating professionals asserted that this initial treatment was reversible, but that it would delay the development of undesired female sex characteristics.² At sixteen, if Alex desired continued treatment, the plan before the court called for the administration of a subcutaneous testosterone implant, which would “induce irreversible masculinisation such as voice change, muscle growth, facial and body hair, growth of the clitoris and behavioral effects ‘that would make [Alex] more assertive/aggressive and have a stronger sexual urge.’”³ Treating physicians would also administer a hypothalamic blocker which would reduce Alex’s “estrogen secretion to prepubertal levels” and thus delay a female puberty.

In reaching its decision, the court carefully considered the testimony of the child, interested relatives, experts, treating physicians, school officials, the caseworker, and guardian, all of whom were in relative agreement that the treatment should proceed given the emotional discomfort and social adjustment problems the child currently experienced.⁴ Despite the concurrence of interested parties, the court’s decision to allow treatment, including hormonal treatment at age thirteen that will retard puberty and irreversible treatment at age sixteen to

masculinize the child, and to facilitate the child's psychosocial desire to present himself at school as a male including by allowing a name change,⁵ was not without substantial controversy in Australia.⁶

Critics of Alex's treatment were unlikely bedfellows. Some critics of treatment argued that such life-altering elective treatment on children should be avoided until the child has full decisional capacity.⁷ Still others questioned the moral and medical legitimacy of sex-change treatment for gender dysphoria generally.⁸ And some in the lesbian and gay community argued that sex reassignment is necessary only because society is intolerant to gender-blending.⁹ Those in the feminist and other communities voiced one of the major arguments against the judgment. They argued that the decision was the result of patriarchal thinking.¹⁰

In brief, gender identity disorder, also called gender identity dysphoria (GID), is defined in the medical and psychological community as the strong and persistent disturbing belief for at least two years, that one is actually a member of the opposite sex.¹¹ The ethical dilemma of whether and how to treat children and adolescents with GID is particularly difficult to sort through in the abstract. In Alex's case, to do no intervention, i.e., to allow the child's reproductive and associated physiological characteristics to emerge at puberty, had consequences. Future treatment to reassign sex would have to be more extensive if the undesired female characteristics had been allowed to emerge. And some authorities suggest that earlier intervention yields a more satisfactory anatomical and psychological outcome.¹² Most crucially, Alex had demonstrated self-harm and threatened suicide should his request be denied.¹³ Thus, doing nothing not only was dangerous but amounted to doing something.

It is undoubtedly tough to be a transgendered minor.¹⁴ As the court was well aware, Alex's depression, suicide risk, and serious social problems at school were so troubling as to require some form of intervention. These psychosocial symptoms can also have lifetime consequences. The emergence of unwanted sex characteristics was producing in Alex its own psychic pain as well. Moreover, Alex's attempts to present himself publicly as a male when his physical appearance was female would likely lead to social stigmatization, rejection, and harassment during his teen years.

While Alex needed something to be done, the other concern is that treatment to facilitate sex change in an adolescent may be premature. Studies suggest that gender identity is fluid in childhood and even, although less so, into adolescence.¹⁵ GID in childhood very often does not persist into adulthood, and adolescent manifestations of GID sometimes do not continue into adulthood.¹⁶ In many instances, the adult outcome of childhood and adolescent GID manifests as homosexuality without the gender dysphoria. Thus, for the adolescent, even allowing reversible treatment and allowing the adolescent to present in the opposite sex has future consequences if it solidifies a gender presentation that might have otherwise been later abandoned.

The issues surrounding treatment of children prior to puberty is even more difficult than that posed by treatment in adolescence. In children the issue is not whether to facilitate change, since hormonal treatment is not recommended prior to the onset of puberty, but instead whether GID can or should be suppressed. Currently there is insufficient data to know whether psychiatric treatment can reduce gender dysphoria and change the adult outcome. Moreover, as for psychiatric treatment to alleviate GID, one has to question whether the motivation is to prevent GID or the more common resulting homosexuality given that either outcome may occur. Although once considered so, homosexuality is no longer considered a psychiatric condition, and therefore treatment to prevent it would be inappropriate.¹⁷ On the other hand, GID remains a disputable psychiatric disorder.¹⁸

Thus, if parents desire such treatment, ethical issues arise concerning the objective of treatment and whether parents have authority to consent to such treatment.

Put simply, there is no single answer as to how to treat children and adolescents with GID. Instead, professionals must exercise clinical judgment in developing and proposing a care plan. Even when sound clinical judgment is exercised, there are substantial risks in treating and in not treating these minors. In light of this, how best can the legal system assist children and adolescents to achieve a satisfactory short and long term outcome? What role can the law play in lessening the social and psychological problems of these youth?

The Australian decision offers a window into the life of a minor with GID. It provides courts with a roadmap as to how to participate in a thoughtful, cautious, individualized and collaborative treatment plan. However, while *Re Alex* is instructive, the authors note that, unless there is disagreement among parents, physicians, and the child, in the United States, generally parties need not seek judicial approval to provide care to minors.¹⁹ Courts in the United States exercise a more circumspect role in medical decision making generally.²⁰

This Article examines the Australian decision, discusses prevailing views on treating GID in children and adolescents, and describes the real-life difficulties these young people suffer. This Article further comments, that in light of recent negative decisions in the United States concerning the legal rights of transgendered individuals, less judicial involvement in deciding whether and how to treat minors with GID is probably best. These medical decisions should occur outside the judicial system when all the parties concur, especially when the treatment falls within established standards of care. When the parties do not concur, other strategies need be considered, and it is here that *Re Alex* gives us guidance.

The Article concludes by acknowledging that treatment decisions are difficult, but must be made. The authors encourage that, whether these decisions are made in court or by parents, in consultation with clinicians, all medical decisions

must be individualized. Decisions should be based on the child's needs, rather than by narrow views regarding gender variation. While the child's future decision-making capacity and autonomy should be preserved if the child is not sufficiently mature to make decisions, these goals should not be an impediment to treating the child who needs treatment now. In every case, the decision as to whether and how to treat, has future consequences. Lastly, the authors present for consideration several other matters that need attention relative to a minor's sexual transition.

II. THE AUSTRALIAN APPROACH: INDIVIDUALIZED, JUDICIALLY APPROVED INTERVENTION

A. A Unique Judicial Role

A case of this type is more certain to come before a court in Australia than in the United States. Under Australia's Family Law Act of 1975, the Family Court of Australia has jurisdiction over matters concerning the welfare of children.²¹ Family law is largely decided at the federal level, thus the standards announced by the court are, except for the state of Western Australia, precedential throughout the country. In a landmark 1992 Australian case, concerning the sterilization of a mentally disabled minor, the court held that parents lack authority to consent on behalf of their children to certain medical decisions and that prior judicial authorization is necessary.²² The court did not base its ruling on the right to procreate, as decisions in the United States have done.²³ It more broadly held: "Court authorisation [to medical treatment] is required, first, because of the significant risk of making the wrong decision, either as to a child's present or future capacity to consent or about what are the best interests of a child who cannot consent, and secondly, because the consequences of a wrong decision are particularly grave."²⁴

Since then, examples of medical care requiring prior judicial approval in Australia have included harvesting bone marrow for the benefit of another family member,²⁵ the refusal of life-saving medical care,²⁶ and sex reassignment in an intersex child.²⁷ Thus, the State (because Alex was a ward of the State) was compelled to seek prior judicial approval, even if all the interested parties, including Alex (a minor lacking capacity to consent), were in agreement.²⁸

The court concluded that the proposed treatment in this instance required prior judicial approval under its case law:

[T]he treatment plan in the present case falls within the category of cases that require court authorization. There are significant risks attendant to embarking on a process that will alter a child or young person who presents as physically of one sex in the direction of the opposite sex, even where the Court is not asked to authorise surgery.

Also, it cannot be said on the evidence that the treatment is to cure a disease or correct some malfunction.²⁹

The court's approach in deciding what treatment Alex should receive was broadly inclusive. The court sought participation and testimony from individuals with an interest in Alex's care and of those with particular expertise to aid the court. The court appointed a Child Representative to represent Alex's interests, in addition to Alex's legal guardian whose input was more parental.³⁰ It invited participation from family members, including the aunt with whom Alex resided, and from his estranged mother.³¹ The court also allowed the Human Rights and Equal Opportunity Commission to intervene and make "submissions on the human rights principles applicable to the case."³²

In addition to testimony from various treating professionals,³³ the court obtained testimony from experts who reviewed Alex's records and commented upon the proposed treatment.³⁴ The court asked its own questions about the treatment, and required follow-up responses from the witnesses.³⁵ The judge met privately with Alex, at the minor's request, and noted that the court was holding certain discussions with Alex confidential.³⁶ It heard testimony from Alex's aunt, and principals from Alex's primary school and his new secondary school.³⁷ It obtained a family report from a psychologist who had treated Alex.³⁸

Early in the proceedings, the court delivered interim orders allowing Alex to enroll in high school with a male first name.³⁹ The court also issued an interim order authorizing "reversible hormonal treatment," in light of the testimony of a treating psychiatrist that "the urgency of treatment is such that it should begin as soon as possible."⁴⁰ As the court acknowledged,

evidence ... was adduced though [sic] a hearing process that differed in a number of respects from the traditional form. [T]he procedural modifications to the hearing process enhanced the depth and richness of the evidence, and thereby better served the aim of an outcome which will be in Alex's best interests.⁴¹

Specifically, the court explained that much of the evidence was taken "in affidavit form," the hearing itself was "inquisitorial rather than adversarial"; it was conducted in a private conference room rather than in a court room; it followed a "discussion format" that allowed for "a dialogue in respect of each other's evidence"; and it took place over a period of time so that witnesses could consider and respond to the testimony of others.⁴² The court characterized the hearing as "an orderly discussion between witnesses and legal representatives ... and myself."⁴³

B. The Factual Circumstances

The case involved a 13 year-old anatomical female diagnosed with gender identity disorder who self-identified as a male.⁴⁴ Alex's troubled family and social

history are worth noting. Alex's father, with whom he enjoyed a loving relationship, one which he characterized as "like best friends," died when Alex was five or six years old.⁴⁵ His death was "clearly devastating," according to the court.⁴⁶ Alex's psychiatrist noted, "Alex reported being able to feel at times his father was alive and able to communicate with him, [although] '[t]here is no evidence of delusions' and '[t]his phenomenon seemed consistent with his own process of bereavement and socially not unacceptable way of managing the loss of [his] father."⁴⁷

Alex regarded his mother as "affectionless and harsh."⁴⁸ After his father's death, Alex's mother remarried and Alex's stepfather sponsored their entry to Australia.⁴⁹ Alex arrived in Australia speaking little English.⁵⁰ Relationships in the new family were unsatisfactory. At ten years of age Alex's mother told child protection workers "that she did not want Alex in her life and did not want to see him again."⁵¹ Alex was eventually removed from the home and placed in substitute residential care.⁵² Although contacted by the court, Alex's mother did not participate in the instant proceedings. In 2001 Alex's mother and step-father had written the court "renouncing their relationship with Alex."⁵³

Although at the time of the hearing Alex resided with a maternal aunt, he remained a ward of the State.⁵⁴ Alex's placement with the aunt had been interrupted at one point, when, due to aggressive and suicidal behavior, Alex was temporarily placed in foster care. This "breakdown" called attention to Alex's need for an assessment of his gender crises.⁵⁵ A caseworker brought the case for treatment on Alex's behalf.⁵⁶ As his caseworker described his earlier placement, "[w]e had to put him in a placement... because he was actually threatening to kill himself and saying he would rather be dead and didn't want to live this way, that he wasn't a girl and didn't want to be a girl. I felt very seriously that he actually meant it."⁵⁷

Alex's male gender identity was reportedly persistent and longstanding.⁵⁸ For example, Alex reported to a psychiatrist that "[he] grew up in [his] first years of life believing that [he] was a boy"⁵⁹ and that "[he] has always thought of [himself] as a boy."⁶⁰

Alex also attempted to present himself as a male to others even though it caused social problems. He told others he was a boy and he used the boys' restroom, even after being advised to use the girls' restroom. When he was told to use the girls' restroom he "started wearing nappies to school and reported... that [he] would not drink any liquids all day so that [he] did not need to use the toilet during school time."⁶¹

Alex's tenacity eventually won out. Alex was so persistent that his primary school finally accommodated him by allowing him to "use the enclosed toilet for people with disabilities."⁶² The principal of his grade school stated that the staff and teachers eventually "accepted that [Alex] was different," explaining, "[s]o it was a matter of counseling the staff to say, 'Well, we need to accept this,' and staff

did.”⁶³

Alex was eventually diagnosed with depression and gender identity disorder at the age of twelve. The court considered Alex’s mental health history in depth – clearly suicide was on the minds of the court and witnesses. Even in primary school, Alex’s severe depression and suicidal ideation was alarming. The principal explained that he “was in my office and [he] was definitely quite distraught and wanting to kill [himself] because nobody was taking this whole thing seriously about gender.”⁶⁴ The treating psychiatrist said, “[t]here was no evidence of delusional disorder or thought disorder and [his] orientation and cognition were intact.”⁶⁵ Nevertheless, Alex “acknowledged having perceptual disturbances, that he would hear his own voice or the voice of his father, and ... said [that] ‘somebody can read my mind and the thoughts in my mind.’”⁶⁶

In the application to approve treatment, Alex’s treating psychiatrist wrote the following: “[T]he urgency of treatment is such that it should begin as soon as possible. [Alex] says that if treatment is delayed and she [sic] has to go to high school with the presence of periods and increasingly feminised body, [he] will be extremely distressed and disadvantaged by that.”⁶⁷

Alex’s psychiatrists also explored his sexual orientation, asking whether his “wish for treatment emanates from his attraction to girls.”⁶⁸ Alex’s caseworker, Ms. R., perhaps the one adult most like a parent figure, was not entirely convinced that sexual orientation might indeed be at issue. She testified:

[E]arly on I actually raised the idea with him that he may simply have a same sex attraction and that this is where his gender issues arise from. He quite vehemently denied that it was anything to do with that. I’m still not totally convinced in every single way possible that that isn’t part of the issue for him. We could actually be looking at two separate issues rather than just one that’s all indicative of the same thing. So I’ve always advocated that we take the timely sort of approach and not rush into anything and have made sure that he understands that there’s a whole range of people in the community and just because he sees a man and a woman and a couple of children and that seems to be the bulk of what he would be exposed to in his own life, that that does not mean that that’s all there is in the world.

I take him to places ... where he sees a far greater diversity of people and genders and images and try and get him to see that may be a far more effeminate looking male might walk past and a very much more masculinised looking woman might be nearby and that this is a whole range of things and it’s quite acceptable to be anywhere within that range and that as he gets older he has more power within himself and more options about what he chooses for himself and that what he’s dealing with right now doesn’t have to continue to be his reality.⁶⁹

The court considered the possibility that Alex's gender identity might not yet be fixed. The court acknowledged that, "with adolescent development Alex may reconsider his gender identity as a male and that if such a change in self-image transpires, he may come to view himself as a lesbian. It is not, however, the current assessment of his state of mind and sense of self."⁷⁰ Although the court acknowledged that Alex's gender identity and sexual orientation might change in time, it concluded:

In light of the adamant nature of Alex's gender identification and the on-going concern as to how traumatised he would be if the proposed treatment were not to otherwise go ahead, I would not delay treatment merely because of the theoretical risk that Alex is constructing his self image as "really" male when in fact he is "really" a female lesbian and will come to see himself that way over time.

It is true that if Alex does shift in his self-perceptions after testosterone has begun being administered he will have certain irreversible masculine characteristics. I am satisfied, however, that in the course of the proposed treatment, which includes ongoing psychological and psychiatric assistance, there will be attention to whether there emerges a change in his self-perceptions which impacts upon the treatment plan I am asked to authorise.⁷¹

Thus, the court had before it, a thirteen year-old female (as measured by gross anatomy and reproductive physiology) with a persistent and longstanding male gender identity, who presented a serious suicide risk, who had a depression rooted, at least in part, in gender identity issues. Alex himself had a strong desire for treatment, his legal guardian and his aunt supported treatment, and all the professionals consulted concurred that treatment was appropriate.

The timing of the application in Alex's case was fortuitous. At the time of the application, the diagnosis had been established for nearly two years by several treating psychiatrists. Alex had also begun to menstruate, and clinical guidelines in treating GID "recommend that young people have had some experience of themselves in the post-pubertal state of their biological sex before starting any physical intervention."⁷² The two years in which Alex had been living as a boy also satisfied one of the criteria in establishing suitability for surgical transition established by the Harry Benjamin International Gender Dysphoria Association (HBIGDA). This is the professional organization primarily concerned with the understanding and treatment of GID.⁷³ In addition, this particular time presented a convenient opportunity to make an easier transition, because Alex was about to switch from primary to secondary school.⁷⁴

C. Informed Consent

The court considered Alex's capacity to consent to the treatment. It assessed Alex's maturity, understanding of his condition, and intellectual capacity. Alex

was described as “mature” and “intelligent.”⁷⁵

A treating psychiatrist stated that he “fully understands at this stage the mechanism of the action for the proposed hormone treatment, and side effects and the benefits.” Nevertheless, the psychiatrist stated, “I believe that it is not appropriate at age 13 [that he] should be wholly responsible for the decision to undergo hormone treatment.”⁷⁶ The court agreed, noting that with regard to sex change treatment, “[i]t is highly questionable whether a 13 year old could ever be regarded as having the capacity ... and this situation may well continue until the young person reaches maturity.”⁷⁷ The court explained that while Alex lacked legal capacity, his wishes were considered in light of his maturity:

In my view, the evidence does not establish that Alex has the capacity to decide for himself whether to consent to the proposed treatment. It is one thing for a child or young person to have a general understanding of what is proposed and its effect but it is quite another to conclude that he/she has sufficient maturity to fully understand the grave nature and effects of the proposed treatment.

However, in the present case, I have uncontroverted evidence not only that the proposed procedure is entirely consistent with Alex’s wishes but also that the expert evidence as to the best interests of Alex accords with those wishes.⁷⁸

Thus, while the court considered Alex’s desires, it did not conclude that Alex was sufficiently mature to make such a life-altering decision without the additional safeguard of court approval.⁷⁹

D. The Treatment Plan

In authorizing a treatment plan, the court considered the justifications for and against treatment and weighed the risks associated with both treatment and nontreatment. The court accepted that Alex’s acute psychological distress justified treatment now. It also acknowledged that his gender identity and sexual orientation might change with maturity, but considered that experts in Alex’s case discounted that possibility:

The evidence speaks with one voice as to the distress that Alex is genuinely suffering in a body which feels alien to him and disgusts him, particularly due to menstruation. It is also consistent as to his unwavering and profound wish to present as the male he feels himself to be. The possibility that Alex is an emerging lesbian has been considered but not accepted by the two expert psychiatric witnesses who have assessed him.⁸⁰

The court considered lesser or alternative interventions, noting that, “[t]he prognosis for behavioral intervention to change Alex’s self-image and behaviour

is poor.”⁸¹ The court weighed the risks, and here paid special attention to Alex’s own appreciation of the consequences:

I have canvassed above the physical consequences arising from each stage of treatment and I am satisfied that Alex has the capacity and indeed does in fact know the side effects that may arise and further that he wishes the proposed treatment with knowledge of such risks. The social implications of the proposed treatment are that Alex will face challenges in his chosen identity in respect of peer relationships, possible bullying and ostracism, but I am satisfied that impressive steps have been taken to anticipate such risks.

On the other side of the balance, if treatment is not permitted there is consistent concern that Alex will revert to unhappiness, behavioural difficulties at home and self-harming behaviour. Socially, he will be significantly ill at ease with body and self-image during his period of adolescent development until he is competent to make his own treatment decision. Transition into a male public identity will be more difficult than if it occurs at the commencement of secondary school.⁸²

The medical treatment the court approved would progress in two stages. The court noted that, “Alex’s mental health and endocrinological treatment would be monitored by a team approach” and that the orders of the court were intended to allow “treatment opportunities” rather than “imposing a requirement of taking such treatment.”⁸³ The court authorized the reversible hormone treatment commenced under its earlier interim orders to continue. The goal of the reversible treatment was to suppress Alex’s menses.⁸⁴

The court further authorized, subject to consensus and an evaluation of his needs at that time, the institution of irreversible hormonal treatment at the age of sixteen.⁸⁵ That treatment would facilitate “masculinisation such as voice change, muscle growth, facial and body hair, growth of the clitoris and behavioural effects ‘that would make [Alex] more assertive/aggressive and have a stronger sex urge.’”⁸⁶

The court also considered the social and educational risks in making the transition. It issued orders to facilitate a social transition as well. The court further authorized a name change and issued an order that Alex be allowed to enroll in school under his new name.⁸⁷ In weighing Alex’s best interests, it also carefully considered evidence concerning how the school would assist and protect Alex’s privacy and prevent stigmatization and bullying.⁸⁸

The applicant did not seek any order to amend Alex’s designated sex on his birth certificate, but the court criticized current laws that focus on surgical reassignment as the *sine qua non* for changing the birth certificate:

I consider it is a matter of regret that a number of Australian

jurisdictions require surgery as a prerequisite to the alteration of a transsexual person's birth certificate in order for the record to align a person's sex with his/her chosen gender identity. This is of little help to someone who is unable to undertake such surgery. The reasons may differ but for example in the present case, a young person such as Alex, on the evidence, would not be eligible for surgical intervention until at least the age of 18 years.⁸⁹

The court noted that requiring surgery as the test for birth certificate amendment could cause hardship, embarrassment, and stigmatization to those who could not or would not undergo surgery. As the court stated, “[a] requirement of surgery seems to me to be a cruel and unnecessary restriction upon a person's right to be legally recognized in a sex which reflects the chosen gender identity and would appear to have little justifications on grounds of principle.”⁹⁰

Remarkably, the court also considered Alex's financial future, especially his ability to eventually pay for future treatment, including surgery. In determining that Alex should remain a ward of the state while in the care of his aunt, the court noted that medical and educational expenses would be provided and that the state also usually offered transitional financial assistance when the child reached majority. Moreover, in the case of disabled children, the state might also provide some continued assistance after the age of eighteen. Finally, because the aunt was being paid by the state for providing care to Alex, and she was saving all such money for Alex in a joint account, there would be money to pay for future treatment.⁹¹ This led the court to conclude that Alex should remain a ward of the state.⁹²

III. TREATING GID IN CHILDREN AND ADOLESCENTS

The following sections briefly explore the complexity of diagnosis and treatment of GID in children and in adolescents. Treatment at each stage of life raises unique ethical and medical dilemmas. In preadolescent children, the issue is whether to offer therapy aimed directly at reducing gender nonconformity, in hopes of preventing adult GID. Three problems of such treatment are: (1) the lack of data supporting the efficacy of such treatment; (2) the inappropriateness of preventing homosexuality as an end goal of treatment; and (3) fundamental skepticism that gender identity dysphoria should be classified as a disorder at all. As to this third problem, many believe that GID, like homosexuality, should be seen as just another human sexual variation rather than a psychosexual problem in need of treatment and should therefore be removed as a DSM diagnosis.⁹³ In adolescents, the ethical problems involve whether to treat certain youth with persistent GID with reversible and partially reversible hormonal treatment before adulthood when psychosocial treatment alone does not alleviate their distress. The problems here again are threefold: (1) the lack of solid data concerning who should be treated; (2) whether such treatment is appropriate

before adulthood; and (3) whether the treatment might eventually prove disadvantageous.⁹⁴

A. GID and Treatment Options in Pre-Adolescents

GID in adults is considered rare; however, accurate prevalence estimates vary broadly.⁹⁵ GID, which encompasses a spectrum of gender discordances,⁹⁶ is generally marked by “a strong and persistent cross-gender identification and a persistent discomfort with their sex or a sense of inappropriateness in the gender role of that sex.”⁹⁷ The individual recognizes his or her biological sex (sexual identity) but considers it inconsistent with gender identity (how the individual prefers to see self within society).⁹⁸

The prevalence of childhood GID is not known with any certainty, and estimates come principally from small studies and clinical experience.⁹⁹ Researchers assume that it is more common in children than in adults, based on the observation that the childhood diagnosis does not usually persist until adulthood.¹⁰⁰ In both adults and children, GID occurs more frequently in males than females; the effect of social and cultural factors to explain the differences is not clear.¹⁰¹ There is some support for the view that boys are identified more often because “parents, teachers, and peers are less tolerant of cross-gender behavior in boys... [and] girls may need to display more cross-gender behavior than boys before a referral is initiated.”¹⁰² Lev has written:

Boys are punished (i.e., treated) for gender-deviant behavior, whereas girls' behavior is tolerated and often rewarded, as long as their behavior stays within certain, less confining, guidelines. The language of the DSM reflects this, since boys need only to “prefer” girl's clothing, but girls must “insist” on boy's clothing to meet diagnostic criteria. The DSM's implicit approval of sex-role divisions does not merely reflect social values but reinforces them.¹⁰³

The etiology of GID is uncertain. Psychological theories focus on parent characteristics, on the child's psychological make-up, and on life events or on a combination of factors as predisposing influences.¹⁰⁴ Biological theories postulate that prenatal hormonal levels, brain development, structure, and chemistry contribute to GID.¹⁰⁵

The diagnosis of childhood GID can be difficult because gender is fluid and “cross gender profiles may change over time” for a variety of reasons.¹⁰⁶ Diagnosis of GID also requires clinical assessment of typical and atypical gender identification and behaviors existing along a spectrum. For instance, “[i]n the more extreme cases [diagnosis] will not be a very difficult task. However, children may take a position anywhere between ‘typical for boys’ or ‘typical for girls’ on various dimensions.”¹⁰⁷ A diagnostician must distinguish between merely atypical gender manifestations that remain within the “normal range.”¹⁰⁸ Compounding the difficulties of diagnosis even further, some children with GID

keep their cross gender feelings secret and are not diagnosed until adolescence.¹⁰⁹

Treatment of childhood GID has evoked considerable controversy. First, the diagnosis can be elusive because gender nonconformity does not always constitute GID, and for some children, it appears self-limiting. The various treatment options have not been tested, so there is the concern of subjecting children to financially costly treatment that might be pointless, or worse, harmful. Finally, depending on what outcome is desired, the treatment goal may itself raise ethical issues.

In childhood, empirical studies demonstrate gender identity is not static and children diagnosed with GID may not be so as adults.¹¹⁰ In fact, in the majority of children, GID “remits by adolescence, if not earlier.”¹¹¹ Follow-up studies of boys who have GID indicate that “a desistance of GID with a co-occurring homosexual orientation is the most common” outcome,¹¹² while GID may persist into adulthood for others, and for still others may desist “with a co-occurring heterosexual sexual orientation.”¹¹³ Less is known about the outcome in girls because “insufficient numbers of girls with GID have been followed prospectively to draw conclusions about long-term outcome.”¹¹⁴

There is some professional thought that intervention with young children can alleviate GID, although this treatment option is not without critics.¹¹⁵ Certainly some proponents of early intervention justify it based upon a religious or moral conservatism.¹¹⁶ In response to the *Re Alex* decision, religious factions were among the more vocal in expressing objection to the court’s decision to allow treatment facilitating transition.¹¹⁷ But others, such as Zucker, acknowledge the complexity of early treatment decisions and assert that treating GID remains an ethical choice in certain cases:

Any contemporary child clinician responsible for the therapeutic care of children and adolescents with GID will quickly be introduced to complex social and ethical issues pertaining to the politics of sex and gender in a post-modern Western culture and have to think them through carefully.... If parents request treatment for their child with GID to divert the probability of a later homosexual orientation, what is the appropriate clinical response?

Perhaps the most acute ethical issue concerns the relations between GID and a later homosexual orientation. As noted earlier, follow-up studies of boys with GID, largely untreated, indicate that homosexuality is the most common long-term psychosexual outcome. Some parents of children with GID request treatment, partly with an eye towards preventing subsequent homosexuality in their child, whether this is because of personal values, concerns about stigmatization, or for other reasons.¹¹⁸

Zucker points out that it “has [not] been shown that any form of treatment for

GID during childhood affects later sexual orientation” and “[f]rom an ethical standpoint... the clinician has an obligation to inform parents about the state of the empiric database.”¹¹⁹ Zucker also cautions that the clinician must explain the “distinctness” of sexual orientation and gender identity in their “[p]sychoeducational work with parents.”¹²⁰ Yet, because it is beneficial to assist children with GID “to resolve the conflicts that are associated with the disorder, regardless of the child’s eventual sexual orientation,” treatment is appropriate.¹²¹ On balance, Zucker opines that “[m]ost clinicians, therefore, take the position that therapeutics that are designed to reduce the gender dysphoria, lessen the degree of social ostracism, and reduce the degree of psychiatric comorbidity constitute legitimate goals of intervention.”¹²²

Therapy can include such things as helping parents create opportunities for the child to experience successful gender conforming experiences, develop same sex friendships, and develop a closer relationship with the same sex parent.¹²³ It might also include behavior modification that results in “reinforcement of gender-typical behavior during therapy sessions and extinction of cross-gender behavior, gradual shaping of gender-typical behavior, and desensitizing fear of failure.”¹²⁴

However, the efficacy of treatment is currently uncertain as Zucker acknowledges:

For children who have GID, clinical experience suggests that psychosocial treatments can be effective in reducing the gender dysphoria.... In considering these various therapeutic approaches, one important sobering fact should be contemplated. With the exception of a series of intrasubject behavior therapy case reports from the 1970s, no randomized controlled treatment trial can be found in the literature. Thus, the treating clinician must rely largely on the ‘clinical wisdom’ that has accumulated in the case report literature and the conceptual underpinnings that inform the various approaches to intervention.¹²⁵

There is no consensus concerning treatment of childhood GID aimed at preventing either adult GTD or homosexuality. For instance, “[some therapists treat the children to prevent homosexuality [while] [m]any [therapists and others] consider this to be unethical, because homosexuality is not a psychiatric disorder.”¹²⁶ Moreover, with so little scientific support of the efficacy of treatment, some question whether treatment to cure GID can be justified under any circumstance:

Despite the many treatment approaches, controlled studies do not exist. It is therefore still unclear whether (an extreme) GID in childhood can truly be cured. Whether homosexuality or transsexualism can be prevented by psychological interventions before puberty also remains to be demonstrated. Nothing is known about the relative effectiveness of various treatment methods. ... Pending

controlled studies, psychotherapy directly aimed at curing GID has no place in the treatment arsenal.¹²⁷

Some commentators argue that it is society's treatment of those with nonconforming gender or orientation that is pathological and children expressing nonconformity do not have a disorder. Therefore, they argue, in children with GID, it is better to try to reduce social stigma and treat symptoms such as depression, rather than treating GID. Law professor Elvia R. Arriola criticizes early intervention in GID geared to guiding children toward heterosexuality, arguing instead that society should commit itself "to undoing the belief systems that keep people in what Warren Blumenfeld calls 'gender envelopes,' which inhibit our personal growth and our potential for living happy and creative lives."¹²⁸ Because studies show that many children who are diagnosed with GID eventually prefer homosexual activities, she argues that treating these children with a goal to have them become heterosexually oriented adults perpetuates the view that homosexuality is a mental disorder. She argues that society should accept atypical gender presentations; that they are not pathological. Moreover, she argues that since homosexuality is not a recognized disorder, it is unethical to treat GID, since it is often merely a precursor to homosexuality. She argues that "the current availability of a mental health diagnosis of GID ... replaces the forms of reparative therapies¹²⁹ supposedly set aside when homosexuality was removed from the official list of mental disorders in 1973 and therefore the basis of GID is blatantly homophobic."¹³⁰

The Harry Benjamin Standards of Care acknowledges the possibility of intervening to affect outcome but stops short of endorsing treatment aimed at "curing" GID, stating "[t]he younger the child the less certain and perhaps more malleable the outcome."¹³¹ In treating children, its Standards of Care advise attending more to psychosocial issues surrounding the diagnosis, rather than offering a clear prescription for treating it.¹³² No one disputes that, at the very least, the psychological distress, stigma, interpersonal difficulties, and depression associated with GID should be treated. Cohen-Kettenis and Pfäfflin write: "[E]ven therapists of opposing backgrounds will agree that certain forms of suffering should be alleviated under all circumstances. Such distress may come from social ostracism, non-GID psychiatric or family problems, or intense unhappiness about one's sex characteristics and being a boy or a girl."¹³³ Co-existing problems might even be of greater concern than those associated with gender.¹³⁴

One final problem with diagnosing a child or adolescent with GID as stipulated in the DSM is that the individual becomes labeled as having a mental disease. The stigma alone can have deleterious effects.

B. GID in Adolescents

Gender becomes less fluid in adolescence; nevertheless the eventual outcome

for adolescents with GID still cannot be predicted with certainty. Studies reveal that “there is a considerable narrowing of [gender] plasticity with age, with regard to long-term gender identity differentiation.”¹³⁵ The apparent fluidity of gender identity in childhood, even into adolescence (albeit to a lesser degree), coupled with inadequate empirical studies to predict outcome and establish reliable treatment necessarily justifies a relatively cautious approach in treating adolescents as well as children.¹³⁶ Another crucial factor, not mentioned before, needs be taken into account. It is now not uncommon for many diagnosed with GID when adolescents to elect to live as transsexuals without surgery as adults.¹³⁷ Thus, treatment plans for adolescents need not assume surgery will be the desired end result.

As with children, the ethical issues of whether and how to treat adolescents is made difficult by the lack of solid research. But in adolescents, the issue is not how to “prevent GID” but how much to facilitate the gender transition. Zucker describes the difficulties of deciding when to treat adolescents: “Although early hormonal treatment is controversial, it may be the treatment of choice after the clinician is confident that other options have been exhausted.”¹³⁸ Importantly, clinicians must explore sexual orientation with their adolescent patients and help them to determine whether GID treatment is truly desirable.¹³⁹

The HBIGDA Standards of Care allow in some cases more proactive medical interventions for adolescents, including both reversible and partially reversible (nonsurgical) interventions. The Standards of Care caution: “Before any physical intervention is considered, extensive exploration of psychological, family and social issues should be undertaken.” Furthermore, it cautions that gender identity remains changeable and unsettled, “[i]dentity beliefs in adolescents may become firmly held and strongly expressed, giving a false impression of irreversibility; more fluidity may return at a later stage.”¹⁴⁰

Treatment in adolescents is divided into three stages: reversible, puberty-delaying treatment; irreversible hormonal treatment; and surgical interventions. As to surgery, HBIGDA states that this should be delayed until the age of majority.¹⁴¹

Reversible treatment, according to HBIGDA is designed to delay puberty. The standard of care permits “puberty-delaying hormones as soon as pubertal changes have begun.”¹⁴² HBIGDA explains the justification for reversible treatment:

Two goals justify this intervention: a) to gain time to further explore the gender identity and other developmental issues in psychotherapy; and b) to make passing easier if the adolescent continues to pursue sex and gender change.¹⁴³

For some adolescents who are trying to make a transition, early treatment may help facilitate their psychological and social adjustment. Offering reversible

puberty-delaying treatment may help to alleviate the adolescent's discomfort at the prospect of developing unwanted sex characteristics.¹⁴⁴ It makes it easier to socially pass in the identified gender.¹⁴⁵ It delays pubertal changes and so makes a later transition surgically and psychologically easier.¹⁴⁶ Moreover, it can help to confirm the diagnosis; delaying puberty “gain[s] time to further explore the gender identity and other developmental issues” while keeping the maturing adolescent's options open.¹⁴⁷

HBIGDA Standards of Care also accept that “partially reversible interventions” may be instituted in 16 year-olds with certain safeguards.¹⁴⁸ HBIGDA does not recommend surgical (irreversible) interventions until adulthood, and then only after the two-year real-life experience (RLE)¹⁴⁹ has been completed:

Irreversible Interventions. Any surgical intervention should not be carried out prior to adulthood, or prior to a real-life experience of at least two years in the gender role of the sex with which the adolescent identifies. The threshold of 18 should be seen as an eligibility criterion and not an indication in itself for active intervention.¹⁵⁰

However, a recent assessment of reported studies on surgical outcomes by a health technology assessment group in New Zealand concluded that while studies to date were quite limited, there was some indication that earlier surgery had a better outcome:

The quality of the evidence is poor and based on a small number of studies with weak study designs and significant methodological limitations. The reviewed studies may indicate that early, rather than delayed, sex reassignment surgery is of greater benefit to transsexual people who have gone through rigorous assessment procedures and have been accepted for surgery.¹⁵¹

Thus it may be that a “too cautious” approach can have its own negative consequences to the outcome.¹⁵²

Currently, whether and how to treat children and adolescents displaying gender identity disorders involves making an individualized clinical judgment.¹⁵³ The HBIGDA Standards of Care offers guidance to physicians, rather than any clear criteria for treating any particular individual. Moreover, the Standards of Care acknowledge the “limitations of knowledge” in treating children and adolescents and the need for further research.¹⁵⁴ The recent New Zealand review of studies, however, may lend some support for early surgery.

C. Alex's Treatment Conforms to Standard Care

In Alex's case, the treatment proposed fell within the HBIGDA Standards of Care. First, the treatment proposed began with fully reversible hormone blocking

treatment. Second, it would allow Alex to receive partially reversible hormonal medication at the age of sixteen, allowing him time to mature and to determine whether he wanted to continue the course of treatment. Third, the treatment was not objectionable to Alex or his guardian. Fourth, the plan did not neglect Alex's psychosocial needs and helped him to make a successful transition. Finally, the court did not authorize surgical treatment prior to Alex reaching the age of majority.¹⁵⁵

Although the care afforded Alex conforms to standard care, the case is nevertheless important and noteworthy. Alex's case offers a rare and comprehensive view into the life of a transsexual minor.¹⁵⁶ A few generalizations are evident. Developmentally, the gender and sexual orientation of children and even young adolescents remains in flux and treatment must therefore be well considered and cautious. There is urgency to the need to treat them, however, because psychological distress, depression, and suicide are real risks. The legal status of children and adolescents and their lack of maturation may prevent them from consenting to treatment but their wishes must be valued and respected. Society can be intolerant to gender incongruity and adults must take responsibility for removing stigma and ostracism. The condition is mysterious, rare, and complicated, so experts must be consulted for diagnosis and treatment. Treatment in every case must be individualized and responsive. For all these reasons, these youth are in for a difficult and protracted struggle that will require them to have the support of adults and social institutions.

The judge's approach to Alex was extraordinary, exemplary, compassionate, cautious, and well-informed. He was not bogged down with rhetoric of gender construction. Alex's dignity, best interest, current needs and future potentiality were the court's only concerns.

The role this judge assumed was equally extraordinary. In Judge Nicholson, Alex found a father with whom to share the burden of this monumental personal decision. It was as though the judge sat with Alex at the kitchen table and asked the questions a good parent might ask of the child and of the medical experts, in deciding what course to follow.

IV. THE COURT'S ROLE IN THE UNITED STATES

Although no published cases have considered the appropriateness of hormonal interventions, there have been surprising glimmers of such understanding in judicial decisions in the United States considering "real life" treatment of adolescent GID.¹⁵⁷ The lack of cases may be because few centers treat adolescents with hormones, or because such decisions need not go to court in the United States.¹⁵⁸ Nevertheless, the several courts confronting issues related to enforcing dress codes, which have had the effect of thwarting psychiatrically approved treatment plans of gender variant youth, have supported the adolescent in suits against educational and residential

institutions.¹⁵⁹ These cases have been brought based upon state laws prohibiting discrimination on the basis of disability.¹⁶⁰ In each, judges have recognized that GID is not a lifestyle or behavior choice but the response to an inner compulsion dictating one's gender behaviors.

In *Doe v. Yunits*,¹⁶¹ a school district dress code prevented Pat Doe, a biologic male fifteen year-old eighth grade student, from wearing female clothing or accessories to school. Doe challenged the dress code, claiming that it constituted discrimination on the basis of disability under the Massachusetts Constitution,¹⁶² among other claims. The court denied the public school's motion to dismiss, concluding that GID did constitute a handicap as defined by Massachusetts's law.¹⁶³ The school also moved for dismissal of the claim that it had constructively expelled her by refusing to allow her to wear female clothing. The court refused to dismiss Doe's claim that constructive expulsion constituted a due process violation, reasoning that refusing to allow Doe to wear female clothing was no different than forbidding a diabetic to take insulin during the school day or demanding that a five foot student not return to school until she were six feet.¹⁶⁴ The court noted that expert testimony supported Doe's allegation that "requiring Doe to wear boy's clothing to school would be ... injurious to her psychiatric health."¹⁶⁵

In *Doe v. Bell*,¹⁶⁶ Jean Doe, a seventeen year-old diagnosed with GID, had resided in foster care in New York State since the age of nine. She had a persistent and intense "need to wear women's clothing and act as a woman." The court considered the testimony of her psychiatrist and an expert on the treatment and its rationale:

[T]he treatment plan for Jean Doe called for Doe to dress according to her identity as a woman, including "wearing girls' clothing, accessories, and makeup, and sometimes other items to make [herself] look ... more feminine, such as breast enhancers."

Dr. Spritz explained the reason for such treatment:

"[t]he goal is to facilitate acceptance of the gender identity of a transgendered person by allowing her to dress in a manner consistent with her internal identity Research has found that forcing youths with GID to dress in conflict with their identity, though it may be in harmony with their biological attributes, causes significant anxiety, psychological harm, and antisocial behavior." Her opinion was seconded by Gerald P. Mallon, Ph.D., a Professor at the Hunter College School of Social Work and founder of the Green Chimneys, Children Services Program for, *inter alia*, transgendered youth, who expressed the opinion that "[t]he proper course of treatment for transgendered boys is to allow them to wear feminine clothing in an integrated environment."¹⁶⁷

Jean had earlier been placed in “two group homes for gay, lesbian, bisexual, and transgendered youth” but had been discharged from each for misconduct.¹⁶⁸ As the court described her: “Jean Doe does have a history of being insubordinate, undisciplined, and on occasion has been involved in violent altercations during her sojourn through many foster homes, group homes and institutions.”¹⁶⁹ Jean was then placed in an all male facility, Atlantic Transitional. Atlantic Transitional restricted her clothing options. For example, its director “issued a memorandum to the staff explaining that Jean Doe was not permitted ‘to wear “female attire” in the facility. He can wear it only if he is walking directly out of the facility. If he returns to the facility, he must be escorted to his room so he can remove the female attire.’”¹⁷⁰ Following a motion for a preliminary injunction, Atlantic Transitional modified its policy to allow female attire, but not skirts and dresses, providing that “[r]esidents who wish to wear female attire may do so as long as the above guidelines are respected. Female attire that does not conform to the policy may only be worn by a resident when leaving facility premises.”¹⁷¹

At issue was whether, under New York State Human Rights Law, the Administration for Children’s Services (ACS) and Atlantic Transitional Foster Facility discriminated against Doe by enforcing a dress code that prohibited Doe from wearing dresses and skirts. The court first considered whether Jean was a disabled person under the protections of the law. The court noted that New York law defines disability broadly, to include any “medically diagnosable impairment” that is “demonstrable by medically accepted techniques” even if that impairment does not “substantially limit that individual’s normal activities.”¹⁷² It therefore held that Doe suffered a disability under New York Law.¹⁷³ The court also held that Atlantic Transitional failed to reasonably accommodate her disability by not exempting her from the dress code. It explained:

The evidence before the Court establishes that, because of her disability, Jean Doe experiences significant emotional distress if denied the right to wear such feminine clothing. Indeed, the treatment she has received for her GID calls for her to wear feminine clothing, including dresses and skirts. Granting her an exemption from the dress policy avoids this psychological distress. Moreover, it allows Ms. Doe the equal opportunity to use and enjoy the facilities at Atlantic Transitional — a right that would be denied to her if forced to endure psychological distress as a result of the ACS’s dress policy.¹⁷⁴

The court also rejected Atlantic Transitional’s argument that permitting Doe to wear feminine attire “would jeopardize the safety of the residents and staff” and “threaten the safety and security of the institution.”¹⁷⁵ The court discounted “[t]he premise of respondents’ argument that cross-dressing by a resident can lead to unsafe sexual behavior and other inappropriate conduct,” pointing out that the facility already “allowed [Jean] to wear fake breasts, make-up, women’s blouses, scarves, nails, hair weaves and other female clothing.”¹⁷⁶ It concluded:

“There is simply no rational basis for treating dresses and skirts differently than the other feminine accoutrements which Jean Doe may now wear.”¹⁷⁷

Atlantic Transitional, an all-male facility, argued that Jean Doe was merely getting her “just desserts” because her own misconduct had led to her expulsion from the gay, lesbian, bisexual, and transgendered youth facility and placement in the all-male facility. Therefore, she should not be entitled to complain about Atlantic Transitional’s rules. However, the court rejected its argument:

ACS’s obligation to act in a nondiscriminatory fashion is not satisfied merely by providing a small number of facilities at which children with GID are assured nondiscriminatory treatment. At each and every facility run and operated by ACS, it must comply with the Human Right Law’s mandate to provide reasonable accommodations to persons with disabilities. That Doe engaged in misconduct ... gives no license to discriminate against her by denying her a reasonable accommodation.

Neither of these cases involved a discussion of medical interventions, but in each case the court supported and protected an adolescent implementing a psychiatrically approved “real life” plan. These cases challenged social institutions to tolerate and support gender variant youth, rather than demanding conformity.

These and other cases where courts have stepped up to support sexual minority youth¹⁷⁸ must be offset by the ever-present reality that not all judges are so enlightened, perhaps especially so in the United States.¹⁷⁹ One need only consider the narrow and unscientific concept of gender espoused in *Kantaras v. Kantaras*,¹⁸⁰ *Littleton v. Prange*,¹⁸¹ *In re Ladrach*,¹⁸² or *In re Estate of Gardiner*,¹⁸³ to understand that not all judges can transcend their own construction of gender and act as courageously as Judge Nicholson did when asked to serve the needs of the child. The hostility of schools, courts, social service agencies, and even parents to sexual minority youth is well known.¹⁸⁴ Thus, it is probably just as well that medical treatment decisions concerning childhood and adolescent GID are not routinely put before the court. However, when and if such a case comes to a United States judge, *Re Alex* offers guidance on how to approach treatment issues and to serve the child’s best interests.¹⁸⁵

We have attempted to present some of the issues involved in *Re Alex*, a case that came before the main Family Court of Australia, and relate it to how similar issues might be dealt with in United States courts. When all parties agree (individual, parents, guardian, therapists) such decisions are typically made outside the legal system in the United States, and we concur that treatment decisions in such cases best remain a decision of parents, children, and doctors, guided by the child’s best interests and with due respect to the child’s maturity.

Of note, Wallbank, the barrister who successfully argued the landmark

Australian case *Re Kevin*, which established the right of a post-operated transsexual to marry in the new sex,¹⁸⁶ criticized the conclusion in *Re Alex* that these decisions *must* be brought to the Australian courts. She has recently argued that once the diagnosis of GID is established, it should be accepted for minors as it is for adults with the result that remedial treatment is supported even without resort to the courts.¹⁸⁷ Wallbank has observed that involving the courts only delays treatment and adds considerably to the total cost.¹⁸⁸

We agree with Wallbank that these decisions should be made privately when possible. However, when there is disagreement among the parties, there is a role for family courts to see that all efforts are directed toward satisfying the best interests of the minor. The ultimate decisions, whether made by court or not, deserves consultation with clinicians and others drawn from the ranks of experts qualified in transsexual matters. When a court is drawn into these decisions, Judge Nicholson's inquisitorial rather than adversarial approach is certainly desirable. Courts considering these cases must take care, as did Judge Nicholson, to preserve the privacy of the minor. Most transsexuals do not seek publicity in their lives and public knowledge of gender transition can have long-term effects in schooling, employment, insurance,¹⁸⁹ medical treatment, and in other regards.¹⁹⁰ Judge Nicholson's opinion is notable because he made sure that Alex's interests were paramount and his interests were well represented. Finally, Judge Nicholson was also mindful of the child's environment and was able to fashion his orders to facilitate Alex's transition.

In addition, in cases where there is disagreement, a court must examine the premises on which parents or others object to or seek particular treatment. While parents traditionally have substantial authority to consent to medical treatment, parents should not be regarded as having the authority to either force a child to submit to unsound, unproven, or unethical treatment that may cause harm, or to deny children treatment that is in the child's best interest. When parental decisions do not serve the child's interests the state has a right and obligation to intervene.¹⁹¹

Like others, Wallbank also argued that the DSM IV, the Harry Benjamin International Gender Dysphoria Association, and their various professional adherents in the fields of psychiatry and psychology, are, though well intentioned, wrong in their association of the conditions Gender Dysphoria, Gender Identity Disorder (on any form of mental disorder or confusion) with transsexualism at any age and that, in continuing to do so, retards the development of proper treatment regimes for children and adolescents.¹⁹² We agree that in a more informed and tolerant society, variations in gender should not be regarded as mental disorders and doing so causes unnecessary stigmatization. We should examine ways to bring these cases in the human rights context rather than as disability discrimination cases on the basis of a mental disorder. Nevertheless, practically speaking, the classification of gender identity dysphoria as a disorder has allowed courts to intervene to protect minors, to

prevent discrimination, and to promote more tolerant treatment of gender variant youth.

In several other significant regards we are in full agreement with Chief Justice Nicholson. We think it is unreasonable to require surgery for a legal change in sexual status. As the court reasoned, we too believe the requirement for surgery is inconsistent with human rights:

“The requirement is more disadvantageous and burdensome for people seeking legal recognition of their transition from female to male than male to female...the requirement of surgery is a form of indirect discrimination.”¹⁹³ And we are in agreement regarding the requirements for changing of one’s birth certificate. It can be detrimental to self-image and overall social and geographic mobility for a minor to provide a birth certificate antithetical to his or her self-image or bodily presentation. We think there is no need for waiting either for the age of majority or for requiring surgery.

The legal status of minors and adults poses challenging problems for courts worldwide. With public awareness of an increasing number of persons undergoing transsexual change this need will similarly increase. In 2002, the European Court of Human Rights, considering a case brought before it from the United Kingdom upheld the rights of post-operative transsexuals “to be recognized as members of their post-operative sex and to receive all rights associated with their acquired sex.”¹⁹⁴ We think, along with similar decisions in other countries,¹⁹⁵ the United States too should recognize the human rights involved and accord full rights to those citizens with a transsexual condition. Moreover, because the transition, either in adulthood, but especially in childhood and adolescence, can be protracted and surgery is increasingly not necessarily the endpoint, it is far better, rather than accepting outdated concepts, to welcome the latest scientific understandings of identity development and to recognize a wide range of gender variation as a reality of the human condition.¹⁹⁶

END NOTES

¹ *Re Alex* (2004) 180 Fam. L. R. 89, 92, available at www.familycourt.gov.au/judge/2004/html/realex.html. The terms “transsexuality” and “Gender Identity Dysphoria” or “Gender Identity Disorder” (GID) are often used interchangeably. See AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM III) 261 (3rd ed. 1980) [hereinafter DSM III] (using the term transsexualism in the classification of Gender Identity Disorders); AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM IV) 532-38 (4th ed. 1994) [hereinafter DSM IV] (using the terms Gender Identity Dysphoria or Gender Identity Disorder (GID)).

In any discussion of transsexuality there is a sensitive issue of how nouns and

pronouns are used. Most people with a transsexual condition identify themselves as unequivocally members of the sex in which they aspire to live. Thus, Alex sees himself and identifies as a male. And to Alex sex and gender are equivalent so that male means boy or man. To most medical personnel and scientists, however, sex and gender are separate so that it is understood that a female can live and identify as a boy or man and a male can live and identify as a girl or woman. Milton Diamond, *Sex and Gender Are Different: Sexual Identity and Gender Identity Are Different*, in *CLINICAL CHILD PSYCHOL. & PSYCHIATRY* 320 (7th ed. 2002). Part of the issue revolves around how an individual's sex is considered. Over the years this has evolved so that different categories can be evaluated in arriving at this determination. *See generally* ALICE DREGER, *HERMAPHRODITES AND THE MEDICAL INVENTION OF SEX* (1998). Most commonly a person's sex is evaluated based on chromosomes, gonads, hormonal titers, internal genitalia, external genital appearance, and social lifestyle. With increasing sophistication and knowledge, however, more factors are being identified so that a final resolution on a person's "sex" can also involve different gene constellations as well as brain sex. Over time an individual's primary sex characteristic came to be regarded as the person's gonads. We now understand that an individual's gonads may not correspond even with other features of gross anatomy or genitalia. There is thus no universally agreed upon standard for how to assess "sex."

These discrepancies have implications over and above any grammatical matter. A resolution of these conflicting assay methods has legal and practical effects. Understanding such difference can account for a person being considered a male in one state, a female in another, and an intersexed person in a third. Persons with an intersexed or transsexual condition consider, not their gonads, but their brains and core sense of self, as the primary consideration in the determination of sex. Currently this is best evaluated by the individual's own admission rather than by any currently available scientifically objective measure. *See* Rachel Wallbank, *Re Kevin in Perspective*, 9 *DEAKIN L. REV.* 461, 468-73 (2004).

² *Re Alex*, 180 *Fam. L. R.* at 110

³ *Id.* at 111.

⁴ *Id.* at 125-27, 207, 211-14.

⁵ *Id.* at 125-32.

⁶ *See, e.g., Sex and Drugs and Media Roll – The Family Court's Decision in Re Alex*, 37 *AUSTRAL. CHILD. RTS. NEWS*, May 2004, at 21, 2 1-27 (discussing reactions to the opinion) [hereinafter *Sex and Drugs*]; *The 7:30 Report: Row Erupts Over Teenage Sex Change Court Ruling* (Australian Broadcasting Corporation, television broadcast, Apr. 14, 2004), available at www.abc.net.au/7.30/content/2004/s1087440.htm (last visited Feb. 22, 2005);

FM Controversy over Teenage Sex Change Court Ruling (Australian Broadcasting Corporation, radio broadcast, Apr. 14 2004), available at www.abc.net.au/pm/content/2004/s1087372.htm (last visited Feb. 22, 2005). Even Prime Minister John Howard expressed his opinion that perhaps the court did not have the jurisdiction to make such a decision. See *State May Stop Teen Sex Change*, NEWS24.COM, Apr. 15, 2004, at www.news24.com/News24/World/News/0,6119,2-10-1462_1512599,00.html (last visited May 26, 2005).

⁷ *Sex and Drugs*, *supra* note 6, at 23.

⁸ *Id.* at 24.

⁹ See *id.* at 22 (explaining how the deciding Judge discounted theoretical concerns that “Alex is constructing his self image as ‘really’ male when in fact he is ‘really’ a female lesbian.”); See also David Skidmore, *Gender Reassignment Surgery Does Not Help in Our Gender-Divided Society*, ON LINE OPINION (Apr. 23, 2004), at www.onlineopinion.com.au/view.asp?article=2160 (“I find it difficult to uncritically endorse gender reassignment surgery because of the implications it has for those of us struggling to be accepted for who we are — openly gay and proud to be so.”); But see Karen Gurney, *It’s Important to Recognize That Sex and Gender Must be Treated Differently*, ON LINE OPINION (May 4, 2004), at www.onlineopinion.com.au/view.asp?article=2184 (rebutting Skidmore’s reasoning).

¹⁰ Sheila Jeffreys, Associate Professor of Political Science at the University of Melbourne, commented:

“[those involved in this decision] should be seen as products of their time and the ideological biases of male dominance. Indeed, their “truth” should be regarded as political opinion. They rely on the notion that there can be a “female” mind in a male’s body and vice versa. Their solution is to use chemicals, amputations, castrations and sterilisations to make the bodies of [gender identity dysphoria] patients fit with their interpretation of what’s happening in the patient’s mind.”

Sheila Jeffreys, *Allowing Alex’s Sex Change Shows Up a Gender-biased Family Court*, ON-LINE OPINION (Apr. 23, 2004), at www.onlineopinion.com.au/view.asp?article=2162 (last visited Feb. 25, 2005); Shelia Jeffreys, *Sex Change Urged by Gender Bias*, FEMSPEAK (Apr. 19, 2004), at www.femspeak.net/features/transrpt.html (last visited Feb. 25, 2005).

¹¹ The DSM describes separate categories for adults and children and adolescents. The assigned diagnostic code depends on the individual’s current age: if the disorder occurs in childhood, the code 302.6 is used; for an adolescent or adult, 302.85 is used. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-IV-TR) 261 (4th ed.

2000) [hereinafter DSM-IV-TR]. See *infra* note 97 for a complete definition of Gender Identity Disorder.

¹² See *infra* note 152 and accompanying text.

¹³ The risk of suicide by Alex had been mentioned by the experts consulted and considered a real possibility by those who knew him. See *infra* notes 64-67 and accompanying text.

¹⁴ See, e.g., *Murdered Transgendered Teen's Name to be Changed*, COURTTV.COM, at www.courttv.com/news/2004/0702/transgender_ap.html (last updated July 2, 2004) (reporting the murder of a transgendered youth and her mother's decision to have the teen's name changed posthumously). It has been reported that in each of the years 2000 and 2001 there were nineteen trans individuals killed in the United States and the year 2002 was marked with two dozen antitransgender murders. See MONICA F. HELMS, NAT'L TRANSGENDER ADVOCACY COALITION, *Transgender Death Statistics*, at www.ntac.org/resources/stats.asp (last modified July 13, 2003) (providing death statistics for transgendered individuals). Gwendolyn Ann Smith, *Remembering Our Dead*, at www.gender.org/remember (last visited Feb. 25, 2005) (providing a memorial for deceased transgendered individuals).

¹⁵ See *infra* notes 134-37 and accompanying text.

¹⁶ See *infra* notes 99-101, 110-14 and accompanying text.

¹⁷ In 1973 homosexuality per se was removed from the DSM-II classification of mental disorders and replaced in DSM-III by the category Ego-dystonic Homosexuality. See AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM II) 39 (2nd ed. 1968) [hereinafter DSM II]; DSM III, *supra* note 1, at 281. This represented a compromise between the view that preferential homosexuality is invariably a mental disorder and the view that it is merely a normal sexual variant. While the 1973 DSM-II controversy was highly public, there remained a related but less public controversy over the DSM-III category of Egodystonic Homosexuality. This latter category was removed from the DSM-IV (1994). See DSM IV, *supra* note 1, at 2 1-22 (Ego-dystonic homosexuality is not categorized on the Gender Identity List).

¹⁸ There are currently, in the United States, Australia and elsewhere, differing opinions as to the suitability of considering Gender Identity Dysphoria a psychiatric disorder any more than homosexuality. See Rachel Wallbank, *Re Alex "Through a Looking Glass,"* AUSTL. CHILD. RTS. NEWS, May 2004, at 28. See also Nancy H. Bartlett et al., *Is Gender Identity Disorder in Children a Mental Disorder?*, 43 SEX ROLES 753, 776 (2000) (summarizing data and studies and concluding "comparisons presented in this paper fail to support a conclusion that GID in children, as it appears in *DSM-IV*, meets the criteria of mental disorder");

Kenneth J. Zucker, *A Factual Correction to Bartlett, Vasey, and Bukowski's (2000) "Is Gender Identity Disorder in Children a Mental Disorder?"*, 46 SEX ROLES 263 (2002) (stating that Bartlett et al. misread the data from the author's report and providing a correction of data reported by Bartlett et al). This "correction" was responded to by the authors and seems to strengthen the original article. Nancy H. Bartlett et al., *Cross Sex Wishes and Gender Identity Disorder: A Reply to Zucker*, 49 SEX ROLES 191 (2003). Zucker and Bartlett and her co-authors are Canadians.

¹⁹ With this decision, minors are required to resort to the Family Court in Australia for resolving future transsexual issues in Australia. Prior to the decision, one might assume that if all parties were in agreement, and the minor was not a ward of the state, treatment decisions were made without legal involvement.

²⁰ See *infra* note 158.

²¹ Family Law Act, 1975, s. 41 (Austl.). The state of Western Australia maintains its own Family Court. See Family Court of Australia, *The Courts Involved*, at www.familycourt.gov.au/presence/connect/www/home/guide/before/basics/step_before_basics_courts (last updated Mar. 29, 2004). See generally Alastair Nicholson, *Setting the Scene: Australian Family Law and the Family Court — A Perspective From the Bench*, 40 FAM. CT. REV. 279 (2002) (providing information on the Family Law Act of Australia and the jurisdiction of the Family Court); Alastair Nicholson & Margaret Harrison, *Specialist But Not Unified: The Family Court of Australia*, 37 FAM. L.Q. 441 (2003).

²² Sec'y, Dep't of Health & Cmty. Servs. v. J.W.B. & S.M.B. [Marion's Case] (1992) 175 CLR 218 (holding that (1) when an application is made to the Family Court, it has jurisdiction to authorize a sterilization in appropriate circumstances; and (2) the Family Court cannot increase the authority of the guardian so that he or she can consent to the sterilization of the child).

²³ *Id.* at 246-50 (providing a discussion of cases from the United States that based their rulings on the fundamental right to procreate and explaining the court's own reasons for refusing to give parents the right to authorize sterilization procedures for their children).

²⁴ *Id.* at 250. See also *In re A* (1993) 16 Fam. L. R. 715 (summarizing Marion's case and giving permission for gender reassignment surgery on a fourteen year old genetic female with Congenital Adrenal Hyperplasia who identified as a male, unable, due to minority status to give informed consent).

²⁵ *In the Marriage of GWW & CMW* (1997) 21 Fam. L. R. 612.

²⁶ *Re Michael* [No. 2] (1994) 19 Fam. L. R. 27.

²⁷ *In re A* (1993) 16 Fam. L.R. 715.

²⁸ See *infra* note 158.

²⁹ *Re Alex* (2004)180 Fam. L. R. 89, 124, available at www.familycourt.gov.au/judge/2004/html/reallex.html.

³⁰ *Id.* at 93, 96-97.

³¹ *Id.* 110.

³² *Id.* at 93. Established in 1986, one of its responsibilities is to provide independent advice to the courts. The HUMAN RIGHTS & EQUAL OPPORTUNITY COMM'N, INFO SHEET, at www.humanrights.gov.au/info_sheet.html (last visited Feb. 23, 2005).

³³ The treating professionals included Professor P, an associate professor of psychiatry; Professor W, an associate professor of pediatrics and a pediatric endocrinologist; Dr. N, a child and adolescent psychiatrist specializing in gender issues. By court order the identity of the experts was sealed.

³⁴ *Re Alex*, 180 Fam. L. R. at 97.

³⁵ *Id.*

³⁶ *Id.* at 98

³⁷ *Id.* at 93, 97

³⁸ *Id.* at 97

³⁹ *Id.* at 99

⁴⁰ *Id.*

⁴¹ *Id.* at 97-98

⁴² *Id.* at 98

⁴³ *Id.*

⁴⁴ The court referred to the minor as Alex a male pseudonym, in the gender identity of the child's choice. *Id.* at 92.

⁴⁵ *Id.* at 100

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.* at 99

⁴⁹ *Id.* at 100

⁵⁰ *Id.*

⁵¹ *Id.* at 101. The mother reported that Alex threatened to kill his step-siblings and that there was “no love between her and Alex and his step-father had said that he has no relationship with Alex and did not see Alex as important.” *Id.* at 101

⁵² *Id.*

⁵³ *Id.* at 102

⁵⁴ *Id.* at 101

⁵⁵ *Id.* at 102-03

⁵⁶ *Id.* at 96

⁵⁷ *Id.* at 102

⁵⁸ *See, e.g., id.* at 103-04

⁵⁹ *Id.* at 105

⁶⁰ *Id.*

⁶¹ *Id.* at 104-05

⁶² *Id.* at 103

⁶³ *Id.*

⁶⁴ *Id.* at 103

⁶⁵ *Id.* at 102

⁶⁶ *Id.*

⁶⁷ *Id.* at 99

⁶⁸ *Id.* at 108 (explaining that sexual orientation (how one views a sexual partner) is distinct from sexual and gender identity (how one views self)). *See* Diamond, *supra* note 1, at 320

⁶⁹ *Re Alex*, 180 Fam.L.R.at 109

⁷⁰ *Id.* Typically transsexuals do not consider themselves as homosexuals when they are involved with a member of their same sex. They view this relationship as heterosexual since they see themselves in terms of their preferred gender. Should Alex in the future see himself as a woman, in that case, she (and society) would consider a relationship with a female as a lesbian one.

⁷¹ *Id.*

⁷² *Id.* at 111 (quoting the Royal College of Psychiatrists' Guidance 1998 Gender Identity Disorders in Children and Adolescents — Guidance for Management). This recommendation is controversial. It is made with the belief that the child should experience some of the features of puberty and sexual maturation before deciding to abandon the birth sex. Other professionals, however, stress that allowing pubertal changes to occur would seriously hamper and compromise anatomic and psychological transition. *See infra* notes 151-52 and accompanying text.

⁷³ *See* The Harry Benjamin Int'l Gender Dysphoria Ass'n, at www.hbigda.org (last visited Feb. 23, 2005).

⁷⁴ *Re Alex*, 180 Fam. L. R. at 100

⁷⁵ *Id.* at 118

⁷⁶ *Id.*

⁷⁷ *Id.* at 120. The age of majority in Australia is 18. *Id.* at 112-13

⁷⁸ *Id.* at 119

⁷⁹ The conclusion that he lacked capacity would likely have been the same under the “mature minor” doctrine followed in some United States’ jurisdictions. In *Cardwell v Bechtell*, 724 S.W.2d 739, 744-46 (Tenn. 1987), a so-called “rule of sevens” was enunciated. If younger than seven years of age the child is presumed to be decisionally incapacitated and that presumption cannot be overcome. From seven to fourteen years of age, the presumption of incapacity can be overridden depending upon the child’s ability to understand the medical problem and consequences of optional procedures and has the ability to express a choice based on stable values. A presumption of decisional capacity is granted after the age of fourteen years.

⁸⁰ *Re Alex*, 180 Fam. L. R. at 125

⁸¹ *Id.*

⁸² *Id.* at 126

⁸³ *Id.* at 112

⁸⁴ The treatment was continuous administration of an oral contraceptive. When taken without monthly interruption, menses are suppressed. Experts testified that the treatment would not affect future “ovarian function and fertility.” *Id.* at 110

⁸⁵ *Id.* at 110-11, 125, 131. Treatment at sixteen could include continuation of

the female hormone-blocking agents (analogue therapy) and subcutaneous testosterone implants. *Id.* at 111. There was disagreement whether the analogue therapy should be instituted first. According to the experts an analogue therapy period was described as “hormonally neutral” and thus “gives these adolescents time to think about the issues.” It therefore constituted a more cautious approach. *Id.* at 94, 111. Ultimately, the court left that decision to Alex and his treating physicians at that time.

⁸⁶ *Id.* at 111

⁸⁷ *Id.* at 95, 113

⁸⁸ *Id.* at 113-14

⁸⁹ *Id.* at 130

⁹⁰ *Id.* at 131

⁹¹ *Id.* at 113

⁹² The expense of all treatment aspects is considerable and effects how many, both within and outside the trans community, view the medical/psychiatric designation of GID. As a medical condition gender identity disorder can be covered under certain insurance plans but maintains a stigma. As a non-psychiatric gender variation there is less stigma but a potentially large expense to be personally borne. In some cases this is a double-edged sword since coverage for sex-reassignment surgery (SRS) is often denied to those with a “mental condition.” *See infra* note 190.

⁹³ See Bartlett et al., *supra* note 18 at 776 (recommending that the GID category in children should not appear in future editions of the DSM); Madeline H. Wyndzen, *A Personal & Scientific Look at a Mental Illness Model of Transgenderism*, DIVISION 44 NEWSL. (Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues, a division of the American Psychological Association), Spring 2004, at 3, available at www.apa.org/divisions/div44/2004Spring.pdf. See GID Reform Advocates, at <http://members.cox.net/gidreform/index.html> (last visited Mar. 1, 2005) (dedicated to GID and DSM reform). See also ARLENE ISTAR LEV, *TRANSGENDER EMERGENCE: THERAPEUTIC GUIDELINES FOR WORKING WITH GENDER VARIANT PEOPLE AND THEIR FAMILIES* 168-81 (2004) (critiquing past diagnoses of transgendered and transsexual people); Richard A. Isay, *Remove Gender Identity Disorder in DSM*, *PSYCHIATRIC NEWS*, Nov. 21, 1997, at 9.

⁹⁴ Unfortunately there have been no large-scale controlled studies, either for children or adults, as to the effectiveness of any sort of treatment for GID compared With another. And there have been no controlled studies comparing the outcome of treatment with the outcome from no treatment. ARIF (the Aggressive Research Intelligence Facility of the University of Birmingham,

England — an entity financed by the British National Health Service to evaluate medically relevant questions), in a statement updated to July 2004, reported that most studies, to date, have been biased pro or con surgery so no definitive conclusion can be made although “the research published generally states that the effects are beneficial.” AGGRESSIVE RESEARCH INTELLIGENCE FACILITY, GENDER REASSIGNMENT SURGERY, at www.bham.ac.uk/arif/genderreassign.htm (last visited Feb. 23, 2005) (discussing the effects of gender reassignment surgery).

⁹⁵ See THE HARRY BENJAMIN INT’L GENDER DYSPHORIA ASS’N, STANDARDS OF CARE FOR GENDER IDENTITY DISORDERS, SIXTH VERSION (Feb. 2001), at www.hbigda.org/socv6.html (last visited Feb. 25, 2005) [hereinafter HBIGDA SOC]. The association summarizes the variations and explains why precise prevalence estimates have been elusive:

When the gender identity disorders first came to professional attention, clinical perspectives were largely focused on how to identify candidates for sex reassignment surgery. As the field matured, professionals recognized that some persons with bona fide gender identity disorders neither desired nor were candidates for sex reassignment surgery. The earliest estimates of prevalence for transsexualism in adults were 1 in 37,000 males and 1 in 107,000 females. The most recent prevalence information from the Netherlands for the transsexual end of the gender identity disorder spectrum is 1 in 11,900 males and 1 in 30,400 females. Four observations, not yet firmly supported by systematic study, increase the likelihood of an even higher prevalence: 1) unrecognized gender problems are occasionally diagnosed when patients are seen with anxiety, depression, bipolar disorder, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, other sexual disorders and intersexed conditions; 2) some nonpatient male transvestites, female impersonators, transgender people, and male and female homosexuals may have a form of gender identity disorder; 3) the intensity of some persons’ gender identity disorders fluctuates below and above a clinical threshold; 4) gender variance among female-bodied individuals tends to be relatively invisible to the culture, particularly to mental health professionals and scientists.

See also Lynn Conway, *How Frequently Does Transsexualism Occur?*, (2001), at <http://ai.eecs.umich.edu/people/conway/TS/TSprevalence.html> (last updated Dec. 17, 2002). Conway’s estimates are much higher than those of the HBIGDA.

⁹⁶ See DSM-IV-TR, *supra* note 11, at 578

⁹⁷ *Id.* at 581-82. The diagnostic criteria of GID in the DSM IV-TR makes particular age related distinctions:

Diagnostic criteria for Gender Identity Disorder

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In children, the disturbance is manifested by four (or more) of the following:

1. repeatedly stated desire to be, or insistence that he or she is, the other sex
2. in boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing
3. strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex
4. intense desire to participate in the stereotypical games and pastimes of the other sex
5. strong preference for playmates of the other sex. In adolescent and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

In children, the disturbance is manifested by any of the following: in boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities; in girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.

In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

C. The disturbance is not concurrent with a physical intersex condition.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Code based on current age:

302.6 Gender Identity Disorder in Children

302.85 Gender Identity Disorder in Adolescents or Adults

Specify if (for sexually mature individuals):

Sexually Attracted to Males

Sexually Attracted to Females

Sexually Attracted to Both

Sexually Attracted to Neither

⁹⁸ When such an inconsistency exists the mantra becomes “change my body, not my mind.” See Diamond, *supra* note 1, at 325. PEGGY T. COHEN-KETTENIS & FRIEDEMANN PFÄFFLIN, *TRANSGENDERISM AND INTERSEXUALITY IN CHILDHOOD AND ADOLESCENCE* 64-66, 83 (2003).

⁹⁹ See also Kenneth J. Zucker, *Gender Identity Disorder*, in *CHILD AND ADOLESCENT PSYCHIATRY* 737, 738-39 (Michael Rutter & Eric Taylor eds., 4th ed. 2002) [hereinafter *Gender Identity Disorder*] (noting the deficiencies in various approaches to estimating the prevalence in children).

¹⁰⁰ Zucker, *Gender Identity Disorder*, *supra* note 99, at 739. Adult transsexuals, invariably say their GID started early in childhood.

¹⁰¹ See Kenneth J. Zucker, *Gender Identity Development and Issues*, 13 *CHILD & ADOLESCENT PSYCHIATRIC CLINICS OF N. AM.* 551, 554 (2004) [hereinafter *Gender Identity*], (Milton Diamond & Alayne Yates eds. 2004) [hereinafter *Sex and Gender*]; COHEN-KETTENIS & PFÄFFLIN, *supra* note 99, at 66

¹⁰² Zucker, *Gender Identity*, *supra* note 101, at 554

¹⁰³ Lev, *supra* note 93, at 176

¹⁰⁴ Zucker, *Gender Identity*, *supra* note 101, at 554. See also *Id.* at 558-62 (summarizing biological and psychosocial theories); COHEN-KETTENIS & PFÄFFLIN, *supra* note 99, at 70-76 (summarizing literature).

¹⁰⁵ Zucker, *Gender Identity*, *supra* note 101, at 558-60; COHEN-KETTENIS & PFÄFFLIN, *supra* note 99, at 76-83. See also Milton Diamond et al., *Atypical Gender Development – A Review*, *INT’L J. TRANSSEXUALITY* (forthcoming 2005). The court commented on the etiology of Alex’s condition, “[i]t has its most likely origins in Alex’s biological and psychological developmental features.” *Re Alex* (2004) 180 Fam. L. R. 89, 125, available at www.familycourt.gov.au/judge/2004/html/realex.html. In many instances of sex related matters males typically show a stronger genetic component to their behavior than do females, e.g., in the

display of homosexual behavior. See Fredrick Whitam et al., *Homosexual Orientation in Twins: A Report On 61 Pairs and Three Triplet Sets*, 22 ARCHIVES SEXUAL BEHAV. 187 (1993) (discussing the display of transsexuality among twins). Milton Diamond & Skyler Hawk, *Transsexuality Among Twins*, Presented Before the American Psychological Association (Honolulu Hawai'i July 31, 2004).

¹⁰⁶ COHEN-KETTENIS & PFÄFFLIN, *supra* note 99, at 106

¹⁰⁷ *Id.*

¹⁰⁸ *Id.* See also Lev, *supra* note 93, at 177-81

¹⁰⁹ COHEN-KETTENIS & PFÄFFLIN, *supra* note 99, at 106 (“Retrospective accounts of adolescents with GID make clear that cross-gender feelings, fantasies, and sometimes even behaviors have persisted [from early childhood] until after puberty without others being aware of it.”).

¹¹⁰ Children with GID “display an array of sex-typed behaviour signaling a strong psychological identification with the opposite sex.” The behaviors may include:

1. identity statements;
2. dress-up play;
3. toy play;
4. roles in play fantasy;
5. peer relations;
6. motoric and speech characteristics;
7. statements about sexual anatomy; and
8. involvement in rough and tumble play.

Zucker, *Gender Identity Disorder*, *supra* note 98, at 737.

¹¹¹ *Id.* at 747

¹¹² Zucker, *Gender Identity*, *supra* note 101, at 556 (citing RICHARD GREEN, THE “SISSY BOY SYNDROME” AND THE DEVELOPMENT OF HOMOSEXUALITY (1987)).

¹¹³ Zucker, *Gender Identity*, *supra* note 101, at 556. Zucker reports that “[m]uch less is known about the long-term outcome of girls who have GID.” He notes in his own clinic the outcomes are variable among girls as well. *Id.*

¹¹⁴ Zucker, *Gender Identity Disorder*, *supra* note 98, at 746. HBGDA Standards of Care explain, “[t]here is greater fluidity and variability in outcomes, especially in pre-pubertal children. Only a few gender variant youths become transsexual, although many eventually develop a homosexual orientation.” HBGDA SOC, *supra* note 95.

¹¹⁵ See LEV, *supra* note 93, at 177-81. For a broad discussion of GID treatment in children, see *Id.* at 317-29.

¹¹⁶ For example, George A. Rekers, a professor of psychiatry at the University of South Carolina is a proponent of intervention in childhood GID based in part on his Christian beliefs that both transsexuality and homosexuality are pathological. He explains his views in a Christian Leadership Ministries article, available at www.leaderu.com/jhs/rekers.html. See also COHEN-KETTENIS & PFÄFFLIN, *supra* note 99, at 120.

¹¹⁷ One of the most vocal opponents to the decision was Roman Catholic ethicist Nicholas Tonti-Filipini who objected saying “[t]his medical treatment [is] completely unproven... . To do it to a 13-year-old who is still in formation, whose body is still forming, whose sense of identity is still forming, it’s just irresponsible.” BBC News, *Sex Change for Australian Child*, at <http://news.bbc.co.uk/1/hi/world/asia-pacific/3624891.stm> (last updated Apr. 14, 2004). Tonti-Filipini is also quoted as saying on an Australian Broadcasting Corporation program “I think [this case] was set up by the Government Department. You can’t get six medical experts with such agreement unless somebody sets it up.” *The 7:30 Report*, *supra* note 6

¹¹⁸ Zucker, *Gender Identity Disorder*, *supra* note 99, at 748

¹¹⁹ Zucker, *Gender Identity*, *supra* note 101, at 563

¹²⁰ *Id.*

¹²¹ *Id.*

¹²² *Id.* See also COHEN-KETTENIS & PFÄFFLIN, *supra* note 99, at 120

¹²³ See Zucker, *Gender Identity*, *supra* note 100, at 563-64 (describing therapy with parents, “limit-setting” of cross gender behaviors, exploring contributing factors; encouraging same sex peer relations, among some techniques); COHEN-KETTENIS & PFÄFFLIN, *supra* note 99, at 122-25 (describing treatments that focus on family dynamics and altering the environment and parental approaches to encourage gender typical behavior through positive experiences). Cohen-Kettenis & Pfäfflin’s approach focuses on factors “related to the child’s suffering or malfunctioning.” They do not advise prohibiting cross dressing. At the same time, they regard it as beneficial to enable children “to have social relationships with both boys and girls” and to encourage children with GID “to play with same-sex peers,” and to “develop broader, perhaps neutral, interests.” *Id.* at 124-25. They may advise parents to limit cross-dressing to the home “to protect the child from being harassed” or to “keep [] them in the reality of their daily world.” *Id.*

¹²⁴ COHEN-KETTENIS & PFÄFFLIN, *supra* note 99, at 121 (citing work of George Rekers).

¹²⁵ Zucker, *Gender Identity*, *supra* note 101, at 563. See also COHEN-KETTENIS & PFÄFFLIN, *supra* note 98, at 129

¹²⁶ COHEN-KETTENIS & PFÄFFLIN, *supra* note 99, at 128-29

¹²⁷ *Id.* at 129

¹²⁸ Elvia R. Arriola, *The Penalties for Puppy Love: Institutionalized Violence Against Lesbian, Gay, Bisexual, and Transgendered Youth*. 1 J. GENDER RACE & JUST. 429, 469-70 (1998). See also Lev, *supra* note 93, at 175-77.

¹²⁹ Reparative therapies are those practices aimed at changing an individual from homosexual to heterosexual orientation. For an extensive consideration of the pros and cons of “reparative therapy” see *Symposium*, 32 ARCHIVES SEXUAL BEHAV. 399 (2003) (issue devoted to studies related to efficacy of “reparative therapy”).

¹³⁰ Arriola, *supra* note 128, at 457.

¹³¹ HBGDA SOC, *supra* note 95.

¹³² The Standards of Care state:

Psychological and Social Interventions. The task of the child-specialist mental health professional is to provide assessment and treatment that broadly conforms to the following guidelines:

1. The professional should recognize and accept the gender identity problem. Acceptance and removal of secrecy can bring considerable relief.
2. The assessment should explore the nature and characteristics of the child’s or adolescent’s gender identity. A complete psychodiagnostic and psychiatric assessment should be performed. A complete assessment should include a family evaluation, because other emotional and behavioral problems are very common, and unresolved issues in the child’s environment are often present.
3. Therapy should focus on ameliorating any comorbid problems in the child’s life, and on reducing distress the child experiences from his or her gender identity problem and other difficulties. The child and family should be supported in making difficult decisions regarding the extent to which to allow the child to assume a gender role consistent with his or her gender identity. This includes issues of whether to inform others of the child’s situation, and how others in the child’s life should respond; for example, whether the child should attend school using a name and clothing opposite to his or her sex of assignment. They should also be supported in tolerating uncertainty and anxiety

in relation to the child's gender expression and how best to manage it. Professional network meetings can be very useful in finding appropriate solutions to these problems.

Id.

¹³³ COHEN-KETTENIS & PFÄFFLIN, *supra* note 99, at 121. *See also* Zucker, *Gender Identity Disorder*, *supra* note 99, at 748 (finding similar sources of distress).

¹³⁴ *See* Ritch C. Savin-Williams & Kenneth M. Cohen, *Homoerotic Development During Childhood and Adolescence*, 13 CHILD & ADOLESCENT PSYCHIATRIC CLINICS OF N. AM. 529,529-51 (2004) (discussing treating individuals with homosexual orientation and commenting “[e]ffective clinicians recognize that homosexuality does not lead to pathology (society’s reaction to it does)”).

¹³⁵ Zucker, *Gender Identity*, *supra* note 101, at 557.

¹³⁶ Zucker, *Gender Identity Disorders*, *supra* note 99, at 749-50.

¹³⁷ Milton Diamond, *What’s In a Name? Some Terms Used In the Discussion of Sex and Gender*, 102 TRANSGENDER TAPESTRY J. 19 (2003).

¹³⁸ Zucker, *Gender Identity*, *supra* note 101, at 565.

¹³⁹ *Id.*

¹⁴⁰ HBIGDA SOC, *supra* note 95.

¹⁴¹ *Id.*

¹⁴² *Id.* For puberty delay it advises, “[b]iologic males should be treated with LHRH agonists (which stop LH secretion and therefore testosterone secretion), or with progestins or antiandrogens (which block testosterone secretion or neutralize testosterone action). Biologic females should be treated with LHRH agonists or with sufficient progestins (which stop the production of estrogens and progesterone) to stop menstruation.” *Id.*

¹⁴³ The SOC criteria for eligibility for reversible treatment state:

In order to provide puberty delaying hormones to an adolescent, the following criteria must be met:

1. throughout childhood the adolescent has demonstrated an intense pattern of cross-sex and cross-gender identity and aversion to expected gender role behaviors;
2. sex and gender discomfort has significantly increased with the onset of puberty;

3. the family consents and participates in the therapy.

Id.

¹⁴⁴ See generally COHEN-KETTENIS & PFÄFFLIN, *supra* note 99, at 144-46. Clinical judgment is essential in determining which adolescents should have treatment. *Id.* In order to be informed and to test the diagnosis, most clinicians recommend allowing the adolescent to experience at least some pubertal change. *Id.* at 145.

¹⁴⁵ *Id.* For anatomic males, medication can suppress “facial hair growth and voice deepening, which make it more difficult to pass in the female social role.” Zucker, *Gender Identity*, *supra* note 101, at 565.

¹⁴⁶ See COHEN-KETTENIS & PFÄFFLIN, *supra* note 99, at 140-41; Zucker, *Gender Identity*, *supra* note 101, at 565.

¹⁴⁷ COHEN-KETTENIS & PFÄFFLIN, *supra* note 99, at 145.

¹⁴⁸ The Standards of Care state:

Partially Reversible Interventions. Adolescents may be eligible to begin masculinizing or feminizing hormone therapy, as early as age 16, preferably with parental consent. In many countries 16-year olds are legal adults for medical decision-making, and do not require parental consent.

Mental health professional involvement is an eligibility requirement for triadic therapy during adolescence. For the implementation of the real-life experience or hormone therapy, the mental health professional should be involved with the patient and family for a minimum of six months. While the number of sessions during this six-month period rests upon the clinicians judgment, the intent is that hormones and the real-life experience be thoughtfully and recurrently considered over time. In those patients who have already begun the real-life experience prior to being seen, the professional should work closely with them and their families with the thoughtful recurrent consideration of what is happening over time.

HBIGDA SOC, *supra* note 95.

¹⁴⁹ This is often called the “real-life test” (RLT) since therapists require it be managed satisfactorily before they will consider recommending surgery. The RLE requires that the individual live completely and full-time as a member of the desired gender. There is some flexibility in the duration required depending upon the individual and therapist.

¹⁵⁰ HBIGDA SOC. *supra* note 95.

¹⁵¹ PETER DAY, NEW ZEALAND HEALTH TECHNOLOGY ASSESSMENT, TECH BRIEF SERIES: TRANS-GENDER REASSIGNMENT SURGERY ii (Feb. 2002), available at <http://nzhta.chmeds.ac.nz/>. It comments, “[f]inally, the study by Smith et al. (2001) showed that adolescent transsexuals (both M to F and F to M) post-operatively resolved their gender dysphoria, body dissatisfaction and psychological functioning better than those (now older) who as adolescents were not approved for treatment.” *Id.* at 13. See also COHEN-KETTENIS & PFÄFFLIN, *supra* note 99, at 179 (characterizing age 18 as “arbitrary” rather than as “intrinsically good for SR applicants”).

¹⁵² Cosmetic elective surgery obtained by minors is not uncommon in the United States in instances other than transsexual considerations. According to the American Society of Plastic Surgeons the number of cosmetic surgeries performed on people under the age of 18 exceeded 74,000 in 2003, a fourteen percent increase from 2000. In 2003 some 3,700 breast augmentation surgeries were performed on teenage girls and almost as many teenage boys had their breasts reduced. A study of patients from twelve to twenty-two years of age from Erasmus University in Rotterdam in the Netherlands asked about their body image and reasons for their surgeries. These respondents reported that after the survey they were no longer concerned about their appearance and felt more self-confident. In contrast, a control group of young people who were dissatisfied with their appearance but who did not have surgery did not develop a better self-image or gain self-confidence with time. Mary Duenwald, *The Consumer; How Young Is Too Young to have a Nose Job and Breast Implants*, N.Y. TIMES, Sept. 28, 2004, at F5, available at www.nytimes.com/2004/09/28/health/28cons.html. Males and females, thus, are denied surgery only if it is associated with a desire to change their sex, not if it is to enhance gender stereotypes.

¹⁵³ Zucker, *Gender Identity*, *supra* note 101, at 564-66.

¹⁵⁴ HBIGDA SOC, *supra* note 95.

¹⁵⁵ *But see* Duenwald, *supra* note 153 (quoting comments of Dr. Steven J. Pearlman, President of the American Academy of Facial, Plastic and Reconstructive Surgery, “[b]y the age of 6, kids can participate in the decision to have surgery and understand why it is being done.”).

¹⁵⁶ A good glimpse into some aspects of the life of transgender youth was conducted in 2001. MAINE GENDER RES. & SUPPORT SERV., TRANSGENDER YOUTH SURVEY (2001) (on file with the authors) (conducted to gain information for mental health professionals, school officials and other professionals that deal with youth).

¹⁵⁷ Under Australian law, in order to treat Alex, prior judicial approval was required because Alex lacked capacity to give legal consent and the “scope of

parental power to consent” to certain medical procedures is limited. “[C]ourt authorization is required firstly because of the significant risk of making the wrong decision and secondly because the consequences of a wrong decision are particularly grave.” *Re Alex* (2004) 180 Fam. L. R. 89, 120, *available at* www.familycourt.gov.au/judge/2004/html/realex.html (citing *In the Marriage of GWW & CMW* (1997) 21 Fam. L. R. 612 (bone marrow donation)). The court concluded that Alex’s proposed treatment fell within that limitation on consent.

There is generally no such categorical requirement in the United States. Most medical decision cases arise where there is a conflict among parties. *See, e.g.*, *Rosebush v. Oakland County Prosecutor*, 491 N.W.2d 633, 637 (Mich. Ct. App. 1992) (“We hold that the decision-making process should generally occur in the clinical setting without resort to the courts, but that courts should be available to assist in decision making when an impasse is reached.”); *In re Doe*, 418 S.E.2d 3 (Ga. 1992) (holding that hospital had standing to seek guidance where mother and father disagreed on “do not resuscitate” orders for their daughter).

Some courts and state laws have required prior judicial approval for certain specific medical treatments of children and incompetents or where parent and child interests may be in conflict. “[C]ategorical conflicts have been found to exist in types of cases where the risk of conflict is so high that court intervention is deemed necessary.” Jennifer L. Rosato, *Using Bioethics Discourse to Determine When Parents Should Make Health Care Decisions for Their Children: Is Deference Justified?*, 73 *TEMPLE L. REV.* 1, 43 (2000) (discussing categories of medical decisions where courts do not accord parents deference, including “extraordinary medical treatment” such as sterilization); *see also* Charles H. Baron, *Medicine and Human Rights: Emerging Substantive Standards and Procedural Protections for Medical Decision Making Within the American Family*, 17 *FAM. L.Q.* 1, 7-9 (1983) (describing scenarios where parent and child interests conflict and prior judicial approval is required). Due process concerns also justify seeking prior judicial approval before certain treatments. Rosato, *supra.* at 45. *See, e.g.*, *In re A.M.P.*, 708 N.E.2d 1235 (Ill. App. Ct. 1999) (approving electroshock therapy to be administered to psychotic teen at parent’s behest and on recommendation of the psychiatrist).

Sterilization of children and incompetents is one notable exception where, by statute or common law, prior judicial approval is required when it is allowed at all. *See, e.g.*, *Little, NCM v. Little*, 576 S.W.2d 493, 497-98 (Tex. App. 1979). *See generally* ROGER B. DWORKIN, *LIMITS: THE ROLE OF THE LAW IN BIOETHICAL DECISION MAKING* 54-60 (1996) (approving the increasingly adopted judicial case-by-case approach in involuntary sterilization cases); Roberta Cepko, *Involuntary Sterilization of Mentally Disabled Women*, 8 *BERKELEY WOMEN’S L.J.* 122 (1993) (describing statutory and case law approaches to sterilization of mentally disabled); *and* Elizabeth Scott, *Sterilization of Mentally Retarded Persons: Reproductive Rights and Family Privacy*, 1986 *DUKE L.J.* 806, 818 (noting “most laws ... embody strict

procedural and substantive requirements that create a strong presumption against sterilization”).

Some jurisdictions require prior judicial approval for non-therapeutic medical procedures. *See, e.g.*, *Grimes v. Kennedy Krieger Inst. Inc.*, 782 A.2d 807 (Md. App. 2001) (holding that parents may not consent to minor’s participation in nontherapeutic research involving greater than minimal risk without judicial approval); *Hart v. Brown*, 289 A.2d 386, 391 (Conn. Super. Ct. 1972) (allowing kidney donation between identical twins, and establishing judicial role, explaining “natural parents of a minor should have the right to give their consent to an isograft kidney transplantation procedure when their motivation and reasoning are favorably reviewed by a community representation which includes a court of equity”).

¹⁵⁸ *See* COHEN-KETTENIS & PFÄFFLIN, *supra* note 99, at 168 (observing that “[t]here are very few specialized treatment centers for GID in children and adolescents”).

¹⁵⁹ *See* *Doe v. Bell*, 754 N.Y.S.2d 846 (N.Y. App. Div. 2003) (holding that a foster care facility unlawfully discriminated against a seventeen year-old biological male resident, who identifies as a female, by keeping him from wearing skirts pursuant to the facility’s dress code); *Doe v. Yunits*, No. 00-1060A, 2001 WL 664947 (Mass. Super. Feb. 26, 2001).

¹⁶⁰ Unlike homosexuality, transsexualism may be regarded as a disorder or disability under state anti-discrimination laws. The medicalization of nonconforming gender identity is, at best, controversial. *See supra* note 93 and accompanying text. *See also* Jennifer L. Nye, *The Gender Box*, 13 BERKELEY WOMEN’S L.J. 226, 236-37 (1998) (discussing and critiquing the medicalization of transsexuality). She notes “a movement has arisen within the transgender community to depathologize transsexuality and to declassify Gender Identity Disorder as a mental disorder.” *Id.* at 237. Nevertheless, and at least for now, regarding it as a disorder has provided some courts a vehicle by which to protect, support, and advance the rights of transsexuals. For example, a number of courts have held that health insurers and government providers must cover treatment. *See, e.g.*, *Davidson v. Aetna Life & Cas. Ins. Co.*, 420 N.Y.S.2d 450, 453 (N.Y. Sup. Ct. 1979) (holding that male to female sex reassignment is not excluded as cosmetic surgery under a health insurance policy); *Pinneke v. Preisser*, 623 F.2d 546, 549 (8th Cir. 1980) (holding that the only surgery available for transsexuals cannot be denied under Medicaid); *J.D. v. Lackner*, 145 Cal. Rptr. 570, 572 (Cal. Ct. App. 1978) (holding that radical sex conversion surgery was not cosmetic and must be covered by Medi-Cal); *Doe v. State Dep’t of Pub. Welfare*, 257 N.W.2d 816, 820 (Minn. 1977) (holding that transsexual surgery cannot be totally excluded from state medical assistance benefits); *M.K. v. Div. of Med. Assistance & Health Servs.*, No. DMA 2345-91, 1992 WL 280789 (N.J. Adm. May 7, 1992) (holding that phalloplasty is medically necessary because it is the only available treatment for transsexualism and therefore, should be covered by Medicaid). *See*

generally Jerry Dasti, Note, *Advocating a Broader Understanding of the Necessity of Sex Reassignment Surgery Under Medicaid*, 77 N.Y.U. L. Rev. 1738, 1743 (2002) (arguing for a broader construction of medically necessary that provides coverage for transsexual treatment but removing the pathology stigma); Hazel Glenn Beh, *Sex, Sexual Pleasure and Reproduction: Health Insurers Don't Want You to Do Those Nasty Things*, 13 WIS. WOMEN'S L.J. 119, 152-59(1998) (describing treatment coverage in private insurance, Medicaid and prison health care contexts).

¹⁶¹ No. 00-1060A, 2001 WL 664947 (Mass. Super. Feb. 26, 2001). An earlier preliminary injunction allowed Pat Doe to attend South Junior High in female attire. The school had accommodated the student by allowing home schooling. The court commented, "[T]his court trusts that exposing children to diversity at an early age serves the important social goals of increasing their ability to tolerate such differences and teaching them respect for everyone's unique personal experience in that "Brave New World" out there." Doe v. Yunits, No. 00-1060A, 2000 WL 33162199 at *8 (Mass. Super. Oct. 11, 2000). The Seventh Circuit Court of Appeals, in *Nabozny vs. Podlesny*, stated in 1996 that gay, lesbian, bisexual and transgender youth are entitled to receive equal protection from harassment in the school, from other youth and from the faculty and administration. The school and the principal personally, can be held liable if they fail in this obligation. *Nabozny v. Podlesny* 92 F.3d 446 (7th Cir. 1996).

¹⁶² No. 00-1060A, 2001 WL 664947 at *4 (Mass. Super. Feb. 26, 2001) (citing Mass. Const. art. CXIV).

¹⁶³ The court noted that prior to a 1992 amendment to the Federal Rehabilitation Act Section 504 specifically excluding "gender identity disorders not resulting from physical impairments," federal courts regarded GID as a disability. *Id.* at *3 (citing 29 U.S.C. § 705(20)(F)(i)).

¹⁶⁴ *Id.* at * 6.

¹⁶⁵ *Id.* at * 6.

¹⁶⁶ N.Y.S.2d 846 (N.Y. App. Div. 2003).

¹⁶⁷ *Id.* at 848-49.

¹⁶⁸ *Id.* at 849.

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ *Id.* at 850.

¹⁷² *Id.* at 851 (quoting *Hazeldine v. Beverage Media, Ltd.*, 954 F. Supp. 697,

706 (S.D.N.Y. 1997)).

¹⁷³ *Id.* at 850.

¹⁷⁴ *Id.* at 853.

¹⁷⁵ *Id.* at 854.

¹⁷⁶ *Id.* at 855.

¹⁷⁷ *Id.*

¹⁷⁸ There are other cases in which the rights of sexual minority youth have been vindicated and safeguarded in court under equal protection, Title IX, or state anti-discrimination laws. *See, e.g.*, *Nabozny v. Podlesny*, 92 F.3d 446 (7th Cir. 1996) (holding homosexual youth could maintain an equal protection claim against school officials and denying qualified immunity); *Flores v. Morgan Hill Unified Sch. Dist.*, 324 F.3d 1140 (9th Cir. 2002) (protecting sexual minority youth under the Equal Protection Clause); *Montgomery v. Indep. Sch. Dist. No. 709*, 109 F. Supp. 2d 1081 (D. Minn. 2000) (denying school district's motions for summary judgment as to state, federal statutory, and constitutional claims of discrimination based on student on student taunting and abusive conduct over the course of ten years).

Courts have also protected sexual minority youth from misguided, abusive or cruel parents. *In re Shane T.*, 453 N.Y.S.2d 590 (N.Y. Fam. Ct. 1982), is also worth noting. There, the court agreed with the Commissioner of Social Services that a fourteen year-old boy whose father referred to him as "fag," "faggot," and "queer" and whose mother who was ineffective in preventing the verbal taunts had suffered "substantial pain" and was abused. *Id.* at 591-92. The court there also showed sympathy and tenderness to the child, calling him a "sensitive, handsome little boy." *Id.* at 593. The father argued that this was "a form of legitimate parental discipline designed to cure the child of certain unspecified 'girlie' behavior. He stated that it would be embarrassing to him if Shane were 'queer.'" *Id.*

The court responded,

It is very sad and even shocking that, at this late date in our constitutional development, many parents continue to view their home as a kingdom where they reign as king and queen and their children are relegated to the role of indentured servants

The behavior of this respondent father is as serious a form of abuse as if he had plunged a knife into the stomach of this child. In fact, it's probably worse since the agony and heartache suffered by Shane has already assailed him for several years and constitutes a grave and imminent threat to his future psychological development.

Id at 594. See also *In re Lori M.*, 496 N.Y.S.2d 940 (N.Y. Fam. Ct. 1985).

¹⁷⁹ For example, one commentator wrote, “[w]hile countries all over the world are moving towards full recognition of the post-operative status of transsexuals, the United States remains in a stalemate, with some states granting full recognition and others adhering to the strict rigidity of biological and chromosomal sex.” Leslie I. Lax, *Is the United States Falling Behind? The Legal Recognition of Post-Transsexuals’ Acquired Sex in the United States and Abroad*, 7 QUINNIPIAC HEALTH L.J. 123, 150 (2003) (reviewing legal recognition of post-operative transsexuals in the United States and elsewhere).

¹⁸⁰ *Kantaras v. Kantaras*, 884 So. 2d 155, 161 (Fla. Dist. Ct.. App. 2004) (holding marriage void *ab initio*. In countering a lower court decision, “[w]e agree with the Kansas, Ohio, and Texas courts in their understanding of the common meaning of male and female, as those terms are used statutorily, to refer to immutable traits determined at birth.”).

¹⁸¹ In *Littleton v. Prange*, the issue was whether a postoperative male to female transsexual could pursue a wrongful death claim on behalf of her deceased husband. The court held she could not, finding the marriage invalid as a same-sex marriage:

Her female anatomy, however, is all man-made. The body that Christie inhabits is a male body in all aspects other than what the physicians have supplied.

We recognize that there are many fine metaphysical arguments lurking about here involving desire and being, the essence of life and the power of mind over physics. But courts are wise not to wander too far into the misty fields of sociological philosophy. Matters of the heart do not always fit neatly within the narrowly defined perimeters of statutes, or even existing social mores. Such matters though are beyond this courts consideration. Our mandate is, as the court recognized in *Ladrach*, to interpret the statutes of the state and prior judicial decisions. This mandate is deceptively simplistic in this case: Texas statutes do not allow same-sex marriages, and prior judicial decisions are few.

9 S.W.3d 223, 231 (Tex. App. 1999) (citing *In re Ladrach*, 513 N.E.2d 828 (Ohio Prob. Ct. 1987)).

¹⁸² 513 N.E.2d 828, 831-32 (Ohio Prob. Ct. 1987) (court held that a post-surgical male to female transsexual could not be married to a male, based on her sex as determined at birth).

¹⁸³ 42 P.3d 120 (Kan. 2002). The Kansas Supreme Court denied J’Noel Gardiner, a post-operative male to female transsexual the intestate spousal share of her husband’s estate even though her Wisconsin birth certificate had been

lawfully amended to recognize her new status. *Id.* at 137. Remarkably, it relied on Black's Law Dictionary and the Webster's Dictionary for a definition of male and female, disregarding the complexity of sex differentiation in the intersexed or transsexual individual in regard to, sexual orientation and gender identity:

The words "sex," "male," and "female" are words in common usage and understood by the general population. Black's Law Dictionary, 1375(6th ed. 1999) defines "sex" as "[t]he sum of the peculiarities of structure and function that distinguish a male from a female organism; the character of being male or female." Webster's New Twentieth Century Dictionary (2nd ed. 1970) states the initial definition of sex as "either of the two divisions of organisms distinguished as male or female; males or females (especially men or women) collectively." "Male" is defined as "designating or of the sex that fertilizes the ovum and begets offspring: opposed to *female*." "Female" is defined as "designating or of the sex that produces ova and bears offspring: opposed to *male*." [Emphasis added.] According to Black's Law Dictionary, 972 (6th ed. 1999) a marriage "is the legal status, condition, or relation of one man and one woman united in law for life, or until divorced, for the discharge to each other and the community of the duties legally incumbent on those whose association is founded on the distinction of sex."

Id. at 135. Judge Robert Gernon, writing for the Court of Appeals of Kansas, on the other hand, adopted a multi-factor test to determine sex that included "factors in addition to chromosome makeup, including: gonadal sex, internal morphologic sex, external morphologic sex, hormonal sex, phenotypic sex, assigned sex and gender of rearing, and sexual identity." *In re Estate of Gardiner*, 22 P.3d 1086, 1110 (Kan. App. 2001). Moreover, Judge Gemon suggested that our definition of sex should continue to be informed by science, commenting, "[t]he listed criteria we adopt as significant in resolving the case before us should not preclude the consideration of other criteria as science advances." *Id.*

¹⁸⁴ See, e.g., Arriola, *supra* note 128; Miye A. Goishi, *Unlocking the Closet Door: Protecting Children From Involuntary Civil Commitment Because of Their Sexual Orientation*, 48 HASTINGS L.J. 1137 (1997); Ruth Robson, *Our Children: Kids of Queer Parents & Kids Who Are Queer: Looking at Sexual Minority Rights From a Different Perspective*, 64 ALB. L. Rev. 915 (2001) (describing specific incidences of hostility from parents, the courts, social services, and schools toward sexual minority youth).

¹⁸⁵ Such a case recently came before a court in the United States. See *Boy Torn Over His Gender*, STEUBENVILLE HERALD-STAR, Sept. 13, 2004, available at http://hsconnect.com/news/story/0911202004_new03news091104.asp (last visited Feb. 25, 2005) (describing the custody battle over a nine year old boy whose mother believed he had GID and whose father did not want him to attend transgender support group meetings or

go to school dressed as a girl); Shelby Zarotney, *Custody Battle Involves Gender of Child*, HEALTHYPLACE.COM, Sept. 19, 2004, at www.healthyplace.com/Communities/gender/Site/story_gender_identity_disorder.htm (last visited Feb. 24, 2005) (reporting a dispute filed in Jefferson County Court of Common Pleas, between parents over how to treat nine year old with GID). The court ruled that the boy could not attend transgender support groups or enroll in school as a female as the mother desired. See *Ruling Made in Case of Gender Identity*, STEUBENVILLE HERALD-STAR, Sept. 26, 2004, available at http://hsconnect.com/news/story/0926202004_new04news092504.asp (last visited Feb. 24, 2005).

¹⁸⁶ Re Kevin: Validity of Marriage of Transsexual (2001) 28 Fam. L. R. 158.

¹⁸⁷ Rachael Wallbank, *Re Alex "Through a Looking Glass"*, AUSTL. CHILD. RT5. NEWS, May 2004, at 28.

¹⁸⁸ *Id.* at 35.

¹⁸⁹ One individual diagnosed with GID lamented "I've been diagnosed [with GID because] I requested this particular surgery. But it's no longer possible for me to get private health insurance. I cannot get life insurance. Nor can I get disability insurance. Because every insurance application asks, "Have you ever been diagnosed with a mental illness?" I have to answer, "Yes." And as soon as I do, I render myself uninsurable." "[W]e [the National Gay and Lesbian Task Force] believe no one — whether gay, lesbian, bisexual, transgender or intersex (hermaphrodite) — should have to accept being pathologized as mentally ill in order to attain wholeness, completeness and civil equality." Jack Drescher, *An Interview with GenderPAC's Riki Witchins*, 6 J. GAY & LESBIAN PSYCHOTHERAPY 67, 72 (2002).

¹⁹⁰ See Jillian Todd Weiss, *The Gender Caste System: Identity, Privacy, and Heteronormativity*, 10 L. & SEXUALITY 123, 133-35 (2001) (describing how public knowledge of transgender status can have long range effects in medical care and other regards).

¹⁹¹ See Hazel Glenn Beh & Milton Diamond, *An Emerging Ethical and Medical Dilemma: Should Physicians Perform Sex Assignment Surgery on Infants with Ambiguous Genitalia?*, MICH. J. GENDER & L. 1, 39 n.183 (2000) (noting that "the state may intervene where parental decision making seemingly fails to adequately protect the interests of the child."); Patrick Henigan, Note, *Is Parental Authority Absolute? Public High Schools Which Provide Gay and Lesbian Youth Services Do Not Violate the Constitutional Childrearing Right of Parents*, 62 BROOK. L. REV. 1261, 1270 (1996) (noting that the "state is able to interfere with parental control whenever there is a compelling reason to protect children, and parental authority is diminished in an effort to recognize the constitutional rights of children.").

¹⁹² Wallbank, *supra* note 188, at 35-36.

¹⁹³ *Re Alex* (2004) 180 Fam. L. R.. 89, 131, available at <http://www.familycourt.gov.au/judge/2004/html/realex.html>. The reliance on surgery, and via its use to remove a penis and consider that a sign of maleness, disregards conditions such as the complete androgen insensitivity syndrome (CAIS), 5-alpha-reductase deficiency, and 17beta-hydroxysteroid dehydrogenase deficiency where males are born without a penis. It similarly can wrongly categorize conditions like congenital adrenal hyperplasia (CAR) where females are born with phalluses. It denies the reality that one's brain sex is more crucial in determining sexual and gender identity than are genitals. See Milton Diamond & Linda Watson, *Androgen Insensitivity Syndrome and Klinefelter's Syndrome Sex and Gender Considerations*, 13 CHILD & ADOLESCENT PSYCHIATRIC CLINICS N. AM. 623 (2004) (discussing the psychological and social features of AIS); Vivian Sobel & Julianne Imperato-McGinley, *Gender Identity in XY Intersexuality*, 13 CHILD & ADOLESCENT PSYCHIATRIC CLINICS N. AM. 609 (2004) (exploring the issues of gender identity associated in types of XY intersexuality); Melissa Hines, *Psychosexual Development in Individuals Who Have Female Pseudohermaphroditism*, 13 CHILD & ADOLESCENT PSYCHIATRIC CLINICS N.AM. 641(2004) (discussing psychological alterations in cases of female pseudohermaphroditism); William G. Reiner, *Psychosexual Development in Genetic Males Assigned Female. The Cloacal Exstrophy Experience*, 13 CHILD & ADOLESCENT PSYCHIATRIC CLINICS N. AM. 657 (2004) (discussing the impact of interventions on children with anomalous genitalia).

¹⁹⁴ Leslie I. Lax, *Is the United States Falling Behind? Recognition of Post Operative Transsexuals' Acquired Sex in the United States and Abroad*, 7 QUINNIPIAC HEALTH L.J. 123 (2003) (discussing *Goodwin v. United Kingdom*, 35 Eur. Ct. H.R. at 18 (2002-VT) (recognizing legal rights of male to female transsexual)). On 1 July 2004 Britain enacted the Gender Recognition Act. The law essentially accords individuals diagnosed with GID the right to a new birth certificate and all rights of their desired gender. Significantly the law does not stipulate that a transsexual must have undergone a sex-change operation; they must only provide evidence that they plan to live permanently in their new gender. Gender Recognition Act, 2004, c. 7 (Eng.), available at <http://www.legislation.hms0.gov.uk/acts/acts2004/40007--a.htm#1> (last visited Feb. 24, 2005).

¹⁹⁵ See Lax, *supra* note 195, at 130-50 (examining cases outside the United States).

¹⁹⁶ See Weiss, *supra* note 191 at 177-80 (arguing that post-surgery status should be irrelevant).

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