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A Review of Gender Affirming Care for Minors

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Abstract

Transgender individuals struggle with a misalignment between their biological and interpersonal self, in order to rectify this issue gender affirming health care is used to re-align the two aspects of themselves. The American Psychiatric Association defines transgender individuals as those who are assigned one gender identity at birth and identify as another later in life (Yarbrough 2023). There are various different gender orientations that a person can identify with but most of the examples will focus on male-to-female (MTF) or female-to-male (FTM) transgender experiences. The current standard on gender affirming care focuses on various steps of diagnosis, traditional therapy, hormone therapy and surgical interventions (Yarbrough 2023). Transgender children suffer academically and socially due to having an internal struggle with their gender dysphoria, often affecting their everyday life (Boyle 2022). The argument against gender affirming care for minors focuses on the ability of minors to conceptualize the long-lasting effects the care will have on their body as well as the fear the individual will change their mind over time. The argument for gender affirming care for minors views the issue as necessary medical care that treats a life-threatening issue. This paper will conduct a thorough review of current opinions on gender affirming care for minors, addressing gaps in understanding of what care is given and the effects the care has on the individual with a special note on beneficence, non-maleficence, and autonomy using a deontological ethical framework.

Keywords: gender affirming, hormone therapy, gender dysphoria

An Ethical Review of Gender Affirming Treatment for Minors

Transgender individuals struggle with a misalignment between their biological and interpersonal self; in order to rectify this issue, gender-affirming health care is used to re-align these two aspects of themselves. The American Psychiatric Association defines transgender individuals as those who are assigned one gender identity at birth and identify as another later in life (Yarbrough, 2023). An example of someone being transgender is an individual being assigned male at birth but later in life identifying as a woman. There are various different gender orientations that a person can identify with but most of the examples will focus on male-to-female (MTF) or female-to-male (FTM) transgender experiences. Gender-affirming care is health care given to individuals to treat the misalignment of gender assignment and gender identity. The current standard on gender-affirming care focuses on various steps of diagnosis, traditional therapy, hormone therapy, and surgical interventions (Yarbrough, 2023). The process from acknowledgement of gender identity to surgical intervention often takes years to complete; additionally, medical practices like hormone therapy and surgical intervention are not always requested or needed.

People who seek out gender-affirming treatment often struggle with psychological distress caused from the misalignment between assigned sex and gender identity. The Association of American Medical Colleges identifies this distress as gender dysphoria (Boyle, 2022). The individuals who seek out gender-affirming care, which others view as extreme, have been battling an internal struggle for years and will continue to struggle until medical support is provided. Further, gender dysphoria is supported as a serious clinical condition by the American Psychiatric Association, focusing on the dangers of a misalignment of gender assignment and

gender identity (Yarbrough, 2023). Additionally, children who express signs of gender dysphoria often have coexisting disorders of depression and anxiety (Coleman et al., 2012).

The special circumstances of minors are that minors face this struggle at a pivotal time in their life. Transgender children suffer academically and socially due to having an internal struggle with gender dysphoria, often affecting their everyday life (Boyle, 2022). The argument against gender-affirming care for minors focuses on the ability of minors to conceptualize the long-lasting effects the care will have on their body, as well as the fear that the individual will change their mind over time. The argument for gender-affirming care for minors views the issue as necessary medical care that treats a life-threatening issue.

This paper will conduct a thorough review of current medical standards on gender-affirming care for minors, addressing gaps in understanding of what care is given, and the effects the care has on the individual with a focus on beneficence, non-maleficence, and autonomy using a deontological ethical framework.

Gender Affirming Care

Gender-affirming care is used to treat the misalignment of gender assignment and gender identity. The first step in gender-affirming care involves mental health evaluations (Kumar et al., 2022). Mental health evaluations ensure the validity of the patient's identity and that there is a documented pattern of gender dysphoria within the minor's medical history. After the evaluation, different steps in treatment can be surgery, hormone therapy, voice/communication therapy, and additional mental health services.

The World Professional Association for Transgender Health has created a guideline called the "Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People," or the SOC for short, which outlines various standards and

safety protocols needed in order to provide gender-affirming care (Coleman et al., 2012). When it comes to the treatment of minors, there are areas of concern due to the growth of their bodies and fear of their growth being stunted if introduced to hormone therapy. However, the SOC has provided an abundance of research into hormone therapy when used at different stages of growth and has developed guidelines especially catered towards the care for minors. The SOC notes that children as young as two years old can start showing signs of gender dysphoria.

The key to the treatment of minors seems to be a strong emphasis on acceptance and support; a minor facing backlash from parents or medical professionals could experience negative effects on their overall health. A strong relationship between the minor and medical professionals is necessary in order for an accurate understanding of the timing of medical treatment. Even social transitioning needs to be timed correctly in order to both validate the minor's condition, and ensure it is the best course of treatment, and this is heavily impacted by their relationship with their parents.

There are three categories of interventions: fully reversible, partially reversible, and irreversible. Dr. Olson at the Children's Hospital Los Angeles explains the steps of fully reversible interventions such as social transitioning and puberty suppression. Social transitioning involves going by new pronouns and using a new name that better aligns with the patient's gender identity. Puberty suppression involves using hormone treatment to stop and postpone puberty until the child is mentally ready. Dr. Olson also recommends social transitioning and puberty suppression to start as early as Tanner Stage 2 of puberty, meaning around the ages of 10-14 years old (Olson & Forbes, 2011). This step in the treatment process can be fully reversed with no physical negative side effects to the adolescent and provides more time for the individual to come to terms with the long-lasting side effects of later treatments.

Partially reversible treatment focuses on cross-gender hormone therapy and is recommended to start at 16 years old at the earliest after being given critical review of the patient's case (Olson & Forbes, 2011). Cross-gender hormone therapy involves the hormone blockers used for puberty suppression as well as additional hormones that align with the gender identity of the individual. Cross-gender hormone therapy can be stopped but the therapy causes physical changes to the individual that take time and more hormone therapy to revert back to the original gender traits.

The last phase of treatment is called irreversible due to the surgical procedures the treatment plan entails. The surgical procedures within the irreversible phase aim to give the individual a physical appearance that matches their gender identity and can include vaginoplasty, jaw shaping, mastectomy, phalloplasty, and a number of other surgeries (Olson & Forbes, 2011). Due to the risk and hardship this takes on the body, this phase of treatment is not recommended for individuals under the age of 18 and often is a step taken after years of other treatment alternatives. Overall, gender-affirming care is well-developed and has barriers in place in order to protect the well-being of the individual.

Arguments Against Gender Affirming Care for Minors

Arguments against gender-affirming care for minors focus on maturity level, when treatment starts, consent for treatment, mental health, and the physical and mental development of the minor.

The maturity level and understanding of the severity of gender-affirming treatments leads parents and healthcare providers hesitant to make decisions on behalf of the minors who want gender identity correction. Parents and healthcare providers are hesitant to make permanent decisions when the minor's feelings of gender dysphoria often do not continue past the

completion of puberty (Kimberley et al., 2018). Additionally, some studies found that the levels of depression and anxiety in children who were allowed to socially transition, compared to those who were not allowed to socially transition, had insignificant differences according to the American Academy of Pediatrics (Kimberley et al., 2018). While the feelings of depression, anxiety, and gender dysphoria are present at the time and are valid, the feelings often do not last, making treatments used to address those feelings unsuccessful. However, the American Academy of Pediatrics does note that the database for these findings were not very large, which leads to the questioning of the significance of the findings (Kimberley et al., 2018).

Adolescence, or teenage years, are meant to be a time of discovery and often have individuals "trying different hats" in order to find the identities that fit them best. Treating minors for gender dysphoria during this time for one gender identity could prevent minors from exploring other identities and discovering the one that fits them best. By focusing on one identity the natural timeline of puberty and self-discovery is being disrupted and denies the individual of healthy maturing (Levine & Abbruzzese, 2023). Disrupting healthy maturing is a genuine concern and should be taken into consideration, since the purpose of the mental health assessments prior to gender-affirming treatments is to address this concern.

Consent, ethically, needs to be informed and continuous in order for medical procedures to be conducted. In the instance of gender-affirming treatment for minors, the parents are in charge of consent. Most hospitals would view gender-affirming treatment as outside of those areas and any treatment while under the age of 18 in the United States would require parental approval (Kimberley et al., 2018). Further, certain hospitals in the United States require both parents to consent which ensures the rights of both parents are respected (Kimberley et al., 2018). Overall, current laws regarding consent means parents have full control over the minor's

care and quite possibly not even one parent can control the treatment decisions regarding their child, the minor.

The biggest concern regarding gender-affirming treatments for minors is the effects hormone treatment will have on their physical growth. Puberty blockers are recommended for the individual to have more time before undergoing the traumatizing experience of going through puberty of an incorrect gender; however, the use of these hormones comes with negative effects. Bone density, growth potential, blood pressure, and neurocognitive development are all areas of interest that could be affected by puberty blockers but have been identified as needing more research by the Annual Review of Medicine's Dr. Lee and Dr. Rosenthal of UCSF (2022). These are serious concerns and should be taken into consideration as the review provides a critical review of the use of hormone blockers in biological processes.

Mental health tends to be an uncertain territory as both hormone treatment and surgical treatment have no long-term effects on the individual's mental health. Dr. Levine and Dr. Abbruzzese found no improvement in the long-term mental health of individuals who underwent treatment in one of their studies and further found that suicide attempts amongst all stages of treatment stayed consistent in a second study (Levine & Abbruzzese, 2023). The most consistent finding of both studies was that transgender individuals, in comparison to the general population, had higher mental health conditions (Levine & Abbruzzese, 2023). Both studies were noted to have flawed methodologies but speak about whether mental health concerns are actually being treated.

Arguments for Gender Affirming Care for Minors

When addressing the concerns over the use of puberty blockers and its effects on the patient's mental health, Dr. Costa et al. (2015), with the Journal of Sexual Medicine, conducted a

study using two hundred adolescents and observed the effects of puberty blockers over a period of time. Dr. Costa acknowledged the need for more research into the effects of puberty blockers and found that when rating the subject's mental health using the Children's Global Assessment Scale, the use of puberty suppression caused a 13.9-point increase after 12 months and that receiving psychological support gave a 12.2-point increase (Costa et al., 2015). These point differences are significant since there are 10 categories based on the child's score in the Children's Global Assessment Scale and each category is separated by 10 points, meaning a child that is doing all right compared to one with some problems is only separated by 10 points. These findings both address the concern presented by the earlier arguments and attempt to address the need for more research in the field. Use of the Children's Global Assessment Scale provides further support by using an already accepted psychosocial scale.

The adolescents having an increase in mental health with psychological support and an even bigger increase with puberty suppressors speaks to the impact any treatment can have on the adolescent. Some parents and health care professionals may be hesitant to start hormone treatments and Dr. Costa's study speaks to a continuous theme that, at the bare minimum, minors experiencing gender dysphoria should be given psychological care to further understand themselves and adjust to the future changes to their bodies as they grow older. Further, even Dr. Lee and Dr. Rosenthal (2022), as previously mentioned, noted that providing gender-affirming care to transgender youth has a beneficial, even going so far as to say lifesaving, effect on the mental health of the youth; Dr. Lee and Dr. Rosenthal just believe caution should be apparent when it comes to how early hormone treatments should be introduced.

When the aspect of physical health is a concern, gender-affirming care is suggested to follow the Standards of Care put forth by the World Professional Association for Transgender

Health. The Standards of Care is an accumulation of research resulting in a guideline for not just the treatment of gender dysphoric individuals, but also the treatment of minors suffering from gender dysphoria, with a section especially dedicated to it.

Concerns about growth, bone density, cardiac health, and neurocognitive development have all been taken into consideration with a psychological therapy first approach (Coleman et al., 2012). The guideline addresses the reports that gender dysphoria present in children does not tend to persist into adulthood and recommends a wait-and-see approach aided with mental health service, the guideline does however report that adolescents (individuals aged 12-18 years) who present with gender dysphoria tend to continue treatments throughout adulthood (Coleman et al., 2012). These studies showed roughly a quarter of children continuing treatment into adulthood, and all seventy of the studied adolescents continuing treatment into adulthood (Coleman et al., 2012). Children are individuals who are under the age of 10 or pre-pubescent and adolescents are individuals entering puberty all the way until adulthood, normally ages 10-19. The maturity and identity-searching vital to puberty seem to have an effect on the persistence of gender dysphoria, which is why the use of therapy-only approaches until the onset of puberty is recommended, as well as, puberty blockers to be used on a case-by-case basis upon consensus between the medical official, parents, and child. Overall, the guideline hopes to focus on support and information for the patients and their families in hopes of understanding the full effects of treatment and non-treatment before making decisions.

The risks associated with non-treatment of transgender youth shows a need to address their health. Not only does providing gender-affirming treatment improve the current mental health of transgender minors, but the treatment also prevents the worsening of mental health outcomes. Transgender youth consistently report 20% higher rates of suicidal thoughts and

attempts compared to others in their age group, with two-thirds reporting suicidal ideation and a quarter reporting attempted suicide (Kimberley et al., 2018). Those who fear gender-affirming treatment will worsen the mental health of the minor and subsequently severely worsen their mental health instead. At this time, a note should be made that societal and familial understanding and support have great impacts on mental health, and transgender individuals who face harassment often turn to either self-treatment, isolation, or self-harm.

Current Laws and Court Cases

Laws restricting gender-affirming care for minors exist in four states currently: Alabama, Arkansas, Texas, and Arizona. The Kaiser Family Foundation assessed the four states as well as 15 states that are looking into similar laws, with Arizona's laws being the only ones not under a review by court order (Kates & Dawson, 2022).

Alabama's governor in 2022 signed a bill that prevents gender-affirming care, puberty blockers, hormone therapy, and surgical intervention including any school, medical, or administrative official supporting these acts were punishable with 10 years in prison (Kates & Dawson, 2022). Additionally, the law required parents and guardians to be informed if a child expresses a gender perception other than the one assigned at birth and states the official should not encourage the minor to continue their gender perception (Kates & Dawson, 2022). This law prevents any minors experiencing gender dysphoria from getting treatment and further perpetuates the hate culture towards individuals experiencing gender dysphoria by creating hostile environments. The bill is meant to affect anyone under the age of 18 seeking treatment, and anyone hoping to aid the treatment, even including counselors simply saying that they understand or simply providing a diagnosis for gender dysphoria. Currently, the bill has been put

on a temporary hold as it is in the 11th Circuit court with the Department of Justice joining the case in hopes to aid the transgender minors.

Arkansas' legislators went against their governor in 2021, overriding Governor Hutchinson's decision regarding a bill preventing any form of gender-affirming treatment for minors, public or private insurance coverage for gender-affirming treatment, and for any referrals from providers for the minor to get the procedure elsewhere (Kates & Dawson, 2022). This addition of the referral attempts to stop individuals from getting or seeking a diagnosis in Arkansas and going out-of-state or to a more lenient district to get treatment. Currently, the law is held up in district courts with arguments against it focusing on the rights of the parents to make decisions for their children, sex-based discrimination, free speech of health care professionals, and various other violations of the 14th and 1st amendments (Kates & Dawson, 2022). Parents' rights to make decisions regarding their children's health often tend to be respected when it comes to non-treatment decisions for gender dysphoric minors, despite its proven negative health impacts, however, in this case it is the parents' rights to make decisions regarding their children's health that is being restricted.

Texas' Governor Abbott declared gender-affirming treatment for minors as child abuse that can result in removal of the child from the parent's custody and removal of medical professional's licensing (Kates & Dawson, 2022). The bill also proposes medical professionals report when they know of these services being provided or having been provided, which is reminiscent of McCarthyism-style fear-mongering. This law is under a temporary hold in enforcement and the case is on trial. A vital point in the case being that the Governor issued this on a directive seemingly outside of his legal authority, for a declaration of this importance it should have gone through the legislature. Those affected by the directive experienced various

life-altering effects such as job loss, medical care withdrawal, and their constitutional rights being violated.

Arizona's restrictive legislation focuses on banning surgical gender-affirming treatment for minors (Kates & Dawson, 2022). This legislation is still standing and follows current medical opinions regarding the earliest recommended age for surgical treatment. This legislation does not address fully reversible or semi-reversible therapies used, just preventing permanent treatment methods. This legislation appears to be a starting point in hearing out both sides of the argument as the law allows treatment for those who seek gender-affirming care, but it prevents the irreversible effects at a young age that the opposing side is concerned about. The Arizona legislation is a basis recommended for other states wishing to regulate this treatment in order to protect the youth from balancing life-altering healthcare decisions and growing up.

These restrictive laws show a paternalistic thought process in which the government has to protect and restrict the people from themselves. The political climate around the legislations' use of protecting the youth aims to bounce back from earlier failures in restricting transgender rights as a whole. Both narratives fight for the restriction of transgender rights, the difference is that after failing to get bills passed as restrictions for the sake of opinions, the new bills are for the sake of 'protecting the children' (Harvard Law Review, 2023). The basis for most legal arguments against these actions center around the 14th Amendment's Equal Protection Clause and further Title IX's prohibition of sex-based discrimination (United States Courts, 2023). Discriminating against individuals seeking gender-affirming treatment based on their sex is in clear violation of the equal protections clause and Title IX, especially when gender-affirming treatment sought out by cis-gender individuals is not prohibited. Cis-gender individuals, those

who identify with their gender assigned at birth, often seek out treatment to reaffirm their gender like breast augmentation (men and women), hormone therapy, and mental health services.

Ethical Dilemmas

Gender-affirming health care for minors presents an ethical dilemma in three key areas: nonmaleficence, beneficence, and respect of patient autonomy (Levine & Abbruzzese, 2023). Nonmaleficence is the effort to do no harm and, in a clinical setting, encompasses physiologic, social, psychological, and medical areas of interest. Nonmaleficence speaks to the struggle of providing treatment that can prevent future harm, but also *cause* future harm. Puberty blockers, for instance, provide temporary relief from the psychological and social harms puberty can have on adolescence but can cause physiologic and medical harm later in life (Levine & Abbruzzese, 2023). Meanwhile non-treatment can cause current psychological and social harms from lack of support and acceptance, also resulting in physiologic and medical harm later in life from self-treatment and self-harm (Levine & Abbruzzese, 2023). Beneficence ensures the treatment is in the best interest of the individual, in this case, the minor. The use of therapy and hormone treatment offer gender-affirming treatment at a lower risk than surgical procedures, however, surgical procedures could offer a bigger reward. When it comes to the treatment of minors, the low-risk treatments tend to be exhausted for as long as possible before introduction of surgical treatments; however, this results in the persistence of gender dysphoria and feelings of dismissal that can affect mental health. The last dilemma of respect for patient autonomy is very critical in the treatment of minors. Parents have a right to make decisions in regard to their child's health and, when the patient is still in the earlier years of development, it is easy to respect this. Once a child reaches adolescence and the patient has a fuller understanding of their identity and is asking for treatment, a parent denying gender-affirming care becomes a moral dilemma.

When reviewing the topic under a deontological framework, the focus is on duty. Healthcare providers and guardians of minors have a duty to treat, support, and care for the gender dysphoria present. Ignoring or actively suppressing gender dysphoria ultimately causes more harm than good and ignores the autonomy of the minor.

Conclusion

The ethical issues presented show the in-depth moral dilemma within gender-affirming treatment for minors. The arguments for treatment versus non-treatment can result in harm in different ways. A treatment beneficial for the minor's health may need to be postponed due to their age, resulting in further mental stress. Parental rights to their child's health care decisions can often clash with the minor's wishes, or even disagreement between parents can make the decision-making process unclear. All of these factors culminate into bioethical decisions being made at home, in health care, and in the courts. The arguments against gender-affirming treatment for minors' centers around concerns about the negative physiological effects, future mental health concerns, lack of research, respect of consent, and denial of maturity. Arguments for gender-affirming treatment for minors' centers around the improvement of mental health with the introduction of treatment, understanding limits needed to protect the medical health of children, a clear understanding of the risks of non-treatment, and nontreatment's strong causation of suicidal tendencies in minors. There is a lack of concrete understanding of the harms of both treatment and non-treatment options; however, the research present does say that while risky, gender-affirming treatment has the greatest benefits on the minor's mental health which ultimately affects their physical health.

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