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Effective Advocacy on Behalf of Transgender and Gender Non-Conforming Minors
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Family creation, or the process of becoming a parent, can be a natural part of a transsexual, transgender, or gender nonconforming (TGNC) person’s life (American Psychological Association [APA], 2015). Historically, it was assumed that transwomen would forgo the ability to “father” a child, that transmen would forgo the ability to “mother” a child, and that “true transsexuals” (the only TGNC people who were considered legitimate candidates to access gender affirmation services) would be uninterested in doing so. In some contexts, sterilization has been a requirement for transition (De Sutter, Kira, Verschoor, & Hotimsky, 2002). However, many TGNC people who transition are interested in one day becoming a parent (De Sutter et al., 2002; Schoen & Arnold, 2010).

Family creation can be an amazing process of discovery and can deepen intimacy in relationships. For some people, the process may also be confusing, disruptive, and overwhelming. TGNC people face unique biological and social considerations that can be a challenge to navigate, especially when current decisions about puberty suppression, hormone therapy, and affirmative surgeries can impact future family creation options in permanent ways. Some TGNC people are unaware of their family creation options and may prematurely foreclose their hopes or desires to create a family. Although TGNC family creation role models and information are increasing, it is critical for TGNC people to have easy access to accurate, empowering information that can guide their thinking and inform their choices in family creation.

Societal Expectations of Family Creation

Societal expectations of family creation can affect TGNC people and cisgender people alike, embedding assumptions about how families should be created and what constellations of adults and children make up a “real” family. Heteronormative expectations might include the presence of a mother and father (Cohler & Galatzer-Levy, 2000). Exploration and deconstruction of these norms and expectations may support TGNC people in making personally fulfilling family creation choices. When socially prescribed scripts for family creation do not fit, this can open up the possibility of creative approaches to family creation, which are a better fit for the people involved (APA, 2015). Mainstream society has low tolerance for unique family creation narratives, although some racial and ethnic groups are more likely to embrace and enact family structures outside of a traditional nuclear family. For example, African American families may create intergenerational parenting relationships more frequently, with grandparents being primary caregivers to grandchildren (Gibson, 2005; Szinovácz, 1998; Wakschlag, Chase-Lansdale, & Brooks-Gunn, 1996). Other cultures identify a variety of family constellations as normative, with intergenerational family units and families made up of children and parents who may not be directly genetically related.
Challenging Gender Dichotomy in Family Creation

In addition to deconstructing societal values about reproduction, it is also important to challenge the typical gender dichotomy in family creation. Community and professional sources describe family creation alternatives for trans women (male to female) and trans men (female to male; Polly & Polly, 2014); however, this focus collapses the diversity of the gender spectrum and can make genderqueer, gender nonconforming, and androgynous people invisible. The language of this article intentionally broadens the family creation dialogue to include a diverse representation of the gender spectrum. When offering support or information to TGNC people about family creation alternatives, the ultimate focus should be the empowerment of the client(s) making the choices. When considering family creation, an open exploration of all options is encouraged, while recognizing that many TGNC people will not have access to all options.

Issues to Consider Prior to Family Creation

Possible interest in having children is an important consideration before beginning hormone therapy or undergoing affirmative surgeries (De Roo, Tillemann, T'Sjoen, & De Sutter, 2016). Informed consent for hormone therapy or affirmative surgery requires that TGNC people receive information about the effects on fertility and the impact this may have on future family creation options (APA, 2015; De Sutter et al., 2002). People with sperm can donate and cryopreserve the sperm prior to beginning hormone therapy or undergoing an affirmative surgery that will impact the vas deferens or testes. This will assist in the retention of the healthiest, most robust sperm sample to be used at a future time. Cryopreservation of sperm for up to 5 years is estimated to cost $2,000 to $3,000 (Gorton & Grubb, 2014). People with eggs can have them surgically removed and cryopreserved prior to beginning hormone therapy or having an affirmative surgery that affects the ovaries. It is estimated that the cost for this process in between $5,000 to $15,000 for each ovulation cycle (Polly & Polly, 2014). As with preservation of sperm, this will allow for the capture of the youngest, healthiest eggs to be used at a future time. The technology for egg preservation is not as advanced as it is for sperm preservation (Gorton & Grubb, 2014).

Legal issues can be significant and can dramatically impact parenting rights and legal custody of children. These legal issues should be carefully considered prior to family creation. Legal decisions are strongly influenced by whose genetic material is used to create a fertilized egg, by the process used to acquire the egg and sperm, and by how the relationships between the people involved in the creation of the fertilized egg are framed or described (Minter & Wald, 2012). TGNC people are strongly encouraged to explore the legal implications of any family creation decisions and process, regardless of the level of trust that exists between partners or people contributing the egg, sperm, or uterus, to ensure that the process being used will create the foundation and legal protections that are needed or desired.

It is important to weigh the personal impact of family creation choices on a TGNC person’s quality of life, transition process, and relationships. Although a TGNC person may want to carry a pregnancy to term, careful consideration should include the impact of disrupting hormone therapy or a transition process because such interruption might significantly intensify gender dysphoria (Murphy, 2012). Carrying a pregnancy may have other psychological impacts, including depression and anxiety (Evans, Heron, Franks, Oke, & Golding, 2001; Huizink, Mulder, Robles de Medina, Visser, & Buitelaar, 2004). Weighing other pressing needs against family creation needs can be difficult. People who choose not to undergo ART may experience feelings of guilt and loss. People who wish to pursue ART but are unable to do so because of a physical contraindication, previous affirming therapy (e.g., hysterectomy or orchietomy), or lack of financial resources may also experience feelings of grief and loss or struggle with a having a body that is not able to provide them the children they would love to raise.
Becoming Pregnant Without Involving Medical Intervention

Becoming pregnant, without involving medical intervention, requires knowledge of the process for fertilizing an egg in a uterus. This may be through vaginal intercourse or do-it-yourself insemination. If either person contributing the egg or the sperm is currently on hormone therapy, hormone therapy should be halted and the body should be permitted to reestablish previous hormone levels. Because hormones are stored in fat tissue, it can take some time for hormones from gender affirmative hormone therapy to flush out of the system. If pregnancy occurs while one or both people are taking hormone therapy, there is a higher chance of birth defects and preterm death (Howard Brown Health Center, 2013a, 2013b). Because of this, informed consent for gender affirmative hormone therapy should include information that while hormone therapy can make unintentional pregnancy less likely, it is not, in and of itself, adequate birth control for TGNC people who engage in sex acts that could result in fertilization. TGNC people who are experiencing an unintended pregnancy and who wish to seek an abortion may have challenges in accessing care.

It may take 2 to 6 months to reestablish biological readiness of the egg and sperm before insemination is attempted, and it may take multiple attempts before a successful fertilization occurs. Maximizing the chance of a pregnancy can require tracking temperature and ovulation, and mixing egg and sperm at carefully timed intervals to maximize chances of fertilization (Polly & Polly, 2014). After cessation of hormone therapy, people with eggs will begin menstruation and will release mature eggs. People with sperm may take 3 months after previous hormone levels are reached to build and produce mature sperm. The best chance for healthy sperm development occurs when temperature is well controlled; tucking testicles is discouraged to avoid overheating and negatively impacting sperm development. Gender affirmative hormone therapy is contraindicated while sperm are needed or, for someone carrying the pregnancy, throughout pregnancy and chest-feeding. Use of testosterone therapy for long periods of time may reduce the likelihood of ovulation when testosterone treatment is halted and estrogen levels in the body increase, although some TGNC people have given birth to healthy babies using this approach. Use of estrogen therapy and/or testosterone blockers for long periods of time is likely to reduce the body’s ability to create healthy, mature, high-count sperm. Recovery of the ability to produce healthy, high-count sperm when estrogen therapy is suspended is unknown and will vary across individuals (Coleman et al., 2012; Eyler, Pang, & Clark, 2014). If a different approach to pregnancy is preferred or needed, it will likely require participation of outside people and organizations, such as medical providers, ART specialists, or adoption agents, in what can be a very intimate process of family creation.

Locating Trans-Affirmative, Informed Medical Providers

Finding trans-affirmative and informed medical providers whenever possible is a significant assistance (Polly & Polly, 2014). Although some providers are supportive, not all are prepared to offer informed guidance about family creation, and some may exoticize or fetishize TGNC bodies and pregnancies. Locating experienced providers in rural or conservative areas may be more challenging. Most people rely on word of mouth, Internet reviews, and personal recommendations to identify providers in their area or in an area they can access regularly. Entering into a process that may involve significant interaction with the health care system can be challenging for TGNC people who may already have a difficult or strained relationship with health care and health care providers (Schilder et al., 1998). Family creation care may intensify this, given the focus on body parts that may not align with gender identity, sometimes rigid technical language for body parts, the lack of control people may experience, and assumptions about which partner will be taking which role (e.g., egg = mom, sperm = dad) in traditional medical settings. When involved in larger medical systems that may not be trans-affirmative, some people have utilized a doula or midwife who can act as an advocate or interpreter, assisting the medical setting to offer more trans-affirmative options and care for TGNC people. Similarly, some people have chosen home birth or birth at a birthing center rather than a hospital in order to minimize the number of providers whom they have not met who may be present during the birth.

ART for TGNC People

The goal of ART is to enhance fertility and the possibility of a viable pregnancy and a healthy birth. Difficulty in conceiving for TGNC people might be due to challenges in accessing reproductive material (such as sperm, eggs, or uterus). This may necessitate the involvement of a donor (for sperm or eggs) and/or a gestational surrogate. One option for TGNC people to have genetically related children is donation of sperm or eggs from a relative that could then be used in conjunction with genetic material from the TGNC person’s partner. Some TGNC people prefer that their children have a genetic link to the other parent and therefore choose not to use sperm or eggs from a donor. In a situation in which one parent is genetically related to the children and the other is not, the parent without the genetic link can struggle with societal messages that they are not “real” parents (Minter & Wald, 2012). Additionally, one or both partners may grieve the inability to conceive children sharing their genetic material.

TGNC people may also have infertility factors like those of cisgender people who have difficulty in reproducing without medical intervention (Eyler et al., 2014). People undergoing ART should be prepared for the intense physical and emotional toll the process can take. ART can have a dramatic impact on emotional functioning because of the cessation of hormone therapy, hormone readjustment, and intense fertility medications that can cause mood swings, depression, irritability, anger, tearfulness, and decision-making difficulty. For TGNC people, the impact of hormone changes and fertility medications is intensified by the presence of hormones and medications that are shifting the body away from a person’s identity. In addition, ART can cause a person to feel as though they have little control of the changes in their body. Given how hard some TGNC people have had to fight to maintain body integrity, this loss of control may be especially anxiety provoking. Finally, ART techniques are expensive, and although fertility treatments are sometimes, though not always, covered by insurance, the way that infertility is defined can result in denial of coverage for TGNC people (Eyler et al., 2014). For example, same-sex couples have had coverage denied for infertility treat-
ment “because their health insurance plan did not consider their condition of infertility to be a ‘disease’” (Eyler et al., 2014, p. 154). This expense may functionally preclude these options for people who do not have the financial resources to pursue them. With regard to telling children born through ART, current recommendations suggest telling children about their genetic heritage in age-appropriate ways as they are growing up (Ethics Committee of the American Society for Reproductive Medicine, 2004). TGNC parents sharing with children about their genetic heritage may also involve talking with children about their own gender history in age-appropriate ways as they are growing up.

**ART for People With a Uterus, Eggs, and Ovaries**

For people with a uterus, eggs, and ovaries, testosterone therapy must be discontinued for the body to return to its hormonal and reproductive cycle (Light, Obedin-Maliver, Sevelius, & Kerns, 2014). Insemination with sperm through an alternative insemination (AI) process occurs and may take multiple attempts. The simplest AI process involves home insemination. Insemination by a medical provider can involve inserting sperm into the vagina or into the uterus. Gender affirmative hormone therapy is contraindicated throughout egg maturation, pregnancy, and chestfeeding. There are multiple types of donors that can be used to provide sperm: (a) unknown donors (sperm is purchased from a facility), or (b) a known or “directed” donor. A known donor can be a partner or significant other, a family member, or friend. Although this article uses the term “donor” to mean an alternate source, caution is offered about using such terminology in legal documents, as this term has a very specific meaning and may minimize the parental rights of someone listed as a donor (Minter & Wald, 2012). If AI is not effective alone, additional male hormones and fertility medications may be prescribed and insemination will be attempted again. A TGNC person may also choose to take high doses of feminizing hormone and fertility medication to “induce increased ovulation” and surgically retrieve the eggs (De Sutter, 2009; Gorton & Grubb, 2014, p. 237).

The psychological ramifications of this treatment can be significant. Once retrieved, the eggs can be externally fertilized and implanted in a uterus, either in the person who produced the eggs or in another person. If the fertilized egg is implanted in the person’s partner, this is called “reciprocal” in vitro fertilization (Eyler et al., 2014). Alternately, a gestational surrogate could carry the pregnancy. Eggs can also be cryopreserved or frozen for use at a future time by the person, a partner, or a surrogate (De Roo et al., 2016; Wierckx, Van Caenegem, et al., 2012). Similarly, once the eggs are fertilized, embryos can be cryopreserved for use at a future time. Gorton and Grubb (2014) estimate that the removal, fertilization, and cryopreservation of eggs costs over $10,000, in addition to annual fees for continued preservation.

**ART for People With Sperm and Testes**

For people with sperm and testes, feminizing hormone therapy and testosterone blockers are discontinued and the body returns to its hormone levels (Wierckx, Stuyver, et al., 2012). If insemination is attempted using the sperm through an alternative insemination (AI) process, this may take multiple attempts. Hormone levels must be maintained until sperm are no longer needed. There are multiple types of donors that can provide eggs and a uterus: (a) unknown donors (frozen egg donor bank), or (b) a known or “directed” donor. A known donor can be a partner or significant other, a family member, a friend, or a hired gestational surrogate (Eyler et al., 2014). If AI is not effective alone, additional male hormones and fertility medications may be prescribed and insemination will be attempted again. If sperm count is low, if sperm do not have strong motility, or if sperm are less mature, intracytoplasmic sperm injection (ICSI) may be used. ICSI is a procedure in which a single sperm is injected directly into an egg (Van Steirteghem, Devroye, & Liebaers, 2002). When ICSI is used with a healthy, high-count sperm sample, the average fertilization rate is over 90%; this technique can increase the likelihood and the number of fertilized eggs that can be produced with sperm samples that are less mature or have lower mobility, which can occur after longer term feminizing hormone therapy (Eyler et al., 2014).

Some TGNC people who lack uteruses are interested in the potential future availability of uterine transplants to allow them to become gestational parents. This technology is currently in an experimental stage and may be years away from availability. Very recently, the first successful uterus transplant was completed and there was a subsequent successful birth (Brännström et al., 2015; Brännström, Wramming, & Altchek, 2010; Johannesson & Enskog, 2014).

**Family Creation Issues for TGNC Children and Adolescents**

Developmentally, family creation is not normally a prepubescent consideration. Given the availability of puberty suppression and hormone therapy for youth under 18, families, parents, and children are considering future life choices far in advance of the usual developmental timeline. Children and adolescents may not always understand the future impact of decisions about medical interventions (APA, 2015). Children should always be involved in discussions in a developmentally appropriate way about this aspect of their care. Parents may worry that youth will make impulsive choices and cut off family creation options that they will regret in future. Some of this caution is warranted given developmental stage, possible inability to fully understand adult choices, and the fact that some youths’ developmental trajectory will not include a TGNC identity in the future. Some caution may also stem from parents’ cultural values that place a high priority on reproduction with genetic material using body parts that do not align with a youth’s gender identity. Parents may struggle to retain their child’s options while also recognizing a youth’s immediate transition needs. It can be hard for parents to balance their hopes and expectations for the future (e.g., plans for how their children’s lives would unfold; being grandparents) while meeting their children’s current emotional and physical needs. At the same time, there is evidence that LGBT youth who are affirmed by their families are more likely to be interested in parenting themselves in the future (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Thus, as more and more families are affirming and supporting their TGNC children, it may also be that some of these youth will be interested in the possibility of becoming parents themselves some day. For TGNC youth who have experienced natal puberty and thus have mature reproductive systems, fertility preservation options are essentially the same as for TGNC adults.
If preserving this distant option is perceived as being in conflict with immediate needs for support in accessing gender-related care, youth may feel that they have to forego the possibility of becoming parents with a genetic link to their children. An exploration with TGNC youth about their immediate goals, long-term life wishes, and potential options may help youth to feel more empowered to claim their identity. This may help them meet immediate needs and plan for a future in which as few options as possible are foreclosed upon because of their gender identity. This should include a discussion of options that may be available later as well as decisions that need to be made and acted on immediately. For example, gonads can be “stored” in the body until and unless surgical intervention to remove them is pursued, although this carries the risk of future infertility following gender affirming hormone therapy (Eyler et al., 2014).

As discussed by Edwards-Leeper, Leibowitz, and Sanggananjavanich (2016), puberty suppression is being increasingly used with adolescents. Puberty suppression (GnRH analogue) halts the development of secondary sex characteristics and the production of viable sperm and eggs, and can occur as early as Tanner Stage 2. This is a reversible medical procedure that does not affect long-term fertility; when exposed to testosterone or estrogen, puberty and the development of secondary sex characteristics will begin (Steensma, Kreukels, de Vries, & Cohen-Kettenis, 2013). Puberty suppression can cost $1,500 to $2,500 per month and is rarely covered by insurance plans (Hembree et al., 2009). If puberty suppression is continued until hormone therapy is prescribed, youth may not develop viable sperm or eggs that could be used for family creation. Interrupting or delaying puberty suppression to allow a youth’s body to produce viable sperm or eggs would result in irreversible secondary sex characteristic development and biological maturation that could directly contradict the youth’s gender identity and that may require surgery to alter.

There are techniques for the cryopreservation of ovarian cortex and testicular tissue that have been developed with children undergoing cancer treatments that can be used with TGNC youth whose bodies will not develop mature sperm or eggs. One technique requires the surgical removal and cryopreservation of the ovaries and then surgical replacement of the ovaries; this technique has resulted in some births. Ovaries can also be surgically removed, cryopreserved and then stimulated outside of the body to produce viable eggs that could be used with other ART; this technique is still in development (Eyler et al., 2014). Using cryopreserved testicular tissue to produce mature sperm is more complicated and less successful. Instead, collection of sperm from children for freezing prior to puberty suppression is the most viable option. Eyler and colleagues (2014) note that case reports document viable sperm collection from children as young as 11 years old. A sperm sample from someone so young may have a low sperm count or may contain sperm that are not mature enough to fertilize an egg. In those circumstances, ICSI could be used to maximize the chances of a fertilized egg. A technique called round spermatid injection injects precursors of mature sperm into an egg; this technique is still experimental but may provide options in the future (Eyler et al., 2014). As with all choices, the impact of sperm collection and surgery on children and adolescents should be carefully considered.

Eyler and colleagues (2014) specifically suggest that legal documents be in place to protect the autonomy of TGNC youth if their genetic material is stored. Because these youth are minors, the parents would be the official owners of the stored genetic material, and it is suggested that the documentation specify that ownership will transfer to the TGNC youth upon their reaching the age of majority, and the genetic material cannot be used until the TGNC youth has reached maturity.

Adoption and Foster Parenting

Some TGNC people may choose adoption or foster parenting as a family creation option. Being TGNC is not a legal impediment to adoption or serving as a foster parent in the United States, but it may be challenging to identify an agency that does not discriminate on the basis of gender identity and/or gender expression. Some agencies explicitly seek TGNC adoptive or foster parent applicants (AFA, 2012). The decision of whether to disclose a TGNC identity when applying to be an adoptive or foster parent should be carefully considered. Given the intensive background check that may occur prior to placement of a child, it may be difficult to avoid discovery of this information and may prove even more difficult to explain the failure to disclose at an earlier stage of the process. Minter and Wald (2012) suggest that many lawyers favor early disclosure to avoid any potential challenges to the adoption process. Adoptions can be completed for an individual or single parent, a joint adoption by an unmarried couple, a second parent adoption, or a step-parent or domestic partner adoption (AFA, 2012). Current recommendations for parents who adopt infants are to tell them about their adoption history in age-appropriate ways as they are growing up (Brodzinsky, 2006; Brodzinsky, Smith, & Brodzinsky, 1998).

Chestfeeding

Chestfeeding may be of interest to TGNC people whose parenting will begin with infants. This may include TGNC people of all gender identities, gestational and nongestational parents, and parents of adoptive children. Parents may be interested in chestfeeding their children for the many documented health benefits (Anderson, Johnstone, & Remley, 1999; Cunningham, Jelliffe, & Jelliffe, 1991; Evenhouse & Reilly, 2005) and/or because they value this aspect of the parenting relationship. For some TGNC people, chestfeeding is an option which is congruent with their gender identity and their identification with being a mother. Other TGNC parents may choose to chestfeed despite gendered assumptions about who chestfeeds, which may not fit their gender identity or family role (see Milk Junkies at http://www.milkjunkies.net). Depending on the circumstances of how parenthood was achieved and what biology the TGNC parent has (including history of hormone therapy and/or chest or breast surgeries), pursuing chestfeeding maybe an endeavor that requires outside support. Regardless of these factors, parents who choose to chestfeed are most likely to succeed in general when they have a support system in place to facilitate their choice (U.S. Department of Health & Human Services, 2011).

When Family Creation Options Are Unsuccessful or Unavailable

It can be intensely discouraging for a person to be unable to actualize personal hopes and dreams of becoming a parent. Many
ART procedures are very expensive, not covered by most insurance plans, and are unattainable by many middle and lower SES groups. Feelings of loss and grief may occur throughout the family creation process and may also sharply exist at each stage of the process that does not result in a viable pregnancy and healthy birth. This may include insemination without ART, attempts with ART, loss of embryos, miscarriages, neonatal loss or still births, failed adoptions, or a surrogate’s choice to keep the baby. TGNC people may have suffered through dysphoria, cessation of hormone therapy, the introduction of high levels of hormones incongruent with their gender identity, invasive procedures in systems, or with providers who were not trans-affirmative. As a result, TGNC people may feel betrayed by their bodies and may grieve the ability to create a family in the manner that matches their gender identity and true selves. In addition to personal loss, the process of family creation can take a toll on relationships. Sharing the loss or inability to create the family the couple or relationship constellation wanted may be too difficult to tolerate together or the relationship may have begun to evolve around family creation and may not be strong enough to survive without that focus. Loss and grief may be mixed with anger and resentment when a lack of financial resources has blocked a TGNC person from accessing procedures that could provide family creation options.

## Conclusion

The advance in available family creation options for TGNC people compared with the past is enormous and there are additional promising options that are likely to be available in the future. Awareness of these options can be empowering to TGNC people. Whether and how they decide to become parents will be limited only by the availability of technologies to support the family creation process and TGNC people’s choices.

## References


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Access to fertility services by transgender persons: an Ethics Committee opinion

Ethics Committee of the American Society for Reproductive Medicine
American Society for Reproductive Medicine, Birmingham, Alabama

This statement explores the ethical considerations surrounding the provision of fertility services to transgender individuals and concludes that denial of access to fertility services is not justified. (Fertil Steril 2015;104:1111–5. ©2015 by American Society for Reproductive Medicine.)

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KEY POINTS

• Transgender persons have the same interests as other persons in having children and in accessing fertility services for fertility preservation and reproduction.
• While current data are sparse, they do not support restricting access by transgender persons to reproductive technologies and do not support concerns that children are harmed from being raised by transgender parents.
• Providers should offer fertility preservation options to individuals before gender transition.
• Programs should ensure that transgender patients who seek fertility services are informed about any distinctive medical risks and the lack of data about long-term outcomes for patients and their offspring.
• Programs should treat all requests for assisted reproduction without regard to gender identity status.

• We encourage programs to collaborate on the collection of outcome data.
• Programs without sufficient resources to offer care have an ethical duty to assist in referral to providers equipped to manage such patients.

INTRODUCTION
The term transgender describes a person whose gender identity, the internal sense of being male or female, differs from the gender assigned at birth. Transgender persons report intense and persistent discomfort with their primary and secondary sex characteristics or their birth sex, often described as “being trapped in the wrong body.” This distress can appear as early as childhood (1). The American Psychiatric Association’s Diagnostic and Statistical Manual has termed this emotional distress gender dysphoria, while noting that gender nonconformity is itself not a mental disorder (2). Transgender persons describe an enduring wish to change their physical appearance, often including genitalia and secondary sexual characteristics, to bring it in line with their gender identity (1, 3, 4).

Transgender persons may wish to transition from female to male (transgender man or FTM) or male to female (transgender woman or MTF). The term transgender includes people who are at different stages of gender transition physically, emotionally, and temporally (1, 4, 5). Transitioning to a different gender is complex and unique to the individual (1, 4, 5). Transgender persons may or may not choose to alter their bodies hormonally or surgically (3, 4). Gender reassignment surgery, which will change a person’s body to conform to their gender identity, is now seen as an effective, safe treatment and is increasing covered by medical insurance. Research indicates mainly positive outcomes, resulting in relief from gender dysphoria and an improved sense of well-being (3, 5–8). Some transgender persons, however, choose not to have surgery and instead use treatments such as hormone therapy for relief of gender dysphoria (4, 5).
ART AND THE CHANGING FAMILY

Transgender persons want to have children for the same reasons as others: intimacy, nurturance, and family. Historically, many transgender persons had children with a partner before their gender transition and shared rearing with the partner after transition (9-13). Until recently, transition to the desired gender meant the loss of reproductive potential. Current research reveals that many transgender persons are of reproductive age at the time of transition, and confirms that many may wish to have children after transition (13-16). The World Professional Association of Transgender Health (WPATH) and the Endocrine Society recommend that all transgender persons be counseled about the effect of treatment on their fertility and options for fertility preservation before they undergo transition (5, 15). Thus, physicians are encouraged to advise their transgender patients about options for fertility preservation and reproduction (5, 8, 13, 18).

Patients who deviate from the heteronormative family have historically been denied access to assisted reproductive technology (ART) (16, 17). The wish of gay, lesbian, and transgender persons to have children has been stigmatized by providers and policy makers who have assumed harmful effects for the children (17). Although there is growing acceptance of the use of ART by gay and lesbian patients, some providers express discomfort about providing fertility services for transgender patients (18). Although ART programs may receive requests for fertility treatment or fertility preservation from transgender persons, programs vary in their acceptance of such patients (14, 19-22). Resistance to providing treatment is typically grounded in either concern for the welfare of the patient or concern for the welfare of the offspring, or both. Some programs believe it unacceptable to treat any transgender persons. Some programs may provide services only for FTM (transgender male) patients with female partners, because of reservations about treating all transgender patients (16, 21, 22). It has been standard for the past 10 years in Belgium, France, and the Netherlands, for example, to provide donor insemination for couples with a transgender man and female partner who wish to have children (22). Increasingly physicians, psychologists, and ethicists have argued that the transgender patient should have access to the same options as any person who will or has lost his or her reproductive capacity (19-21, 23).

Requests for treatment from transgender individuals present questions about reproductive rights, the welfare of offspring, nondiscrimination, and professional autonomy. The overarching ethical issue is whether it is acceptable to help transgender persons to reproduce. If it is ethical to provide such services, the second question is whether programs have a duty to treat all transgender persons, regardless of their gender identity.

HISTORY AND ETIOLOGY

Many cultures throughout history have documented gender variant behavior (1, 3, 4, 7). The prevalence of gender variant persons is difficult to determine, but after a review of 10 studies in eight countries, WPATH estimated the prevalence from 1:12,000 to 1:45,000 for male-to-female individuals and 1:30,400 to 1:200,000 for female-to-male individuals (14). Others have suggested the prevalence is higher (1, 5).

Because gender variance was viewed historically as evidence of psychopathology, transgender persons were encouraged to undergo treatment, with a variety of interventions including medication and shock treatment (3, 7). There is no evidence however that psychological or psychiatric methods can bring about change of a transgender identity (1). While the etiology of gender dysphoria remains poorly understood, biological elements, genetics, prenatal influences, hormonal imbalances, and environmental factors may all be factors (1, 3, 4, 7). The American Psychological Association, the American Psychiatric Association, and WPATH, among other organizations, have concluded that there is no single explanation for gender variant behavior and that gender dysphoria, by itself, does not constitute a mental disorder (1, 2, 5). Research has found that transgender persons can be highly educated, stably employed, sustain long-term partnered relationships, and do not exhibit mental disorders more often than any other group (8, 13, 24, 25).

Recognizing that transgender people face discrimination in health care, professional organizations have begun to incorporate anti-discrimination clauses into policy and ethics documents. The American Medical Association (AMA) policy position on lesbian, gay, bisexual, and transgender (LGBT) issues explicitly opposes discrimination in health care, physician education and training, and the physician workplace, based on gender identity. With respect to the physician-patient relationship, the AMA asserts that while generally a physician is free to decline to undertake the care of a patient, physicians who offer their services to the public may not refuse to accept patients because of sexual orientation or gender identity [26]. The Code of Professional Ethics of the American Congress of Obstetricians and Gynecologists (ACOG) states that the principle of justice requires strict avoidance of discrimination based on sexual orientation or perceived gender [27]. Similarly, the ACOG Committee Opinion on Health Care for Transgender Individuals reiterates, “ACOG opposes discrimination based on gender identity” [28].

Literature and research surrounding the experience of transgender patients in health-care settings suggests that many continue to face stigma and confusion by providers, often in the form of insensitivity to preferred gender pronouns, displays of discomfort, and substandard care [29]. Suggestions for improving relations between transgender patients and health-care providers include consultation with organizations devoted to supporting transgender individuals and increased education that highlights cultural competency with this community.

OFFSPRING WELFARE AND THE FAMILY

Many persons who oppose reproduction by transgender persons do so out of concern for the well-being of the
intended offspring and question whether access to fertility services serves the needs of the children of transgender persons (13, 16, 22). Providers have expressed doubts about whether transgender individuals are suitable candidates for parenthood (8–21). Some have argued that the psychosexual development and mental health of the offspring will be at risk (9, 20). These arguments parallel earlier, now disproved, arguments against providing fertility services to gay and lesbian persons (23).

There has been only a handful of studies about parenting by transgender persons, and these studies have enrolled relatively small numbers of subjects. Much of the research has focused on families where a transgender man or transgender woman had children before gender transition. In a small 1978 study, Green examined 16 children, mean age of 11 years, who were living with at least one transgender parent. In most cases, the children had been aware of the parent’s gender transition and lived with the parent during the transition. Green’s work focused on psychosexual development. These children did not appear to differ in gender identity, gender role, or sexuality from children raised in heterosexual families (10). Green’s second study in 1998 looked at 18 children who had either continued to live with the transgender parent or maintained regular contact with the parent. None of these children exhibited gender variant behavior or disturbances in gender identity. The children typically showed acceptance of their parents’ gender change and a wish to preserve a close relationship with the parent (11). In a 2002 study, David Freedman et al. examined the gender development, mental health, and family and peer relationships of 18 British children of transgender parents, most of whom had been born before their parents’ gender transition. None of these children exhibited gender dysphoria. Further, few of the children displayed significant psychosocial problems, high levels of distress, or depression. The children did experience difficulties in family relationships because of high levels of conflict between the transgender and nontransgender parent (9). Thus, it appears that while a parent’s gender transition is not a neutral event for a child, there are protective factors that contribute to resilience and successful coping (9, 12).

The most recent data comes from a 12-year follow-up study of 42 French children, conceived by donor insemination, born into families with a transgender man and his wife. The research concluded that the children, interviewed by three different mental health professionals, are healthy, well-adjusted, show secure attachment to their parents, and do not evidence any gender-variant behavior (30). Thus, the data available do not support the fear that being raised by a transgender parent will necessarily result in psychopathology, identity disturbance, or impairment in psychosocial functioning (9–12, 30).

The security of a child’s attachments to his or her parents and the capacity of the parent to be warm and responsive to the child’s needs are strong determinants of a child’s well-being (17). Research on families where a transgender man or transgender woman had children before gender transition has found no evidence that transgender parents have unhealthy relationships with their children (9–12). Not only do most transgender parents report positive relationships with their children, research suggests the loss of contact with the transgender parent may cause more harm than the gender change itself (9–12). Transgender parents exhibit these same characteristics associated with good parenting including warmth, commitment to the child, and attention to the child’s needs (30–34). There is no evidence that being transgender prevents parents from establishing caring and responsive relationships with their children. The American Academy of Child and Adolescent Psychiatry affirms that “there is no evidence to support that parents who are….transgender are per se deficient in parenting skills, child-centered concerns, and parent-child attachments compared with heterosexual parents” (35).

As noted in the Committee’s previous report on Child-rearing ability and the provision of fertility services, it is difficult to make accurate predictions about parental child-rearing, and providers should be extremely careful in making them. A wide range of family types and parents can ensure that child welfare and children can develop normally in families where a parent is socially stigmatized (36).

### MEDICAL RISKS AND INFORMED CONSENT

Programs must also ensure that transgender patients who request fertility preservation and assisted reproduction are informed about any known medical risks and the lack of medical data on outcomes. There are currently no practice guidelines for physicians providing fertility preservation and reproductive care to transgender persons, and it is beyond the scope of this document. However, further research is needed to provide evidence-based and patient-centered care and to understand the medical and psychosocial risks and impacts for parent and offspring during treatment, the perinatal period, and on future health.

Providers should offer psychological counseling by a qualified mental health professional to assist transgender persons with questions about disclosure to offspring and others, of the use of donor gametes, disclosure of the parents’ transgender status, as well as to provide support for the bio–psycho–social impacts of treatment. Additional areas of counseling exploration might include the impact of discontinuing hormone therapy, impact of fertility treatments on gender dysphoria, and the need for emotional support and resources. Further research is needed on the psychosocial and counseling needs of transgender patients receiving reproductive care.

Exogenous hormones and gonadectomy have well-recognized impacts on fertility. Providers may encounter patients seeking fertility preservation and/or assisted reproduction. Fertility preservation options include sperm, oocyte, and embryo cryopreservation. Ovarian tissue and prepubertal testicular cryopreservation remain experimental. Reproduction in transgender persons who have initiated transition will often involve discontinuation of exogenous hormones. Long-term exogenous hormone use may be associated with a number of risks (4, 5, 15). Assisted reproduction may include the full range of fertility services and do not differ materially from those provided to non-transgender
patients. Whether long-term hormone exposure confers any unique medical risk to the patient undergoing assisted reproduction procedures or any long-term impact on gametes and/or offspring is currently unknown. Consistent with the principles and practice of informed consent, patients should be provided information that is material to their decision making to proceed with or forgo fertility treatment, including that there remain uncertainties and gaps in knowledge as to short-term and long-term impacts of treatment on patients and offspring.

There may be additional ethical considerations for children and adolescents on pubertal suppression therapy who desire fertility preservation, but are hesitant to undergo pubertal development in the gender assigned at birth. Since the options of ovarian tissue banking and prepubertal testicular cryopreservation remain experimental, the Committee recommends that decisions regarding gonadectomy for fertility preservation be delayed until adulthood.

**LEGAL CONCERNS**

Although transgender persons experience discrimination, a majority of federal and state civil rights laws do not include express protections against discrimination based on gender identity or transgender status. Several courts and federal agencies have determined that transgender people are protected from discrimination by laws that prohibit sex discrimination. Currently, 17 states, the District of Columbia, and over 100 counties or cities in the United States have anti-discrimination laws that provide express protections for transgender persons [37]. Denial of treatment based solely on gender identity thus may be prohibited discrimination in some jurisdictions [37]. No states prohibit reproduction or parenting by transgender persons, although there are no strong policies to protect that right [34]. A few courts have ruled that a parent’s transgender identity alone should not be a determining factor in custody decisions. Transgender parents face many complex legal issues, including legal recognition of their gender, questions about validity and recognition of their marriages, recognition of their legal relationship to their child, and child custody concerns. Thus, providers should encourage transgender patients to consult appropriate professionals to become informed about the legal issues involved in becoming a parent through ART.

**CONCLUSION**

The Committee concludes that transgender identity/status by itself should not automatically bar a person from accessing fertility preservation and assisted reproductive services. Unless other factors disqualify transgender persons from fertility services, based on empirical evidence rather than stereotype or bias, we find no ethical basis to deny reproductive services to transgender individuals. Professional autonomy, while a significant value in deciding whom to treat, is limited in this case by a greater ethical obligation, and in some jurisdictions, a legal duty, to regard all persons equally, regardless of their gender identity. Programs without sufficient resources to offer care have an ethical duty to assist in referral to providers equipped to treat such patients.

Treatment is best provided in consultation with a multidisciplinary team, which can include endocrinologists, specialists in transgender medicine, and mental health professionals.

**Acknowledgments:** This report was developed by the Ethics Committee of the American Society for Reproductive Medicine as a service to its members and other practicing clinicians. While this document reflects the views of members of that Committee, it is not intended to be the only approved standard of practice or to dictate an exclusive course of treatment in all cases. This report was approved by the Ethics Committee of the American Society for Reproductive Medicine and the Board of Directors of the American Society for Reproductive Medicine.

This document was reviewed by ASRM members and their input was considered in the preparation of the final document. The following members of the ASRM Ethics Committee participated in the development of this document. All Committee members disclosed commercial and financial relationships with manufacturers or distributors of goods or services used to treat patients. Members of the Committee who were found to have conflicts of interest based on the relationships disclosed did not participate in the discussion or development of this document.


**REFERENCES**

Examples of Policies and Emerging Practices for Supporting Transgender Students

U.S. Department of Education
Office of Elementary and Secondary Education
Office of Safe and Healthy Students
May 2016
May 2016
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This guide is also available on the Office of Safe and Healthy Students website at www.ed.gov/oese/oshs/emergingpractices.pdf. Any updates to this guide will be available at this website.

If you need technical assistance, please contact the Office of Safe and Healthy Students at: OESE.Info.SupportingTransgenderStudents@ed.gov

Availability of Alternate Formats
Requests for documents in alternate formats such as Braille or large print should be submitted to the Alternate Format Center by calling 202-260-0852 or by contacting the 504 coordinator via e-mail at om_eeos@ed.gov.

Notice to Limited English Proficient Persons
If you have difficulty understanding English you may request language assistance services for Department information that is available to the public. These language assistance services are available free of charge. If you need more information about interpretation or translation services, please call 1-800-USA-LEARN (1-800-872-5327) (TTY: 1-800-437-0833), or e-mail us at ED.Language.Assistance@ed.gov. Or write to U.S. Department of Education, Information Resource Center, LBJ Education Building, 400 Maryland Ave. SW, Washington, DC 20202.
Examples of Policies and Emerging Practices for Supporting Transgender Students

The U.S. Department of Education ("ED") is committed to providing schools with the information they need to provide a safe, supportive, and nondiscriminatory learning environment for all students. It has come to ED’s attention that many transgender students (i.e., students whose gender identity is different from the sex they were assigned at birth) report feeling unsafe and experiencing verbal and physical harassment or assault in school, and that these students may perform worse academically when they are harassed. School administrators, educators, students, and parents are asking questions about how to support transgender students and have requested clarity from ED. In response, ED developed two documents:

- ED’s Office for Civil Rights and the U.S. Department of Justice’s Civil Rights Division jointly issued a Dear Colleague Letter ("DCL") about transgender students’ rights and schools’ legal obligations under Title IX of the Education Amendments of 1972.¹ Any school that has questions related to transgender students or wants to be prepared to address such issues if they arise should review the DCL.

- ED’s Office of Elementary and Secondary Education compiled the attached examples of policies² and emerging practices³ that some schools are already using to support transgender students. We share some common questions on topics such as school records, privacy, and terminology, and then explain how some state and school district policies have answered these questions. We present this information to illustrate how states and school districts are supporting transgender students. We also provide information about and links to those policies at the end of the document, along with other resources that may be helpful as educators develop policies and practices for their own schools.

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² In this document, the term policy or policies refers generally to policies, guidance, guidelines, procedures, regulations, and resource guides issued by schools, school districts, and state educational agencies.

³ ED considers emerging practices to be operational activities or initiatives that contribute to successful outcomes or enhance agency performance capabilities. Emerging practices are those that have been successfully implemented and demonstrate the potential for replication by other agencies. Emerging practices typically have not been rigorously evaluated, but still offer ideas that work in specific situations.
Each person is unique, so the needs of individual transgender students vary. But a school policy setting forth general principles for supporting transgender students can help set clear expectations for students and staff and avoid unnecessary confusion, invasions of privacy, and other harms. The education community continues to develop and revise policies and practices to address the rights of transgender students and reflect our evolving understanding and the individualized nature of transgender students’ needs.

This document contains information from some schools, school districts, and state and federal agencies. Inclusion of this information does not constitute an endorsement by ED of any policy or practice, educational product, service, curriculum or pedagogy. In addition, this document references websites that provide information created and maintained by other entities. These references are for the reader’s convenience. ED does not control or guarantee the accuracy, relevance, timeliness, or completeness of this outside information. This document does not constitute legal advice, create legal obligations, or impose new requirements.
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Student Transitions

1. How do schools find out that a student will transition?

Typically, the student or the student’s parent or guardian will tell the school and ask that the school start treating the student in a manner consistent with the student’s gender identity. Some students transition over a school break, such as summer break. Other students may undergo a gender transition during the school year, and may ask (or their parents may ask on their behalf) teachers and other school employees to respect their identity as they begin expressing their gender identity, which may include changes to their dress and appearance. Some school district or state policies address how a student or parent might provide the relevant notice to the school.

- Alaska’s Matanuska-Susitna Borough School District issued guidelines (“Mat-Su Borough Guidelines”) advising that transgender students or their parents or guardians should contact the building administrator or the student’s guidance counselor to schedule a meeting to develop a plan to address the student’s particular circumstances and needs.

- The guidelines issued by Washington’s Superintendent of Public Instruction (“Washington State Guidelines”) offer an example of a student who first attended school as a boy and, about midway through a school year, she and her family decided that she would transition and begin presenting as a girl. She prefers to dress in stereotypically feminine attire such as dresses and skirts. Although she is growing her hair out and consistently presents as female at school, her hair is still in a rather short, typically boyish haircut. The student, her parents, and school administrators asked her friends and teachers to use female pronouns to address her.

2. How do schools confirm a student’s gender identity?

Schools generally rely on students’ (or in the case of younger students, their parents’ or guardians’) expression of their gender identity. Although schools sometimes request some form of confirmation, they generally accept the student’s asserted gender identity. Some schools offer additional guidance on this issue.

- Los Angeles Unified School District issued a policy (“LAUSD Policy”) noting that “[t]here is no medical or mental health diagnosis or treatment threshold that
students must meet in order to have their gender identity recognized and respected” and that evidence may include an expressed desire to be consistently recognized by their gender identity.

- The New York State Education Department issued guidance (“NYSED Guidance”) recommending that “schools accept a student’s assertion of his/her/their own gender identity” and provides examples of ways to confirm the assertion, such as a statement from the student or a letter from an adult familiar with the student’s situation. The same guidance also offers the following example: “In one middle school, a student explained to her guidance counselor that she was a transgender girl who had heretofore only been able to express her female gender identity while at home. The stress associated with having to hide her female gender identity by presenting as male at school was having a negative impact on her mental health, as well as on her academic performance. The student and her parents asked if it would be okay if she expressed her female gender identity at school. The guidance counselor responded favorably to the request. The fact that the student presented no documentation to support her gender identity was not a concern since the school had no reason to believe the request was based on anything other than a sincerely held belief that she had a female gender identity.”

- Alaska’s Anchorage School District developed administrative guidelines (“Anchorage Administrative Guidelines”) noting that being transgender “involves more than a casual declaration of gender identity or expression but does not require proof of a formal evaluation and diagnosis. Since individual circumstances, needs, programs, facilities and resources may differ; administrators and school staff are expected to consider the needs of the individual on a case-by-case basis.”

3. How do schools communicate with the parents of younger students compared to older transgender students?

Parents are often the first to initiate a conversation with the school when their child is transgender, particularly when younger children are involved. Parents may play less of a role in an older student’s transition. Some school policies recommend, with regard to an older student, that school staff consult with the student before reaching out to the student’s parents.

- The District of Columbia Public Schools issued guidance (“DCPS Guidance”) noting that “students may choose to have their parents participate in the transition process, but parental participation is not required.” The guidance further
recommends different developmentally appropriate protocols depending on grade level. The DCPS Guidance suggests that the school work with a young student’s family to identify appropriate steps to support the student, but recommends working closely with older students prior to notification of family. The guidance also provides a model planning document with key issues to discuss with the student or the student’s family.

- Similarly, the Massachusetts Department of Elementary and Secondary Education issued guidance ("Massachusetts Guidance") that notes: “Some transgender and gender nonconforming students are not openly so at home for reasons such as safety concerns or lack of acceptance. School personnel should speak with the student first before discussing a student’s gender nonconformity or transgender status with the student’s parent or guardian. For the same reasons, school personnel should discuss with the student how the school should refer to the student, e.g., appropriate pronoun use, in written communication to the student’s parent or guardian.”

- Chicago Public Schools' guidelines ("Chicago Guidelines") provide: “When speaking with other staff members, parents, guardians, or third parties, school staff should not disclose a student’s preferred name, pronoun, or other confidential information pertaining to the student’s transgender or gender nonconforming status without the student’s permission, unless authorized to do so by the Law Department.”

- Oregon’s Department of Education issued guidance stating, “In a case where a student is not yet able to self-advocate, the request to respect and affirm a student’s identity will likely come from the student’s parent. However, in other cases, transgender students may not want their parents to know about their transgender identity. These situations should be addressed on a case-by-case basis and school districts should balance the goal of supporting the student with the requirement that parents be kept informed about their children. The paramount consideration in such situations should be the health and safety of the student, while also making sure that the student’s gender identity is affirmed in a manner that maintains privacy and confidentiality.”
Privacy, Confidentiality, and Student Records

4. How do schools protect a transgender student’s privacy regarding the student’s transgender status?

There are a number of ways schools protect transgender students’ interests in keeping their transgender status private, including taking steps to prepare staff to consistently use the appropriate name and pronouns. Using transgender students’ birth names or pronouns that do not match their gender identity risks disclosing a student’s transgender status. Some state and school district policies also address how federal and state privacy laws apply to transgender students and how to keep information about a student’s transgender status confidential.

- California’s El Rancho Unified School District issued a regulation (“El Rancho Regulation”) that provides that students have the right to openly discuss and express their gender identity, but also reminds school personnel to be “mindful of the confidentiality and privacy rights of [transgender] students when contacting parents/legal guardians so as not to reveal, imply, or refer to a student’s actual or perceived sexual orientation, gender identity, or gender expression.”

- The Chicago Guidelines provide that the school should convene an administrative support team to work with transgender students and/or their parents or guardians to address each student’s individual needs and supports. To protect the student’s privacy, this team is limited to “the school principal, the student, individuals the student identifies as trusted adults, and individuals the principal determines may have a legitimate interest in the safety and healthy development of the student.”

- The Mat-Su Borough Guidelines state: “In some cases, a student may want school staff and students to know, and in other cases the student may not want this information to be widely known. School staff should take care to follow the student’s plan and not to inadvertently disclose information that is intended to be kept private or that is protected from disclosure (such as confidential medical information).”

- The Massachusetts Guidance advises schools “to collect or maintain information about students’ gender only when necessary” and offers an example: “One school reviewed the documentation requests it sent out to families and noticed that field trip permission forms included a line to fill in indicating the student’s gender. Upon consideration, the school determined that the requested information was irrelevant to the field trip activities and deleted the line with the gender marker request.”
5. **How do schools ensure that a transgender student is called by the appropriate name and pronouns?**

One of the first issues that school officials may address when a student notifies them of a gender transition is determining which name and pronouns the student prefers. Some schools have adopted policies to prepare all school staff and students to use a student’s newly adopted name, if any, and pronouns that are consistent with a student’s gender identity.

- A regulation issued by Nevada’s Washoe County School District ("Washoe County Regulation") provides that: “Students have the right to be addressed by the names and pronouns that correspond to their gender identity. Using the student’s preferred name and pronoun promotes the safety and wellbeing of the student. When possible, the requested name shall be included in the District’s electronic database in addition to the student’s legal name, in order to inform faculty and staff of the name and pronoun to use when addressing the student.”

- A procedure issued by Kansas City Public Schools in Missouri ("Kansas City Procedure") notes that: “The intentional or persistent refusal to respect the gender identity of an employee or student after notification of the preferred pronoun/name used by the employee or student is a violation of this procedure.”

- The NYSED Guidance provides: “As with most other issues involved with creating a safe and supportive environment for transgender students, the best course is to engage the student, and possibly the parent, with respect to name and pronoun use, and agree on a plan to reflect the individual needs of each student to initiate that name and pronoun use within the school. The plan also could include when and how this is communicated to students and their parents.”

- The DCPS Guidance includes a school planning guide for principals to review with transgender students as they plan how to ensure the school environment is safe and supportive. The school planning guide allows the student to identify the student’s gender identity and preferred name, key contacts at home and at school, as well as develop plans for access to restrooms, locker rooms, and other school activities.
6. How do schools handle requests to change the name or sex designation on a student’s records?

Some transgender students may legally change their names. However, transgender students often are unable to obtain identification documents that reflect their gender identity (e.g., due to financial limitations or legal restrictions imposed by state or local law). Some school district policies specify that they will use the name a student identifies as consistent with the student’s gender identity regardless of whether the student has completed a legal name change.

- The NYSED Guidance provides that school records, including attendance records, transcripts, and Individualized Education Programs, be updated with the student’s chosen name and offers an example: “One school administrator dealt with information in the student’s file by starting a new file with the student’s chosen name, entered previous academic records under the student’s chosen name, and created a separate, confidential folder that contained the student’s past information and birth name.”

- The DCPS Guidance notes: “A court-ordered name or gender change is not required, and the student does not need to change their official records. If a student wishes to go by another name, the school’s registrar can enter that name into the ‘Preferred First’ name field of [the school’s] database.”

- The Kansas City Procedure recognizes that there are certain situations where school staff or administrators may need to report a transgender student’s legal name or gender. The procedure notes that in these situations, “school staff and administrators shall adopt practices to avoid the inadvertent disclosure of such confidential information.”

- The Chicago Guidelines state: “Students are not required to obtain a court order and/or gender change or to change their official records as a prerequisite to being addressed by the name and pronoun that corresponds to their gender identity.”

- The Massachusetts Guidance also addresses requests to amend records after graduation: “Transgender students who transition after having completed high school may ask their previous schools to amend school records or a diploma or transcript that include the student’s birth name and gender. When requested, and when satisfied with the gender identity information provided, schools should amend the student’s record.”
Sex-Segregated Activities and Facilities

7. **How do schools ensure transgender students have access to facilities consistent with their gender identity?**

Schools often segregate restrooms and locker rooms by sex, but some schools have policies that students must be permitted to access facilities consistent with their gender identity and not be required to use facilities inconsistent with their gender identity or alternative facilities.

- The Washington State Guidelines provide: “School districts should allow students to use the restroom that is consistent with their gender identity consistently asserted at school.” In addition, no student “should be required to use an alternative restroom because they are transgender or gender nonconforming.”

- The Washoe County Regulation provides: “Students shall have access to use facilities that correspond to their gender identity as expressed by the student and asserted at school, irrespective of the gender listed on the student’s records, including but not limited to locker rooms.”

- The Anchorage Administrative Guidelines emphasize the following provision: “However, staff should not require a transgender or gender nonconforming student/employee to use a separate, nonintegrated space unless requested by the individual student/employee.”

8. **How do schools protect the privacy rights of all students in restrooms or locker rooms?**

Many students seek additional privacy in school restrooms and locker rooms. Some schools have provided students increased privacy by making adjustments to sex-segregated facilities or providing all students with access to alternative facilities.

- The Washington State Guidelines provide that any student who wants increased privacy should be provided access to an alternative restroom or changing area. The guidelines explain: “This allows students who may feel uncomfortable sharing the facility with the transgender student(s) the option to make use of a separate restroom and have their concerns addressed without stigmatizing any individual student.”
• The NYSED Guidance gives an example of accommodating all students’ interest in privacy: “In one high school, a transgender female student was given access to the female changing facility, but the student was uncomfortable using the female changing facility with other female students because there were no private changing areas within the facility. The principal examined the changing facility and determined that curtains could easily be put up along one side of a row of benches near the group lockers, providing private changing areas for any students who wished to use them. After the school put up the curtains, the student was comfortable using the changing facility.”

• Atherton High School, in Jefferson County, Kentucky, issued a policy that offers examples of accommodations to address any student’s request for increased privacy: “use of a private area within the public area of the locker room facility (e.g. nearby restroom stall with a door or an area separated by a curtain); use of a nearby private area (e.g. nearby restroom); or a separate changing schedule.”

• The DCPS Guidance recommends talking to students to come up with an acceptable solution: “Ultimately, if a student expresses discomfort to any member of the school staff, that staff member should review these options with the student and ask the student permission to engage the school LGBTQ liaison or another designated ally in the building.”

9. How do schools ensure transgender students have the opportunity to participate in physical education and athletics consistent with their gender identity?

Some school policies explain the procedures for establishing transgender students’ eligibility to participate in athletics consistent with their gender identity. Many of those policies refer to procedures established by state athletics leagues or associations.

• The NYSED Guidance explains that “physical education is a required part of the curriculum and an important part of many students’ lives. Most physical education classes in New York’s schools are coed, so the gender identity of students should not be an issue with respect to these classes. Where there are sex-segregated classes, students should be allowed to participate in a manner consistent with their gender identity.”

• The LAUSD Policy provides that “participation in competitive athletics, intramural sports, athletic teams, competitions, and contact sports shall be facilitated in a
manner consistent with the student’s gender identity asserted at school and in accordance with the California Interscholastic Federation bylaws.” The California Interscholastic Federation establishes a panel of professionals, including at least one person with training or expertise in gender identity health care or advocacy, to make eligibility decisions.

- The Rhode Island Interscholastic League’s policy states that all students should have the opportunity to participate in athletics consistent with their gender identity, regardless of the gender listed on school records. The policy provides that the league will base its eligibility determination on the student’s current transcript and school registration information, documentation of the student’s consistent gender identification (e.g., affirmed written statements from student, parent/guardian, or health care provider), and any other pertinent information.

10. How do schools treat transgender students when they participate in field trips and athletic trips that require overnight accommodations?

Schools often separate students by sex when providing overnight accommodations. Some school policies provide that students must be treated consistent with their gender identity in making such assignments.

- Colorado’s Boulder Valley School District issued guidelines (“Boulder Valley Guidelines”) providing that when a school plans overnight accommodations for a transgender student, it should consider “the goals of maximizing the student’s social integration and equal opportunity to participate in overnight activity and athletic trips, ensuring the [transgender] student’s safety and comfort, and minimizing stigmatization of the student.”

- The Chicago Guidelines remind school staff: “In no case should a transgender student be denied the right to participate in an overnight field trip because of the student’s transgender status.”
11. What can schools do to make transgender students comfortable in the classroom?

Classroom practices that do not distinguish or differentiate students based on their gender are the most inclusive for all students, including transgender students.

- The DCPS Guidance suggests that “[w]herever arbitrary gender dividers can be avoided, they should be eliminated.”

- The Massachusetts Guidance states that “[a]s a general matter, schools should evaluate all gender-based policies, rules, and practices and maintain only those that have a clear and sound pedagogical purpose.”

- Minneapolis Public Schools issued a policy providing that students generally should not be grouped on the basis of sex for the purpose of instruction or study, but rather on bases such as student proficiency in the area of study, student interests, or educational needs for acceleration or enrichment.

- The Maryland State Department of Education issued guidelines that include an example of eliminating gender-based sorting of students: “Old Practice: boys line up over here.” New Practice: birthdays between January and June; everybody who is wearing something green, etc.”

12. How do school dress codes apply to transgender students?

Dress codes that apply the same requirements regardless of gender are the most inclusive for all students and avoid unnecessarily reinforcing sex stereotypes. To the extent a school has a dress code that applies different standards to male and female students, some schools have policies that allow transgender students to dress consistent with their gender identity.

- Wisconsin’s Shorewood School District issued guidelines (“Shorewood Guidelines”) that allow students to dress in accordance with their gender identity and remind school personnel that they must not enforce a dress code more strictly against transgender and gender nonconforming students than other students.

- The Washington State Guidelines encourage school districts to adopt gender-neutral dress codes that do not restrict a student’s clothing choices on the basis of gender: “Dress codes should be based on educationally relevant considerations, apply
consistently to all students, include consistent discipline for violations, and make reasonable accommodations when the situation requires an exception.”

13. How do schools address bullying and harassment of transgender students?

Unfortunately, bullying and harassment continue to be a problem facing many students, and transgender students are no exception. Some schools make clear in their nondiscrimination statements that prohibited sex discrimination includes discrimination based on gender identity and expression. Their policies also address this issue.

- The NYSED Guidance stresses the importance of protecting students from bullying and harassment because “[the] high rates experienced by transgender students correspond to adverse health and educational consequences,” including higher rates of absenteeism, lower academic achievement, and stunted educational aspirations.

- The Shorewood Guidelines specify that harassment based on a student’s actual or perceived transgender status or gender nonconformity is prohibited and notes that these complaints are to be handled in the same manner as other discrimination, harassment, and bullying complaints.

- The DCPS Guidance provides examples of prohibited harassment that transgender students sometimes experience, including misusing an individual’s preferred name or pronouns on purpose, asking personal questions about a person’s body or gender transition, and disclosing private information.

14. How do school psychologists, school counselors, school nurses, and school social workers support transgender students?

School counselors can help transgender students who may experience mental health disorders such as depression, anxiety, and posttraumatic stress. Mental health staff may also consult with school administrators to create inclusive policies, programs, and practices that prevent bullying and harassment and ensure classrooms and schools are safe, healthy, and supportive places where all students, including transgender students, are respected and can express themselves. Schools will be in a better position to support transgender students if they communicate to all students that resources are available, and that they are competent to provide support and services to any student who has questions related to gender identity.
• The NYSED Guidance suggests that counselors can serve as a point of contact for transgender students who seek to take initial steps to assert their gender identity in school.

• The Chicago Guidelines convene a student administrative support team to determine the appropriate supports for transgender students. The team consists of the school principal, the student, adults that the student trusts, and individuals the principal determines may have a legitimate interest in the safety and healthy development of the student.

15. How do schools foster respect for transgender students among members of the broader school community?

Developing a clear policy explaining how to support transgender students can help communicate the importance the school places on creating a safe, healthy, and nondiscriminatory school climate for all students. Schools can do this by providing educational programs aimed at staff, students, families, and other community members.

• The Massachusetts Guidance informs superintendents and principals that they “need to review existing policies, handbooks, and other written materials to ensure they are updated to reflect the inclusion of gender identity in the student antidiscrimination law, and may wish to inform all members of the school community, including school personnel, students, and families of the recent change to state law and its implications for school policy and practice. This could take the form of a letter that states the school’s commitment to being a supportive, inclusive environment for all students.”

• The NYSED Guidance states that “school districts are encouraged to provide this guidance document and other resources, such as trainings and information sessions, to the school community including, but not limited to, parents, students, staff and residents.”

16. What topics do schools address when training staff on issues related to transgender students?

Schools can reinforce commitments to providing safe, healthy, and nondiscriminatory school climates by training all school personnel about appropriate and respectful treatment of all students, including transgender students.
• The Massachusetts Guidance suggests including the following topics in faculty and staff training “key terms related to gender identity and expression; the development of gender identity; the experiences of transgender and other gender nonconforming students; risks and resilience data regarding transgender and gender nonconforming students; ways to support transgender students and to improve school climate for gender nonconforming students; [and] gender-neutral language and practices.”

• The El Rancho Regulation states that the superintendent or designee “shall provide to employees, volunteers, and parents/guardians training and information regarding the district’s nondiscrimination policy; what constitutes prohibited discrimination, harassment, intimidation, or bullying; how and to whom a report of an incident should be made; and how to guard against segregating or stereotyping students when providing instruction, guidance, supervision, or other services to them. Such training and information shall include guidelines for addressing issues related to transgender and gender-nonconforming students.”

17. How do schools respond to complaints about the way transgender students are treated?

School policies often provide that complaints from transgender students be handled under the same policy used to resolve other complaints of discrimination or harassment.

• The Boulder Valley Guidelines provide that “complaints alleging discrimination or harassment based on a person’s actual or perceived transgender status or gender nonconformity are to be handled in the same manner as other discrimination or harassment complaints.”

• The Anchorage Administrative Guidelines provide that “students may also use the Student Grievance Process to address any civil rights issue, including transgender issues at school.”
Terminology

18. What terms are defined in current school policies on transgender students?

Understanding the needs of transgender students includes understanding relevant terminology. Most school policies define commonly used terms to assist schools in understanding key concepts relevant to transgender students. The list below is not exhaustive, and only includes examples of some of the most common terms that school policies define.

- **Gender identity** refers to a person’s deeply felt internal sense of being male or female, regardless of their sex assigned at birth. (Washington State Guidelines)

- **Sex assigned at birth** refers to the sex designation, usually “male” or “female,” assigned to a person when they are born. (NYSED Guidance)

- **Gender expression** refers to the manner in which a person represents or expresses gender to others, often through behavior, clothing, hairstyles, activities, voice or mannerisms. (Washoe County Regulation)

- **Transgender or trans** describes a person whose gender identity does not correspond to their assigned sex at birth. (Massachusetts Guidance)

- **Gender transition** refers to the process in which a person goes from living and identifying as one gender to living and identifying as another. (Washoe County Regulation)

- **Cisgender** describes a person whose gender identity corresponds to their assigned sex at birth. (NYSED Guidance)

- **Gender nonconforming** describes people whose gender expression differs from stereotypic expectations. The terms *gender variant* or *gender atypical* are also used. Gender nonconforming individuals may identify as male, female, some combination of both, or neither. (NYSED Guidance)

- **Intersex** describes individuals born with chromosomes, hormones, genitalia and/or other sex characteristics that are not exclusively male or female as defined by the medical establishment in our society. (DCPS Guidance)

- **LGBTQ** is an acronym that stands for “lesbian, gay, bisexual, transgender, and queer/questioning.” (LAUSD Policy)
• **Sexual orientation** refers to a person’s emotional and sexual attraction to another person based on the gender of the other person. Common terms used to describe sexual orientation include, but are not limited to, heterosexual, lesbian, gay, and bisexual. Sexual orientation and gender identity are different. (LAUSD Policy)

19. **How do schools account for individual preferences and the diverse ways that students describe and express their gender?**

Some students may use different terms to identify themselves or describe their situations. For example, a transgender male student may identify simply as male, consistent with his gender identity. The same principles apply even if students use different terms. Some school policies directly address this question and provide additional guidance.

• The Washington State Guidelines recognize how “terminology can differ based on religion, language, race, ethnicity, age, culture and many other factors.”

• Washington’s Federal Way School District issued a resource guide that states: “Keep in mind that the meaning of gender conformity can vary from culture to culture, so these may not translate exactly to Western ideas of what it means to be transgender. Some of these identities include Hijra (South Asia), Fa’aafafine (Samoa), Kathoey (Thailand), Travesti (South America), and Two-Spirit (Native American/First Nations).”

• The Washoe County Regulation, responding to cultural diversity within the state, offers examples of “ways in which transgender and gender nonconforming youth describe their lives and gendered experiences: trans, transsexual, transgender, male-to-female (MTF), female-to-male (FTM), bi-gender, two-spirit, trans man, and trans woman.”

• The DCPS Guidance provides this advice to staff: “If you are unsure about a student’s preferred name or pronouns, it is appropriate to privately and tactfully ask the student what they prefer to be called. Additionally, when speaking about a student it is rarely necessary to label them as being transgender, as they should be treated the same as the rest of their peers.”
Cited Policies on Transgender Students


- Chicago Public Schools (IL), *Guidelines Regarding the Support of Transgender and Gender Nonconforming Students* (2016), [cps.edu/SiteCollectionDocuments/TL_TransGenderNonconformingStudents_Guidelines.pdf](http://cps.edu/SiteCollectionDocuments/TL_TransGenderNonconformingStudents_Guidelines.pdf)


• Massachusetts Department of Elementary and Secondary Education, *Guidance for Massachusetts Public Schools Creating a Safe and Supportive School Environment Nondiscrimination on the Basis of Gender Identity* (2014), www.doe.mass.edu/ssce/GenderIdentity.pdf


• Washoe County School District (NV), *Gender Identity and Gender Non-Conformity – Students* (2015), washoecountyschools.net/csi/pdf_files/5161%20Reg%20%20Gender%20Identity%20v1.pdf
Select Federal Resources on Transgender Students

- U.S. Department of Education
  - Office for Civil Rights, *Publications on Title IX*, [www.ed.gov/about/offices/list/ocr/publications.html#TitleIX](http://www.ed.gov/about/offices/list/ocr/publications.html#TitleIX)
  - Office for Civil Rights, *How to File a Discrimination Complaint*, [www.ed.gov/about/offices/list/ocr/docs/howto.html](http://www.ed.gov/about/offices/list/ocr/docs/howto.html)
  - National Center on Safe Supportive Learning Environments, [safesupportivelearning.ed.gov](http://safesupportivelearning.ed.gov)

- U.S. Department of Health and Human Services
  - Centers for Disease Control and Prevention, *LGBT Youth Resources*, [www.cdc.gov/lgbthealth/youth-resources.htm](http://www.cdc.gov/lgbthealth/youth-resources.htm)

- U.S. Department of Housing and Urban Development
• U.S. Department of Labor

PURPOSE

[Name of] school district is committed to providing a safe, supportive, and inclusive learning environment for all students, including transgender students, and to ensuring that every student has equal educational opportunities and equal access to the District’s educational programs and activities.

New Jersey and federal law (N.J.S.A. 2C:16-1, N.J.S.A. 10:1 et seq, N.J.S.A.18A:37-13 through 17, and Title IX, 20 U.S.C. § 1681) require schools to treat transgender students equally and fairly. State and federal law require school districts to provide equal educational opportunities to all pupils, regardless of the student’s actual or perceived gender identity, gender expression, or gender. This mandate includes access to all programs, activities, and facilities. New Jersey further provides that public schools have an affirmative obligation to combat bias. The New Jersey Law Against Discrimination Gender Identity and Expression amendments of 2007 (N.J.S.A. 10:1 et seq) specify that transgender students have a right to facilities that match their gender identities (e.g., transgender girls have a right to use girls’ rooms, transgender boys have a right to use boy’s rooms; N.J.S.A. 10:5-12(11)(f)(1)). Additionally, federal law under Title IX of the Education Amendments of 1972 (Title IX) generally prohibits discrimination on the basis of sex in federally funded programs and activities (20 U.S.C.§1681(a) (2006)). The United States Department of Education’s Office for Civil Rights (OCR) and the United States Department of Justice’s Civil Rights Division have issued guidance recognizing that Title IX protects transgender and gender nonconforming students.1

This policy sets out guidelines for appropriately addressing the needs of transgender students and complying with applicable anti-discrimination laws. This document does not anticipate every situation that might occur with respect to transgender students, and the needs of each student must be assessed on a case-by-case basis. In all cases, the goal is to ensure the safety, comfort, and healthy development of all students, including transgender students.

DEFINITIONS

These definitions are not meant to label any student, but are intended as functional descriptors. Students may or may not use these terms to describe themselves.

Gender: Socially determined characteristics, roles, behaviors, and attributes a society expects from and considers appropriate for males and females; these characteristics are often referred to as “feminine” and “masculine.”

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Gender expansive: A term that conveys a wider, more flexible range of gender identity and/or expression than typically associated with the binary gender system.

Gender Expression: A person’s gender-related appearance and behavior “whether or not stereotypically associated with the person’s assigned sex at birth” (N.J.S.A. 10:5-5(5)(rr)). It is the manner in which a person represents or expresses their gender to others, such as through their behavior, clothing, hairstyles, activities, voice or mannerisms.

Gender Identity: A person’s internal, deeply held sense of their own gender, regardless of the gender they were assigned at birth. All people have a gender identity, not just transgender people.

Gender Nonconforming: Displaying gender traits that are not consistent with stereotypical characteristics associated with one’s legal sex assigned at birth, or others’ perceptions of that sex. This term can be used to describe people whose gender expression differs from stereotypical expectations about how boys and girls are “supposed to” look or act.

LGBTQ: An umbrella term that stands for “lesbian, gay, bisexual, transgender, and questioning.”

Sexual Orientation: A person’s romantic or sexual attraction to people of the other and/or same gender. (N.J.S.A. 10:1 et seq) Common terms used to describe sexual orientation include, but are not limited to, heterosexual, lesbian, gay, and bisexual. Sexual orientation and gender identity are different. Transgender students may identify as gay, lesbian, bisexual, or heterosexual.

Transgender: A term for people whose gender identity, expression or behavior is different from those typically associated with their assigned sex at birth.

Transition: The process through which a person brings their outer appearance into closer alignment with their gender identity. This process can have a number of different components, including legal, medical, and social, and will look different for each person. Thus, there is no one step or series of steps that "makes" the person who they are. A person is entitled to have their gender identity respected and affirmed based on their declaration alone.

DETERMINING A STUDENT’S GENDER IDENTITY

The responsibility for determining a student’s gender identity rests with the student or, in the case of young students not yet able to advocate for themselves, with the parent or guardian.

A school should accept a student’s asserted gender identity when there is evidence that it is a sincerely held part of the student’s core identity. A school may not question or disregard the student’s assertion of his or her gender identity unless school personnel have a credible basis for believing that the student is asserting a particular gender identity for some improper purpose. In those situations, the school administrator shall document those concerns to the student and
provide the student an opportunity to present documentation or other information demonstrating the sincerity of their gender identity.

There is no threshold medical or mental health diagnosis or treatment requirement that any student must meet in order to have his or her gender identity recognized and respected by a school. The term “gender transition” describes the experience by which a transgender person goes from living as one gender to living and identifying as another. For most transgender youth, the experience of gender transition involves no medical intervention. Rather, most transgender youth will undergo gender transition through a process commonly referred to as “social transition,” whereby they begin to live and identify as the gender consistent with their gender identity. Some transgender youth who are close to reaching puberty, or after commencing puberty, may complement social transition with medical intervention under the care of a physician. Whether such interventions are available or appropriate will depend on the unique circumstances of each individual.

Similarly, a student is not required to have obtained a court-ordered name or gender change in order to have his or her requested name and gender identity recognized and respected by a school.

PROHIBITION OF DISCRIMINATION

No person shall be subjected to discrimination on the basis of actual or perceived gender identity, gender expression, gender, or sexual orientation. (N.J.S.A. 10:1 et seq, 20 U.S.C. § 1681 (Title IX))

PRIVACY

All persons, including students, have a right to privacy: the right to decide when, with whom, and how much highly personal information one wants to share about oneself to others. This includes the right to control dissemination of highly personal and private information such as one’s transgender status or sexual orientation.

District and school personnel should not disclose a student’s transgender status to others, including, but not limited to, other students, parents, and/or other school personnel, unless they are legally required to, or the student has authorized such disclosure, or there is a specific and compelling “need to know” in order to protect the transgender student’s interests. In those rare circumstances where disclosure is deemed to be absolutely necessary, before making any disclosure, school officials should inform the transgender student of the need to disclose and provide them with the opportunity and resources they may need to make the disclosure themselves.

District and school personnel may encounter situations where a transgender student has not disclosed their transgender status to their parents. Whenever possible, school administrators should speak with the student to confirm the manner in which the student will be referred to in conversation with the parent/guardian. Generally, when contacting the parent or guardian of a transgender student, school personnel should use the student’s legal name and the gender
pronoun that corresponds to their legal sex, unless the student, parent, or guardian has specified otherwise.

All students, including transgender students, have the right to openly discuss and express their gender identity or transgender status and to decide when, with whom, and how much to share that private information. In sharing this information, a student does not give up the right to privacy and at no time may the school use a student’s self-disclosure as grounds for sharing information about the student’s gender identity or transgender status without the student’s written permission.

**NAMES/PRONOUNS**

Should a student or parent/legal guardian request to have the student addressed by a name and pronoun different from those associated with the student’s sex at birth, the school will honor that request and set expectations for their consistent use. District and school officials may not require proof of a court-ordered name or gender change before honoring such a request. Districts and schools should also endeavor to proactively adapt student information systems to accommodate requested names and pronouns to prevent inadvertently revealing information that would violate the student’s privacy.

While inadvertent slips or honest mistakes in the use of names or pronouns may occur, staff or students intentionally and persistently refusing to respect a student’s gender identity by using the wrong name and gender pronoun is discriminatory and is a violation of this policy.

**SCHOOL RECORDS**

School Districts are required to maintain an official, permanent pupil record with the legal name and gender appearing on the student’s birth certificate. A student’s legal name is not determined solely by their birth certificate, New Jersey recognizes common law name changes even for students under the age of 18 with parental consent. However, a school district’s obligation to treat a student in accordance with their gender identity does not hinge on the students ability to obtain a court-ordered or other type of official name or gender marker change. Thus, irrespective of the student’s permanent pupil file, on all other school-related records or documents, at the request of the student or with the consent of the student’s parent/legal guardian (unless the student is over 18), schools should use a transgender student’s requested name, gender marker, and gender pronoun. This would include physical records and documents, diplomas and other certificates of advancement, electronic records and documents, and school IDs. Every effort should be made to update student records with the student’s correct name and gender marker, and not to circulate records with the student’s assigned birth name or gender marker. Schools should also identify routine areas where a transgender student’s privacy could be violated by the improper usage of the legal name and gender marker. These include but are not limited to pre-printed labels, standardized tests, student IDs or library cards, lunch tickets, school photos, notices from the main office, attendance slips, grade books, posted lists of student names, lesson plans, seating charts and roll sheets used by substitute teachers, and any other places where students’ names are commonly written.
In order to protect the student’s privacy, and to prevent accidental disclosure of a student’s transgender status, the school should maintain the official, permanent pupil record in a secure location, separate from the student’s other records. If the official record is maintained electronically, similar security measures should be implemented to protect student privacy.

In the event that a student identifies as transgender, but is unable to obtain consent from a parent or legal guardian, a school administrator should meet with the student to discuss how the student would like to be addressed at school and implement a plan to ensure that the student’s privacy is protected.

When a student or parent/legal guardian presents the school with documentation of a court-ordered legal name and/or gender change, the school must then change the official, permanent pupil record, to reflect the student’s new legal name and gender.

Transgender students who transition after having graduated may ask their previous schools to amend school records or a diploma or transcript that include the student’s birth name and gender. When requested, schools should amend the student’s record, including reissuing a high school diploma or transcript, to reflect the student’s current name and gender.

RESTROOM AVAILABILITY

Schools may maintain separate restroom facilities for male and female students. However, students shall have access to the restroom that corresponds to their gender identity (N.J.S.A. 10:5-12(1)(f)(1)).

Where available, a single stall, “gender neutral” restroom (such as in the health office) may be used by any student who desires increased privacy, regardless of the underlying reason. The use of such a “gender neutral” restroom shall be a matter of choice for a student and no student shall be compelled to use such a restroom.

As a proactive measure, administrators should take steps to identify private gender-neutral restrooms on their campus, as well as to de-stigmatize the use of such private options. Establishing clear guidelines and expectations with regards to students’ physical privacy and boundaries is also important. Both can be reinforced through language in student handbooks, posted expectations, and through orientation and other processes for familiarizing students and guardians to the school and its facilities.

LOCKER ROOM ACCESSIBILITY

Schools may maintain separate locker room facilities for male and female students. However, students shall have access to the locker room facility that corresponds to their gender identity.

If any student has a need or desire for increased privacy or safety, regardless of the underlying reason, they may be provided access to a reasonable alternative changing area or locker room such as:
Use of a private area in the public area of the locker room facility (i.e., a nearby restroom stall with a door, an area separated by a curtain, or a P.E. instructor’s office in the locker room).

A separate changing schedule (either utilizing the locker room before or after other students).

Use of a nearby private area (i.e., a nearby restroom or a health office restroom).

However, use of such an alternative changing space shall be a matter of choice for a student and no student shall be compelled to use such an alternative. School administrators should also work to de-stigmatize the use of such options, as well as to establish clear guidelines and expectations with regard to respecting privacy and boundaries in changing areas and other close quarters.

SPORTS AND PHYSICAL EDUCATION CLASSES

Transgender students shall be permitted to participate in physical education classes, intramural sports, and competitive athletic activities in a manner consistent with their gender identity. This is consistent with New Jersey and federal law as well as the policies established by the New Jersey State Interscholastic Athletic Association (NJSIAA). For rules and procedures governing sports eligibility for transgender student-athletes, please review the NJSIAA Handbook, available at www.njsiaa.org.

DRESS CODES/SCHOOL UNIFORM POLICIES

All students have the right to dress in accordance with their gender identity and gender expression. School dress code and uniform policies should be gender-neutral, and should not restrict students’ clothing choices on the basis of gender or traditional stereotypes about what males and females “should” wear.

HARASSMENT AND BULLYING

Each school must ensure that all students, including transgender students, are provided a safe and supportive learning environment that is free of discrimination, harassment, and bullying.

Administrators, faculty and staff are required to intervene when they witness discrimination, harassment, or bullying of any student if they can do so safely.

Complaints alleging discrimination, harassment or bullying based on a student’s gender identity, gender expression, or gender nonconformity, are to be handled with the same seriousness as other discrimination/harassment/bullying complaints. Complaints alleging discrimination or harassment based on a student’s gender identity, gender expression, or gender nonconformity should be given immediate attention; fully and appropriately investigated in a timely manner; and resolved through appropriate corrective action.
Sample discretionary Policy*

*Sample discretionary policies compiled and distributed by NJSBA are not model district policies or suggested best practices and should not be adopted without district revisions and consultation with your board attorney.

Based on guidance from the NYC Department of Education found at:  (http://schools.nyc.gov/RulesPolicies/TransgenderStudentGuidelines/default.htm)

**gender identity and expression**

The board of education believes that a school culture that supports student achievement, respects the values of all students and fosters understanding of gender identity and expression within the school community is a safe learning environment. New Jersey law and district policy require that all programs, activities, and employment practices be free from discrimination based on sex, sexual orientation, gender identity or gender expression. Therefore in keeping with these mandates the board is committed to creating a safe learning environment for all students and to ensure that every student has equal access to all school programs and activities.

The board believes that fostering this understanding successfully requires cooperation and good communication between the parents/guardians, school administration, school staff and the school community. The chief school administrator shall ensure that students with gender identity or expression concerns and their parents/guardians shall be given the opportunity to discuss these issues and participate in the educational planning and programing for their student. The chief school administrator may consult the experiences and expertise of qualified school staff as well as external resources where appropriate.

To proactively plan for a safe learning environment free of discrimination and harassment students and parents/guardians of students with gender identity and expression concerns are encouraged to alert the school district and schedule a meeting with the chief school administrator. Upon request, the chief school administrator shall schedule a meeting with the parent/guardian and the student for the purpose of evaluating the needs of the student and planning any accommodations that may be considered to facilitate a respectful and comfortable school program that supports the student’s achievement.

**Definitions:**

A. “Gender Identity” is a person's deeply held sense or psychological knowledge of their own gender, regardless of the gender they were assigned at birth. Everyone has a gender identity.

B. “Transgender” is a term which describes people whose gender identity or gender expression is different from their assigned gender at birth.

C. “Gender expression” refers to the way a person expresses gender to others in ways that are socially defined as either masculine or feminine, such as through behavior, clothing, hairstyles, activities, voice or mannerisms.

D. “Gender non-conforming” refers to gender-related identity and/or gender expression which does not conform to the social expectations or norms for a person of that gender assigned at birth.

E. “Transition” refers to the process in which a person goes from living and identifying as one gender to living and identifying as another.

**Harassment, Intimidation and Bullying**
The board shall make every effort to maintain a safe and supportive learning and educational environment that is free from harassment, intimidation, and/or bullying and free from discrimination on account of actual or perceived race, color, national origin, ancestry, age, sex, affectional or sexual orientation, gender identity or expression, marital status, domestic partnership status, nationality, atypical hereditary cellular or blood trait of any individual, genetic information, or refusal to submit to a genetic test or make the results of a genetic test known, disabilities, social or economic status, pregnancy, childbirth, pregnancy-related disabilities, actual or potential parenthood, family status or other distinguishing characteristic.

Complaints alleging discrimination shall be reported to the school affirmative action officer according to board policies (2224, 4111.1/4211.1 and 6121 Nondiscrimination/Affirmative Action).

Any student experiencing or observing harassment, intimidation and bullying is encouraged to report the incident to a member of school staff. Any staff member observing or receiving a report of harassment, intimidation or bullying shall report the incident to the principal the same day the incident is observed or the report received according to board policy 5131.1 Harassment, Intimidation and Bullying. All reported incidents of discrimination, harassment, intimidation, and bullying shall be promptly investigated and resolved according to law and board policy.

Confidentiality and Privacy

School personnel may not disclose information that may reveal a student's transgender or gender non-conforming status, except as allowed by law. Under the Family Education Rights Privacy Act (FERPA), only those school employees with a legitimate educational need may have access to a student's records or the information contained within those records. Disclosing confidential student information to other employees, students, parents, or other third parties may violate privacy laws, including but not limited to FERPA. Transgender students have the ability, as do all students, to discuss and express their gender identity and expression openly and decide when, with whom, and how much of their private information to share with others.

Students who do not want their parents/guardians to know about their transgender status shall be addressed on a case-by-case basis. In some cases, notifying parents/guardians carries risks for the student, such as being kicked out of the home. Prior to notification of any parent or guardian regarding the transition process, school staff should work closely with the student to assess the degree to which, if any, the parents/guardians will be involved in the process and must consider the health, well-being, and safety of the transitioning student. The school counselor shall balance the rights of the student needing support and the requirement that parents/guardians be kept informed about their child. In accordance with law, parents/guardians and/or the appropriate local officials shall be informed when there is any suspicion of injury or harm to the student or other students.

Coordination of School Accommodations

In planning appropriate accommodations for a student who is transitioning, the chief school administrator, parents/guardians and the student and other qualified staff or consultants as necessary shall meet to discuss actions that the district and school personnel may take to create safe learning environment, including:

A. Names/Pronouns

School staff shall be directed to address the student by the name and pronoun corresponding to their gender identity that is consistently asserted at school. Students are not required to obtain a court ordered name and/or gender change or to change their pupil personnel records as a prerequisite to being addressed by the name and pronoun that corresponds to their gender identity. To the extent possible and consistent with these guidelines, school personnel shall make efforts to maintain the confidentiality of the student's transgender status.

School documentation such as student IDs shall be issued in the name that reflects a student’s gender identity that is consistently asserted at school.
B. Sports and Physical Education

Transgender students shall be provided the same opportunities to participate in physical education as are all other students. Generally, students may be permitted to participate in physical education and sports in accordance with the student's gender identity that is consistently asserted at school. Participation in competitive interscholastic athletic activities will be resolved on a case-by-case basis and according to the standards established by the New Jersey State Interscholastic Athletic Association (NJSIAA).

C. Restroom and Locker Room Accessibility

The district aims to support transgender students while also ensuring the safety and comfort of all students. The chief school administrator together with the parents/guardians, student and other qualified staff or consultants shall evaluate options for the use of restrooms and locker rooms by the transgender students and consider the following factors, including, but not limited to:

1. The transgender student's preference;
2. Protecting student privacy;
3. Maximizing social integration of the transgender student;
4. Minimizing stigmatization of the student;
5. Ensuring equal opportunity to participate;
6. The student's age; and
7. Protecting the safety of the students involved.

Generally students may have access to the restroom or locker room that corresponds to the gender identity or expression that they consistently assert at school and no student shall be forced to accept an accommodation with which he/she disagrees. A transgender or transitioning student who expresses a need or desire for increased privacy may be provided with reasonable alternative arrangements. Reasonable alternative arrangements may include the use of a private area, or a separate changing schedule, or use of a single stall, gender neutral restroom. Any alternative arrangement shall be provided to the extent possible in a way that protects the student's ability to keep his or her transgender status confidential.

A transgender student should not be required to use a locker room or restroom that conflicts with the student's gender identity or expression consistently asserted at school.

D. Gender Segregation in Other Areas

As a general rule, in any other circumstances where students are separated by gender in school activities (i.e. overnight field trips), students may be permitted to participate in accordance with the gender identity or expression consistently asserted at school. Activities that may involve the need for accommodations to address student privacy concerns will be addressed on a case-by-case basis considering the factors set forth above.

E. Dress Code

Students have the right to dress in accordance with their gender identity or expression that is consistently asserted at school, within the constraints of the school policy for student dress (5132 Student Dress). School staff shall not enforce a school's dress code more strictly against transgender and gender nonconforming students than other students.

F. Privacy

The chief school administrator and/or his or her designees are expected to work closely with the student and his or her parents/guardians in formulating an appropriate plan regarding the confidentiality of the student's transgender or transitioning status that works for both the student and the school. Privacy considerations may also vary with the age of the student.
Where the transgender or transitioning student feels more supported and safe when other students are aware that they are transgender or transitioning, school staff shall be given guidance and training appropriate for facilitating a respectful school climate. School personnel may be directed to work closely with the student, parents/guardians, other family members and other staff members on a plan to inform and educate the student’s peers. It may also be appropriate to engage external resources to assist with educational efforts.

**Resources for Transgender or Transitioning Students**

If a school staff member observes that a gender identity issue is creating challenges for a student at school or if a student indicates an intention to transition, the staff member shall alert the school counselor and encourage the student to meet with the school counselor if appropriate. School staff shall make every effort to support the student and encourage the support and respect of student peers and staff during school.

When a student indicates an intention to transition, the school counselor, as appropriate, shall offer assistance and provide the student, and/or their parents/guardians as appropriate, with information, resources and referral services regarding the issues associated with gender identity and expression and/or formal gender transition. The school counselor shall also provide information regarding gender transition planning at school. The counselor shall coordinate the measures planned and taken at school for supporting the student and creating a sensitive supportive environment at school. These measures may include:

A. Making resources available to parents/guardians who have additional questions or concerns;
B. Developing age-appropriate lessons for students about gender diversity and acceptance; and
C. Staff training surrounding vigilance to prevent possible harassment, intimidation and bullying issues that may arise for transgender or transitioning students.

Reports of harassment, intimidation and bullying shall be promptly investigated and resolved according to board policy 5131.1 Harassment, Intimidation and Bullying.

**Official Records**

To the extent that the school is not legally required to use a student’s legal name or gender on school records and other documents, the school shall use the name and gender preferred by the student.

Each school is required to maintain a permanent student record of each student, which includes the legal name of the student as well as the student’s biological gender. In addition, schools are required to use a student's legal name and gender on standardized tests and reports to the State Education Department.

A student’s permanent student record may be changed to reflect a change in legal name or gender only upon receipt of documentation that such legal name and/or gender have been changed pursuant to applicable law. The following documentation may be provided:

A. A court order or birth certificate demonstrating the student’s new name.
B. For a legal change of gender, the student must provide a birth certificate indicating the student’s legal gender, or a valid passport indicating the student’s legal gender.

Adopted:

**Key Words**

Gender Identity, Transgender, Gender Expression, Gender Non-conforming
Legal References:

N.J.S.A. 2C:16-1 Bias intimidation
N.J.S.A. 2C:33-4 Harassment
N.J.S.A. 10:5-1 et seq. Law Against Discrimination
N.J.S.A. 18A:6-5 Inquiry as to religion and religious tests prohibited
N.J.S.A. 18A:26-1.1 Residence requirements prohibited
N.J.S.A. 18A:37-14 Harassment, intimidation, and bullying defined; through -19 definitions
N.J.S.A. 18A:36-20 Discrimination; prohibition
N.J.A.C. 6A:7-1.1 et seq. Managing for Equality and Equity in Education
N.J.A.C. 6A:30-1.1 et seq. Evaluation of the Performance of School Districts
N.J.A.C. 6A:32-12.1 Reporting requirements
N.J.A.C. 6A:32-14.1 Review of mandated programs and services

Executive Order 11246 as amended


20 U.S.C.A. 1681 - Title IX of the Education Amendments of 1972


Comprehensive Equity Plan, New Jersey Department of Education

Doe v. Regional School Unit 26, No. 12-582 (Me. Jan. 30, 2014)

NJSIAA, Constitution, Bylaws, Rules and Regulations, Transgender Policy (pg. 75), http://www.njsiaa.org/resources/njsiaa-handbook

Possible Cross References: *2224 Nondiscrimination/affirmative action
*4111 Recruitment, selection and hiring
*4111.1 Nondiscrimination/affirmative action
*4131/4131.1 Staff development; inservice education/visitations/conferences
*4211 Recruitment, selection and hiring
*4211.1 Nondiscrimination/affirmative action
*4231/4231.1 Staff development; inservice education/visitations/conferences
*5131 Conduct/discipline
*5131.1 Harassment, intimidation and bullying
*5145.4 Equal educational opportunity
*6121 Nondiscrimination/affirmative action
*6145 Extracurricular activities


The following organizations provide support to transgender individuals:

- **GLSEN** (The Gay, Lesbian, Straight Education Network) model policy. GLSEN is a prominent organization supporting GLBT youth. They have resources about creating safe and supportive environments for students.

- **The Trevor Project** is the leading national organization focused on crisis and suicide prevention efforts among lesbian, gay, bisexual, transgender and questioning youth.
Resources For Parents, Educators, And Service Providers:

Founded in 1972 with the simple act of a mother publicly supporting her gay son, PFLAG is the nation's largest family and ally organization.

PFLAG Resources

• Welcoming our Trans Families and Friends
  Download this free guide (PDF) to get the basics on what being transgender means, how to talk about it, and how to find the resources that can support you.

• Find a PFLAG Chapter
  There are more than 350 chapters of Parents, Families and Friends of Lesbians and Gays (PFLAG) across the U.S. Find one near you right now.

Partner Organizations Resources

• National Center for Transgender Equality
  Knowing and using correct language can be very important to transgender and gender non-conforming people, just like everyone else. Here is a handy terminology guide regarding gender identity.

• American Psychological Association
  This downloadable pamphlet from the APA answers questions about transgender people, gender identity and gender expression.

Parent and Educator Resources

• Gender Spectrum
  Raising children who don’t fit neatly into male or female boxes brings a wealth of questions and uncertainties. Here you will find information and support to assist you in your search for answers.

• Trans Youth Equality Foundation
  The Trans Youth Equality Foundation is based in Maine, but offers education, advocacy and support for transgender and gender non-conforming children and youth and their families everywhere by sharing information about the unique needs of this community and partnering with families, educators and service providers to help foster a healthy, caring, and safe environment for all transgender children.

• Families in TRANSition: A Resource Guide for Parents of Trans Youth
  Families in TRANSition: A Resource Guide for Parents of Trans Youth is the first comprehensive Canadian publication (created by Central Toronto Youth Services) to address the needs of parents and families supporting their trans children. It summarizes the experiences, strategies, and successes of a working group of community consultants – researchers, counselors, parents, advocates as well as trans youth themselves.

• Matt Kailey, author of My Child is Transgender: 10 Tips for Parents of Adult Trans Children
  This gentle and easy-to-use FAQ gives people an accessible set of guidelines that can be used in everyday life.

• Working with Transgender Youth (Lambda Legal & Child Welfare League of America)
  Like all young people in care, transgender youth are entitled to bias-free attention to their unique needs and to be safe in their placements and services. This guide, created by Lambda Legal and the Child Welfare League of America, provides child welfare professionals who work with transgender young people with education about transgender issues and tools to help prepare them to work sensitively with these clients.

• Trans Youth Family Allies (TYFA)
  TYFA works to empower children and families by partnering with educators, service providers and communities, to develop supportive environments in which gender may be expressed and respected. They envision a society free of suicide and violence in which all children are respected and celebrated.
Boy or Girl: Who Gets To Decide? Gender-Nonconforming Children in Child Custody Cases

David Alan Perkiss*

I. INTRODUCTION: GENDER IDENTITY DISORDER IS RECOGNIZED IN CHILDREN

Six-year-old Bradley was diagnosed with gender identity disorder in children: Bradley was assigned male at birth and identifies as a girl. However, Bradley’s treatment plan prohibits her from playing with Barbie or Polly Pocket dolls, dressing as Dorothy from *The Wizard of Oz*, or playing with girls. With these restrictions, Bradley is clingy, is sent into crying fits by the smallest provocation, sneaks away and hides to play with dolls, and “really struggles with the color pink.” Bradley’s mother reported, “[H]e’s like an addict. He’s like, ‘Mommy, don’t take me there! Close my eyes! Cover my eyes! I can’t see that stuff; it’s all pink!’”

Also consider Marty, who is biologically female and identifies as male. When breast buds first appeared, Marty exclaimed, “Mommy, feel this lump! You have to do something!” It is easy to see that Bradley and Marty’s struggles with gender identity are difficult to endure when Bradley is not allowed to perform her gender identity and Marty begins to develop physically into the gender he rejects. As a transgender adult woman described her experience as a gender-nonconforming child,

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1. See infra Part II.A for definition of gender identity disorder in children.


3. Id.


5. Throughout this paper, I attempt to use the gender pronoun associated with the gender that the subject self-identifies.
“[transsexuality] hurts like hell until it is remedied. . . . [T]he loss of years of desired experiences can never be remitted.”

Transgender youth, like Bradley and Marty, have few routes to appropriate treatment without support of their parents. The Transgender Law Center recognized that when separated parents disagree about whether to support their gender-nonconforming children in their felt genders, especially as more transgender youth come out at earlier ages, disagreement leads to renewed custody challenges. This disagreement was adjudicated in the custody dispute Smith v. Smith. This essay analyzes Smith and applies to cases involving gender-nonconforming children, regardless of a court’s finding of gender identity disorder in children (“GIDC”), since courts may erroneously conclude that a child fails to meet the diagnostic criteria for GIDC.

This essay contributes to a growing discussion in the legal academy about transgender youth. As one scholar observed, “Only one federal judge has explicitly disavowed, with specific reference to children, the state’s interest in fostering heterosexuality.” An increasingly visible

7. For the purposes of this paper, “youth” means individuals under the age of 18, because at 18, individuals are considered legally emancipated from their parents and may direct their own medical care.
8. Amanda Kennedy, Because We Say So: The Unfortunate Denial of Rights to Transgender Minors Regarding Transition, 19 HASTINGS WOMEN’S L.J. 281 (2008).
discussion about gender identity and sexual orientation in youth also appears in some state legislatures.\^14

This essay argues that presenting evidence in favor of supporting a gender-nonconforming child’s felt gender identity and debunking evidence rejecting it is of utmost importance because trial courts have broad discretion in evaluating evidence in child custody cases regarding parental medical decision-making authority, to which appellate courts overwhelmingly defer. Part II argues that medical information about transgender youth shows that early treatment in support of a child’s gender nonconformity is appropriate. Part III shows that trial courts have wide discretion in making custody decisions involving parental decision-making authority regarding a child’s health care. Further, appellate courts overwhelmingly defer to trial court rulings in these cases. Therefore, the trial court’s assessment of medical testimony and ruling are most important in these cases. Part III analyzes two custody disputes involving disagreements between parents over whether and how to treat their gender-nonconforming children.

This essay concludes by suggesting that attorneys should be careful about advocating for the best interest of gender-nonconforming children, and providing expert testimony that includes a clear GIDC diagnosis and recognizes appropriate medical treatment. Additionally, advocates should educate trial and appellate court judges to improve the judges’ understanding of the issues facing transgender children, including appropriate treatment recognized by mainstream medical institutions. Advocates should also show judges that they should give less weight to expert testimony advocating rejection of a child’s nonconforming gender identity.

II. MEDICAL INFORMATION ABOUT TRANSGENDER YOUTH SHOWS THAT EARLY TREATMENT IS APPROPRIATE

A. THE DIAGNOSTIC CRITERIA THAT COURTS USE TO DETERMINE THE PRESENCE OF GENDER IDENTITY DISORDER IN CHILDREN ARE ESTABLISHED

In child custody disputes involving gender-nonconforming children, courts consider expert testimony to determine whether the child at issue has

gender identity disorder ("GID"). Individuals are formally designated as suffering from GID when they meet the specified criteria appearing in the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition ("DSM"). In general terms, the DSM describes GID as appearing in "those with 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." Depending on age, such individuals may be diagnosed with GID in adults, adolescents, and children. To be diagnosed with GID in children, GIDC, a patient must meet four criteria.


16. THE HARRY BENJAMIN INTERNATIONAL GENDER DYSPHORIA ASSOCIATION, STANDARDS OF CARE FOR GENDER IDENTITY DISORDERS 2 (6th ed. 2001), available at http://www.wpath.org/Documents/socv6.pdf [hereinafter HBIGDA Standards of Care]. At the time of this writing, the DSM-IV was the most recent version of the DSM. DSM-V replaced GID with "Gender Dysphoria" and made other substantive changes. These modifications do not change this article’s analysis and ultimate conclusions since medical decision-making authority in custody disputes is analyzed the same way under either version of the DSM and since advocates should educate judges about transgender youth under either version of the DSM. Gender Dysphoria, AMERICAN PSYCHIATRIC ASS’N (2013), available at http://www.dsm5.org/Documents/Gender%20Dysphoria%20Fact%20Sheet.pdf.

17. HBIGDA Standards of Care, supra note 16, at 4.


19. “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 at least 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; 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; 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.” Kenneth J. Zucker, The DSM Diagnostic Criteria for Gender Identity Disorder in Children, 39 ARCH. SEX BEHAV. 477, 481 (2009), available at http://www.dsm5.org/Documents/Sex%20and%20GID%20Lit%20Reviews/GID/ZUCKERDSM.pdf. In his paper, Zucker argues that the criteria for diagnosis for GID should be “tighter” to allow mental health professionals to better distinguish between GID and mere gender-nonconforming behaviors. Notably, Zucker is a proponent of enforcing normative gender roles as a treatment for GIDC.
B. TRANSGENDER YOUTH SUFFER SIGNIFICANT PHYSICAL AND PSYCHOLOGICAL HARMs, ESPECIALLY WHEN THEIR FAMILIES EXHIBIT REJECTING BEHAVIORS TOWARDS THEM

Transgender youth are at high risk for significant physical and psychological harms, and practicing harmful behaviors that adversely affect their overall well-being.20 Moreover, studies show that transgender youth are at higher risk for such harms than other categories of gender-nonconforming (e.g., lesbian, gay, or bisexual) youth.21 The risk is especially high when families exhibit rejecting behaviors toward their transgender children, such as pressuring a child to conform his or her gender expression to his or her biological gender.22 Mental health research supports these conclusions. In particular, the mental health difficulties that transgender individuals frequently experience “typically arise from conflict with the external environment . . . rather than from internal pathology.”23 Further, researchers failed to find “the often-assumed association between transsexualism and psychopathology.”24


22. CAITLIN RYAN, SUPPORTIVE FAMILIES, HEALTHY CHILDREN: HELPING FAMILIES WITH LESBIAN, GAY, BISEXUAL & TRANSGENDER CHILDREN (2009), available at http://familyproject.sfsu.edu/files/English_Final_Print_Version_Last.pdf. The study’s findings are applicable to all gender-nonconforming youth, including transgender children. The study measured well-being by considering the children’s risk for depression, suicide, substance abuse, HIV, and sexually transmitted diseases. The study concluded, “Transgender . . . children who are supported by their families have higher self-esteem, a more positive sense of the future[,] and are at lower risk for [physical] health and mental health problems as young adults. They also have greater life satisfaction and well-being than those who lack family support or who are rejected by their families.” Id. at 17. The study found that transgender youth who were highly rejected by their parents and caregivers were more than 8 times as likely to have attempted suicide, nearly 6 times as likely to report high levels of depression, more than 3 times as likely to use illegal drugs, and more than 3 times as likely to be at high risk for HIV and sexually transmitted diseases. Id. at 5. Moreover, even in families that exhibited only moderately rejecting behavior, transgender youth were significantly more likely to be at risk for attempting suicide, using illegal drugs, and contracting HIV. Id. at 6–7. The study defines “moderately rejecting” as “had some negative reactions to their . . . transgender child – but also had some positive reactions.” Id. at 6.


24. Id. In other words, being transgender does not inherently constitute a mental disorder. Rather, conflict with the external environment, such as parents pressuring their child to conform to his or her biological gender, causes the mental health difficulties in transgender individuals.
Mental health research also found that the difficulties for transgender youth increase in magnitude and frequency with age, especially when the children are prevented from beginning to transition. As transgender youth become increasingly self-aware with age, they “suffer discomfort, even despair,” as they recognize their bodies fail to conform to their internal gender identity. These harms increase with age as “[t]hey have to cope with . . . living with a self-concept that is never socially acknowledged or reinforced.” Further, when transgender youth attempt to conform their gender expression to their bodies, their motivation is often to please their families, which may not reflect a permanent change in gender identity. Moreover, delaying gender transition until adulthood leaves transgender children knowing that they will have to await treatment, which causes feelings of hopelessness that hinder social, psychological, and intellectual development.

C. FAMILY ACCEPTING BEHAVIORS AND EARLY TREATMENT OF GIDC CAN REDUCE HARMs AFFLICTING TRANSGENDER YOUTH

Families’ avoiding rejecting behaviors and, instead, exhibiting accepting behaviors reduces the risk of physical and psychological harms in transgender youth. For example, a study recommended avoiding rejecting behaviors such as “[b]locking access to LGBT friends, events & resources,” “[p]ressuring your child to be more (or less) masculine or feminine,” and “[m]aking your child keep their LGBT identity a secret in the family and not letting them talk about it.” Instead, the study recommended deploying accepting behaviors such as “support[ing] your child’s gender expression,” “support[ing] your child’s LGBT identity even though you may feel uncomfortable,” “advocat[ing] for your child when he or she is mistreated because of their LGBT identity,” “believ[ing] your child can have a happy future as an LGBT adult,” and “requir[ing] that other family members respect your LGBT child.”

The study concluded that supporting transgender children in their nonconforming gender identity, despite disagreeing with it, is the best way

25. Shield, supra note 23, at 383.
27. Shield, supra note 23, at 383.
29. RYAN, supra note 22, at 8. The study recommends avoiding the following additional rejecting behaviors: hitting, slapping or physically hurting your child because of their LGBT identity; verbal harassment or name-calling because of your child’s LGBT identity; excluding LGBT youth from family and family activities; blaming your child when they are discriminated against because of their LGBT identity; telling you child that God will punish them because they are gay; and telling your child that you are ashamed of them or that how they look or act will shame the family.
30. RYAN, supra note 22, at 9. The study recommends deploying the following additional accepting behaviors: talk with your child or foster child about their LGBT identity; connect your child with an LGBT adult role model to show them options for the future; and welcome your child’s LGBT friends and partners to your home.
to behave. The study found that many parents feel conflicted and lack knowledge on how to help their transgender child. Parents may want to discourage or change their children’s transgender identity because of a fear that others may try to hurt their children because of their nonconforming gender expression.\textsuperscript{31} However, support will help transgender children develop a sense of self-worth and self-esteem. Developing a sense of self-worth and self-esteem builds transgender children’s inner strength that they can use to deal with discrimination and rejection from others.\textsuperscript{32} Further, developing self-esteem and attendant coping skills reduces the physical and mental health risks associated with family rejection.

D. PUBERTY-BLOCKING HORMONE THERAPY CAN REDUCE HARMs IN TRANSGENDER YOUTH

Early treatment of GIDC in the form of puberty-blocking hormones can also reduce the risk of harms facing transgender youth.\textsuperscript{33} Early commencement of sex reassignment by administering puberty-blocking hormones may be appropriate because puberty causes physical changes that are erased only with great difficulty, if at all, at a later age.\textsuperscript{34} Therefore, delaying sex reassignment until adulthood makes transitioning more difficult, less convincing, more expensive, and more invasive.\textsuperscript{35} In the interim, such as during adolescence and early adulthood, a transgender individual who has not received puberty-blocking hormones may experience extreme anxiety in anticipation of transitioning. In fact, a primary cause of mental health issues for postoperative transgender individuals is imperfect physical outcomes.\textsuperscript{36} Thus, faithfully presenting in accordance with their affirmed gender identity contributes to transgender individuals’ self-confidence in their ability to “pass” for their affirmed sex.\textsuperscript{37}

\begin{thebibliography}{9}
  \bibitem{31} RYAN, supra note 22, at 9–12.
  \bibitem{33} This treatment is consistent with the Family Acceptance Project’s recommendations because it is a form of supporting a transgender child’s gender expression. As its research has show, “families need to create a nurturing and supportive environment long before they know who their children will become.” See RYAN, supra note 22, at 2.
  \bibitem{34} See, e.g., Shield, supra note 23, at 378 (citing Henk Asscherman & Louis J.G. Gooren, \textit{Hormone Treatment in Transsexuals}, 5 J. PSYCHOL. & HUMAN SEXUALITY 39 (1992)) (finding that studies found that certain physical characteristics “cannot be redressed [by hormone treatment] once they have reached their final size at the end of puberty.”) For example, for transgender adults assigned male at birth, greater height, jaw shape, size and shape of hands and feet, and narrow pelvis cannot be changed to resemble a feminine body. Additionally, hormone treatment does not satisfactorily redress male-type facial hair or low-pitch voice. Similarly for transgender adults assigned female at birth, hormone treatment cannot redress lower height, broader hips, or breast size.
  \bibitem{35} JULIA SERANO, \textit{WHIPPING GIRL: A TRANSEXUAL WOMAN ON SEXISM AND THE SCAPEGOATING OF FEMININITY} 229 (Seal Press 2007).
  \bibitem{36} Shield, supra note 23, at 379.
  \bibitem{37} See SERANO, supra note 35, at 176 (discussing and critiquing the term “passing” in
\end{thebibliography}
Where advanced transition in the form of body-altering surgery is inappropriate for a transgender minor, a doctor may prescribe hormones to delay the physical changes caused by puberty. \(^{38}\) The Harry Benjamin International Gender Dysphoria Association’s Standards of Care for Gender Identity Disorders (“HBIGDA Standards of Care”), considered a touchstone for diagnosing and treating GID, justifies this treatment not only to avoid the harms associated with commencing transition as an adult but also to give subjects time to explore their gender identity further. Importantly, this treatment is fully reversible: Once halted, puberty will recommence as usual without adverse consequences. \(^{39}\) Because the effects of puberty are virtually irreversible, initiating the treatment at or even before puberty commences is crucial to the treatment’s success and, therefore, appropriate. \(^{40}\)

the context of transgender individuals).

38. HBIGDA Standards of Care, supra note 16. Specifically, LHRH agonists or medroxyprogesterone suppress estrogen or testosterone production or action that causes puberty.


E. OPPONENTS OF A CHILD’S NONCONFORMING GENDER IDENTITY AND PUBERTY-BLOCKING HORMONE THERAPY ADVOCATE A DANGEROUS TREATMENT THAT MAINSTREAM MEDICAL INSTITUTIONS DEBUNKED

Opponents of puberty-blocking hormone treatment claim that it is damaging to the health and well-being of gender-nonconforming youth. They believe that supporting children’s nonconforming gender identity exacerbates the harms the children face because their gender identity further subjects them to ridicule and rejection by their peers and society at large and is a sign of internal distress. However, more thorough analysis shows that the harms result from external factors, rather than internal pathology. Opponents also believe that administering hormone therapy in youth can cause sterilization. However, opponents of hormone therapy fail to distinguish between puberty-blocking hormone therapy and hormone therapy that promotes the development of characteristics associated with one gender or the other: It is the latter that may cause sterilization because once puberty-blocking hormone therapy ceases, sexual maturation will restart.

Additionally, opponents believe that hormone therapy is unnecessary because when most gender-nonconforming youth reach adulthood, they identify as homosexual, not transgender. Therefore, the opponents question whether and how early puberty-blocking hormone treatment should be administered. However, the opponents fail to recognize the risk that denying puberty-blocking hormone therapy to gender-nonconforming youth forces them to develop into a gender that may not conform to their gender identity as an adult. Because the effects of puberty are virtually impossible to erase, the opponents deprive the individual of a critical


43. As Dr. Norman Spack, who has treated over 95 gender-nonconforming children with GIDC with puberty-blocking hormone therapy, stated, “We’re talking about a population that has the highest rate of suicide attempts in the world, and it’s strongly linked to nontreatment, especially if they are rejected within their family for being who they think they are.” Bella English, Led By the Child Who Simply Knew, BOSTON GLOBE (Dec. 11, 2011), at A1, available at http://bostonglobe.com/metro/2011/12/11/led-child-who-simply-knew/5SH1UpNr9JrAtunDxal/story.html. Dr. Norman Spack is a co-founder of the Children’s Hospital Gender Management Services Clinic, established in 2007.
choice during their development and foreclose the option of a more
successful transition as an adult.\footnote{Chloe Johnson, \textit{Transgender Teens: Doctors Refine Hormone, Other Therapies}, \textit{Foster's Daily Journal} (Jan. 27, 2008), http://www.fosters.com/apps/pbcs.dll/article?AID=/20080127/GJNEWS_01/205304745/-1/FOSNEWS (quoting Anne Boedecker, “You don’t have to rush to assign kids a gender. It really needs to be driven by the child.” Children are more likely to accept a gender-nonconforming peer’s gender transition when the transition commences at an earlier age.).} Moreover, transgender youth experiencing puberty become extremely distressed by the onset of physical characteristics associated with the gender they reject.\footnote{Sana Loue, \textit{Faith-Based Mental Health Treatment of Minors: A Call for Legislative Reform}, 31 J. LEGAL MED. 171, 181 (2010). Reparative therapy is often carried out by extreme faith-based institutions. “[In a 2003 letter to the editor] in the \textit{Journal of the American Academy of Child and Adolescent Psychiatry} [Dr. Simon Pickstone-Taylor] called [Dr. Zucker’s reparative therapy] techniques ‘something disturbingly close to reparative therapy for homosexuals,’ and author Phyllis Burke has questioned the idea that transgendered children should be treated as mentally ill.” Japhy Grant, \textit{Dr. Kenneth Zucker’s War on Transgenders}, QUERETY (Feb. 6, 2009), http://www.queerty.com/dr-kenneth-zuckers-war-on-transgenders-20090206/ (citing Simon D. Pickstone-Taylor, \textit{Children With Gender Nonconformity}, 423 J. AM. ACAD. OF CHILD AND ADOLESCENT PSYCH. 266 (2003); Phyllis Burke, \textit{Gender Shock: Exploding the Myths of Male and Female} (1996)). In addition, proponents of this type of therapy in children are aligned with the National Association for Research and Therapy of Homosexuality (“NARTH”), which advocates reparative therapy in homosexual adults. Stephanie Wilkinson, \textit{Drop the Barbie! If You Bend Gender Far Enough, Does It Break?}, \textit{BRAIN, CHILD: THE MAGAZINE FOR THINKING MOTHERS} (2001), reprint available at http://ai.eecs.umich.edu/people/conway/TS/News/Drop%20the%20Barbie.htm#Article.}

Opponents favor another form of treatment, which is essentially
“conversion” or “reparative” therapy.\footnote{Mathew D. Staver, \textit{Transsexualism and the Binary Divide: Determining Sex Using Objective Criteria}, 2 LIBERTY U. L. REV. 459, 506 (2008) (describing reparative therapy as “instill[ing] positive identification of the child with the child’s biological sex.”). It is important to understand Staver’s homo- and trans-phobic perspective. He is the founder and chairman of Liberty Counsel, a public interest litigation, education, and policy organization, and dean and professor of law at Liberty University School of Law, a conservative Christian and notoriously anti-LGBT university. Sunnivie Brydum, \textit{Mat Staver Calls Sen. Rob Portman and Other Pro-Gay Republicans ‘Cockroaches’[sic]}, \textit{ADVOCATE} (Mar. 29, 2013, 6:15 PM), http://www.advocate.com/politics/marriage-equality/2013/03/29/listen-mat-staver-calls-sen-rob-portman-and-other-pro-gay.} Proponents of conversion therapy characterize it as a way of helping gender-nonconforming children become more secure with their sex assigned at birth to reduce the harms associated with expressing a nonconforming gender identity.\footnote{See generally Benjamin Kaufman, \textit{Why Narth? The American Psychiatric Association’s Destructive and Blind Pursuit of Political Correctness}, 14 REGENT U. L. REV. 423 (2002). Dr. Kaufman is a professor and clinical practitioner of psychiatry, and is a founding officer of NARTH. NARTH characterizes itself as an “organization that offers hope to those who struggle with unwanted homosexuality.” NARTH MISSION STATEMENT, http://ai.eecs.umich.edu/people/conway/TS/News/Drop%20the%20Barbie.htm#Mission}. Generally, proponents of conversion therapy believe that gender nonconformity is morally wrong and that gender-nonconforming individuals can adjust their behavior and identity accordingly, based on tenets of conservative Judeo-Christian religions.\footnote{Opponents of conversion therapy characterize it as a program ... and that gender nonconforming children become more secure with their sex assigned at birth to reduce the harms associated with expressing a nonconforming gender identity. Generally, proponents of conversion therapy believe that gender nonconformity is morally wrong and that gender nonconforming individuals can adjust their behavior and identity accordingly, based on tenets of conservative Judeo-Christian religions. Opponents of conversion therapy characterize it as a program...}
of psychotherapy that attempts to “cure” individuals of their non-normative gender identity by directing them to conform to traditional gender norms.\textsuperscript{49} The methods deployed in conversion therapy include behavioral therapy, such as depriving a gender nonconforming boy of toys associated with girls and female playmates.\textsuperscript{50} Methods also include “electrical shock therapy, chemical aversive therapy, drug and hormone therapy, surgery, and psychotherapy.”\textsuperscript{51}

While both proponents and opponents of conversion therapy believe that early treatment is beneficial and are motivated by the health and well-being of children, mainstream medical institutions oppose conversion therapy.\textsuperscript{52} Conversion therapy causes significant internal harms in otherwise healthy gender-nonconforming children, including suicide, self-mutilation, nervous breakdowns, paranoia, feelings of guilt, and post-traumatic stress disorder, and it has a low “success rate.”\textsuperscript{53} Conversion therapy may be more dangerous for youth than for adults.\textsuperscript{54} Also, conversion therapy for children may constitute legal neglect\textsuperscript{55} and could be considered analogous to bleaching a black child’s skin to appear Caucasian to avoid social ostracism. Overall, conversion therapy has been discredited by the mainstream medical community, and much healthier treatments are available. Accepting children’s nonconforming gender identity and allowing them to begin to transition, or at least giving them time to determine their gender identity by using puberty-blocking hormones, make a gender-nonconforming child much more physically and mentally healthy.

III. THE ISSUE OF PARENTS’ MEDICAL DECISION-MAKING AUTHORITY REGARDING THEIR CHILDREN ARISES IN CUSTODY DISPUTES

A. TRIAL COURTS HAVE WIDE DISCRETION IN RESOLVING DISPUTES AROUND PARENTAL DECISION-MAKING AUTHORITY REGARDING A CHILD’S HEALTH CARE AND APPELLATE COURTS OVERWHELMINGLY DEFER TO TRIAL COURTS IN THESE CASES

Disagreements between parents over whether and how to initiate their child’s medical care arise in custody disputes. Trial courts have broad
discretion in determining the outcome of such disputes because they must base their findings on the inherently broad best-interests-of-the-child standard. In some states, the parent who has the majority of physical custody presumptively has ultimate decision-making authority regarding a child’s major medical treatment when the parents disagree with each other.\textsuperscript{56} Additionally, decision-making authority need not be equal and may be divided between parents based on the best interests of the child.\textsuperscript{57} Moreover, appellate courts overwhelmingly defer to and rarely overturn the trial court decisions for abuse of discretion in these cases. Therefore, presenting persuasive evidence and winning at the trial court level are imperative to favorable outcomes for parents who want to support their gender-nonconforming children in their nonconforming gender identity.

In \textit{Johnson v. Johnson}, the parents disagreed over what type of prosthesis to provide for their child whose hand was amputated.\textsuperscript{58} The mother wanted to provide a hand-like prosthesis, and the father, a hook-like one.\textsuperscript{59} The trial court based its ruling on the father’s own testimony that most amputees preferred a hook and reported that experts advised the use of a hook.\textsuperscript{60} The trial court also based its decision on its findings that the father was a pediatrician, was concerned about the child’s welfare, and had taken a course on juvenile amputees.\textsuperscript{61} Thus, the trial court ruled in favor of the father and awarded him ultimate medical decision-making authority.\textsuperscript{62} On appeal, the court ruled that the trial court did not abuse its discretion because the trial court found the father’s testimony credible.\textsuperscript{63} The appellate court did not articulate what, if any, countervailing evidence the mother proffered.\textsuperscript{64}

In \textit{Winters v. Brown}, the parents disagreed over whether to immunize their child.\textsuperscript{65} The father wanted to have the child vaccinated, and the


\textsuperscript{57} Mars v. Mars, 729 N.Y.S.2d 20, 22 (N.Y. App. Div. 2001) (holding that dividing decision-making authority is appropriate when each parent takes an active interest in the child’s life, that both parents remain involved is in the child’s best interest, and when neither parent can be trusted not to obstruct the other’s relationship with the child). Generally, courts will not completely deprive a noncustodial parent, who is otherwise to remain fully involved with the child’s life, of decision-making authority in all areas of a child’s care.

\textsuperscript{58} Johnson v. Johnson, 78 Wis. 2d 137, 149 (1977). Notably, in dissent, Justice Abrahamson stated, “I would have the trial court consider the wishes of the child involved; the views of a twelve-year old as to her prosthesis are, to my mind, worthy of careful attention.” \textit{id.} at 160. Notably, too, Justice Abrahamson recognized the larger role of sex stereotypes in family law matters. \textit{id.} at 159.

\textsuperscript{59} \textit{id.} at 149.

\textsuperscript{60} \textit{id.}

\textsuperscript{61} \textit{id.}

\textsuperscript{62} \textit{id.} at 148.

\textsuperscript{63} \textit{id.} at 148–49.

\textsuperscript{64} \textit{id.}

mother objected to vaccinations based on her religious beliefs. The trial court based its ruling on the expert testimony of three doctors. Two of the doctors testified that vaccinations are safe and effective in preventing infections. The doctors also testified that postponing vaccinations results in increased risk of infections for the child and the other children who interact with the child at school and at play. The third doctor testified that vaccinations may cause abnormal neurological development and concluded that it is less risky not to immunize children. Thus, the trial court awarded the father ultimate responsibility for the child’s health care. Because the prevailing party presented competent, substantial expert testimony about the benefits and harms of vaccinations, the appellate court affirmed the trial court’s ruling, even though the other party also presented competent, substantial evidence.

In In re Marriage of Jaeger, the parents disagreed over the type of professional who would provide mental health counseling to their child. The father wanted the child to receive counseling through his Christian Science church, based on his religious beliefs. The mother wanted the child to receive counseling through a non-Christian Science professional, which the trial court ordered and the mother ratified. The trial court found that the father failed to present evidence that the child’s physical health would be endangered or emotional development significantly impaired by ordering the treatment through a non-Christian Science professional. Thus, the appellate court found no error.

In McGrath v. Mountain, the parents disagreed over whether to immunize their child. The father wanted to immunize the child, and the mother, a chiropractor who used holistic medicine and homeopathy in treating her son, opposed immunization. At trial, the father presented testimony as to the benefits of immunization, and the mother presented

67. Id. at *658 n.1.
68. Brown, 51 So. 3d 656, at *658 n.1.
69. Id.
70. Id. at *658.
71. Id.
73. Id. at *581.
74. Id. at *581–582.
75. Id. The finding was based on Colorado statute § 14-10-130(1), C.R.S. (1987 Repl. Vol. 6B), under which “the custodial parent has the right to determine the child’s health care and religious training, even if the noncustodial parent disagrees.” The statute is modeled on Uniform Marriage and Divorce Act, which was “designed to promote family privacy and prevent intrusions upon the prerogatives of the custodial parent at the request of the noncustodial parent.” § 408. [Judicial Supervision]. Unif. Marriage & Divorce Act § 408 (Comment) (1973).
76. McGrath v. Mountain, 784 So. 2d 607 (Fla. Dist. Ct. App. 2001). This case originated as a paternity action, and the parties eventually stipulated as to the alleged father’s paternity.
77. Id. at *608.
evidence to support her position on both medical and religious grounds. The appellate court found that the parties presented conflicting positions on immunization, each supported by "competent, substantial evidence," which the trial court properly weighed and ruled thereon. Therefore, even though both parties presented competent, substantial evidence, the appellate court found no error in the trial court’s ruling.

Overall, trial courts have wide discretion in making custody decisions involving parental decision-making authority regarding a child’s health care under the best-interests standard. Trial courts also have broad discretion when evaluating expert testimony and choosing between various, equally competent, substantial evidence. Additionally, appellate courts overwhelmingly defer to the trial court’s assessment of evidence and rarely overturn trial court decisions for abuse of discretion, the applicable, high standard of review, in these cases. Therefore, presenting persuasive expert evidence and winning at trial are essential to a favorable ultimate outcome.

B. ANALYSIS OF CUSTODY CASES INVOLVING PARENTS’ MEDICAL DECISION-MAKING AUTHORITY FOR GENDER-NONCONFORMING CHILDREN: SMITH AND SHRADER

Similar to the cases described above, disputes involving medical decision-making authority for gender-nonconforming children arise in custody trials. In these cases, the trial courts similarly evaluated medical expert testimony, to which the appellate courts deferred, to determine custody based on the best interests of the child. However, in these cases, the trial courts appeared to have evaluated the expert testimony without appropriately vetting the experts or full knowledge of GIDC and the treatment options. These cases reveal that in the absence of appropriate experts and information, courts favor the parent who rejects the child’s nonconforming gender identity.

In Smith v. Smith, the parents disagreed over whether to support their child in her gender identity and contested custody. The child was assigned male at birth and “exhibited signs from a very early age that he wanted to be treated as a girl.” The mother supported the child in her female gender identity by allowing her to wear girl’s clothing, go by the name Christine, participate in transgender support groups, and generally to

78. Documents from the trial court proceedings are unavailable, so the content of the evidence is unknown.
79. McGrath, 784 So. 2d at *608.
80. Id.
82. Id. at 1. The trial court found that the child displayed some female tendencies as early as age two.
be treated as a girl. Additionally, the mother was considering puberty-blocking hormone therapy for the child as treatment for the child’s alleged GIDC. The father, in contrast, wanted to treat the child as a boy.

Upon the dissolution of marriage in 2001, when Christine was approximately six years old, the mother was designated the child’s residential parent, and the father was granted standard visitation. When the mother moved towns in 2004 and enrolled the child in a new school as a girl, the father requested the trial court change custody. The trial court ultimately designated the father as the residential parent. On appeal, the court found no error in the trial court proceedings and affirmed the trial court’s ruling.

While the trial was pending, the trial court issued an emergency temporary order for the mother “to stop any treatment for counseling for gender disorder; to stop the child from attending transgender support groups; to stop addressing the boy as Christine or any other female name; and to stop allowing or encouraging him to wear girl’s clothing.” The trial court also prohibited the parties from treating the child for GIDC during the pendency of the trial. However, the mother violated the order by taking Christine to a swimming pool dressed in a girl’s swimsuit and continuing to refer to her with feminine pronouns and names. Thus, the trial court criticized the mother for violating the temporary order and for “clouding the issue of what [the child’s] feelings would have been at this point had Mother been more supportive of [the child’s] masculine identity or even remained neutral.

The trial court found that Christine did not have GIDC, despite her affirmation of her female gender identity to her parents. In a 2003 email to her father, Christine stated “God made a mistake” about her gender and included photographs of herself dressed in girl’s clothing. Additionally, in a 2004 videotape she sent to her father, Christine explained her gender to her father: that she “is a girl, wants to be a girl, and that [she] would live a normal life as a girl . . . [wants to] wear girl’s clothes all the time . . . [is] a girl even if s[he] does not have all the body parts of a girl . . . [and wants to] go to school as a girl.”

84. Id. at 9.
85. Id. The child was born on September 28, 1994.
86. Id. at 1.
87. Id. at 2.
88. Id.
89. Id.
90. Id.
91. Id. at 4.
92. Id.
93. Id. at 13.
94. Id. at 5–6.
95. Id. at 6–7.
In considering the GIDC\textsuperscript{96} diagnosis, the trial court relied on four witnesses’ expert testimony concerning the DSM criteria. The father called two expert witnesses, who rejected a GIDC diagnosis.\textsuperscript{97} The mother also called two expert witnesses, who affirmed a GIDC diagnosis.\textsuperscript{98} The trial court concluded that two of the doctors found GIDC and two did not. Also, the trial court found that none of the doctors recommended the hormone therapy, at least not without further study.\textsuperscript{99} Moreover, the trial court conducted its own investigation into a GIDC diagnosis, finding that Christine did not have GIDC.\textsuperscript{100} After hearing the expert testimony and conducting its own investigation, the trial court entered a temporary judgment that ordered residential custody divided between the parents and prohibited the parents from treating the child as a girl. The trial court then called Mark King, Ph.D., to perform psychological evaluations to aid in

\textsuperscript{96} Smith v. Smith, No. 05-JE-42, 2007 LEXIS 1282, 8–9. Although the courts in Smith used the term “GID,” they were actually referring to GIDC because they found that the expert witnesses were using the DSM criteria for GIDC.

\textsuperscript{97} Whether these doctors diagnosed or treated other individuals with GIDC is unknown. One, Dr. Warren Thockmorton, Ph.D., met with the child only twice and concluded that the child did not have GIDC and recommended against puberty-blocking hormone therapy. Dr. Thockmorton based his conclusion on finding that two of the DSM factors were present, one was partially present, and two were absent. Id. at 10. The trial court gave great weight to Dr. Thockmorton’s testimony because it found that his evaluation closely tracked to the DSM criteria for GIDC. The other, Dr. Richard Fitzgibbons, M.D., met separately with the father and child once. Id. He also concluded that the child did not have GIDC and opposed the hormone therapy, but recommended counseling. The trial court discounted Dr. Fitzgibbons’s testimony because it found it to be a “mixture of psychology and religion.” Id. at 10–11.

\textsuperscript{98} One, Dr. Gregory Lehne, Ph.D., had been treating the child since 2003. Dr. Lehne diagnosed the child with GIDC and recommended the hormone therapy. The trial court discounted his testimony because it found that his diagnosis did not track to the DSM criteria, and he appeared to recant his testimony during cross-examination when he said that more study was necessary to determine the diagnosis and treatment. Id. at 11. The other, Dr. Richard Pleak, M.D., met separately with the mother and child once. Dr. Pleak testified that he personally treated about 100 people with GID, that exhibiting cross-gender behavior at a very early age is typical for individuals with GID, that children over the age of 10 continue to manifest signs of GID into adulthood, that children with GIDC change their gender performance to conform with their sex assigned at birth to avoid conflict with others, and, ultimately concluded that the child met the DSM criteria for GIDC. However, the trial court discounted his testimony because it found that he did not “sufficiently rely” on the DSM criteria and stated that further study was needed to determine appropriate treatment. Id. at 11–12.

\textsuperscript{99} Id.

\textsuperscript{100} At the trial judge’s in camera interview of the child, the trial judge “observed that the child acted like a girl only when he was around his mother, and seemed to have no trouble behaving like a typical boy when he was with his father.” Id. at 33. The trial court judge “did not sense anything particularly feminine” about the child and found that the child had “little interest in being a girl other than in his desire to wear girl’s clothing.” Id. at 31–32. The trial court also found that the child enjoyed stereotypical male activities such as wrestling, playing video games, and shooting a BB gun. Id. at 14. The trial court also found that the child had only male friends and could not name any female heroes or idols. Id. Additionally, the trial judge personally reviewed the child’s video and did not believe the child exhibited female characteristics in it. Id.
making its final decision. Dr. King concluded that the positive GIDC diagnosis was mistaken and that the hormone therapy was inappropriate.\textsuperscript{101} Ultimately, the court found that the child did not have GIDC and prohibited the hormone therapy.

Since Dr. King’s testimony served as a “tiebreaker,” his statements were important. Regarding the GIDC diagnosis, the court appears to have mischaracterized Dr. King’s testimony. When asked whether the child has GIDC, Dr. King actually stated, “I have almost no opinion on that.”\textsuperscript{102} Also, Dr. King appeared to have interviewed the child only once, and then let approximately six months pass before he compiled his report. It is also unknown whether Dr. King diagnosed or treated other individuals for GIDC. Further, throughout Dr. King’s testimony, the mother’s attorney\textsuperscript{103} failed to ask questions concerning Dr. King’s diagnosis and recommended course of action. This failure was probably detrimental because the attorney could have attempted to expose any unfair bias and assumptions, the doctor’s lack of expertise, and failures and inconsistencies in his diagnostic methodology, if present.\textsuperscript{104}

The trial court’s evaluation of the expert testimony is troubling because the testimony it gave weight to was from doctors who interviewed the child very few times and did not establish whether they diagnosed or treated other individuals with GIDC. The trial judge’s personal evaluation of the child is also troubling because the judge himself lacked experience in dealing with children with GIDC. Furthermore, the facts surrounding a child’s gender identity, particularly in the context of a gender-nonconforming child exploring medical treatment for GIDC, are not subject to judicial notice.\textsuperscript{105} Additionally, the judges in other medical decision-making authority cases did not undertake a personal investigation. The trial judge’s personal evaluation also appears to have been uninformed. The trial court’s finding that the child behaved like a “typical boy” around her father could be explained by social pressure to conform their gender expression to traditional gender norms.\textsuperscript{106} Additionally, the trial court’s finding that “the change of environment [from supportive mother to

\textsuperscript{101} Smith v. Smith, No. 05-JE-42, 2007 LEXIS 1282, 16.
\textsuperscript{102} Transcript of Proceedings at 9, Smith v. Smith, No. 05-JE-42, 2007 LEXIS 1282 (2007) (No. 01-86) [hereinafter Transcript].
\textsuperscript{103} It is worth noting that the proceedings were held at the attorneys’ offices based in or near Steubenville, Ohio, which supports a notoriously conservative Christian population, which is likely biased against LGBT individuals.
\textsuperscript{104} Transcript, supra note 102, at 14-27.
\textsuperscript{105} See, e.g., Fed. R. of Evid. 201. Such facts are certainly not “generally known” in the context of the rules governing judicial notice. So too, such facts are not “accurately and readily determined from sources whose accuracy cannot reasonably be questioned” because, as discussed throughout, expert medical testimony on diagnosis and treatment of GIDC is clearly disputed.
\textsuperscript{106} See, e.g., GREYTAK, supra note 21, at 91. Schools can reinforce gender conformity through every day practices and policies.
rejecting father)\textsuperscript{107} would influence the child’s gender identity is erroneous because the consensus of the psychological profession is that gender identity is determined by innate, not external factors.\textsuperscript{108}

The trial court’s finding and the appellate court’s affirming that hormone therapy was an inappropriate treatment and deciding “that by making [the father] the residential parent, the child would be permitted to find out if he . . . really was a transgender child” is misguided. The more logical and prudent course of treatment would have been to proceed with hormone treatment because its effects are reversible and have no known negative consequences.\textsuperscript{109} Thus, the court’s decision actually foreclosed Christine’s options, rather than maintain them as it thought it did.

Further, by affirming the trial court order for the child to become “disassociated with that lifestyle,” it essentially ordered the child to undergo conversion therapy, despite the absence of a GIDC diagnosis and not explicitly ordering conversion therapy. By prohibiting the child from expressing her female gender identity, ordering the child enroll in school as a boy, and ordering the child to live with the unsupportive father as the sole residential parent, the court expressed its view that the gender-nonconforming child should become more comfortable with her biological gender.\textsuperscript{110}

However, the appellate court affirmed the trial court’s ruling that the child should not be treated for GIDC. The appellate court maintained the possibility that the mother could request a change in custody, and therefore support her child’s female gender identity, if circumstances later changed.\textsuperscript{111} The court’s recommendation, however, is misguided. Because the child was 12-years-old at the time of the ruling, she was likely then experiencing puberty at Tanner Stage Two, where she would have been developing irreversible physiological traits commonly associated with the male gender, the gender she rejected. Administering puberty-blocking hormone therapy later would likely have been ineffective to reduce the male physical traits she already developed. Even so, the appellate court deferred to the trial court’s evaluation of the evidence in this case and, for this reason, declined to overturn its ruling.

\textsuperscript{108} See supra Part II.
\textsuperscript{109} See discussion of hormone therapy supra Part II.D. With hormone treatment administered early, the child could arrest puberty and take more time to consider her gender identity. However, without hormone therapy at this age around Tanner Stage Two, the possibility of later transitioning would be substantially more difficult.
\textsuperscript{110} See supra Part II.D. These prohibitions and orders track closely to the dangerous reparative therapy that opponents of puberty-blocking hormone therapy deploy to treat children with GIDC.
\textsuperscript{111} The court offered two conditions that would constitute a change in circumstances in this case: “the onset of puberty . . . or a more clear and concise medical diagnosis.” Smith, No. 05-JE-42, 2007 LEXIS 1282, at *81.
Similarly, in *Shrader v. Spain*, the parents disagreed over whether their gender-nonconforming, natal male child had GIDC and should undergo treatment. Little information about the proceedings in *Shrader* is available, but the holding further demonstrates the court’s preference to award custody to the parent who rejects the child’s nonconforming gender identity. The trial court found that the child in question “was diagnosed with gender identity disorder, a serious medical condition.” The court based this conclusion on the testimony of two psychologists who testified that the mother’s accepting behaviors and home environment were problematic. Accordingly, the trial court awarded custody to the father, who rejected the child’s nonconforming gender identity. The trial court also, however unwittingly, effectively ordered the child to undergo conversion therapy: having gender-nonconforming children exist in a space to reinforce their sex assigned at birth is precisely the program of conversion therapy, and what the *Shrader* court ordered. The appellate court found that the record supported the trial court’s ruling, and deferred to the trial court’s decision to award custody to the rejecting father.

### C. How Bias Enters the Decision-Making Process in Gender Nonconforming Child Custody Cases

*Smith* and *Shrader*, the only two publicly available cases adjudicating this type of disagreement, can be generalized to show the likely decision calculus that judges will deploy to determine custody in cases involving gender-nonconforming youth. Notably, these cases were initiated by the unsupportive parent. These cases reveal that three possible lines of decision-making are available to courts in custody cases where a parent is in dispute with another parent about whether to support their child’s nonconforming gender identity, and neither the child nor anyone else is a party.

In the first scenario, initially, a court will determine whether the child is clinically diagnosed with GIDC. If a court finds no GIDC diagnosis, it will suggest that it is not pathologizing the child and is not ordering treatment. Additionally, the court will find that the child is being harmed by living in an environment where a parent supports the child’s nonconforming gender identity. Thus, the court will award residential custody to the rejecting parent.

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114. *Id.* Dr. Doyle “testified that [the child] had not made as much progress in therapy as she had hoped, and that [the child’s] home environment would be important to his therapy.” *Id.* Dr. Otis “testified that Wife was unable to admit that [the child] had a problem, and that [the child] needed to separate his identity from his mother’s.” *Id.*
115. *Id.* at *1.
116. These cases are published but unreported, and are the only such cases available at the time of this writing.
117. See generally Sarah Valentine, *When Your Attorney Is Your Enemy: Preliminary Thoughts on Ensuring Effective Representation for Queer Youth*, 19 COLUM. J. GENDER & L.
custody and medical decision-making authority to the parent who rejects the child’s nonconforming gender identity. Here, the court also effectively orders the child to undergo conversion therapy. This scenario represents the decision-making process in Smith.

In the second scenario, a court will also initially determine whether the child is clinically diagnosed with GIDC. The court will then find GIDC to be present and find that treatment is appropriate. Additionally, similar to the first scenario, the court will find that the child is being harmed by living in an environment where a parent supports the child’s nonconforming gender identity. Thus, like the first scenario, the court will award custody to the rejecting parent and effectively order reparative therapy. The second scenario represents the decision-making process in Shrader.

The third scenario closely tracks the second scenario until the court decides on the source of harm. Here, the court will find that commencing a physical gender transition is appropriate and that the child benefits from living with the supportive parent. Thus, the court will have the supportive parent maintain custody. Later in this scenario, the court will allow the gender-nonconforming child to begin a treatment regimen of puberty-blocking hormone therapy, giving the child time to determine his or her gender identity independently. This scenario has not been represented in a published decision.

Significantly, the decision points in all versions of this analytical framework turn on medical determinations: GIDC diagnosis and appropriate treatment options. Additionally, all scenarios result in effectively ordering some kind of treatment, regardless of whether a judge explicitly orders treatment. The treatment options described above are to a large extent environmental, “nurture versus nature.” Children have two options: to be placed in either a supportive or rejecting environment.

Similarly, a judge adjudicating these cases has two choices: award custody and medical decision-making authority to either the supportive parent or the rejecting parent. If to the supportive parent, children undergo treatment that would help them become comfortable in their nonconforming gender identity. If to the rejecting parent, children undergo treatment, forcing them to reject their nonconforming gender identity.

Significantly, only one scenario, the third, provides for custody to the supportive parent. The other two scenarios provide for custody to the unsupportive parent, even though one scenario finds GIDC and the other

773 (2010). “In addition, a child may be treated as queer or ‘potentially queer’ by those who imbue harm in children being raised in a queer or ‘non-traditional’ environment.” Id. at 773 n.2.

118. See supra Part II for a discussion of how courts can effectively order conversation therapy.

119. See supra Part II for a discussion of puberty-blocking hormone therapy.

120. Rachmilovitz, supra note 12, at 28 (criticizing the gendered assimilation demands in the home and articulating an argument favoring self-determination of gender in children).
does not. Notably, these two scenarios provide for conversion therapy: the first does so implicitly and the second, explicitly. Therefore, sheer probability suggests that a court is unlikely to find in favor of the supportive parent.

In addition to probability, scholarship about legal issues surrounding gender-nonconforming individuals suggests that bias and stereotypes also play a role in the outcomes of these custody cases. For example, one study found,

like the old theory of homosexuality, the new theory of GIDC blames mothers for fostering effeminacy in boys. . . . Much like conversion therapists, GIDC theorists often reserve the harshest criticism for mothers who display “any tolerance” for effeminacy in sons. . . . [The theory blames] a surplus of mothering and a deficit of fathering for inhibiting the development of masculine, heterosexual boys. 121

Thus, as another study found “encouraging or even permitting a child to be gender non-conforming reflects negatively upon a parent’s fitness . . . [and courts] will take extreme measures, like placing children in unsupportive homes, to deter [a child from growing up to be transgender].”122 This theory seems to be present in Smith because it similarly involved a supportive mother and gender-nonconforming biological son.

Scholarship about the medical model of transgenderism as applied to the legal status of parentage for a transgender parent can also illuminate the bias and stereotypes at play in gender-nonconforming child custody cases.123 When adjudicating custody disputes, some courts look to the effect of the transgender parent’s gender identity on the child. Specifically, a court may consider a parent’s GID diagnosis to determine custody and deny or at least reconsider awarding custody to the gender-nonconforming

121. Clifford J. Rosky, Like Father, Like Son: Homosexuality, Parenthood, and the Gender of Homophobia, 20 YALE J.L. & FEMINISM 257, 304–5 (2009). The study analyzes a collection of cases involving homosexual parents (particularly lesbian parents) and the stereotype the homosexuals “recruit” or somehow influence children’s sexual orientation.
122. Shannon Shafron Perez, Is it a Boy or a Girl? Not the Baby, the Parent: Transgender Parties in Custody Battles and the Benefit of Promoting a Truer Understanding of Gender, 9 WHITTIER J. CHILD & FAM. ADVOC. 367, 393 (2010). Perez also observed that in custody cases involving transgender parents, the outcome was more favorable to transgender men than to transgender women. This finding supports Rosky’s conclusion that masculine gender is more often supported by courts.
123. As one such study found, “In the area of custody, the medical model actually has negative distributive consequences for those who conform to it, as both the pathologization of the parent’s identity and the desire to subject one’s child to the model provide a basis for challenging custodial rights.” Jonathan L. Koenig, Distributive Consequences of the Medical Model, 46 HARV. C.R.—C.L. L. REV. 619, 640 (2011).
parent in the first instance. Therefore, in applying the medical model of transgenderism, the presence of bias in favor of traditional gender norms and negative stereotypes about parents who promote gender nonconformity may explain why courts favor custody with the rejecting parent in cases involving gender-nonconforming children, where one parent is supportive and the other is rejecting.

IV. CONCLUSION: SOLUTIONS MUST INVOLVE ADVOCATES, EXPERTS, AND JUDGES

Transgender youth, especially those in families that express rejecting behavior, are at great risk for physical and psychological harms, including suicide, depression, substance abuse, and sexually transmitted diseases. These harms can be alleviated by families expressing accepting behavior and by supporting their children’s transitions. In particular, administering puberty-suppressing hormone therapy at an early age around Tanner Stage Two can be especially helpful.

Potential solutions should address several aspects of the adjudicative process in such cases. First, advocates should more carefully represent the best interests of the child, as the law demands. As Sarah Valentine observed about Smith, “While there is no indication that there was an attorney for the children in the case, the trial court transcript seemed to indicate that much of the judicial animosity toward the mother stemmed from her refusal to follow a court order concerning the child.” Thus, a guardian ad litem, for example, “may have been able to separate the child from his mother in the judge’s mind[,] . . . would have been able to educate the judge on gender nonconformity[,] and possibly keep the child with the supportive parent.”

Second, expert testimony is crucial in custody cases involving medical care decision-making authority because the trial court’s ruling on GIDC diagnosis and treatment are crucial in light of the appellate court’s deference. Such cases involving gender-nonconforming children are no


125. Erika Skougard also outlines specific recommendations for both advocates and judges to work effectively and respectfully for the benefit of gender-nonconforming youth in family disputes in light of her analysis of Smith. Erika Skougard, Note, The Best Interests of Transgender Children, 3 UTAH L. REV., 1161, 1198–1200 (2011). This essay works in conjunction with Skougard’s by teasing out the decision calculus available to judges when they adjudicate custody cases involving parents’ disputes over their gender nonconforming children.


127. Id.
different. As the appellate court in *Smith* suggested, if the supportive
parent had “a more clear and concise medical diagnosis [of GIDC],” she
would have fared better in the trial’s outcome. Therefore, “[a]ttorneys
representing the parent of a transgender child in a custody dispute likely
will need to support the parent’s position with expert testimony.”

Finally, if judges were better informed by advocates about the limited
efficacy of testimony about GIDC from experts who reject transitioning
and support reparative therapy, they will be more likely to rule in favor of
the supportive parent. Judges can also participate in the Williams Institute
Judicial Training Program at UCLA School of Law to educate
themselves, perform self-guided research, and demand that advocates
possess the requisite “legal knowledge, skill, thoroughness[,] and
preparation reasonably necessary for the representation” of supportive
parents of transgender children. With more reliable information, judges
would be able to make decisions based on proper medical and
psychological findings, rather than on unfair bias and erroneous
assumptions, and apply less weight to the flawed medical testimony that
supports the unsupportive parent’s position. The medical data show that a
factual presumption in favor of supportive families and puberty-blocking
hormone treatment is appropriate and desirable.

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Institute’s Judicial Training Program provides state and federal judges with substantive
training on legal issues impacting lesbian, gay, bisexual, and transgender people. The goal
of our training program is to provide judges with the most up-to-date legal and policy
information they will need when considering sexual orientation [and gender identity] law
issues in cases coming before them.” Id.
130. MODEL RULES OF PROF’L CONDUCT R. 1.1, American Bar Association Center for
Professional Responsibility (2010), available at http://www.americanbar.org/groups/
professional_responsibility/publications/model_rules_of_professional_conduct/rule_1_1_co
131. Valentine, *supra* note 126, at 1099. “While queer children can be harmed by overt
acts of their own lawyer, they can also be harmed by non-action. . . . It is quite possible that
if the child at issue [in *Smith*] had an attorney who zealously represented his position, there
may have been a different outcome in the proceeding. Such an attorney may have been able
to separate the child from his mother in the judge’s mind. Additionally, he would have been
able to educate the judge on gender nonconformity and possibly keep the child with the
supportive parent.”
132. See *supra* Part II.
Commentary

Recognizing and Respecting the Rights of LGBT Youth in Child Custody Proceedings

Matthew J. Hulstein†

ABSTRACT

This Commentary addresses how the legal rights of lesbian, gay, bisexual, and transgender (LGBT) children affect child custody disputes. The legal standard for determining child custody is the “best interests of the child” standard. This standard is subjective and highly discretionary. In cases concerning LGBT youth, judges must ultimately rely upon their own, possibly skewed conception of sexual orientation and gender identity and expression. Absent a strong assertion of the child’s rights, a judge could decide that being LGBT is undesirable and place the child with a parent who would discourage the child from growing into an LGBT adult.

To guide judges in their decision, this Commentary argues that, under Lawrence v. Texas, an LGBT youth possesses the constitutional right to be treated with respect equal to that afforded straight or cisgender youth in regards to their sexual orientation or gender identity and expression. After Lawrence, a judge may not consider becoming an LGBT adult as an undesirable outcome for a child in a child custody determination. Although the LGBT youth’s minority permits the state and parents to limit the youth’s rights in certain ways, there is no interest of sufficient weight to override the youth’s rights under Lawrence. In practice, the youth’s rights weigh in favor of placing an LGBT youth with the parent most capable of helping the youth develop into a healthy, autonomous LGBT adult.

INTRODUCTION............................................................................................................. 172

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INTRODUCTION

Christine understood herself to be a girl.\(^1\) Christine was assigned male at birth, but around age four she wanted to dress in girls’ clothes.\(^2\) Her parents divorced in 2001 when she was six years old.\(^3\) Pursuant to the couple’s stipulation, the court granted Christine’s mother Victoria residential custody.\(^4\) By age ten, Victoria allowed Christine to be addressed by her feminine name and attend transgender support groups.\(^5\) Victoria also relocated her family to enroll Christine as a girl in school.\(^6\) Victoria intended to allow Christine to undergo hormone therapy and possibly sex-reassignment surgery when Christine was older.\(^7\) This was all too much for Christine’s distant father Kevin.\(^8\)

In early 2004, Kevin learned that Victoria was treating Christine as a girl

\(^2\) Id. at *2.
\(^3\) Id. at *1.
\(^4\) Id. at *1.
\(^5\) Id. at *1.
\(^6\) Id. at *1.
\(^8\) Id. at *1.
and secured an emergency court order. The order modified the custody arrangement to joint physical custody, required Victoria to stop treating Christine as a girl, and also barred Christine from attending transgender support groups.

Later, Kevin alleged that Victoria violated the order and sought sole custody. During these proceedings, Christine sent her father a video in which she pled with him that she was a girl and wanted to stay a girl. Despite having “very little” contact with Christine prior to the proceeding and a qualified expert’s recommendation that Christine be allowed to explore her gender, the lower court granted Kevin’s request and awarded him sole residential custody. The court also ordered Victoria to treat Christine as a boy.

In Smith v. Smith, the Ohio Court of Appeals affirmed the lower court’s determination, noting, “[a]lthough this case reveals some of the severe limitations in using the judicial system to resolve complex and possibly controversial childrearing and childhood mental health issues, we are bound by the law in this matter.”

The 2007 case of Smith v. Smith illustrates a pressing issue in our courts. In 2010, there were over 870,000 divorces in the United States. As lesbian, gay, bisexual, and transgender minors (“LGBT youth”) come out at younger and younger ages, courts will increasingly face custody disputes where divorcing parents disagree about the desirability of their child’s emerging sexual orientation or gender identity and expression. This Commentary addresses the substantive due process rights an LGBT youth possesses in her sexuality or gender identity/expression in custody proceedings.

9. Id. at *1.
10. Id. at *1.
11. Id. at *1.
12. Id. at *2.
14. Id. at *2–6.
15. Id. at *5.
16. Id. at *12.
17. See id. at *12; see also Shannon Safron Perez, Is It a Boy or Girl? Not the Baby, the Parent: Transgender Parties in Custody Battles and the Benefit of Promoting a Truer Understanding of Gender, 9 WHITTIER J. CHILD & FAMILY ADVOC. 367, 367–93 (2010) (providing a further discussion of Smith v. Smith and other custody cases involving transgender parties).
19. See Sarah E. Valentine, Traditional Advocacy for Nontraditional Youth: Rethinking the Best Interest for the Queer Child, 2008 MICH. ST. L. REV. 1053, 1086 (2008) (“[w]hile there are no statistics suggesting that queer youth are more often the subjects of custody disputes, sexuality and gender-nonconformity can become an issue during custody litigation. Parents often have strong reactions to a child’s queerness, and those reactions are exacerbated in custody and visitation disputes...A parent who is supportive of his or her child’s sexual or gender identity risks a custody battle if the other parent disagrees.”) [hereinafter Traditional Advocacy].
20. Because transgendered youth may require hormone therapy and surgical procedures, their
First, this Commentary explains how courts decide custody issues and focuses specifically on the “best interests of the child” standard. The “best interests” standard is the universal guiding principle for courts when determining custody. It is also famously subjective, leaving LGBT youth uniquely vulnerable in cases where a judge misunderstands or is hostile to the youth’s sexuality or gender identity/expression. To adequately protect these youth, courts must have a more robust and objective understanding of the rights these youth possess.

Second, this Commentary argues that an LGBT youth’s sexual orientation or gender identity/expression affords her legal rights, which a court must recognize and respect when determining custody. Relying upon “Enjoyment Theory of Children’s Rights” and Supreme Court cases concerning the right of a minor to obtain an abortion, this Commentary posits that a minor possesses substantive due process rights and that a parent and the state hold these rights in trust until the minor is mature enough to exercise them.

Ultimately, this Commentary argues that, under Lawrence v. Texas, LGBT minors possess the right to be treated with the same respect afforded heterosexual or cisgender children in regards to their sexuality or gendered behavior in child custody proceedings. A court violates this right when, with the intent of discouraging the child’s sexual orientation or gender identity/expression, awards custody to a parent who is also hostile to the orientation or identity/expression.

Finally, this Commentary examines the possible objections of the non-supportive parent. Relying upon Meyer v. Nebraska and Prince v. Massachusetts, this Commentary argues that although a parent has the right to raise her child they way she would like, the minor’s rights and the state’s interest in protecting the minor limit the parent’s right. Additionally, the nature of custody determinations precludes the parent from asserting these rights. In the end, the LGBT youth’s right to her sexual orientation or gender identity/expression trumps parental rights.


24. Meyer v. Nebraska, 262 U.S. 390 (1923) (holding that parents have the right to control the education and upbringing of their children).

25. Prince v. Massachusetts, 321 U.S. 158 (1944) (holding that the state’s interest in protecting children from exploitation overrides a parent’s right to control child’s religious upbringing).
I. LGBT YOUTH AND THE INSUFFICIENCY OF THE “BEST INTERESTS OF THE CHILD” STANDARD

This Section sets forth why the “best interests of the child” standard, which is the guiding principle in making child custody determinations, is insufficient to protect LGBT youth. Part A explains who LGBT youth are; Part B outlines the general principles governing child custody determinations including the “best interest of the child” standard and its constitutional bounds; finally, Part C explains why the traditional “best interests” standard fails to guard the interests of LGBT youth.

A. Who Are LGBT Youth?

Quite simply, this Commentary uses the term “youth” to refer to people under the age of eighteen. States typically consider persons over eighteen as legal adults. In custody proceedings, persons over eighteen may decide for themselves with whom they wish to live.26 These persons are also competent to make major legal and medical decisions and are usually not subject to their parents’ consent.27

“LGBT” is an umbrella term that stands for lesbian, gay, bisexual, and transgender.28 Sexual orientation is “a person’s emotional and sexual attraction to other people based on the gender of the other person.”29 Transgender is an umbrella term used to describe people whose “gender expression is nonconforming and/or whose gender identity is different from their birth-assigned gender.”30 Gender identity is a “person’s internal, deeply felt sense of being either male, female or something other, or in between.”31 Gender expression is an individual’s “characteristics and behaviors such as appearance, dress, mannerisms, speech patterns, and social interactions that are perceived as masculine or feminine.”32

Today, no major mental health organization regards sexual orientation as a

26. For a state-by-state survey of the age of majority and medical decisions, see NATIONAL ASSOCIATION OF SOCIAL WORKERS, LEGAL RIGHTS OF CHILDREN, 41 App. A (2010) [hereinafter NASW]; see also, Paul Arshagouni, “But I’m an Adult Now…Sort Of”: Adolescent Consent in Health Care Decision-Making and the Adolescent Brain, 9 J. HEALTH CARE L. & POL’Y 315, 331–32 (2006) (stating “[t]he general age of majority in the United States has shifted downwards from twenty-one to eighteen...in most legal contexts, the age of majority is now eighteen years. This is certainly true with respect to matters of health care consent.”).
27. See Arshagouni, supra note 26, at 331–32.
29. Id.
30. Id.
31. Id.
32. Id.
disorder. Such was not always the case, however. For many years, the American Psychiatric Association ("APA") included homosexuality in its Statistical Manual of Mental Disorders ("DSM"). The APA reversed its position in 1973. In 1975, the American Psychological Association followed suit and declared, “homosexuality per se implies no impairment in judgment, stability, reliability, or general social and vocational capabilities.” These organizations and others like them uniformly condemn attempts to alter a person’s sexual orientation by means of counseling or therapy.

The APA still includes some forms of transgender identities in the DSM under the term Gender Identity Disorder ("GID"). The proposed DSM-V replaces the term GID with Gender Dysphoria and defines the condition as “[a] marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months duration.”

The DSM’s inclusion of nonconforming gender identity and expression is controversial. Some argue that this label pathologizes variant gender identities/expressions and leads to greater stigmatization. Others note that the inclu-

33. See Am. Psychol. Ass’n, Just the Facts about Sexual Orientation and Youth: A Primer for Principals, Educators, and School Personnel 6 (2008), available at http://www.nasponline.org/advocacy/docs/Just_the_Facts_012308.pdf ("The American Academy of Pediatrics, the American Counseling Association, the American Psychiatric Association, the American Psychological Association, the American School Counselor Association, the National Association of School Psychologists, and the National Association of Social Workers, together representing more than 480,000 mental health professionals, have all taken the position that homosexuality is not a mental disorder and thus is not something that needs to or can be ‘cured.’") [hereinafter Just the Facts].


37. See Just the Facts, supra note 33, at 5.


39. Gender Dysphoria in Children, American Psychiatric Association (May 4, 2011), http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=192. The DSM-V lists eight factors, six of which must be present for a Gender Dysphoria diagnosis: 1. a strong desire to be of the other gender or an insistence that he or she is the other gender (or some alternative gender different from one’s assigned gender); 2. in boys, a strong preference for cross-dressing or simulating female attire; in girls, a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing; 3. a strong preference for cross-gender roles in make-believe or fantasy play; 4. a strong preference for the toys, games, or activities typical of the other gender; 5. a strong preference for playmates of the other gender; 6. in boys, a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; in girls, a strong rejection of typically feminine toys, games, and activities; 7. a strong dislike of one’s sexual anatomy; 8. a strong desire for the primary and/or secondary sex characteristics that match one’s experienced gender. Id.

sion may be necessary for transgender people, particularly minors, to secure hormone treatment or surgery.41

The Standards of Care for Gender Identity Disorders produced by the Harry Benjamin International Gender Dysphoria Association (HBIGDA) is the most widely used manual for treating persons with a GID diagnosis.42 The manual provides criteria that must be met for a child to be diagnosed with GID.43 Diagnosing GID in youth is complex as the outcomes of gender identity disorders in children are more fluid and varied.44 The goal of the treatment for persons with GID is “lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment.”45 This may include physically transitioning to the person’s understood gender by means of hormone therapy or reassignment surgery.46

LGBT youth are a vulnerable population in today’s society, and they face unique challenges in schools, foster care and juvenile systems, medical contexts, and in their families and communities.47 At least half of the LGBT youth who come out to their families face negative reactions, and roughly a third of them are subsequently physically abused.48 LGBT youth also suffer from significantly higher rates of suicidal ideation and suicide attempts, the most reliable indicators

41. See id. (reviewing the arguments in support of and against the medical model and describing its pros and cons); see also, J. Lauren Turner, From the Inside Out: Calling on States to Provide Medically Necessary Care to Transgender Youth in Foster Care, 47 Fam. Ct. Rev. 552 (July 2009).
43. HBIGDA, supra note 42, at 5.
44. Id. at 8–9.
45. Id. at 1.
46. Should a youth be diagnosed as having GID, the HBIGDA manual recommends three escalating levels of physical intervention: fully reversible, partially reversible, and irreversible. Fully reversible intervention refers to administering puberty-delaying hormones; partially reversible intervention refers to administering masculinizing or feminizing hormones; and irreversible intervention refers to sex reassignment surgery in which masculine or feminine physical characteristics are surgically constructed. The manual recommends surgery not be undertaken prior to age eighteen. Id. at 9–11. For a critique of the manual’s three categories, see Shield, supra note 42, at 392 (noting “[b]ecause it imposes a significant series of requirements the transgender person must meet, and places doctors and social workers in a gatekeeper role between the transgender individual and the treatment sought, the HBIGDA Standards of Care has been criticized as ‘unnecessarily restrict[ing] access to hormones and surgery.’”).
48. See Barbara Fedders, Coming Out for Kids: Recognizing, Respecting, and Representing LGBTQ Youth, 6 REV. L.J. 774, 787 (Spring 2006).
of suicide risk. Transgender youth face additional duress as their bodies develop into a sex with which their understood gender does not conform. To protect LGBT youth, many legal commentators have advocated a more robust understanding of LGBT youth’s rights, and though advances have been made, many LGBT youths’ rights remain far from realized. Having explored the nature of sexuality and gender in LGBT youth, this Commentary turns to the nature of child custody proceedings.

B. Child Custody Proceedings and the “Best Interests of the Child” Standard

Ordinarily, both parents share the rights and responsibilities of raising their child. However, when parents divorce, these rights and responsibilities fragment and a judge must determine a custody arrangement for the child. Most basically, these rights and responsibilities fall into two categories: legal custody and physical custody. Legal custody carries with it the power to make major legal decisions concerning the child, such as education and healthcare. Physical custody refers to whom the child will live with. A judge may order any combination of these two types of custody.

In awarding either type of custody, a judge must decide what arrangement is in the “best interests of the child” and rule accordingly. The “best interests” standard is the “lodestar principle” in the United States guiding child custody determinations. This standard reflects the government’s traditional power as parens patriae—the ultimate protector of a child’s welfare. When determining custody between parents, the child’s best interests override practically any other concern.

50. See Shield, supra note 42, at 383.
51. See, e.g., Fedders, supra note 48, at 798–805.
52. See LGBT Youth Bibliography, supra note 47, at 452 (“Since the mid-1980s, studies have been funded, articles published, lawsuits brought, schools started, policy reform undertaken, and public education pursued, all with the intent of bettering the situation of queer kids….Still, while gains have been made, queer youth continue to face horrendous obstacles.”).
53. Child Custody & Visitation § 10.03[2] (Matthew Bender & Co., Lexis, 2012) (“As long as there is no court directive in effect, both parents continue to have equal rights in the child.”).
54. Id. at § 10.03[1].
55. Id. at § 10.03[3].
58. Child Custody & Visitation, supra note 53, at § 1.05[3].
59. Id.
60. Id. at § 1.03.
61. Id. at § 10.01[2][b].
THE RIGHTS OF LGBT YOUTH IN CHILD CUSTODY PROCEEDINGS

Determining the “best interests” of the child ultimately consists of two questions: first, what is the desirable long-term goal for the child; and second, what present arrangement is most conducive to the child reaching that goal? Because judges must rely upon their own understanding of the present situation and possible future outcomes, the inquiry is very fact-intensive and famously subjective. One court has gone so far as to describe the “best interests” standard as the fact-finder’s “best guess.” Due to the nature of the inquiry, appellate courts generally defer to the trial court’s decision and only reverse upon an abuse of discretion. One scholar places the chances of reversal around sixteen percent.

Oftentimes, codified factors guide the court’s considerable discretion. These factors could include the wishes of the parents, the child’s preferences, and the mental stability of the parties. These factors do not typically bind a judge, however, and the judge must rely on her own subjective understanding to make a ruling.

A trial judge’s discretion is also limited by constitutional principles. Since federal and state courts have “constitutionalized” the area of family law, determinations based upon the parties’ gender, race, ethnicity, or religion are now subject to constitutional review. A judge’s use of any of the aforementioned factors must be justified by a state interest of sufficient importance.

Parties’ religion is a highly relevant factor to this Commentary as many parents oppose their LGBT child’s sexuality or gender identity/expression for religious reasons. In making custody determinations involving religious claims, judges must remain neutral, neither favoring religion nor irreligion. A judge may only consider a party’s religious beliefs when the beliefs pose harm to the child. Further discussion of this issue is reserved for Section IV, which ex-

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63. See CHILD CUSTODY & VISITATION, supra note 53, at § 10.06[2].
64. Id. at § 1.01[6][c] ("Traditional federal deference to state law and policy on domestic relations issues no longer protects those laws from challenge under the federal constitution. Furthermore, although not necessarily arising in domestic relations contexts, Supreme Court decisions in areas such as religious liberty, equal protection for nonmarital children and their fathers, equal protection for woman and racial minorities, and personal liberties protection under the Due Process Clause of the fourteenth amendment, have had an enormous effect in the area of family law, including child custody and visitation.").
65. Id.
66. Id.
67. For a detailed discussion of each factor and its respective level of judicial review, see id. at § 1.01[6][c] (gender), § 10.10[2] (race), § 10.10[3] (religion), and § 10.10[4] (ethnicity).
plores parental rights.

Additionally, a judge may not consider society’s possible negative reaction to gender, race, ethnicity, or religion in making a “best interests” determination after the U.S. Supreme Court’s decision in Palmore v. Sidotti.\textsuperscript{74} In Palmore, a white couple divorced and the trial court granted custody of their daughter to the mother.\textsuperscript{75} Subsequently, the mother started cohabitating with a black man.\textsuperscript{76} The trial court granted the father’s petition for custody, reasoning that the child would suffer “from the social stigmatization that is sure to come” if she remained in a mixed-race household.\textsuperscript{77} The Supreme Court reversed the lower courts, holding that they had inappropriately made the custody determination on the basis of race.\textsuperscript{78} The Court acknowledged that the state had an interest in guarding the child’s best interests and that a child living in a mixed-race household could be subjected to stigmatization.\textsuperscript{79} Still, the Court found this interest illegitimate, stating, “[t]he Constitution cannot control such prejudices but neither can it tolerate them. Private biases may be outside the reach of the law, but the law cannot, directly or indirectly, give them effect.”\textsuperscript{80}

C. LGBT Youth and the Insufficiency of the Traditional “Best Interests” Standard

Because the traditional “best interest” standard is highly subjective, LGBT youth are uniquely vulnerable in custody cases where the deciding judge regards the youth’s sexual orientation or gender identity/expression as undesirable.\textsuperscript{81} In the past, judges’ biases against LGBT parents often resulted in these parents losing custody of their children.\textsuperscript{82} Even after homosexuality or nonconforming gender identity/expression ceased to be \textit{per se} reasons for finding par-

\textsuperscript{75} Id. at 430.
\textsuperscript{76} Id.
\textsuperscript{77} Id. at 431.
\textsuperscript{78} Id. at 432.
\textsuperscript{79} Id. at 433.
\textsuperscript{81} See Traditional Advocacy, supra note 20, at 1086 (“Parental sexual orientation and gender-nonconformity have long been used as weapons in custody proceedings. It is not surprising that a child’s sexual orientation or gender non-conformity would likewise become an issue.”); see also Charlotte J. Patterson, \textit{Parental Sexual Orientation, Social Science Research, and Child Custody Decisions, in THE SCIENTIFIC BASIS OF CHILD CUSTODY DECISIONS} 285, 286–87 (Robert M. Galatz-Lévy et al. eds., 2d ed. 2009) (reviewing custody cases in which courts were hostile toward the parent’s sexual orientation).
\textsuperscript{82} See \textsc{Jonathan W. Gould}, \textit{Conducting Scientifically Crafted Child Custody Evaluations} 156–57 (1998); \textsc{Child Custody & Visitation, supra note 53, at § 10.12[2][c]; Hazel Beh & Milton Diamond, \textit{Ethical Concerns Related to Treating Gender Nonconformity in Childhood and Adolescence: Lessons from the Family Court of Australia, 15 Health Matrix} 239, 278–79 (Summer 2005) (stating that “[w]e need only consider the narrow and unscientific concept of gender espoused in Kantaras v. Kantaras, Littleton v. Prange, In re Ladrach, or In re Estate of Gardiner, to understand that not all judges can transcend their own construction of gender.”).
ents unfit, judges still often granted custody to the heterosexual or gender normative parent out of fear that a child living with an LGBT parent would develop into an LGBT person.\(^83\)

Today, most judges have accepted that an LGBT parent cannot dictate her child’s sexual orientation or gender identity/expression.\(^84\) However, the implicit argument still lingers that if an LGBT parent could influence her child to be gay or transgender, then the “best interests” standard would require awarding custody to the heterosexual or cisgender parent.\(^85\) In short, a child developing into an LGBT person is still seen by some judges as a harm to be avoided.\(^86\)

In situations where a judge is hostile to homosexuality or nonconforming gender identities/expressions, the “best interests of the child” standard ironically fails to protect the LGBT child’s best interests. A hostile judge may place an LGBT youth with a non-supportive parent and potentially exposes the child to neglect or mistreatment. Even absent mistreatment, a non-supportive parent would likely inhibit the LGBT youth’s ability to develop into a mentally healthy, autonomous LGBT person.\(^87\)

As explained above, constitutional principles restrict judges’ discretion when making “best interests” determinations. However, without a more robust understanding and assertion of an LGBT youth’s constitutional rights, discrimination in child custody decisions would likely go undetected and unchallenged. The next Section sets forth a legal framework for understanding how an LGBT youth’s constitutional rights operate in such a context.

\(^83\). See David K. Flaks, Gay and Lesbian Families: Judicial Assumptions, Scientific Realities, 3 WM. & MARY BILL OF RTS. J. 345, 368 (1994) (noting that “legislators and judges often use this assumption to deny homosexual parents custody, visitation, or other parental rights for fear that children raised by gay parents might themselves become gay in greater proportions. In fact…judges often consider the possibility of a child’s becoming homosexual to be one of the most undesirable and perhaps even “tragic” outcomes of awarding custody to lesbian mothers.”); GOULD, supra note 83, at 156–57; Patterson, supra note 81, at 287 (explaining that despite the fall of the per se ban against homosexual parents, there still remains in some jurisdictions a “nexus test” that if the parent’s sexual orientation distresses the child, the parent may lose custody).

\(^84\). See Patterson, supra note 81, at 290–93.

\(^85\). See, e.g., Timothy E. Lin, Social Norms and Judicial Decisionmaking, 99 COLUM. L. REV. 739, 762 (1999) (“The ‘best interests of the child’ standard may easily cloak personal animus, as well as more subtle biases, toward homosexuality under the guise of concern for the welfare of the child. Indeed, courts may seize the opportunity to promote a social ideology that conflicts with what is actually in the best interests of the child.”).

\(^86\). On a personal note, this author has had the privilege of working with several judges and in no way doubts their objectivity and understanding regarding LGBT issues. This Commentary’s concern is that such objectivity and understanding is not universal and that, when they are absent, an LGBT youth may be vulnerable to harmful discrimination.

\(^87\). See Caitlin Ryan, Helping Families Support Their Lesbian, Gay, Bisexual, and Transgender (LGBT) Children (Fall/Winter 2009), http://nccc.georgetown.edu/documents/LGBT_Brief.pdf (“LGBT youth who are accepted by their families are much more likely to believe they will have a good life and will become a happy, productive adult. In families that are not at all accepting of their adolescent’s gay or transgender identity, only about 1 in 3 young people believes they will have a good life as a gay adult. But in families that are extremely accepting, nearly all LGBT young people believe they can have a happy, productive life as an LGBT adult.”).
II. PROTECTING AN LGBT YOUTH’S RIGHTS IN CHILD CUSTODY PROCEEDINGS

In order to protect LGBT youth in child custody proceedings, courts and litigants must move away from the traditional “best interests” standard, which allows judges to rely upon their subjective, possibly mistaken understandings of sexuality and gender, and move towards a rights-based approach. Indeed, such an approach is not only prudent but legally required. Part A outlines the substantive due process rights of minors generally and Part B explains the rights an LGBT minor possesses in her sexual orientation or gender identity/expression. Part C then explains how an LGBT youth’s rights operate in the child custody context.

A. The Substantive Due Process Rights of an LGBT Youth

The Due Process Clause of the Fourteenth Amendment protects persons from deprivations of liberty without “due process of law.” The term “liberty” within this clause does not refer to just “freedom from bodily restraint” but includes numerous interests such as the right to privacy, marriage, and many rights generally associated with the original Bill of Rights. Such rights are typically labeled “substantive due process rights.” Depending upon the importance of the right, different state interests can override the right and justify its regulation or even deprivation.

Despite their youth, minors possess substantive due process rights. U.S. Supreme Court cases concerning a minor’s right to obtain an abortion best illustrate the nature and extent of a minor’s constitutional rights.

88. See Barbara Bennett Woodhouse, *Talking about Children’s Rights in Judicial Custody and Visitation Decision-Making*, 36 Fam. L.Q. 105 (Spring 2002) (reviewing a judicial deskbook often used for making custody determinations and concluding, “[w]hile the Deskbook makes many important contributions to the judicial decision-making process, it fails to give adequate weight to the rights of children…Talking about children’s rights is one way of making sure that this truth is not forgotten. Judicial decision-making would be more accurate, balanced, and just if children’s stake in the resolution of custody disputes could be moved from the periphery to the center of the process and if children were to gain equal protection as a right and not as a mere interest.”).

89. U.S. Const. amend. XIV, § 1 (“[N]o state shall deprive any person of life, liberty, or property without due process of law.”).


92. Id.

93. Id.


minor’s right to obtain an abortion, the Court famously stated, “[c]onstitutional rights do not mature and come into being magically only when one attains the state defined age of majority. Minors as well as adults are protected by the Constitution and possess constitutional rights.”

Even though youth possess rights, “the constitutional rights of children cannot be equated with those of adults.” A state may regulate a minor’s right to an abortion only if the regulation serves a “significant state interest … that is not present in the case of an adult.” The Court has recognized three main differences between adults and minors: minors are (1) “particularly vulnerable,” (2) largely unable “to make critical decisions in an informed, mature manner,” and (3) dependent upon their parents. Because of these limitations, the state has a legitimate interest in ensuring that its minors make “knowing and intelligent” decisions. Also, parents have an interest in discussing the “religious and moral implications of the…decision” with the minor and in providing the child with “needed guidance and counsel.”

Despite these valid interests, the Court has held that a parental consent limitation on a minor’s right to obtain an abortion without a judicial bypass procedure is invalid. Such a regulation goes beyond serving those interests and arms the parent with an “absolute, and possibly arbitrary, veto” against a minor’s right. In subsequent cases, the Court found the following regulations valid: parental consent requirements with a judicial bypass procedure, parental notice requirements with a judicial bypass procedure, and a limited waiting period. These limitations serve the special interests of minors without “vetoing” their right.

In short, a minor has constitutional rights, but these rights cannot be “fully equated” with the rights of an adult. This classification is a dilemma. If children truly are persons, then they should have the same full constitutional rights as adults. If children are “beings who are always in some form of custo-
dy,” then they should not have any constitutional rights.109

The “Enjoyment Theory of Children’s Rights,” as proposed by legal philosopher Lawrence D. Houlgate, resolves this dilemma. According to this theory, a child’s rights are not limited in scope or balanced against the rights of the parent or interests of the state.110 Instead, a child’s rights are held in trust by the parent or state. The child possesses the same constitutional rights as adults, but complete enjoyment of the right is postponed until the child reaches legal maturity and can properly exercise the right.111 A minor need not exercise her right to possess it.112

Under this theory, the duty of government is to “provide conditions for the child to become an adult who is able freely and in an informed way to make choices, that is, to become autonomous.”113 Closing off the minor’s ability to fully exercise a right in the future violates the minor’s right presently.114 Any limitations on the minor’s rights must therefore be tied to the minor’s current inability to use the right or the risk that minor might damage her future ability to exercise her rights if allowed to enjoy them now.115 Otherwise, limitations are illegitimate.116 The state delegates this trusteeship to the parents and grants them wide discretion, presuming that the parent has the child’s best interests at heart.117

The Enjoyment Theory finds strong support in case law concerning a minor’s right to obtain an abortion and a parent’s right to make certain child-rearing decisions. This second set of cases is further discussed in Subsection III.A. In the abortion cases, the Court explained that the state and parents have a strong interest in ensuring minors, who are presumably immature, make informed decisions.118 However, neither the state nor the parent could veto a mentally mature minor’s choice.119 In the child-rearing cases, the Court generally deferred to parents’ decisions but would step in, as parens patriae, if the parent acted beyond the scope of this trusteeship and harmed the child.120

B. The Substantive Due Process Rights of an LGBT Minor Specifically

The U.S. Supreme Court has not directly addressed the substantive due

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109. Id.
110. Id. at 38–47.
111. Id. at 43–44.
112. Id.
113. Id. at 45.
114. Id. at 43.
115. Id.
116. Id. at 45.
118. See, e.g., Hodgson v. Minnesota, 497 U.S. 417, 447 (1990) (finding the parent has an interest in “discuss[ing] the decision’s religious and moral implications with the minor and provid[ing] needed guidance and counsel as to how the decision will affect her future.”).
120. See Troxel, 530 U.S. at 65.
process rights of LGBT minors. This Commentary constructs these rights by reading cases concerning LGBT rights in conjunction with cases concerning minors’ rights to an abortion as set forth above.

*Lawrence v. Texas* is the seminal case protecting rights of LGBT citizens. *Lawrence* expressly overruled *Bowers v. Hardwick*, an earlier Supreme Court case, which found an Georgia anti-sodomy statute constitutional.\(^{121}\) In upholding this statute, the *Bowers* Court reasoned that the Due Process Clause did not confer “a fundamental right to homosexuals to engage in acts of consensual sodomy.”\(^{122}\) The *Lawrence* Court found that the *Bowers* Court had framed the issue in that case too narrowly.\(^ {123}\) Quoting *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Court stated:

> These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one’s own concept of existence, of meaning, of the universe, and the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under the compulsion of the state.\(^{124}\)

Finding the state’s proffered justifications for the anti-sodomy statute entirely illegitimate, the Court famously proclaimed, “[t]he State cannot demean [homosexuals’] existence or control their destiny.”\(^ {125}\)

Although the facts in *Lawrence* concerned a criminal statute that prohibited same sex couples from engaging in consensual sex acts in private, the right articulated in the case goes well beyond such facts.\(^ {126}\) First, the Court expressly denounced attempts to limit this right to only sexual conduct, finding the Bowers decision was incorrect for doing just that.\(^ {127}\) The protected right is far broader and concerns gay and lesbian peoples’ “existence” and “destiny.”\(^ {128}\) The Court’s mode of analysis supports this interpretation. Although the Court based its ruling in substantive due process, the opinion straddles the traditional line between due

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121. *Bowers v. Hardwick*, 478 U.S. 186 (1986); *Lawrence v. Texas*, 539 U.S. 558, 578 (2003) (“Bowers was not correct when it was decided, and it is not correct today. It ought not to remain binding precedent. *Bowers v. Hardwick* should be and now is overruled.”).
123. *Lawrence*, 539 U.S. at 567.
124. *Id. at 574* (citing *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 at 851 (1992)).
125. *Id. at 578*.
126. *Id. at 567*.
127. *Lawrence v. Texas*, 539 U.S. 558, 567 (2003) (“To say that the issue in *Bowers* was simply the right to engage in certain sexual conduct demeans the claim the individual put forward, just as it would demean a married couple were it to be said marriage is simply about the right to have sexual intercourse. The laws involved in Bowers and here are, to be sure, statutes that purport to do no more than prohibit a particular sexual act. Their penalties and purposes, though, have more far-reaching consequences….”).
128. *Id. at 578.*
process and equal protection.129 Ultimately, the Lawrence opinion protects “the right of gay people to equal respect for their life choices.”130 The standard of review did not matter as “laws that reflect nothing more than class-based animosity against gay people lack even a legitimate government purpose—a conclusion that, whatever the Court's doctrinal handle, sounds in equal protection.”131 The protected right is not just to certain conduct, though conduct is protected. The right is to be free from arbitrary state animus against gay and lesbian people.132

Second, even though Lawrence is typically considered a sexual orientation case, the interest it protects—the ability “to define one’s concept of existence”133—has profound implications for transgender persons. One scholar notes, “[a] person's sexual anatomy, and hence that person’s sense of sexual self, is core to an individual's self-definition. Similarly, one’s sense of gender is core to one’s sense of self.”134 According to the Lawrence Court, “[b]eliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.”135

Finally, both minors and adults possess the rights Lawrence protects. Concededly, the opinion states, “This case does not involve minors . . . . It does involve two adults who, with full and mutual consent, engaged in sexual practices common to a homosexual lifestyle.”136 However, this phrase does not create a “minor exception” as some lower courts initially proposed.137 Considered in its context, this phrase addresses situations in which a minor may be sexually exploited and is calculated to shut the door to adults who might claim a “privacy defense” to criminal sexual conduct that harms children.138

To date, no federal court has directly addressed the substantive due process rights an LGBT minor possesses under Lawrence. The highest court to have wrestled with the issue is the Kansas Supreme Court in its 2005 decision, Kansas

129. See Pamela S. Karlan, The Boundaries of Liberty after Lawrence v. Texas, Forward: Loving Lawrence, 102 MICH. L. REV. 1447, 1450 (2004) (“By moving away from conceiving of liberty as involving distinct conduct, the Court recast the right as involving not just autonomy but equality as well.”).

130. Id. at 1450.

131. Id. at 1450–51 (footnotes omitted).

132. Id.


134. Id. at 124 (emphasis added).


136. Id. at 560.

137. See Joseph J. Wardenski, A Minor Exemption?: The Impact of Lawrence on LGBT Youth, 95 J. CRIM. L. & CRIMINOLOGY 1363 (Summer 2005) (examining and dismissing a possible “minor exemption” to Lawrence v. Texas). Note that this article was in response to the Kansas Court of Appeals’s 2005 affirmation of Limon’s conviction in State v. Limon, 83 P.3d 234 (Kan. Ct. App. 2004). To Mr. Wardenski’s credit, the Kansas Supreme Court overruled the appellate court’s decision using analysis similar to Mr. Wardenski’s. See also, Caitlyn Silhan, The Present Case Does Involve Minors: An Overview of the Discriminatory Effects of Romeo and Juliet Provisions and Sentencing Practices on Lesbian, Gay, Bisexual, and Transgender Youth, 20 LAW & SEXUALITY 97 (2011).

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v. Limon. 139 There, respondent Matthew Limon, age eighteen, was convicted of statutory rape because he engaged in oral sex with a fourteen-year-old boy. 140 Ordinarily, the Kansas statutory rape statute allowed for a “Romeo and Juliet” exception, which greatly reduced the penalty when the offender and victim were within four years of age. 141 However the statute outlining the exception required the offender and victim to be the opposite sex, so Limon did not qualify. 142 Limon argued, pre-Lawrence, that this limitation and his conviction violated his equal protection rights. 143

The Kansas Court of Appeals and Kansas Supreme Court initially upheld Limon’s conviction. 144 While Limon’s request for certiorari was pending, the U.S. Supreme Court handed down Lawrence and remanded Limon’s case to the Court of Appeals of Kansas to be reconsidered under the new decision. 145 The Court of Appeals again affirmed Limon’s conviction. 146 That court concluded that Lawrence did not pertain to minors 147 and that Kansas had legitimate interests in excluding same-sex sexual conduct from the Romeo and Juliet exception, namely preserving “the traditional sexual mores of society” and the “traditional sexual development of children.” 148

The Kansas Supreme Court reversed the Court of Appeals and struck the opposite sex requirement from the “Romeo and Juliet” exception. 149 The Court found that Lawrence applied to youth, and that the Court of Appeals’s proffered interest—that the statute protected “traditional sexual development of children”—was insufficient. 150 The Court based this determination on the grounds that the appellate court’s justification was not factually based as “efforts to pressure teens into changing their sexual orientation are not effective” and legally illegitimate as “moral disapproval of a group cannot be a legitimate governmental interest” after Lawrence.

Although the Limon court expressly based its decision on equal protection grounds 152 and declared that sodomy was not a “fundamental right,” 153 the court’s dependence on Lawrence and its use of Casey implicates the substantive due process rights articulated in those decisions. 154 More directly, the court’s
own statements that the case “involve[d] individual rights”\(^\text{155}\) and Limon possessed a “right to liberty and privacy”\(^\text{156}\) imply that a substantive due process right was at issue. Though \textit{Limon} is not binding on other states, it is the most authoritative case on the subject of an LGB youth’s substantive due process rights under \textit{Lawrence}. 

In summation, LGBT youth, like straight and cisgender youth, possess the substantive due process rights protected by \textit{Lawrence}: the right to their sexual orientation or gender identity/expression and the right to be free from state action primarily expressing animus against their sexual orientation or gender identity/expression. As explained in Subsection III.A, the state and the youth’s parents hold this right in trust and may only limit the youth’s exercise of the right to protect the right’s future vitality. This Commentary now turns to how these rights affect a court’s “best interest” determination in a child custody proceeding and what, if any, interests the state and parents may assert to regulate or curtail the youth’s rights.

C. The Substantive Due Process Rights of an LGBT Youth and the “Best Interests of the Child” Standard

When parents divorce, a court deciding custody must determine which parent would continue to serve the child’s best interests.\(^\text{157}\) Viewed through the “Enjoyment Theory of Children’s Rights,” the question becomes: which parent would serve as the best trustee of the rights the minor possesses but cannot yet exercise? As an agent of the state, the judge essentially acts as \textit{parens patriae}, the ultimate trustee, and delegates this duty to the parent most capable of carrying it out.

As discussed in Subsection II.B, this determination consists of two questions the judge must answer. First, what is a desirable long-term goal for the child; and second, which parent would best support the child in attaining that goal?\(^\text{158}\) As shown in the following two Subsections, an LGBT youth’s substantive due process rights limit the judge’s discretion in answering these questions. Because sexual orientation and gender identity/expression are distinct, this Commentary addresses them separately in the following two Subsections.

In these Subsections, this Commentary often concludes that a court should place the LGBT youth with the supportive parent in order to respect the youth’s rights. However, in some cases, countervailing factors might make the non-supportive parent a better choice. For example, the supportive parent might be mentally unstable, and the non-supportive parent may not be aggressively...

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\(^{155}\) State v. Limon 122 P.3d 22, 28 (Kan. 2005).

\(^{156}\) \textit{Id.} at 36.

\(^{157}\) \textit{See infra} Section II.B.

\(^{158}\) \textit{Id.}
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hostile. This Commentary does not argue that the LGBT youth’s rights always require a custody determination in favor of the supportive parent. Rather, this Commentary argues that the LGBT youth’s rights forbid a court from considering the youth’s sexuality or expression as an unfavorable result. This holds true in all cases. In many, though not all, cases, the youth’s rights may impose an affirmative duty upon the court to favor the supportive parent so that the youth may fully realize her sexuality or gender identity/expression. This final statement is especially true for transgender youth, as shown in Subsection III.C.2, below.

1. The Substantive Due Process Rights of a Lesbian, Gay, or Bisexual (“LGB”) Youth and the Best Interests Standard

Subsection III.B established the principle that LGB youth possess the right set forth in Lawrence and Limon, namely the right to respect for their developing sexual orientations equal to that given straight or cisgender children.

In determining custody, there are no state or parental interests sufficient to outweigh the LGB youth’s right to equal respect. According to Limon, the most authoritative case considering the rights of LGBT youth, enforcing the “traditional sexual development of a child” and preserving the “traditional sexual mores of society” are insufficient interests. The abortion cases do hold that the state and parents have powerful interests in ensuring that a youth makes informed life decisions. Even if sexual orientation were a choice, under Lawrence, the choice is entirely personal and should not be subject to compulsive force of the state. Finally, a court may not consider society’s possible condemnation of an LGB youth’s life choices as weighing against the youth’s orientation in light of Palmore.

Of course, an LGB youth is not suddenly free to exercise her sexuality in harmful ways simply because she is gay, lesbian, or bisexual. A court may properly consider conduct that would be harmful to any child, straight or gay, since such consideration does not violate the right to equal respect of one’s sexual orientation.

Together, Lawrence and Limon answer the two “best interests” questions that a judge must consider in determining custody. First, a judge may not consider an LGB youth’s emerging sexual orientation as an undesirable goal for the child. Such a determination violates the right to equal respect, and in the Lawrence Court’s words, seeks to “control [the youth’s] destiny.” Second, the

160. See infra Section III.A (outlining a minor’s right to obtain an abortion and the counterbalancing parental and state interests).
163. Lawrence, 539 U.S. at 578.
LGB youth’s rights weigh heavily in favor of granting custody to the supportive parent. Such an arrangement would almost certainly be more conducive to helping the child develop into a healthy, autonomous LGB person who could fully exercise her rights than a placement with the non-supportive parent. Viewed through the lens of the “Enjoyment Theory,” the supportive parent would likely serve as a better trustee of the LGB youth’s rights than the non-supportive parent. Of course, if the non-supportive parent’s hostility translated into mental or physical neglect or abuse, the traditional “best interests” standard would support placing the child with the supportive parent.

2. The Substantive Due Process Rights of a Transgender Youth and the Best Interests Standard

The rights a transgender youth possesses in her gender identity/expression are more nuanced that those possessed by an LGB youth. The origins and nature of these rights vary greatly depending upon whether she has a gender identity disorder (“GID”) diagnosis.

Regardless of whether a transgender youth has a GID diagnosis, the freestanding language of Lawrence provides a right to her gender identity and expression. As noted in Subsection III.B, Lawrence may be interpreted to protect the rights of transgender youth. According to the Lawrence Court, “[b]eliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.” If a judge, in an attempt to inhibit a transgender child’s emerging gender identity/expression, grants custody to the non-supportive parent, the judge would effectively impose her own understandings of “the attributes of personhood” upon the transgender youth using the compulsive force of the state and thus violate the principles underlying the Lawrence decision.

The practical and legal realities facing transgender youth underscore this concept. Transgender persons often wish to transition to their understood gender, which could entail a legal name change and perhaps medical treatment such as hormone therapy or reassignment surgery. In most states, a minor lacks the

164. See Houlgate, supra note 22.
165. See Feldblum, supra note 133.
166. Id.
168. See Amanda Kennedy, Because We Say So: The Unfortunate Denial of Rights to Transgender Minors Regarding Transition, 19 Hastings Women’s L.J. 281, 290 (2008) (explaining “[i]f a minor wants to pursue psychological and medical treatment, there are significant hurdles to overcome. In many states, youth are unable to consent to medical treatment without the support of their parents. Some states allow ‘mature minors’ to consent to medical treatment. Even in these states, youth must often get a court to determine they are ‘mature.’”).
169. Id.
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power to make these legal decisions without the consent of her parent.\textsuperscript{170} Although there are some instances where the state considers minors competent, these instances remain the exception to the dominating rule.\textsuperscript{171} If a judge grants legal custody of a transgender youth to a parent who is not supportive of that youth’s gender identity/expression, the judge effectively forecloses the child’s ability to transition to her understood gender.\textsuperscript{172} As the Court stated in \textit{Danforth}, the judge would effectively hand the parent an “absolute, and possibly arbitrary, veto” against a minor’s right.\textsuperscript{173}

Should a youth be diagnosed as having GID, her rights relating to her gender identity/expression go beyond the right to “define one’s existence” and could include the right to medical treatment. Despite its surrounding controversy, the current Diagnostic and Statistical Manual of Mental Disorders (“DSM”) does define GID as a mental disorder requiring some form of treatment.\textsuperscript{174} The HBIGDA \textit{Standards of Care for Gender Identity Disorders} states that some form of psychotherapeutic, endocrine, or surgical therapy may be necessary for a transgender person to have lasting personal comfort in the gendered self.\textsuperscript{175} However, a transgender youth typically lacks the legal capacity to consent to the treatments she would need in order to transition.\textsuperscript{176} Such consent rests with the parent.\textsuperscript{177} If a parent withholds her consent for such treatments, a transgender youth could suffer anxiety, depression, and an increased risk of suicide.\textsuperscript{178} Regardless of the transgender youth’s right to self-expression, the traditional best interests of the child standard strongly favors granting custody to the parent who is supportive of the youth’s transgender identity, if only to avoid these harms.

Regardless of whether a transgender youth is diagnosed with GID, the state could have a legitimate interest in ensuring that minors make informed and carefully considered life decisions concerning medical treatments.\textsuperscript{179} Because a youth’s gender is often in flux, a youth could conceivably latch on to the wrong

\textsuperscript{170} See NASW, supra note 26.
\textsuperscript{171} See Arshagouni, supra note 26, at 331–40 (exploring the abortion context, the rule of sevens, the mature minor’s doctrine, and emancipated minors).
\textsuperscript{172} See Kennedy, supra note 168, at 300 (stating “[u]nfortunately, at this point, there are few decisions that transgender youth are able to make for themselves regarding the path that their transitions take. For the most part, youth cannot consent to medical treatment without parental consent. The ability of youth to obtain formal psychological treatment, as opposed to support groups or informal counseling, is also limited by parental consent. Youth also cannot change their names or legal gender without the consent of their parents.”)
\textsuperscript{174} DSM, supra note 34, at §§ 302.6, 302.85.
\textsuperscript{175} HBIGDA, supra note 42, at 1.
\textsuperscript{176} See Arshagouni, supra note 26, at 331–32 (2006) (“The general age of majority in the United States has shifted downwards from twenty-one to eighteen…[I]n most legal contexts, the age of majority is now eighteen years. This is especially true with respect to matters of health care consent.”).
\textsuperscript{177} Id.
\textsuperscript{178} See Shield, supra note 42, at 383.
\textsuperscript{179} See infra Section II.C.1.
gender, undergo sex reassignment, and later regret the decision.\textsuperscript{180}

When facts raise such a concern, a court should defer to the HBIGDA Standards of Care for Gender Identity Disorders. The HBIGDA Standards of Care recommends escalating levels of physical intervention that correlate with the youth’s maturity—the older the youth, the more permanent the intervention may be.\textsuperscript{181} The manual only recommends irreversible physical intervention after the youth turns eighteen.\textsuperscript{182} Prior to that point, interventions are either entirely reversible or largely reversible.\textsuperscript{183} The reversible nature of the treatment thus mitigates the state’s interest in preventing a transgender youth from making the wrong choice concerning sex reassignment.\textsuperscript{184} Finally, a judge may not consider society’s potentially negative reaction to the youth’s gender identity/expression as weighing against the youth’s rights.\textsuperscript{185}

Again, \textit{Lawrence} answers the two questions a judge must consider in making a custody determination. First, the judge may not consider the transgender youth’s emerging gender identity/expression as an undesirable outcome. Under the freestanding language of \textit{Lawrence}, a judge may not force a youth to define the attributes of her personhood under the compulsion of the state,\textsuperscript{186} here, the compulsive force of a custody determination. If a youth has diagnosable GID, the youth could require medical treatment or face serious mental or physical harm. The traditional “best interest” standard, which seeks to avoid harm, thus requires the judge to respect the youth’s emerging gender expression. Second, to help the transgender child reach this end, the judge should favor a placement with the supportive parent. A transgender youth often requires parental consent for medical treatment related to GID. If the court awards custody to the non-supportive parent, the court effectively vetoes the youth’s \textit{Lawrence} rights, as the youth would unlikely be able to secure sex reassignment until after she reaches the age of eighteen. By that time, sex reassignment is far more difficult to accomplish.\textsuperscript{187}

There remains one final and powerful consideration: the rights of the non-supportive parent. This Commentary now turns to this issue.

\section*{II. The Rights of the Parent Who Objects to Her Child’s Sexuality or Gender}

As explained in Section II, a judge making a child custody determination for an LGBT youth should respect the youth’s rights under \textit{Lawrence}. This re-
spect may, in many instances, direct the judge to place the LGBT youth with the supportive parent. Almost inevitably, a non-supportive parent might object that denying her custody because of her opposition to her child’s sexuality or transgender identity violates her own substantive due process rights. If this parent’s opposition is based in religion, she may also claim that the court’s refusal to grant her custody because of that belief violates her First Amendment rights.

As will be shown, such arguments ultimately fail for the following reasons: first, such an assertion of a parent’s rights is a misunderstanding of parental rights; and second, the focus of custody proceedings is necessarily on the child and not on the competing rights of the parents.

A. Parental Rights Generally

Parents have a substantive due process right in deciding how to raise their children.\textsuperscript{188} The U.S. Supreme Court first recognized this right in \textit{Meyer v. Nebraska}, stating that parents have the right to “establish a home and bring up children,”\textsuperscript{189} and to “control the education of their own.”\textsuperscript{190} Shortly after \textit{Meyer}, the Court stated in \textit{Pierce v. Society of Sisters} that “[t]he child is not the mere creature of the state; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations.”\textsuperscript{191} Since \textit{Meyer} and \textit{Pierce}, the Court has found that a parent’s substantive due process rights include the right to exercise control over the child’s education,\textsuperscript{192} to order or refuse certain medical care, and to instruct the child in religion.\textsuperscript{193}

Although courts often refer to a parent’s power over her children as a right, correctly understood, it is a duty to raise the child into a mature, responsible citizen.\textsuperscript{194} As explained in Subsection III.A, a child’s rights are held in trust by the parent who acts as trustee. A parent’s rights are therefore analogous to the powers of a trustee and can only extend so far as what is necessary to affect this trusteeship.\textsuperscript{195} The state generally defers to the parent’s judgment, presuming

\begin{itemize}
\item \textsuperscript{188} Troxel v. Granville, 530 U.S. 57, 66 (2000) (“[I]t cannot now be doubted that the Due Process Clause of the Fourteenth Amendment protects the fundamental right of parents to make decisions concerning the care, custody, and control of their children.”); for a review of the relevant U.S. Supreme Court case law, see Susan E. Lawrence, \textit{Substantive Due Process and Parental Rights: From Meyer v. Nebraska to Troxel v. Granville}, 8 J. L. & FAM. STUD. 71 (2006).
\item \textsuperscript{189} Meyer v. Nebraska, 262 U.S. 390, 399 (1923).
\item \textsuperscript{190} \textit{Id.} at 401.
\item \textsuperscript{191} \textit{Pierce} v. Soc’y of Sisters, 268 U.S. 510, 535 (1925) (striking down as a violation of the fourteenth amendment a state statute that required public school attendance).
\item \textsuperscript{192} \textit{Meyer}, 262 U.S. at 401.
\item \textsuperscript{193} Wisconsin v. Yoder, 406 U.S. 205, 214 (1971) (holding that the state must balance compulsory education with the right of parents to exercise their First Amendment right to bring up their children in their religion).
\item \textsuperscript{195} \textit{See} Anderson, \textit{supra} note 194, at 943.
\end{itemize}
that the parent has the best interests of the child at heart. In certain situations, the presumption no longer applies, in which case the government may exercise its role as *parens patriae* to remove certain child-rearing decisions from the parent and decide for itself what is in the minor’s best interest. Ultimately, the best interests of the child, which include the eventual realization of the child’s own rights, trump the parent’s rights. Cases concerning a parent’s First Amendment rights illustrate this concept well.

A parent has a powerful substantive due process right in deciding how her child is raised in terms of religion. However, even this powerful right is limited. *Prince v. Commonwealth of Massachusetts* is the touch-point U.S. Supreme Court case in this area. In *Prince*, the petitioner, a Jehovah’s Witness, had been arrested for allowing her minor daughter to sell religious magazines on the street in violation of a state statute that prohibited minors from soliciting. The petitioner claimed that the statute violated her due process rights in raising her child. The Court recognized a parent’s right to control her child’s religious upbringing was “sacred” and “basic in a democracy.” However, the state as *parens patriae* also had a valid interest in protecting the child’s welfare, and this interest was not “nullified merely because the parent grounds her claim to control the child’s course of conduct on religion or conscience.” The Court found the state’s interest in protecting children from exploitation overrode the petitioner’s rights in raising her children.

Courts have applied the holding of *Prince* to numerous cases in which a parent claimed a due process right to raising her child in accordance with her religion to the detriment of the child. Courts addressing such questions have

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196. See Troxel v. Granville, 530 U.S. 57, 65 (outlining the history of the U.S. Supreme Court’s recognition of parents’ liberty interest in raising their children); Santosky v. Kramer, 455 U.S. 745, 753 (1982) (holding that parents have a “fundamental liberty interest...in the care, custody, and management of their child.”).


198. *Child Custody & Visitation*, supra note 53, at § 10.01[2][b].


200. Anderson, supra note 194, at 943 (“[P]arental rights have a dual purpose. They do recognize and protect the parent’s personal interest in the care and companionship of the child, in inculcating values and perpetuating tradition. But they have the further purpose of promoting the welfare of the family as an institution. Parents have a trusteeship not only or their children as individuals, but for the family organization itself....Within the family, a parent’s interests are entitled weight, but they are not absolute or necessarily superior to those of the child. They must accommodate the interests of other family members. Nor, of course, are the parents’ interests unqualified vis-à-vis the world outside the family. Those interests (or rights) are strong, but they must take account of the interests of the larger society.”).


202. *Id*.

203. *Id.* at 165.

204. *Id.* at 166.

205. *Id.* at 170–71.

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consistently held that parents may not exercise their religious belief if doing so would cause the child serious harm. The courts often recite Prince: “[p]arents may be free to become martyrs themselves [for their religious beliefs]. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.”

When applied to the conflict between the wishes of the non-supportive parent and the best interest of the LGBT youth, it becomes clear that a parent cannot subject her LGBT child to harm simply because her actions are grounded in religious beliefs. Outside of the child custody context, this harm must be serious. Inside the child custody context, the standard for the level of harm is much lower, as the judge simply compares the benefits and harms presented by each parent.

B. Parental Rights in Child Custody Disputes Involving LGBT Youth

Parental rights operate very differently in child custody proceedings. As explained in Section II.A, both parents ordinarily share the rights and duties of raising their child. However, when these parents divorce, their rights and duties fracture, and the court must determine which parent will continue to serve the child’s best interests. In a child custody dispute where parents disagree as to what is in the child’s best interest, the court must decide for itself which parent will continue to carry out his/her duty best. The parent to whom the court does not grant custody cannot object that her rights are violated because, as a trustee, her rights could only be used to secure the child’s best interest—a fact the court has determined against her.

Newmark v. Williams, 588 A.2d 1108, 1116 (Del. 1990); See, e.g., In re McCauley, 565 N.E.2d 411, 413–14 (Mass. 1991) (listing five factors a court should consider in determining whether to order a blood transfusion against the parents’ religiously motivated objections); Commonwealth v. Twitchell, 617 N.E.2d 609 (Mass. 1993).

207. Prince v. Massachusetts, 321 U.S. 158, 170 (1944); see THOMAS JACOBS, CHILDREN AND THE LAW: RIGHTS AND OBLIGATIONS § 10:09, 26–33 (2010); see, e.g., In re McCauley, 565 N.E.2d at 414 (upholding the lower court’s order to move forward with blood transfusion for eight-year-old leukemia victim); compare In re Eric B. 189 Cal. App. 3d 996 (1987) (upholding a lower court’s order to continue chemotherapy for a seven-year-old cancer victim), with Newmark, 588 A.2d at 1120 (honoring the parent’s decision to refuse chemo treatment for child cancer victim where there was a 40% chance of survival and the child expressed strong fears).

208. Prince, 321 U.S. at 170.

209. See CHILD CUSTODY & VISITATION, supra note 53, at § 10.03[1].
Additionally, when a court makes a custody determination, and the two parents’ views as to how to raise their child conflict, the court cannot advance one parent’s rights without violating the other parent’s rights. It is a tug of war—gain for one parent necessarily means loss to the other. Conflicts over religious upbringing and instruction are again illustrative, especially since many parents object to their LGBT child’s sexual orientation or gender identity/expression on religious grounds.211

Under the First Amendment, the state can neither establish a religion nor inhibit the free-exercise thereof.212 For example, suppose that in the introductory case Smith v. Smith, Kevin, the father, had objected to Christine’s gender expression for religious reasons and asserted his view as a First Amendment right.213 If the court recognized this “right” and ruled in favor of Kevin, the court would have endorsed religion.214 This endorsement would violate Victoria’s right to be free from a state establishment of religion. The converse would be true if Victoria had asserted her view as a First Amendment right. Consequently, a court generally does not recognize First Amendment rights in child custody proceedings.215 A court must “maintain an attitude of ‘neutrality,’ neither ‘advancing’ nor ‘inhibiting’ religion.”216 Rather than resolve parental rights conflicts, courts focus solely on the welfare of the child.217 As such, attempts to justify the violation of an LGBT youth’s rights by asserting parental substantive due process or First Amendment rights fail.

**CONCLUSORY REMARKS AND RECOMMENDATIONS TO JUDGES AND ATTORNEYS CONCERNING LGBT YOUTH IN CUSTODY PROCEEDINGS**

An LGBT youth possesses the same substantive due process right to respect for her sexual orientation or gender identity/expression as a straight or cisgender child. Because the best interests of the child standard is highly subjective and deferential, it is insufficient to protect the rights of the LGBT youth. Instead, a court must move beyond its own conceptions of the child’s best interest, recognize the LGBT youth’s rights, and rule accordingly. In short, a judge cannot

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211. See Lawrence v. Texas, 539 U.S. 558, 571 (2003) (stating, “[i]t must be acknowledged, of course, that the Court in Bowers was making the broader point that for centuries there have been powerful voices to condemn homosexual conduct as immoral. The condemnation has been shaped by religious beliefs, conceptions of right and acceptable behavior, and respect for the traditional family. For many persons these are not trivial concerns but profound and deep convictions accepted as ethical and moral principles to which they aspire and which thus determine the course of their lives.”).

212. U.S. CONST. amend I.


214. Id.

215. CHILD CUSTODY & VISITATION, supra note 53, at § 10.10[3][a].


217. CHILD CUSTODY & VISITATION, supra note 53, at § 10.10[3][a].
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consider an LGBT youth’s sexual orientation or gender expression as a harm to be avoided. Lawrence enjoins the state from arbitrarily demeaning or controlling an LGBT person’s destiny. Lawrence may also create a presumption in favor of the supportive parent in order to help the LGBT child develop into a healthy and autonomous LGBT adult. Although it is impossible to fully know what entered the judge’s calculations in Smith v. Smith, it is more than possible that the result would have been very different, and more respectful of Christine’s gender identity, had the court better understood the constitutional implications of its decision.

Although this Commentary specifically addresses LGBT youth in custody determinations, one may apply the concepts outlined here in numerous other contexts. The best interests of the child standard reigns in guardianship cases, guardian ad litem recommendations, and child support determinations. In all such cases, LGBT youth are vulnerable and their rights must be understood, asserted, and respected.

219. For an exploration on how a guardian ad litem can effectively represent the best interests of an LGBT youth, see Sarah Valentine, When Your Attorney is Your Enemy: Preliminary Thoughts on Ensuring Effective Representation for Queer Youth, 19 COLUM. J. GENDER & L. 773, 774 (2010).