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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 children¹: Bradley was assigned male at birth and identifies as a girl.² 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!'"³

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!"⁴ 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 her⁵ 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,

*Graduate of UCLA School of Law, 2012, and Editor-in-Chief of the *Dukeminier Awards Journal of Sexual Orientation and Gender Identity Law*, Vol. 11. I am privileged to have had outstanding mentors to whom I am very grateful, and to have enrolled in Professor Nancy Polikoff's Rights of LGBT Parents course, which inspired this essay. Thanks to Professor Nancy Polikoff, Professor Orly Rachmilovitz, and Professor Michael Boucai for their thoughtful guidance and encouragement. Thanks also to Stephanie Plotin and the research staff of UCLA's Hugh & Hazel Darling Law Library. Finally, thanks to my family and friends for their unconditional support.

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

2. Alix Spiegel, *Two Families Grapple with Sons' Gender Identity: Psychologists Take Radically Different Approaches in Therapy*, NPR (May 7, 2008, 4:00 PM), <http://www.npr.org/2008/05/07/90247842/two-families-grapple-with-sons-gender-preferences>.

3. *Id.*

4. Lauren Smiley, *Girl/Boy Interrupted: A New Treatment for Transgender Kids Puts Puberty on Hold So They Won't Develop Into Their Biological Sex*, SF WEEKLY (July 11, 2007), <http://www.sfweekly.com/2007-07-11/news/girl-boy-interrupted/>.

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.”⁶

Transgender youth,⁷ like Bradley and Marty, have few routes to appropriate treatment without support of their parents.⁸ 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.⁹ This disagreement was adjudicated in the custody dispute *Smith v. Smith*.¹⁰ This essay analyzes *Smith* and applies to cases involving gender-nonconforming¹¹ 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.¹² As one scholar observed, “Only one federal judge has explicitly disavowed, with specific reference to children, the state's interest in fostering heterosexuality.”¹³ An increasingly visible

6. Jennifer Diane Rietz, *Why Did This Have to Happen to Me?*, posting to Transsexual.org, (Mar. 23, 2009), <http://transsexual.org/Why1.html>.

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).

9. *Transgender Family Law Facts: A Fact Sheet for Transgender Spouses, Partners, Parents, and Youth*, TRANSGENDER LAW CENTER (Oct. 2006), <http://transgenderlawcenter.org/transgender-family-law-facts>. The Transgender Law Center (“TLC”) recommends that supportive parents in this situation “contact the TLC or another knowledgeable legal resource prior to taking any significant steps.” *Id.*

10. *Smith v. Smith*, No. 05-JE-42, 2007 LEXIS 1282 (Ohio Ct. App. Mar. 23, 2007).

11. GENDER SPECTRUM, <http://www.genderspectrum.org/understanding-gender> (last visited Dec. 14, 2011). Gender variance exists when a person's preferences and self-expression for one's own gender fall outside commonly understood gender norms.

12. See, e.g., Orly Rachmilovitz, *Masters of Their Own Destiny: Children's Identities, Parents' Assimilation Demands and State Intervention*, 98 MINN. L. REV. (forthcoming 2014), available at <http://www.bu.edu/law/faculty/scholarship/workingpapers/documents/RachmilovitzO081313.pdf>; Noa Ben-Asher, *Paradoxes of Health and Equality: When a Boy Becomes a Girl*, 16 YALE J.L. & FEMINISM 275 (2004).

13. Michael Boucai, *Sexual Liberty and Same-Sex Marriage: An Argument from Bisexuality*, 49 SAN DIEGO L. REV. 415, 483 (2012) (citing *Lofton v. Sec'y of the Dep't of Children & Family Servs.*, 377 F.3d 1275, 1300 (11th Cir. 2004) (Barkett, J., dissenting)). See also Carlos A. Ball, *Lesbian and Gay Families: Gender Nonconformity and the Implications of Difference*, 31 CAP. U. L. REV. 691, 740 (2003) (arguing for a strong doctrinal basis for claiming that the state does not have any legitimate interest in attempting to influence children's gender identity, expression, or behavior by fostering masculinity in boys or femininity in girls); Kim H. Pearson, *Mimetic Reproduction of Sexuality in Child Custody Decisions*, 22 YALE J.L. & FEMINISM 53, 57 (2010) (non-heterosexual parents “create an environment in which it is safer for children to openly express their own sexual orientations”).

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

14. For example, the California and New Jersey legislatures enacted laws banning so-called conversion therapy for children. Paul Elias, *California Gay Conversion Therapy Ban Upheld by Federal Court*, HUFFINGTON POST (Aug. 29, 2013, 5:58 PM), http://www.huffingtonpost.com/2013/08/29/california-gay-conversion-therapy-ban_n_3837922.html; Aaron Blake, *Christie Signs Bill that Bans Gay Conversion Therapy*, THE WASHINGTON POST (Aug. 19, 2013, 12:48 PM), <http://www.washingtonpost.com/blogs/post-politics/wp/2013/08/19/christie-will-sign-bill-that-bans-gay-conversion-therapy/>.

gender identity disorder (“GID”).¹⁵ 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”).¹⁶ 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.”¹⁷ Depending on age, such individuals may be diagnosed with GID in adults, adolescents, and children.¹⁸ To be diagnosed with GID in children, GIDC, a patient must meet four criteria.¹⁹

15. See *Smith v. Smith*, No. 05-JE-42, 2007 LEXIS 1282, at *31–32 (Ohio Ct. App. Mar. 23, 2007); *Shrader v. Spain*, No. 05-95-01649-CV, 1998 LEXIS 686, at *2 (Tex. App. Feb. 4, 1998), discussed *infra*.

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/Documents2/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.

18. 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

20. K. Clements-Nolle, R. Marx & M. Katz, *Attempted Suicide Among Transgender Persons: The Influence of Gender-Based Discrimination and Victimization*, 51(3) J. HOMOSEXUALITY 53–69 (2006). Approximately one-third of transgender youth have attempted suicide.

21. EMILY A. GREYTAK, JOSEPH G. KOSCIW & ELIZABETH M. DIAZ, *THE GAY, LESBIAN AND STRAIGHT EDUCATION NETWORK HARSH REALITIES: THE EXPERIENCES OF TRANSGENDER YOUTH IN OUR NATION’S SCHOOLS* vi (2009), available at http://www.glsen.org/binary-data/GLSEN_ATTACHMENTS/file/000/001/1375-1.pdf.

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.

23. Sonja Shield, *The Doctor Won’t See You Now: Rights of Transgender Adolescents to Sex Reassignment Treatment*, 31 N.Y.U. REV. L. & SOC. CHANGE 361, 382 (2007).

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.²⁵ These harms increase with age as “[t]hey have to cope with . . . living with a self-concept that is never socially acknowledged or reinforced.”²⁶ 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.²⁷ 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.²⁸

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.”²⁹ 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.”³⁰

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.

26. Shield, *supra* note 23, at 383.

27. Shield, *supra* note 23, at 383.

28. Shield, *supra* note 23, at 383–84.

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.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.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.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.³⁴ Therefore, delaying sex reassignment until adulthood makes transitioning more difficult, less convincing, more expensive, and more invasive.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.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.³⁷

31. RYAN, *supra* note 22, at 9–12.

32. See Holning Lau, *Pluralism: A Principle for Children's Rights*, 42 HARV. C.R.-C.L. L. REV. 317, 327–28 (2007) (describing the resilience of gay children).

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.

34. See, e.g., Shield, *supra* note 23, at 378 (citing Henk Asscherman & Louis J.G. Gooren, *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.

35. JULIA SERANO, *WHIPPING GIRL: A TRANSEXUAL WOMAN ON SEXISM AND THE SCAPEGOATING OF FEMININITY* 229 (Seal Press 2007).

36. Shield, *supra* note 23, at 379.

37. See SERANO, *supra* note 35, at 176 (discussing and critiquing the term "passing" in

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.

39. HBIGDA Standards of Care, *supra* note 16 (categorizing treatment involving puberty-delaying hormones as a "fully reversible intervention"); *see also* Shield, *supra* note 23, at 379. Additionally, administering puberty-blocking hormones is well established as a method of treating Precocious Puberty, a condition where puberty commences unusually early in children. Precocious Puberty is the development of secondary sexual characteristics before 8 years old in girls, and 9 years old in boys. In the United States, the incidence of Precocious Puberty is 1 per 5,000–10,000 individuals. MONICA TRANETZKI, TANNER STAGING (2006), available at [http://pediatrics.uchicago.edu/chiefs/documents/Precocious Puberty.pdf](http://pediatrics.uchicago.edu/chiefs/documents/Precocious%20Puberty.pdf). Since its introduction in the 1970s, no ill consequences of using puberty-blocking hormone treatment to children with Precocious Puberty are known. *See also* Bella English, *Led By the Child Who Simply Knew*, BOSTON GLOBE (Dec. 11, 2011), <http://www.bostonglobe.com/metro/2011/12/11/led-child-who-simply-knew/SsH1U9Pn9JKArTiumZdxal/story.html>.

40. *See* W. A. Marshall & J. M. Tanner, *Variations in the Pattern of Pubertal Changes in Boys*, 45 ARCH. DIS. CHILDH. 13 (1970), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2020414/pdf/archdisch01548-0015.pdf>; W. A. Marshall & J. M. Tanner, *Variations in Pattern of Pubertal Changes in Girls*, 44 ARCH. DIS. CHILDH. 291 (1969), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2020314/pdf/archdisch01552-0003.pdf>. Tanner Staging is a widely accepted model for determining the development of puberty in both boys and girls. Tanner Staging identifies five distinct points of pubertal maturation by measuring the development of genitalia and pubic hair. This method is reliable because puberty occurs with an identifiable sequence and timing, with minor variation. The HBIGDA Standards of Care recommends initiating the treatment at Tanner Stage Two, for example where for females breast buds and pubic hair begin to appear. However, it maintains the option of initiating the treatment earlier. The five Tanner Stages are reproduced in the Child Growth Foundation report. JAMES M. TANNER, CHILD GROWTH FOUNDATION, PUBERTY AND THE TANNER STAGES (2010), available at http://www.childgrowthfoundation.org/psm_tanner_stages.htm (last visited Sept. 4, 2013). Tanner Staging is not intended to determine an individual's age. The adult entertainment industry has criticized prosecutors for using Tanner Staging inappropriately to determine the chronologic ages of subjects of pornographic images, which led to false child pornography convictions. *See, e.g.*, Thomas Hymes, *Lupe Fuentes Saves Man From Bogus "Child Porn" Charge*, AVN (Apr. 16, 2010, 04:39 PM), <http://business.avn.com/articles/legal/Lupe-Fuentes-Saves-Man-From-Bogus-Child-Porn-Charge-394003.html>; *Adult Film Star Verifies Her Age, Saves Fan From 20 Years In Prison*, RADAR ONLINE (Apr. 21, 2010),

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.⁴¹ 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.⁴²

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.⁴³ Because the effects of puberty are virtually impossible to erase, the opponents deprive the individual of a critical

<http://www.radaronline.com/exclusives/2010/04/adult-film-star-verifies-her-age-saves-fan-20-years-prison>.

41. See generally Kenneth Zucker, *Commentary on Langer and Martin's (2004) "How Dresses Can Make You Mentally Ill: Examining Gender Identity Disorder in Children,"* 23 CHILD & ADOLESCENT SOC. WORK J. 5–6, (2006), available at <http://www.springerlink.com/content/t1k888xr4n655x18/>.

42. A. Jain & C. Bradbeer, *Gender Identity Disorder: Treatment and Post-Transition Care in Transsexual Adults*, 18 INT'L J. OF STD AND AIDS 147, 147–50; P.T. Cohen-Kettenis, H.A., Delemarre-van de Waal, & L.J. Gooren, *The Treatment of Adolescent Transsexuals: Changing Insights*, 5 J. OF SEXUAL MED. 1892, 1892–97 (2007); P.T. Cohen-Kettenis & S.H.M. van Goozen, *Pubertal Delay as an Aid in Diagnosis and Treatment of a Transsexual Adolescent*, 7 EUR. CHILD & ADOLESCENT PSYCHIATRY 246 (1998).

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/SsH1U9Pn9JKArTiumZdxal/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.⁴⁴ Moreover, transgender youth experiencing puberty become extremely distressed by the onset of physical characteristics associated with the gender they reject.⁴⁵

Opponents favor another form of treatment, which is essentially “conversion” or “reparative” therapy.⁴⁶ 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.⁴⁷ 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.⁴⁸ Opponents of conversion therapy characterize it as a program

44. Chloe Johnson, *Transgender Teens: Doctors Refine Hormone, Other Therapies*, 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.).

45. Johnson, *supra* note 44.

46. Sana Loue, *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 *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, *Dr. Kenneth Zucker’s War on Transgenders*, QUEERTY (Feb. 6, 2009), <http://www.queerty.com/dr-kenneth-zuckers-war-on-transgenders-20090206/> (citing Simon D. Pickstone-Taylor, *Children With Gender Nonconformity*, 42.3 J. AM. ACAD. OF CHILD AND ADOLESCENT PSYCH. 266 (2003); PHYLLIS BURKE, *GENDER SHOCK: EXPLODING THE MYTHS OF MALE AND FEMALE* (1996)). In addition, proponents of this type of therapy in children are aligned with National Association for Research and Therapy of Homosexuality (“NARTH”), which advocates reparative therapy in homosexual adults. Stephanie Wilkinson, *Drop the Barbie! If You Bend Gender Far Enough, Does It Break?*, 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>.

47. Mathew D. Staver, *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. Sunnive Brydum, *Mat Staver Calls Sen. Rob Portman and Other Pro-Gay Republicans ‘Cockroaches’[sic]*, 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>.

48. See generally Benjamin Kaufman, *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,

of psychotherapy that attempts to “cure” individuals of their non-normative gender identity by directing them to conform to traditional gender norms.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.⁵⁰ Methods also include “electrical shock therapy, chemical aversive therapy, drug and hormone therapy, surgery, and psychotherapy.”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.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.”⁵³ Conversion therapy may be more dangerous for youth than for adults.⁵⁴ Also, conversion therapy for children may constitute legal neglect⁵⁵ 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

<http://narth.com/menus/mission.html> (last visited Sept. 3, 2013).

49. Although reparative therapy and its various forms are usually associated with lesbian, gay, and bisexual individuals, it may be applied to transgender individuals as well.

50. See discussion of Bradley *supra* Part I.

51. Karolyn Ann Hicks, “Reparative” Therapy: Whether Parental Attempts to Change a Child’s Sexual Orientation Can Legally Constitute Child Abuse, 49 AM. U. L. REV. 505, 515 (1999).

52. *Id.* at 513–15 (citing the American Academy of Pediatrics; the American Psychoanalytic Association; the American Psychiatric Association; and the American Psychological Association).

53. *Id.* at 513–20.

54. *Id.* at 517.

55. *Id.*

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.⁵⁶ Additionally, decision-making authority need not be equal and may be divided between parents based on the best interests of the child.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 *Johnson v. Johnson*, the parents disagreed over what type of prosthesis to provide for their child whose hand was amputated.⁵⁸ The mother wanted to provide a hand-like prosthesis, and the father, a hook-like one.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.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.⁶¹ Thus, the trial court ruled in favor of the father and awarded him ultimate medical decision-making authority.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.⁶³ The appellate court did not articulate what, if any, countervailing evidence the mother proffered.⁶⁴

In *Winters v. Brown*, the parents disagreed over whether to immunize their child.⁶⁵ The father wanted to have the child vaccinated, and the

56. *Plemer v. Plemer*, 436 So.2d 1348, 1351 (La. Ct. App. 1983); *Smith v. Smith*, 459 So.2d 646, 647 (La. Ct. App. 1984); *Rhoades v. Rhoades*, 535 P.2d 1122, 1125 (Colo. 1975).

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.

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." *Id.* at 160. Notably, too, Justice Abrahamson recognized the larger role of sex stereotypes in family law matters. *Id.* at 159.

59. *Id.* at 149.

60. *Id.*

61. *Id.*

62. *Id.* at 148.

63. *Id.* at 148-49.

64. *Id.*

65. *Winters v. Brown*, 51 So. 3d 656, *657-58 (Fla. Dist. Ct. App. 2011).

mother objected to vaccinations based on her religious beliefs.⁶⁶ The trial court based its ruling on the expert testimony of three doctors.⁶⁷ Two of the doctors testified that vaccinations are safe and effective in preventing infections.⁶⁸ 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.⁶⁹ Thus, the trial court awarded the father ultimate responsibility for the child's health care.⁷⁰ 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.⁷¹

In *In re Marriage of Jaeger*, the parents disagreed over the type of professional who would provide mental health counseling to their child.⁷² The father wanted the child to receive counseling through his Christian Science church, based on his religious beliefs.⁷³ The mother wanted the child to receive counseling through a non-Christian Science professional, which the trial court ordered and the mother ratified.⁷⁴ 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.⁷⁵ Thus, the appellate court found no error.

In *McGrath v. Mountain*, the parents disagreed over whether to immunize their child.⁷⁶ The father wanted to immunize the child, and the mother, a chiropractor who used holistic medicine and homeopathy in treating her son, opposed immunization.⁷⁷ At trial, the father presented testimony as to the benefits of immunization, and the mother presented

66. Brown, 51 So. 3d 656, *657–58, *657.

67. *Id.* at *658 n.1.

68. Brown, 51 So. 3d 656, at *658 n.1.

69. *Id.*

70. *Id.* at *658.

71. *Id.*

72. *In re Marriage of Jaeger*, 883 P.2d 577 (Colo. App. 1994).

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.⁷⁸ Based on the evidence and the best interest of the child, the trial court awarded the mother ultimate authority to make decisions regarding the child's immunization.⁷⁹ 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.⁸⁰ 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.⁸¹ The child was assigned male at birth and "exhibited signs from a very early age that he wanted to be treated as a girl."⁸² 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.*

81. *Smith v. Smith*, No. 05-JE-42, 2007 LEXIS 1282 (Ohio Ct. App. Mar. 23, 2007).

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.⁸³ Additionally, the mother was considering puberty-blocking hormone therapy for the child as treatment for the child's alleged GIDC.⁸⁴ 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,⁸⁵ the mother was designated the child's residential parent, and the father was granted standard visitation.⁸⁶ 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.⁸⁷ The trial court ultimately designated the father as the residential parent.⁸⁸ On appeal, the court found no error in the trial court proceedings and affirmed the trial court's ruling.⁸⁹

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."⁹⁰ The trial court also prohibited the parties from treating the child for GIDC during the pendency of the trial.⁹¹ 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.⁹² 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."⁹³

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.⁹⁴ 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."⁹⁵

83. Smith v. Smith, No. 05-JE-42, 2007 LEXIS 1282, 1.

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 GIDC⁹⁶ 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.⁹⁷ The mother also called two expert witnesses, who affirmed a GIDC diagnosis.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.⁹⁹ Moreover, the trial court conducted its own investigation into a GIDC diagnosis, finding that Christine did not have GIDC.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

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.

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.

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.

99. *Id.*

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.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."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 attorney¹⁰³ 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.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.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.¹⁰⁶ Additionally, the trial court's finding that "the change of environment [from supportive mother to

101. Smith v. Smith, No. 05-JE-42, 2007 LEXIS 1282, 16.

102. Transcript of Proceedings at 9, Smith v. Smith, No. 05-JE-42, 2007 LEXIS 1282 (2007) (No. 01-86) [hereinafter Transcript].

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.

104. Transcript, *supra* note 102, at 14-27.

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.

106. *See, e.g.*, GREYTAK, *supra* note 21, at 91. Schools can reinforce gender conformity through every day practices and policies.

rejecting father]”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.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.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.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.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.

107. *Smith v. Smith*, No. 05-JE-42, 2007 LEXIS 1282, at *17–18 (Ohio Ct. App. Mar. 23, 2007).

108. *See supra* Part II.

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.

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.

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*,¹¹² 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."¹¹³ The court based this conclusion on the testimony of two psychologists who testified that the mother's accepting behaviors and home environment were problematic.¹¹⁴ 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.¹¹⁵

C. HOW BIAS ENTERS THE DECISION-MAKING PROCESS IN GENDER NONCONFORMING CHILD CUSTODY CASES

Smith and *Shrader*, the only two publicly available¹¹⁶ 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.¹¹⁷ Thus, the court will award residential

112. *Shrader v. Spain*, No. 05-95-01649, 1998 WL 40632 (Tex. App. Feb. 4, 1998).

113. *Spain*, No. 05-95-01649, 1998 WL 40632, at *5.

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.¹¹⁸ 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.¹¹⁹ 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.¹²⁰

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 conversion 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.¹²⁴ 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 JUDGES¹²⁵

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."¹²⁶ 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."¹²⁷

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

124. See, e.g., *J.L.S. v. D.K.S.*, 943 S.W.2d 766, 773 (Mo. Ct. App. 1997) (discussing expert evidence of a transgender parent's GID and its effect on children noting that the parent's gender identity could cause emotional problems for the children and remanding to the trial court to "determine the mental and emotional status of the parents and children to determine what is in the best interests of the children.").

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.

126. Sarah E. Valentine, *Traditional Advocacy for Nontraditional Youth: Rethinking Best Interest for the Queer Child*, 2008 MICH. ST. L. REV. 1053, 1099 (2008).

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.”¹²⁸

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 Law¹²⁹ 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”¹³⁰ of supportive parents of transgender children.¹³¹ 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.¹³²

128. Shannon Minter. 1 Sexual Orientation and the Law § 9:18.

129. See *Education: Judicial Training Program*, THE WILLIAMS INSTITUTE, <http://williams.institute.law.ucla.edu/judicial-training-program/> (last visited Sept. 1, 2013). “The Williams 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_competence.html (last visited Sept. 1, 2013).

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.
