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At the Bedside

Caring for Transgender Adolescents

Edmund G. Howe

ABSTRACT

This introductory article presents some subtle and, perhaps, controversial aspects of providing care to adolescents who identify as transgender. I will describe (1) how praise from careproviders can benefit parents who have difficulty accepting the gender identity of their child that was not assigned at birth; (2) how adolescents who identify as transgender may follow the internet advice of peers on how to "con" careproviders; (3) how it may be difficult for careproviders to decide whether to further patients' felt needs and to protect them, paternalistically, from making an irreversible decision they may later regret; and (4) how careproviders can benefit adolescents by taking the initiative to discuss sex and how to say "no." I emphasize how careproviders who see these patients, even when they have no special expertise in this area, may be able to enhance patients' equality in every respect, even when they otherwise might not choose to do so.

In this issue of *The Journal of Clinical Ethics*, Laura Kimberly, Kelly McBride Folkers, Baer Karrington, Jeremy Wernick, Samantha Busa, and Caroline Salas-Humara, in "Navigating Evolving Ethical Questions in Decision Making for Gender Affirming Medical Care for Adolescents," discuss how careproviders can most help youth who identify as transgender and gender expansive.[1] The authors model a commitment to bettering adolescents' life experiences that all careproviders should emulate. Why? First, individuals want to change their gender to be or become who they *are*. There are other compelling reasons. For example, these adolescents are stigmatized in our society and in many others. As Kimberly and colleagues point out, one state in the United States tried to pass a law that would make it a criminal offense to help an ado-

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lescent change gender. The leader of another country described changing gender as a "monstrous" act, on the verge of being no less than "a crime against humanity."[2] Parents may reject adolescent children who want to change gender. For instance, one father said, "it turns my stomach to look at him. He looks like a freak." But he also said that *he* felt "like a monster" when he said it.[3] I will report on the outcome of their relationship at the end of this article.

Given this societal and sometimes parental rejection, adolescents may emotionally fare poorly. The percentage of these individuals who seriously consider suicide is reported to be very high, approaching 50 percent.[4]

In this article I will build on the insights of Kimberly and colleagues and discuss particularly how careproviders may apply them. Because others have masterfully begun this work, I will focus on issues that are less commonly considered: (1) parents and peers, (2) access to interventions, and (3) ways that careproviders may help. In the last section of this article I will discuss what careproviders may directly do for these adolescents. I include ethics consultants in these recommendations because adolescents who identify as transgender may not know many others with whom they can talk safely and openly. A challenging task for all careproviders is to not further medicalize adolescents who want to change their gender.

PARENTS AND PEERS

I will discuss ways careproviders may maximally help adolescents by helping their parents. Even when parents love and support their child unconditionally, they may still confront extreme stresses, such as having to cut ties with close relatives and friends who reject the adolescent for wanting to change the gender assigned to the child at birth. Helping parents cope well with these stresses may, in some cases, do more for the adolescent than using the same amount of time to help the child directly, as when careproviders provide assistance to caregivers of elderly patients. Helping a patient's caregiver may maximize the degree to which the patient does well. It is important that careproviders help parents to care maximally for their child, because adolescents—as anyone—may internalize any negative views their parents have toward them. This also may occur with their peers. These negative influences may produce catastrophic results. These difficult tasks for parents may begin in early childhood, as I will outline below.

Parents

Parents, even when they are optimally supportive, may face multiple traumas. In some cases, traumas may include deciding what to name their child and how to dress their child, and, later, whether and when to approve puberty-blocking drugs, gender-enhancing medications, and surgeries that may be irreversible. Their greatest challenge may be, however, to become able to love their child just as the child is.

How, then, if parents are initially not fully accepting, might careproviders best try to help them? The core approaches are well described elsewhere.[5] If parents use these approaches, their child's gains are likely to last.[6] A critically important intervention that is sometimes not emphasized, however, is how to respond with parents in a way that may leave them most open to change. This intervention may be underemphasized partly because it seems to go against common sense. It is paradoxical. I suggest that careproviders *praise parents for their toxicity.*

It may seem to be contrary to reasoning to praise parents, but the praise may be genuine, because it is likely that it will be deserved. That is because parents' toxicity likely stems from their great love for their child. This great love may be why they so object to their child's desire to transition. It may be that the intensity of the parents' feelings, more than the form their feelings take, reflects the extent of their caring. Pragmatically, careproviders who recognize this possibility, and who praise parents for their deep feelings of caring, may maximally move parents to be open to what careproviders say, when otherwise they might not. Careproviders who specialize in this area may be best equipped to educate struggling parents. Yet many parents may first present with their child to a nonspecialist. Nonspecialists may best help parents to be open and motivated to fully accept their child's wishes by affirming the parents' loving concern, rather than in any way criticizing or judging them, even implicitly.

Careproviders could explicitly say that they believe, from the intensity of the parents' views, that they must love their child dearly. Careproviders can then consistently suggest that they can understand, for this reason, why the parents are extremely upset. A careprovider could

respond this way to the father, described above, who said his adolescent son was a freak.

Some parents may be toxic for other reasons, but I believe this will rarely be the case. I recall, for instance, a mother who acknowledged with great shame that she hated her infant son. As she said this, tears streamed down her face. "I so much want to love him," she said, "but I can't. He has woken me up, screaming, literally every hour, every night, since he was born. I have gotten no sleep since that time." These feelings exemplify how parents may love their child deeply, but still be toxic. It suggests the many hidden reasons parents may have for this. Their reasons, like the mother's not getting sleep, may become an Achilles's heel—a weakness in an otherwise strong person that may destroy her or him. A first step may be to help parents accept their feelings. This is because parents can't change their feelings by just wanting them to change. Following this acceptance, careproviders may be able to help parents by exploring with them the precise, idiosyncratic sources of their toxic feelings and help them to ameliorate them.

If careproviders are able to bridge parents' initial distrust, they can try to move parents to an attitude of acceptance of their child, at their own pace. Careproviders may use an approach based on motivational interviewing. It sets the seed of a new belief while it recognizes that most people will need time to accept it. In this way, careproviders may be able to work with parents to explore their deepest concerns. The first step is to establish a safe setting.

When parents disagree on an intervention, careproviders may find they prefer the views of one parent over the views of the other, and the parent whose views are not preferred may feel abandoned or attacked. Parents may then feel defensive, and these feelings may prevail over their capacity to think and use logic. Should this happen, parents may find it difficult to change their views, when change might otherwise be quite possible.

Parents' deepest concern may be for their child to find happiness in life. Careproviders can point out to parents that their child's finding happiness may not result from acquiescing to others' views regarding gender. Finding happiness might come, at least in part, from experiencing their parents' love and respect. Parents may find such reasoning close to compelling. Children's greatest need may be to be seen and embraced as they see themselves.

Careproviders' greatest challenge may be to try to help parents and children. Adolescents may ally with a parent who supports them and oppose a parent who does not.[7] An optimal approach may be the same: to attempt to help *all parties*—parents and children—to appreciate that *both* parents may love their child equally, despite acting differently and despite a toxic parent's behavior that seems to contradict this. Shortly, I will consider how careproviders may best respond.

When both parents reject their child's wanting to change gender, the above approach still may be better than any other. Careproviders should seek, together with parents, to discern how they may best benefit their child. Surprisingly, there are reports that some parents support their child's wish to transition, but only when they see that their child is depressed.[8] These parents may benefit from their careproviders' instructions. Careproviders should advise these parents that they need to support their child when the child is not depressed. Careproviders can explain to parents that their support is preventive, and it may protect their child from becoming depressed, as opposed to reversing depression once it occurs. Careproviders can add the familiar saying that an ounce of prevention is worth a pound of cure. They might also inform parents that they should not expect to see any proof their effort has succeeded, as the only indication of success may be that their child's depression does not become worse.

There are gains from keeping families emotionally and physically together.[9] To achieve these gains, careproviders may have to consider practicing at the far edge of their professional standards. That is, careproviders may know these families, and the parents may already trust their careproviders. For example, the father who called his son a "freak" felt enough trust to bring his concern to his child's careprovider in the first place.

Careproviders might see toxic parents as emotionally abusive, and consider reporting them to Child Protective Services. But it is probably preferable that they do not. This is because careproviders' best chance to help parents and, thus, their children, may be to treat them, not report them. When careproviders report parents, it may destroy their relationship with the family, when having a relationship is the best, and perhaps even only, possible means by which these parents can change. I will later present an-

other example in which careproviders may have to act at the edge of their professional standards, or even outside of them.

What if none of these interventions moves parents to support their children? Careproviders' best hope may be, especially when the children are older, to tell them that although their parents greatly love them, yet still reject them, the parents may be wholly wrong, and the children should only feel proud about themselves. The courage that these children must have to present themselves to the world as they *are* is huge. These adolescents (rightly or wrongly) may see their careproviders as having expertise that their parents lack. This may enable them to believe what their careproviders suggest, rather than what their parents say.[10] It may enable these adolescents to acquire and retain self-esteem.

Peers

In this next section I will discuss peers. The influence of peers may be most beneficial when the peers have experienced transitioning, or are still going through it and are doing well. As this is the case, careproviders should try to arrange for contacts with these peers whenever possible, as long as both parties want that. Peers may, on the other hand, be toxic. When this is the case, parents should end their child's exposure to toxic peers, in the same way that they may cut ties with even close relatives who are destructive and hurtful.[11] These decisions may be among the most difficult conflicts parents and children will face. The stress created by toxic peers may become progressively more and more harmful. If parents suspect this, they are right to cut ties between children and their peers. Parents may realize that sometimes the only way for their child—as for anyone—to avoid greater and greater harm is to get away from its source.

Yet children may understandably oppose parents' doing this. Children may, for example, not want to lose some friends by cutting ties with other friends, or may not want those who are toxic to know that they have a strong, negative effect. I think of a male high school student who had a friend who was female. He learned that her boyfriend was two-timing her, and told her. The boyfriend then threatened him. His parents had to decide whether to report the threat to the school principal, over their son's objections. They reported the threat, and the entire experience was agonizing for them and their son.

Reflexive responses may be to always report, and to always cut off toxic peers, but there are always at least two sides to these kinds of interactions. Therefore, careproviders should remain neutral, rather than, for example, give their undivided support to parents. There may be other, mutually more acceptable ways to proceed, and, in any case, when adolescents feel they have their careprovider's support, it may help them retain their self-esteem and, more importantly perhaps, allow them to want to continue to meet with their careprovider.

I will focus now on an issue that is less discussed: that peers may share, over the internet, ways in which to best "con" careproviders, so that their careproviders will give them the interventions they want. Peers may even provide the precise words to say.[12] The results may be most harmful. For example, adolescents may move to make changes regarding their gender earlier than they would otherwise, and they may come to see their careproviders as enemies, which drains their trust in the relationship. This may be especially harmful when adolescents have no one else to confide in. While there are ways to preserve these important relationships, it is possible that careproviders' responses that make sense in other contexts may undermine their relationships with these adolescents, and even an unconsciously raised eyebrow at the wrong time may have a calamitous effect.

Here are two examples. First, careproviders may take the initiative to ask adolescent patients whether they have viewed advice on how to "con" careproviders on the internet. Some authors advise this approach.[13] But some adolescents may find this approach to be too "top-down," too infantilizing, and it may chill their willingness to continue interaction with their careproviders, because it has eroded their trust. A second example is more controversial. Careproviders usually ask patients why they came in.[14] It is almost a universal beginning, and it is often most productive, as it may bring up concerns that would otherwise remain hidden. Yet, in this context, it may dampen adolescents' trust. Taking the initiative to ask this question may do harm, as it may convey to adolescent patients that their careproviders regard themselves as too much in "the driver's seat," medicalizing patients in a self-assumed, paternalistic way that the patients resent.

Careproviders may reduce this risk by instead saying something like, "Sometimes it is

helpful to ask the question why an individual comes in at a particular time. Do you think it would helpful for *us* to begin by together considering this question?" Two general principles are expressed in this way. The careproviders first give their reason for asking, prior to asking. To do this includes the other person to a greater extent, and suggests that they are working together as a team—which they are. Second, by doing this, careproviders are asking patients whether this is a question they should ask, as opposed to just asking it. This has a similar effect. Both approaches may prove optimal in other situations, as well.

ACCESS TO INTERVENTIONS

Often, two levels of access to an intervention may apply. One is at the micro-allocation level—which interventions careproviders, on their own, are able and willing to supply. A second is at the macro-allocation level—what interventions society can and will make available. Here I will focus first on a core micro-allocation decision that careproviders, adolescents, their parents, and others may have to make: whether to give priority to an intervention that will help adolescents be and become who they *are,* or to withhold an intervention, to better protect adolescents from making choices that they may later want to reverse.[15] An obvious example is the choice to have a surgery that is not easily reversible. Grace Lidinsky-Smith described in *Newsweek* and on *60 Minutes* the harm that surgery that is hard to reverse may cause:

> I started my transformation with cross-sex hormones injections. Four months later, I had my breasts removed in the masculinizing surgical procedure known as "top surgery." The day I got my first testosterone shot, I wept with joy. I thought I had discovered my path to self-actualization as a transgender man. One year later, I would be curled in my bed, clutching my double-mastectomy scars and sobbing with regret.[16]

Given this powerful and sad example, how should careproviders and others prioritize between helping young persons become who they are, and protect—or at least guide—them from making a choice to have an irreversible intervention that they may later regret? Careproviders should primarily limit themselves to pointing out what others may overlook. For example, careproviders might point out that it is possible that an adolescent may be responding to an exceptional fear of a regret they may feel if the outcome they choose is the worst one, which is known as "anticipated regret."[17] This might be, for example, fear of the possible result of top surgery as experienced by Lidinsky-Smith.

An alternative point that careproviders might raise was put forth by an individual who was considering changing gender. He said, "I would rather live 10 years shorter but live a very happy life being myself, than live 10 years longer and be unhappy my whole life." This self-described "trans boy" was 17 years old.[18] The regret described by Lidinsky-Smith was after the fact. Regret may stem from multiple factors.

Careproviders may choose not to share what they fear might be personal biases when they seek to help adolescents make choices that are the most genuine for themselves. But this does not mean that careproviders should share or not share information that may prove helpful. Decisions about what to share may be fraught with uncertainty: for example, at present, data that report the frequency with which adolescents who transition later reverse their decision are not consistent. Different countries use different criteria to determine who has already changed gender, as well as who, having changed gender, changed their mind about their decision.[19] On the one hand, it may be helpful for careproviders to share this kind of information. But sharing it may instead add to adolescents' anxiety, due to its irresolvable complexity. And patients may hear this as "See how others have changed their mind," and see it as diminishing.

Access to interventions may involve careproviders' acting as gate keepers. To any degree that careproviders accept this role, it may risk violating their sole alliance with their patients. Careproviders who act as gate keepers should be particularly wary of any unconscious bias they may have when they make decisions about access. For example, they may paternalistically want to protect patients from an outcome similar to that described by Lidinsky-Smith.

Careproviders should remain aware that adolescents may be reluctant to share what they really feel, because they may fear that their careprovider will hold a gate-keeping role while the careprovider is *their* careprovider—or in the future. They may feel reluctant to discuss having been pregnant or having made someone pregnant, "as these things are traditionally under-

stood to be contradictory to a desire to gender transition."[20] At present there are enormous discrepancies in the interventions that are available to individuals in their efforts to change their gender. Access to reproductive assistance is a paradigmatic example.[21]

The Role of Careproviders

As I noted previously, it is important that careproviders not further medicalize individuals who identify as transgender.[22] This proscription is consistent with eliminating gender dysphoria as a precondition for having an intervention such as surgery. It might also involve going further, by seeing all possible gender identities as typical: as lying along very different points on a spectrum. A few specific examples will help to illustrate the basis and extent of this concern. Some careproviders have, for instance, seen individuals who want to change their gender as much like persons who see a part of their body as not part of themselves, or even as alien. People may, for example, after a stroke, feel that their arm or leg is not their own, but an alien part of their body. Others, although they have not had a stroke, may still find a limb to be alien and want it amputated. One careprovider's view is described by a colleague as follows: "Expanding his curiosity beyond gender identity to bodily integrity (when someone might want an amputation of a normal limb to feel that their body is correctly aligned), he wonders if these can be called 'misalignment syndromes.' "[23] While we may retain some distinctions regarding pathology, we must at the same time abhor interventions that are intended to deprive people's convictions regarding who they *are.*

Historically, other issues around gender and sexual preference have been medicalized: not long ago, being gay was seen as a disorder by the American Psychiatric Association. Infants who were born with ambiguous genitalia were perceived to need surgery as early as possible, to "render" them male or female, and it was assumed that their gender identity would follow suit.[24] This background suggests that careproviders who work with adolescents should check for residual bias that may have been acquired in their earlier years that they may still have, whether consciously or unconsciously.

Careproviders, as any persons, may not be completely able to either identify the biases they have or to remove them, no matter how hard they try. These limitations have far-reaching implications. One is that, to an extent, careproviders should accept that this may be so, and then they can expend more effort on how, notwithstanding their possible bias, they will respond.[25] Beyond this, careproviders might ask themselves what they should do, should their biases affect them too much, as they might, for example, if their biases are religiously based. I suggest that, under these circumstances, careproviders should inform patients about their bias, indicate that they would still like to treat the patients (if they would), but at the same time make absolutely clear that if the patients would like to be referred to another careprovider, they will help the patients to find one. And, that, whatever the patients decide, they can still, at any time, change their mind.

Should careproviders indicate that they would like to continue to treat a patient, this unequivocally places pressure on a patient to say "yes" to that arrangement. Although this might seem somewhat coercive, it may be a small price to pay for careproviders who want to convey that, despite their beliefs, they want to continue to care for a patient. Moreover, on hearing this, a patient may want to continue to see this careprovider.

General Interventions

To the degree that they can, all careproviders should be open to conversing with adolescents who wish to transition if and when the adolescents want this. The reason for this is that many adolescents may lack the opportunity to discuss their concerns with others whom they trust. In the past, all too often, careproviders who did not specialize in treating these adolescents believed that their needs and wants were so distinct that they should not meet with them, because, if they did, they would likely do harm. A paradigmatic example in which this happened, and still happens, is in regard to reproduction. An important question that many adolescents who want to transition ask is whether they should freeze their eggs or sperm if they take gender-enhancing hormones. Careproviders may lack the most up-to-date information, and accordingly feel ill-equipped to discuss this.

Yet, adolescents might want to discuss this question more generally because they want to retain their capacity to have biologically related children, not for themselves, but for a future

partner. They may want to discuss it to have more information for the future. It may help them in discussions with a future partner. If patients want this information, careproviders can refer them to a clinician who has more expertise, if needed. Careproviders may think, possibly reflexively, that adolescents should only choose a partner who is willing to adopt. Some adolescents may not be able to give up their hope for biologically related offspring. We know this from parents who found out that children they thought were biologically related to them were not. In spite of the best help, some had feelings that changed about their children. This is an example of why discussions with non-experts may be helpful. Even if patients do not gain new awareness from the discussion, being able to discuss any fears and doubts they feel may reduce the feelings, and help them feel less alone.

I said that to best meet adolescents' needs, careproviders may need to be willing to go to the edge of their usual professional standards, and perhaps beyond. This may be necessary to be able to have discussions like the ones just described. Some adolescents may want to have discussions with their careproviders, but only if their careproviders are willing to not make any notes in their chart. Some careproviders have agreed to this, had conversations with their patients, and were glad they did.

Confidentiality is very important to many adolescents who are considering transitioning. They will need to decide in every relationship they have when, if ever, to disclose that they are transgender. Thus, careproviders must consider respecting requests for confidentiality to the degree that they can. I think of a father who had a son, then changed gender when the child was too young to know. The parent greatly feared that, when the child was older, he would learn that his parent had changed gender. We might respond that the parent should tell the child about the gender change at some time, and that the child would accept the parent. This could happen, but, at the same time, it might not.

Capacity

A final challenging question that affects all individuals who make these decisions is when they should be deemed to have the capacity to do so. For those who want surgery, this is usually legally prescribed, although there may be some exceptions. It is not uncommon for transgender young men, for example, to pursue chest masculinization surgery with parental support and consent during adolescence. Some have argued for the benefits of vaginoplasty for transgender women prior to the age of 18.[26] The difficulty of making such decisions is compounded by the uncertainty in predicting individuals' outcomes. Some careproviders argue that the criteria for decisional capacity should be less than for other surgeries; others argue that the criteria should be greater.[27] Researchers report that adults are capable of making medical decisions for themselves, even when their decisional capacity is less than that of a 10 year old.[28]

It is well documented that some individuals want to transition, even at an early age, and the desire may be most intense. One mother relates: " 'Since he was two, all he can say is that he wants to be a girl, or that he is a girl. He knows he is not, but there is no way to change his mind. He is 6 now, and he still asks me every day, "Mom, can I be a girl when I grow up?" ' "[29]

Some careproviders suggest that the intensity with which these individuals wish to transition is the best guideline to use in making decisions, even though there is currently no more solid data that can be used to predict the outcomes of interventions.[30] Other careproviders argue that the best and only reliable guideline is how these individuals continue to fare.[31] At least it is agreed that there should be more than one gate keeper for interventions.[32]

Specific Interventions

The specific interventions I will address here involve discussing reproduction, sex, and "saying no" with adolescents who want to transition. I chose these three topics because they are reputed to be the most difficult for these adolescents to discuss with their careproviders, although it appears that they want to discuss these topics. Reproduction we have already considered. Adolescents may question whether they should freeze their eggs or sperm, in part because a future partner may want this. Some careproviders discourage freezing eggs or sperm, as they see this as going too far to please another, future person. As this is the case, careproviders may want to take a special initiative to raise the topic, to see if their patients want to accept or refute this argument.

A second specific question careproviders might want to raise is whether their adolescent

patients have specific concerns regarding sex. Disclosure of their transition will be an ongoing challenge, particularly when they are dating.[33] Careproviders may feel, rightly, that they have little to nothing to offer these patients. Yet, as in the example involving reproduction, the opportunity to share these concerns may be beneficial. These individuals should, with or without discussion with their careproviders, come to feel that they have absolute agency over what they disclose. This is especially important for careproviders to keep in mind, since it has been reported that these adolescents may have greater difficulty asserting themselves with a sexual partner than others have.[34] Some have recommended that one ground rule for adolescents who transition to follow is that they discuss, in advance, anything that might be a surprise to their partner, so that their partner may be able to anticipate what they will experience. Their partner may thus be better able to respond in a way that does not negate what they would otherwise experience.[35]

Some individuals who have transitioned report on the dilemmas they have encountered, and, in doing so, suggest why patients may gain from discussions with careproviders and others. Samantha G. Haley and colleagues conducted in-depth interviews with 11 non-minor transgender and nonbinary youth. One youth said, " '[M]ost people don't want to have [genital] surgery, because they think, "If I'm not going to feel anything, I don't want it just for the looks" ' (Transgender man, aged 20)." Another youth "emphasized the importance of anticipating changes in sexual function and planning ahead to address them with a partner: 'One thing that I've heard is that . . . when you go on hormones if you have vulva, then you lose the ability to self-lubricate. So [discussing with your partner] what that would mean. Do you use a lube?'—(Transgender man, age 18)."[36] These adolescents may find it more difficult than others to say "no" to having sex. The 20-year-old youth quoted above said that this may be because they are and look different. Careproviders may challenge the views of adolescents who feel that they should acquiesce to sex they don't want. They can role play how to say "no."

Careproviders may take the initiative to discuss with adolescents how they might ask a partner to refer to their body parts. Haley and colleagues report: "They might want to say, for example, 'This is what I call my genitals; this is stuff I don't want you to call my genitals.' "[37] Haley and colleagues also suggest that careproviders and adolescents can practice how they can respond to invasive questions from people they don't know well; for instance: " 'Hey, you aren't entitled to my story.' "[38]

CONCLUSION

The needs of transgender individuals are unique, and the importance of their needs may transcend those of most other patients. For these reasons I have discussed some of the areas that may be most important: their parents and peers, their access to medical interventions, and how careproviders may best help them. I have suggested that careproviders might praise parents when they are toxic, and might not ask adolescents if they have seen advice on how to "con" careproviders on the internet. I have suggested that careproviders, when they act as gate keepers, should consider giving priority to who it is adolescents want to be, rather than prioritize protecting them because they may later change their mind about what they want.

I have suggested that careproviders pay attention to their possible biases. That they can, in some cases, consider adapting the usual standards of cognitive capacity in response to the intensity of patients' needs. And that they can discuss with adolescents who want to transition how to assert what they want with a partner.

I have suggested that careproviders involve themselves in efforts to increase the equity of these patients and decrease their stigma in the greater society, in any and every way that they can. Usually, I feel that it is quite enough for careproviders to invest themselves wholly in caring for their patients. Going further than this to work with others on behalf of patients, I find, in most cases, to be praiseworthy, but fundamentally a morally alternative option. For these adolescents, however, this may be less the case. Taking the initiative on their behalf requires virtue. As Jennifer Markusic Wimberly put it, "Virtue ethics is the appropriate paradigm for which bioethics can address the framework that poses barriers to access to health care and maintenance of health through a lack of competent, knowledgeable and compassionate providers for the transgender population."[39]

At the beginning of this article, I said I would give a follow up of what happened between the father I quoted, and his son. The father had seen

his son as a freak, and saw himself, because he felt that way, as a monster. But, he reports, "I have changed this. I have replaced this with hugs."[40]

NOTES

I thank Norman Quist for numerous insights he gave me on this article.

1. L. Kimberly, K. McBride Folkers, B. Karrington, J. Wernick, S. Busa, and C. Salas-Humara, "Navigating Evolving Ethical Questions in Decision Making for Gender Affirming Medical Care for Adolescents," in this issue of *The Journal of Clinical Ethics* 32, no. 4 (Winter 2021).

2. A. Cheng, "Putin Slams Trans Rights, Other Values, of the West," *Washington Post*, 23 October 2021, A7. See also B.M. Dickens, "Transsexuality: Legal and Ethical Challenges," *International Journal of Gynecology and Obstetrics* 151, no. 1 (October 2020): 163-7 for practices in other countries.

3. J. Malpas, "Between Pink and Blue: A Multidimensional Family Approach to Gender Nonconforming Children and Their Families," *Family Process* 50, no. 4 (2011): 453-70, 462-3.

4. A.H. Grossman and A.R. Augelli, "Transgender Youth and Life-Threatening Behaviors," *Suicide and Life Threatening Behavior* 37, no. 5 (2007): 527-37.

5. Malpas, "Between Pink and Blue," see note 3 above. "In the spirit of transparency, clinicians should clarify their position on gender nonconformity as a normal human expression and admit that predicting the adolescent and adult future of a gender nonconforming child is nearly impossible" (page 458). "Initial conversations should emphasize how critical the parents' roles are, not in the making of gender nonconformity, nor in the curing of it, but in their ability to find collaborative ways to nurture their children, to affirm their personality and choices." Ibid. See also A. Dangaltcheva, C. Booth, and M.M. Moretti, "Transforming Connections: A Trauma-Informed and Attachment-Based Program to Promote Sensitive Parenting of Trans and Gender Non-conforming Youth," *Frontiers in Psychology* 26, no. 12 (July 2021): 643823, doi: 10.3389/fpsyg.2021.643823; and D. Coolhart and D.L. Shipman, "Working Toward Family Attunement: Family Therapy with Transgender and Gender-Nonconforming Children and Adolescents," *Psychiatric Clinics of North America* 40, no. 1 (March 2017): 113-25.

6. J. Högström et al., "Two Year Findings from a National Effectiveness Trial: Effectiveness of Behavioral and Non-behavioral Parenting Programs," *Journal of Abnormal Child Psychology* 45 (2017): 527- 42.

7. "The triangulation is intensified by the power of the son's identification with mom and her femininity, which risks demonizing dad as representative of the stereotypical gender norms rejected by the child." Malpas, "Between Pink and Blue," see note 3 above, p. 463.

8. V.D. Kolbuck et al., "Psychological Functioning, Parenting Stress, and Parental Support among Clinic-Referred Prepubertal Gender Expansive Children," *Clinical Practice in Pediatric Psychology* 7, no. 3 (September 2019): 254-66.

9. A case posing this same question, to a degree, is when adolescents who are Jehovah's Witnesses want to go along with their parents' wishes and refuse blood even though, as a result, they may be more likely to die. Continuing their life with their parents' approval may be more important to them than their life.

10. D. Ehrensaft, "From Gender Identity Disorder to Gender Identity Creativity: True Gender Self Child Therapy," *Journal of Homosexuality* 59, no. 3 (2012): 337-56.

11. J. Drescher and J. Pula, "Ethical Issues Raised by the Treatment of Gender-Variant Prepubescent Children," in "LGBT Bioethics: Visibility, Disparities, and Dialogue, Special Report," *Hastings Center Report* 44, no. 5 (2014): s17-22.

12. L. Littman, "Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria," *PLOS One*. 13, no. 8 (16 August 2018): e0202330, doi: 10.1371/journal.pone.0202330. These sites instruct individuals how to deceive parents, doctors, and therapists to obtain hormones quickly. See, though, A.J. Restar, "Methodological Critique of Littman's (2018) Parental-Respondents Accounts of 'Rapid-Onset Gender Dysphoria,'" *Archives of Sexual Behavior* 49, no. 1 (January 2020): 61-6.

13. D. Singh, S.J. Bradley and K.J. Zucker, "A Follow-up Study of Boys with Gender Identity Disorder," *Frontiers in Psychiatry* 12 (2021): 632784, doi.org/10.3389/fpsyt.2021.632784.

14. Ibid.

15. Drescher and Pula, "Ethical Issues," see note 11 above, p. s22.

16. G. Lidinsky-Smith, "Opinion: There's No Standard for Care When it Comes to Trans Medicine," *Newsweek,* 25 June 2021, *https://www.newsweek.com/theres-no-standard-care-when-it-comes-trans-medicine-opinion-1603450;* "Health care challenges for transgender youth," *60 Minutes,* 23 May 2021, *https://www.cbsnews.com/video/transgender-healthcare-60-minutes-video-2021-05-23/*

17. This psychological propensity that may go against people's ability to pursue their best interests is known as "anticipated regret." D. Kahneman and A. Tversky, "Prospect Theory: An Analysis of Decision under Risk," *Econometrica* 47, no. 2 (1979): 263-92. See also A. Galinsky, "The 'Psychology of Regret' Helps Explain Vaccine Hesitancy," *Washington Post*, 13 November 2021, B3.

18. L.J. Vrouenraets et al., "Perceptions of Sex, Gender, and Puberty Suppression: A Qualitative Analysis of Transgender Youth," *Archives of Sexual Behavior* 45, no. 7 (October 2016): 1697-703, 1700.

19. "In the Netherlands, the estimated prevalence

of transgender adolescents ranges from 1/10,000 in boys to 1/30,000 in girls. In the United States, anecdotal data reported by the Transgender Youth Family Alliance claim that about one in five hundred children presents as cross-gendered identified in the schools and communities they have visited." Malpas, "Between Pink and Blue," see note 3 above, p. 455.

20. J. Veale, R.J. Watson, J. Adjei and E. Saewyc, "Prevalence of Pregnancy Involvement Among Canadian Transgender Youth and its Relation to Mental Health, Sexual Health, and Gender Identity," *International Journal of Transgender Health* 17, no. 3-4 (2016): 107-13, doi:10.1080/15532739.2016.1216345.

21. In a survey of 121 transgender women from 11 countries, it was found that that among those with no children, 40 percent would like to have their own biological children. Ibid.

22. Ethics Committee of the American Society for Reproductive Medicine, "Access to Fertility Services by Transgender and Nonbinary Persons: An Ethics Committee Opinion," *Fertility and Sterility* 115, no. 4 (April 2021): 874-78. The difficulty and inequity for individuals who are short of funds were recently exacerbated by a company that stopped making a puberty-blocking medication that cost one-eighth as much as any other available medication. S. Lupkin, "With an Off-label Drug Discontinued, Families' Other Option Costs Thousands More," *All Things Considered*, 1 November 2021, *https://www.npr.org/2021/11/01/1051215638/with-an-off-label-drug-discontinued-families-other-option-costs-thousands-more.* See generally T.F. Murphy, "The Ethics of Helping Transgender Men and Women Have Children," *Perspectives in Biology and Medicine* 53, no. 1 (2010): 46-60.

23. D.N. Graham, "Non-conforming, Part 1: ICD-11," *Lancet Psychiatry* 6, no. 6 (June 2019): 470-1.

24. H.S. Moffic, "Rearview: A Psychiatrist Reflects on Practice and Advocacy in a Time of Healthcare System Change," *Psychiatric Times*, 21 April 2021, *https://www.psychiatrictimes.com/view/rearview-psychiatrist-reflects-practice-advocacy-time-healthcare-system-change.*

25. J. Money and A.A. Ehrhardt, *Man and Woman, Boy and Girl: Differentiation and Dimorphism of Gender Identity from Conception to Maturity* (Baltimore, Md.: Johns Hopkins University Press, 1972). See also D. Ehrensaft, "Gender Nonconforming Youth: Current Perspectives," *Adolescent Health, Medicines and Therapeutics* 8 (May 2017): 57-67.

26. R. Schwartz, "Working With Our Internalized Racism, *Psychotherapy Networker* 44, no. 5 (September 2020): 30-3, 49-50, 30. See also J.L. Eberhardt, *Biased* (New York: Viking, 2019).

27. D. Chen, L. Edwards-Leeper, T. Stancin, and A. Tishelman, "Advancing the Practice of Pediatric Psychology with Transgender Youth: State of the Science, Ongoing Controversies, and Future Directions," *Clinical Practice in Pediatric Psychology* 6 (2018): 73-83.

28. Ehrensaft, "From Gender Identity Disorder," see note 10 above. See also M. Tunick, "State Authority, Parental Authority, and the Rights of Mature Minors," *Journal of Ethics* 4 (September 2021): 1-23; and L.A. Weithorn, "When Does a Minor's Legal Competence to Make Health Care Decisions Matter?" *Pediatrics* 146, supp. 1 (August 2020): s25-32.

29. Malpas, "Between Pink and Blue," see note 3 above, p. 453.

30. T.D. Steensma et al., "Factors Associated with Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-up Study," *Journal of the American Academy of Child and Adolescent Psychiatry* 52, no. 6 (June 2013): 582-90, 589.

31. "Although not a universal phenomenon, one simple rule of thumb is that if the assessment is correct, the child shows signs of getting better; if the assessment was incorrect, the child gets worse, or at least no better." Ehrensaft, "From Gender Identity Disorder," see note 10 above, pp. 346-7.

32. See, generally, S.B. Levine, "Reflections on the Clinician's Role with Individuals Who Self-identify as Transgender," *Archives of Sexual Behavior* 50, no. 8 (November 2021): 3527-36.

33. S. Fröjd, M. Marttunen and R. Kaltiala, "Normative and Negative Sexual Experiences of Transgender Identifying Adolescents in the Community," *Scandinavian Journal of Child and Adolescent Psychiatry and Psychology* 8 (20 November 2020): 166-75.

34. S.G. Haley et al., "Sex Education for Transgender and Non-Binary Youth: Previous Experiences and Recommended Content," *Journal of Sexual Medicine* 16, no. 11 (November 2019): 1834-48.

35. Ibid.

36. Ibid., 1841.

37. Ibid., 1842.

38. Ibid.

39. J.M. Wimberly, "Virtue Ethics and the Commitment to Learn: Overcoming Disparities Faced by Transgender Individuals," *Philosophy, Ethics, and Humanities in Medicine* 14, no. 1 (22 August 2019): 10, doi: 10.1186/s13010-019-0079-2. "The anti-transgender legislation sends a chilling message to transgender youth. . . .' The message of these bills is, essentially, 'you shouldn't be who you are. . . .' " K. O'Connor, "Record Number of Anti-Trans Bills Filed in States This Year," *Psychiatric News* 56, no. 6 (June 2021): 8-9.

40. Malpas, "Between Pink and Blue," see note 3 above, p. 463.