Comment, Gender-Affirming Care for Transgender Adolescents: A Comparison of Approaches Among Countries

I. Introduction

One of the most critical factors in an adolescent’s development comes from the support and care of family, friends, and community. Support from the community is especially important for pre-teens and teenagers experiencing the internal turmoil and discomfort that comes from simply feeling like they are not situated in the right body – a condition known as gender dysphoria. The best environment for these teens, as recommended by healthcare professionals, is a collaborative space for decision-making between the youth, family, and healthcare providers. Decisions and treatment regarding this discomfort in a supportive environment have been proven to be much more catered towards the health and safety of the minor than those where the minor is lacking familial support.

Many reports have shown that lack of support and feelings of unacceptance have deep and strong negative effects on a teen’s emotional development and mental state, causing the adolescent to experience increased thoughts of suicide, anxiety, and depression. As an individual experiences disagreement and lack of acceptance of their gender identity from close relationships and their community or state, suicidal ideation, anxiety, and depression increase. These negative consequences from societal disapproval are greater in transgender adolescents who are going through a pivotal time in their development into adulthood. However, where transgender

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2 Id.
4 Id.
5 See generally Catherine Schaefer, et al., *Discriminatory Transgender Health Bills Have Critical Consequences for Youth*, CHILD TRENDS, Apr. 21, 2022,
adolescents are accepted and given support to transition in a positive and caring environment, suicidal ideation rates drop and an increased sense of connectedness with oneself is experienced.6

The statistics regarding the mental health of transgender youth are concerning and require special attention to find methods of support that help. According to the Substance Abuse and Mental Health Services Administration, 4.9 percent of adults in the United States experienced suicidal ideation in 2020 and 0.5 percent of those adults attempted suicide.7 In comparison, roughly 82 percent of transgender individuals experienced suicidal ideation in 2020 and 40 percent of these transgender individuals made a previous suicide attempt.8 The numbers are even greater among transgender youth in the United States with the threat of gender-affirming care bans on the rise with a finding of 86 percent of transgender youth reporting suicidal ideation or being at risk of suicide and 56 percent of transgender youth reporting a previous suicide attempt.9

These percentages are striking considering the number of transgender youth in the United States. According to the Williams Institute, nearly 300,000 youth in the United States identified as transgender in the year 2022.10 Considering this number in light of the rate of suicide, this means that more than 250,000 transgender youth in the United States experience suicidal ideation and over 160,000 transgender youth in the United States have attempted suicide in the past. The statistics of the high risk of suicide among transgender teens provide enough evidence that transgender

8 Austin Ashley, et. al., Suicidality Among Transgender Youth: Elucidating the Role of Interpersonal Risk Factors, 37 J. INTERPERSONAL VIOLENCE 1 (2020).
9 Id.
adolescents must be provided sufficient support from their community to lower the rates of suicidality among transgender youth.

This Comment will discuss the overall experiences and treatment of gender-diverse and gender-nonconforming adolescents and the many social and legal challenges they face that further isolate them from their community when they try to obtain gender-affirming care. The treatment of these adolescents will be examined by an international comparison among several countries and regions that differ in values, laws, and political structure from the United States. For instance, the responses to gender-affirming care have ranged from capital punishment resulting in the death penalty, as in Afghanistan, to gender-affirming care focused on the need of the patient in Europe. Countries are even further divided when the issue is viewed in light of minors seeking gender-affirming care. The vastly different views reflect the drastic differences in motivation behind the policies enacted regarding the treatment of gender-diverse youth.

This Comment is divided into five sections, each providing further understanding of the treatment of transgender youth and insight into the varying approaches to gender-affirming care for adolescents and the motivations that drive this treatment. Section I dives into the terminology necessary to understand gender-nonconforming individuals’ needs for gender-affirming care. Section II will discuss the United States’ approach to gender-affirming care, examining the drive behind anti-trans policies in the United States and the challenges transgender adolescents are facing in the country due to this legislation. This section will also take a look at the constitutionality of gender-affirming care bans implemented through legislation and their effects on the rights of the transgender adolescent, parents, and physicians.

Section III will review approaches taken by European countries and their guiding concerns; specifically, the section will look at the trend among European countries to pull back from the liberal policies that were in place years prior. The motivating concerns of these policies and pullbacks will be discussed, as well as the view of outlier European countries showing no intention of implementing restrictions on gender-affirming care among adolescents.

Section IV will break down the approaches taken by several other countries with established laws that are the most restrictive on gender-affirming care for youth and adults. This section will discuss the effect these laws have had on transgender adults and adolescents and the lengths to which individuals who do not conform with the heteronormative must go to live in conformity with their experienced gender identity.

Finally, this Comment will discuss the medical profession’s outlook on gender-affirming care for adolescents. In particular, Section V will dive into the recommendations by medical professionals and associations and how legislation can be used to support gender-nonconforming youths.

II. The Context and Importance of Gender-Affirming Care

Gender identity is described as an individual’s “internal sense” of gender; this is the deep connection felt as a boy, girl, both, or neither.12 A sense of one’s gender identity begins early in life, around ages two to four years and matures around adolescent years.13 In many instances, boys are told and shown what being a boy entails and girls are taught how girls normally behave, dress, and talk. There is a clear demarcation between the two, allowing no room for youth to grow into their internal sense of gender identity. The classifications shown through blue and pink baby blankets and limitations on attire is termed “the gender binary.”14 The gender binary has dominated societal norms to create a foundational ordering principle that instructs the population that gender is concretely divided into two classifications: a person assigned male at birth must identify as a boy and display masculine traits and a female assigned  

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13 Id.

14 See, e.g., Cynthia Lee, The Trans Panic Defense Revisited, 57 AM. CRIM. L. REV. 1411, 1497 (2020)(“The terms ‘binary gender’ and ‘gender binary’ are used to describe the fact that most people tend to think of sex and gender in binary terms – one is either a man or a woman or is female or male – with nothing in between.”).
at birth must identify as a girl and develop into womanhood, with no room for any more gender categories in between.\textsuperscript{15}

Gender-diverse and transgender individuals do not fit into this model of the gender binary. Instead, their lived experiences indicate that gender is more complex than the gender binary comprehends. Many individuals, but not all, who are gender-diverse or transgender experience a condition known as gender dysphoria.\textsuperscript{16} Gender dysphoria involves a feeling of emotional distress from a lack of harmony between the individual’s sex assigned at birth and their personal sense of male, female, or other.\textsuperscript{17} This lack of harmony between one’s assigned sex at birth and gender identity can cause intense distress and unease.\textsuperscript{18}

Many, but not all, transgender and gender-nonconforming individuals experience some form of gender transition, whether it is a social transition or a medical transition.\textsuperscript{19} A social transition involves the process of changes in the individual’s name, pronouns, clothing, hairstyle, and appearance.\textsuperscript{20} This transition does not involve any medical procedure or treatment affecting the physical nature of the individual; instead, such a transition requires support from friends and family and a respect for the gender-diverse individual’s wishes as to name change, identity presentation, and preferred pronouns. This is the only transition that takes place prior to puberty.\textsuperscript{21}

A further treatment for gender dysphoria for gender-nonconforming teenagers may be through medical treatments during or after puberty.\textsuperscript{22} Medical treatments available to adolescents come


\textsuperscript{16} Diane Chen et al., Multidisciplinary Care for Gender-Diverse Youth: A Narrative Review and Unique Model of Gender-Affirming Care, 1.1 Transgender Health 117, 117 (2016).

\textsuperscript{17} Id.


\textsuperscript{19} Claire Houston, Respecting and Protecting Transgender and Gender-Nonconforming Children in Family Courts, 33 CAN. J. Fam. L. 103, 105 (2020).

\textsuperscript{20} Get the Facts on Gender-Affirming Care, HUMAN RIGHTS CAMPAIGN (July 25, 2023), https://www.hrc.org/resources/get-the-facts-on-gender-affirming-care.

\textsuperscript{21} Id.

\textsuperscript{22} Id.
in multiple forms, such as puberty blockers and gender-affirming hormones. These provide adolescents with the ability to further transition and separate from their disconnected biological sex, improving the mental and physical discomfort of gender dysphoria.

Puberty blockers are an FDA approved treatment that are reversible and have minimal side effects. Ultimately puberty blockers stop the body’s natural ability to make sex hormones, including testosterone and estrogen. These hormones affect the sexual organs present at birth and the physical changes in the body that typically appear with puberty, such as breast development and facial hair. Puberty blockers, known as GnRH analogues, slow down growth of facial and body hair, prevent the voice from deepening, and limit the growth of sexual organs that develop during the stages of puberty for males; in females, GnRH limits breast development and prevents menstruation. Overall, these changes in an adolescent caused by puberty blockers simply pause the physical changes that naturally occur at puberty, but they are not permanent physical changes, allowing the teen the space to explore and understand more about their gender identity.

Gender-affirming hormones are a prescription medication that allow transgender and gender-nonconforming adolescents to develop certain physical characteristics that align with their gender identity. The hormones prescribed include estrogen or testosterone, which allow gender-nonconforming adolescents to naturally develop these characteristics. For transgender girls, estrogen therapy allows changes that include the softening of skin, reduced muscle bulk, breast growth, decreased growth of body hair, and reapportionment of body fat. For transgender boys, testosterone therapy promotes increased muscle bulk, pause in menstruation, voice deepening, and the growth of facial and body hair.

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23 Id.
25 Id.
26 Id.
27 Id.
28 *Get the Facts on Gender-Affirming Care*, supra note 20.
29 Davidge-Pitts, et al., *supra* note 12.
30 Id.
31 Id.
development and voice deepening are irreversible effects and are generally safe for adolescents seeking gender-affirming care.  

Specialists in gender-affirming care have found that these treatments are beneficial for transgender adolescents in many ways. One of the concerns noted by parents and medical providers is the heightened risk of self-harm among transgender adolescents associated with certain changes in the body that naturally occur during puberty. As puberty approaches for these adolescents, anxiety regarding the changes that are to occur increases. Parents of transgender youth have relayed conversations they have had with their child who has had extreme anxiety about puberty. Specific stories have discussed how a transgender boy mentioned the desire to cut off his breasts that would develop in puberty because they did not match his gender identity. One parent shared their experience with their child’s pubertal-focused anxiety, noting that the transgender boy refused to eat to prevent the growth of breast and body fat. This type of anxiety leads to increased rates of suicidal ideation since the adolescent is unable to prevent changes in their body that do not match their gender identity. Gender-affirming care prevents the developmental changes that occur at puberty and eases the anxiety that may be detrimental to the child.

III. The United States’ Approach

The United States has left the issue of gender-affirming treatment of transgender teens to the states to determine. This includes not only decisions of what treatments will be permitted in gender-affirming care to individuals, but also the determination of criminal penalties for physicians administering gender-affirming care to minors and for parents as supporters of gender-affirming care.  

32 Id.
34 Id.
35 Id.
36 Id.
37 Id.
care for their children.\textsuperscript{39} This has left gender-nonconforming adolescents as pawns in a political and culture war that is dividing states.

The United States’ approach to gender-affirming care has largely been influenced by political views and moral beliefs about what is acceptable.\textsuperscript{40} Conservatives in the United States often oppose gender-affirming treatment for all individuals and especially for treatment of minors, based on historic societal gender norms and the embrace of the gender binary.\textsuperscript{41}

A wave of conservative state legislation swept the United States around 2020 to prevent the use of gender-affirming care for youth.\textsuperscript{42} By September, 2023, 142 bills were introduced by lawmakers in 37 states to restrict gender-affirming care for transgender and gender-nonconforming individuals.\textsuperscript{43} As of September 2023, 23 states in the United States have complete bans on gender-affirming care for minors.\textsuperscript{44} These anti-transgender bills banning gender-affirming care for minors share a few common themes, including religious beliefs, child abuse, and scare tactics focused on medically-unsupported information of the long-term effects of gender-affirming care for minors.\textsuperscript{45} Many of these bills claim to be motivated by the impulse to protect children and cite authority regarding the state’s interest in its protection of children; however, many of these bills are contrary to scientific findings and the opinions of medical professionals.\textsuperscript{46}

In Texas, although not enacted, HB68 and HB1339 were introduced to add gender-affirming care of minors to the state’s definition of child abuse and to prohibit malpractice insurance

\textsuperscript{39} Scott J. Schweikart, \textit{What’s Wrong with Criminalizing Gender-Affirming Care of Transgender Adolescents?}, 25 AMA J. Ethics 414 (2023).
\textsuperscript{40} Id.
\textsuperscript{42} Kraschel, et al., \textit{supra} note 38.
\textsuperscript{44} Davis, \textit{supra} note 41.
\textsuperscript{45} Id.
\textsuperscript{46} Kraschel, et al., \textit{supra} note 38.
providers from providing coverage for any damages related to gender-affirming care for minors. Governor Greg Abbot signed an executive directive in 2022 which ordered an investigation into parents and medical providers who allowed healthcare for transgender minors. HB68 placed a total ban on gender-affirming care for minors in the state and added gender-affirming care to the statutory definition of child abuse.

Alabama enacted Senate Bill 184 which prevented the necessary medical care to anyone under the age of nineteen seeking gender-affirming treatment and threatened possible criminal prosecution, resulting in jail time for anyone, including doctors and parents, who allowed the gender-affirming care to occur. Alabama makes it a class C felony to provide certain types of care to transgender youth. A violation of S.B. 184 may result in the penalty of up to ten years of prison time and a fine of up to $15,000.

In West Virginia, Governor Jim Justice signed into law a prohibition on administering hormone therapy and puberty blockers to transgender youth. This law does contain an exception, allowing pubertal modulating and hormonal therapy in cases where the treatment is medically necessary to treat the minor’s psychiatric symptoms and to limit self-harm. This exception requires parental consent from both parents and a recommendation from two medical providers.

In Missouri, H.B. 33 was introduced in 2021 but later failed; it would have dictated that medical professionals providing such gender-affirming care to adolescents may face possible medical license revocation. Further, though the introduction of the Save Adolescents From Experimentation (SAFE) Act in 2022, which
failed that same year, Missouri sought to disallow the use of public funds to any organization or individual providing gender-affirming care to transgender minors and creating a civil claim against medical professionals providing this care to transgender minors.\footnote{57}

Although only a few cases have specifically targeted the constitutionality of these bills, cases that have challenged these laws provide some suggestions as to when these laws are unconstitutional. Cases in Alabama and Arkansas have challenged the constitutionality of the anti-transgender bills as violating the constitutional rights of the transgender minor, parents, and physician providing the gender-affirming care.\footnote{58}

In \textit{Brandt v. Rutledge}, a federal district court in Arkansas held that Act 626, the Arkansas state version of anti-transgender legislation, violated the Equal Protection Clause of the Fourteenth Amendment, the parents’ rights to substantive due process, and the First Amendment.\footnote{59} Act 626 prohibits a physician from providing gender-affirming care to a minor under the age of eighteen and making a referral for a minor to receive gender-affirming care from another physician.\footnote{60} Specifically, Act 626 provides:

“Gender transition procedures” means the process in which a person goes from identifying with and living as a gender that corresponds to his or her biological sex to identifying with and living as a gender different from his or her biological sex, and may involve social, legal, or physical changes; (6)(A) “Gender transition procedures” means any medical or surgical services, including without limitation physician’s services, inpatient and outpatient hospital services, or prescribed drugs related to gender transition that seeks to:

(i) Alter or remove physical or anatomical characteristics or features that are typical for the individual’s biological sex; or
(ii) Instill or create physiological or anatomical characteristics that resemble a sex different from the individual’s biological sex, including without limitation medical services that provide puberty-blocking drugs, cross-sex hormones, or other mechanisms to promote the development of feminizing or masculinizing features in the opposite biological sex, or genital or nongenital gender reassignment surgery performed for the purpose of assisting an individual with a gender transition.\footnote{61}

\footnote{57} Id.
\footnote{58} Id.
\footnote{61} Id.
The Act includes a provision for a private right of action for a violation or threatened violation of the statute.\(^{62}\)

The court in *Brandt* found that Act 626 violated the Equal Protection Clause of the Fourteenth Amendment because it discriminates on the basis of sex.\(^{63}\) According to this decision, transgender individuals fall under a quasi-suspect class due to the understanding that a minor’s assigned sex at birth determines whether the minor can receive certain types of medical care.\(^{64}\) The court also found that the Act discriminates against transgender people because it prohibits medical treatment that is specific for transgender individuals.\(^{65}\) The court noted that under this act, a minor assigned male at birth is permitted to receive testosterone treatment or other gender-affirming care so long as his gender identity aligns with his sex assigned at birth, while a minor assigned female at birth cannot; the basis on which a minor can receive care is dependent on the biological sex of the minor patient.\(^{66}\)

In evaluating the substantive due process claim, the court found that the Act violated the Substantive Due Process clause of the Fourteenth Amendment.\(^{67}\) The court determined that parents have a right to direct their child’s medical care, found in the fundamental liberty interest of parents in the “care, custody, and control of their children,” in directing their child’s medical care.\(^{68}\) Finally, the *Brandt* court held that Act 626 violates a physician’s First Amendment right to freedom of speech by providing that a physician is prohibited from making a referral of an individual under eighteen years old for the purpose of receiving gender-affirming care.\(^{69}\)

These cases are just the beginning of the United States’ recognition of adequate gender-affirming care for minors. With the controversies surrounding a minor’s ability to transition and parents’ restrictions on supporting their children’s social and medical decisions, psychological and physical attacks on transgender

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\(^{62}\) *Id.*

\(^{63}\) *Brant*, No. 4:21CV00450 JM.

\(^{64}\) *Id.*

\(^{65}\) *Id.*

\(^{66}\) *Id.*

\(^{67}\) *Id.* at *36.


\(^{69}\) *Brant*, No. 4:21CV00450 J, .. at *37.
adolescents have increased within the states. Violence has transpired as misconceptions about gender-affirming care for minors has spread. In 2022, twenty children's hospitals were named and targeted in online harassment campaigns. The social media accounts spreading this harassment and stigma strive to incite violence and stop the spread of resources and gender-affirming care for transgender adolescents. These online attacks led several hospitals and clinics to temporarily stop services or shut down completely. Other hospitals and clinics were forced to pull information and resources from their websites for the safety of their patients due to these threats. Specifically, claims were made online that Boston Children's Hospital was performing hysterectomies on minors, advocating for the hospital to be shut down. The Boston Children's Hospital reported multiple bomb threats, causing the hospital to go on temporary lockdown and evacuation from the building.

After the mass shooting at an LGBTQ+ club in Colorado Springs, the founder of an anti-transgender hate group, Gays Against Groomers, stated on the Trucker Carlson Network that “shootings like the one at Club Q in Colorado Springs, Colo., would continue until the ‘evil agenda’ of gender-affirming health care was put to an end.” This type of harassment culminating in violence has furthered extremist views on gender-affirming care for minors and furthered a negative mission to stop the necessary treatment for transgender minors. Threats and harassment of this kind force medical providers to pull the necessary resources and treatment for minors experiencing gender dysphoria and further political agendas unrelated to the actual health, care, and safety of the minor.

The United States’ approach to gender-affirming care has allowed an array of views and legal action to occur within the region. Although the overall approach of the United States may seem liberal compared to conservative nations, transgender adolescents are regularly threatened in their ability to receive gender-affirming care. The push for complete bans on gender-affirming care for minors and the push on the other side for complete allowance for full access has caused a constant concern of families that the limited access granted to transgender minors will be pulled. Although the United States may be considered lax in its approach to gender-affirming care, with the wide array of views, some individuals may be concerned that the United States will follow the models of more restrictive countries.

IV. European Countries’ Approaches

Although European countries have taken a different approach than the United States, they have been somewhat divided on the appropriate care for transgender youth. Many European countries previously implemented liberal gender-affirming care policies; however, several larger countries in the continent have begun pulling back on gender-affirming policies. Medical care providers in the Netherlands were the first to treat adolescents with puberty blockers in 1998. The United Kingdom established the Tavistock Centre in 1990s, which has assisted thousands of transgender adolescents since its opening. In the year 2011, Tavistock received 250 referrals; comparatively, in 2021, Tavistock received over 5,000 patient referrals. Policies implemented regarding gender-affirming care among European countries have primarily been based on the recommendations of medical professionals.

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83 Id.
While political agendas may be a partial motivator, the primary focus has been on the health and safety of the patient.

A. United Kingdom

In 2020 England’s National Health Service (NHS) led an independent review of gender-affirming care for transgender youth.\(^{84}\) An interim report, released in 2022, offered advice from specialists, suggesting that gender-affirming care should be provided with only the most focused attention on the health and development of the child.\(^{85}\) This interim report was implemented based on several findings: (1) there has been a sharp rise in referrals to the Gender Identity Development Service (GIDS); (2) there has been a dramatic change in the mix of referrals; (3) there is a lack of evidence to support clinical decision making; and (4) long waiting times for the initial assessment showed operational failures in the previous model.\(^{86}\)

The new NHS healthcare guide for transgender youth got rid of the previous gender-affirming care model and takes the position that most children seeking gender-affirming care need psychoeducation and psychotherapy before receiving any transitional care.\(^{87}\) The new NHS guidance maintains that even social transitioning is strongly discouraged and should only be implemented, with informed consent, to relieve clinically significant amounts of distress or where there is significant impairment in social function due to a finding of gender dysphoria.\(^{88}\) Based on NHS’s recommendations, general practitioners are encouraged to collaborate with gender specialists before prescribing hormone therapy to adolescents.\(^{89}\)

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\(^{86}\) Interim Service Specification for Specialist Gender Dysphoria Services for Children and Young People, NHS England (Oct. 20, 2022).

\(^{87}\) The NHS Ends the “Gender-Affirmative Care Model” for Youth in England, Soc’y for Evidence Based Gender Med. (Oct. 24, 2022).

\(^{88}\) Id.

The United Kingdom, although pulling back on gender-affirming care, has fallen in line with the recommendations and advice made by the NHS. The U.K. has focused the primary considerations regarding gender-affirming on the health and wellness of the patient, instead of focusing on a political agenda. The U.K. has made few decisions on the rights of parties involved in the treatment of gender dysphoria for adolescents; however, the leading cases in the United Kingdom have provided greater legal protection for transgender minors.

In 2021, *Bell v. Tavistock* held that persons under the age of sixteen years old experiencing gender dysphoria can provide legal consent to be prescribed puberty-blockers where the child is competent to understand the impact of the treatment. Before 2011, puberty-blockers were made unavailable for those under the age of sixteen. Puberty-blockers became available to those between the ages of 12-15 years old as part of a research study in 2011. At the time *Bell v. Tavistock* was decided, there were two types of endocrine clinics: one that provided services for children under the age of fifteen and one for children over fifteen years old. The service specification permits puberty-blockers to be prescribed to children under the age of twelve years old only if the child is established in puberty.

In the *Bell* case, the Gender Identity Development Service (GIDS) stated that it would only refer an adolescent for puberty-blockers if it determines the patient is competent enough to give consent. In the U.K., people aged sixteen and older are presumed competent to provide consent to treatment unless evidence suggests otherwise. For children under the age of sixteen, the U.K. has created a method of determining an individual’s ability to provide consent through the *Gillick* competency test. The test was developed

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90 See generally Health and Care Act 2022 (Nov. 4, 2022).
91 Bell v. Tavistock and Portman NHS Foundation Trust [2021] EWHC 1363, 1 (Eng.).
92 Id.
93 Id.
94 Id.
95 Id.
96 Id.
98 Id.
in the case of *Gillick v. West Norfolk and Wisbech Health Authority*. In *Gillick*, the court decided that a child under the age of sixteen could be considered competent to provide consent to treatment if a court finds that the child has enough intelligence, competence, and understanding to completely grasp the impact of their treatment. If *Gillick* competency is not shown, consent may be provided for the child by someone with parental responsibility.

*Bell v. Tavistock* held that the determination of whether a minor is *Gillick* competent should not be made in a blanket legislative or judicial rule, but doctors should have the discretion to determine a minor’s competency in this area on a case-by-case basis. The U.K. has commissioned its public health authority to conduct an ongoing independent review of gender identity services for minors to find out more about gender dysphoria and determine the best way to provide care for these individuals. The court stated that given the experimental nature of gender-affirming care for minors, it is unlikely that an adolescent under the age of thirteen would meet the requirements to be deemed *Gillick* competent. The court further stated that it would be extremely difficult for an adolescent under the age of sixteen to provide evidence that they are *Gillick* competent. These determinations in individual cases are steered by the conclusions of medical professionals rather than have legislatively-created blanket rules influenced by political forces like the United States. In Europe, policy approaches are due primarily to the concern of medical professionals in mental and medical treatments for transgender youth. The medically-informed approach in the European Union is mirrored in laws there: 25 of the 27 E.U. member states provide legal procedures of gender recognition.

B. *Sweden*

Sweden’s National Board of Health and Welfare (NBHW) has altered its view about prescribing puberty blockers and hormone

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100 Id.
101 Id.
102 *Bell*, EWHC (Admin) 1363.
103 Davis, *supra* note 41.
104 Id.
105 Id.
106 Id.
treatment with strong recommendations to only prescribe such treatment in exceptional circumstances.\textsuperscript{107} In 2022, the NBHW made the determination that the risks of puberty blockers and treatment with hormones currently outweigh the possible benefits for minors.\textsuperscript{108} Now, the NBHW provides that only a small number of minors experiencing gender dysphoria will be considered for treatment with hormonal medications.\textsuperscript{109} Those who will be considered to receive puberty blockers in Sweden are people with “‘classic’ childhood onset of cross-sex identification and distress, which persists and causes clear suffering in adolescence.”\textsuperscript{110} For those whose gender dysphoria appeared during or after puberty, the treatment available includes psychiatric care and gender-exploratory psychotherapy.\textsuperscript{111} The doctors may prescribe hormonal treatment to people with gender dysphoria during or after puberty in limited circumstances.\textsuperscript{112} Sweden has also stated that fewer highly specialized centralized care centers will be available, reducing the number and availability of clinics that provide pediatric gender-affirming care.\textsuperscript{113}

The NBHW has prioritized gender-affirming care for youth using non-invasive interventions.\textsuperscript{114} The Board has stated that non-invasive interventions will be the primary recommendation to allow the child to continue to mature and for their gender identity to fully form.\textsuperscript{115} The goal of the Board currently is to mirror the “Dutch protocol,” and administer invasive treatments in research settings only.\textsuperscript{116} This Dutch protocol includes a prerequisite


\textsuperscript{108} Jennifer Block, Gender Dysphoria in Young People Is Rising – and So Is Professional Disagreement, BMJ Investigation 1, Feb. 23, 2023, https://www.bmj.com/content/380/bmj.p382.

\textsuperscript{109} Summary of Key Recommendations, supra note 107.

\textsuperscript{110} Id.

\textsuperscript{111} Id.

\textsuperscript{112} Id.

\textsuperscript{113} Id.

\textsuperscript{114} Id.

\textsuperscript{115} Id.

for hormonal treatment of youth of prepubertal onset of gender dysphoria that persists into adolescent years and has caused clear suffering. The gender dysphoria must have been long-lasting, meaning the child must have experienced the gender dysphoria for a minimum of five years. Further restrictions of the Dutch protocol include allowing puberty blockers only in extreme circumstances to adolescents with post-pubertal onset of gender dysphoria and the presence of a history of gender dysphoria in the adolescent.

C. Finland

Finland issued guidelines similar to those of Sweden through its monitoring agency for public health services, the Council for Choices in Healthcare. The Finnish Health Authority called for psychological support as the first line of treatment, rather than the use of puberty blockers and hormone treatments. Finland also follows the Dutch protocol and has issued new guidelines after a finding from a systematic review of studies that the evidence for pediatric transition was inconclusive. The Finish guidelines stated concern over the uncertainty of the irreversible effects of gender-affirming treatment for people twenty-five and under. Similar to other European countries, Finland became concerned with the surprisingly sharp rise in adolescents reporting gender dysphoria.

Finland conducted a study which found that adolescents who classified as high functioning prior to receiving cross-sex hormones did well post-treatment; however, the study found that adolescents who had underlying psychiatric needs or problems with school

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117 Id.
118 Care of Children and Adolescents with Gender Dysphoria, supra note 116.
119 Summary of Key Recommendations, supra note 107.
120 Block, supra note 108.
121 One Year Since Finland Broke with WPATH “Standards of Care,” Soc’y for Evidence Based Gender Med. (July 2, 2021), https://segm.org/Finland_deviates_from_WPATH_prioritizingPsychotherapy_no_surgery_for_minors.
122 See supra discussion in text at notes 106-108.
123 One Year Since Finland Broke with WPATH “Standards of Care,” supra note 121.
124 Id.
125 Id.
and social life continued to have issues.\textsuperscript{126} Finland’s approach to gender-affirming care for adolescents is primarily focused on the long-term health and safety of the minor.

V. Australia’s Gender Affirming Care Model

Australia has generally allowed gender-affirming care among minors with some restrictions to ensure the minor receives gender-affirming care in a supportive environment and is confident in their decision.\textsuperscript{127} Australia’s approach to gender-affirming care has been focused on the various types of treatment an adolescent may receive.\textsuperscript{128} Australia views gender-affirming care in two (2) stages.\textsuperscript{129} Stage one (1) involves the administration of puberty suppressers, or blockers.\textsuperscript{130} Stage two (2) involves the administration of the gender-affirming hormones estrogen or testosterone.\textsuperscript{131} These two stages involve no surgical intervention.\textsuperscript{132}

Prior to 2013, Australia required a minor seeking any stage of gender-affirming care to accompany their parents in requesting judge authorization for the care.\textsuperscript{133} In 2013, the Australian high court decided in Re Lucy\textsuperscript{134} that adolescents could receive stage 1 puberty blockers without first obtaining court authorization.\textsuperscript{135} Australia kept court authorization as a requirement in allowing adolescents to receive stage 2 gender-affirming hormones as affirmed in 2013 in the case of Re Jamie\textsuperscript{136} due to the finding that some of the effects of stage 2 cross-sex hormone treatment were not reversible.\textsuperscript{137}
Following *Re Jamie*, more than sixty cases came before the Australia Family Court, and stage 2 cross-hormone treatment was allowed in all cases that came before the court. Petitioners seeking gender-affirming hormones waited an average of eight months from the time the treatment was recommended by clinicians and when the case came before the Family Court. During this waiting period, many adolescents reported increased rates of anxiety, depression, and self-harm. Other difficulties were that the cost of petitioning to the court for authorization for gender-affirming hormones was significant and burdensome for families. These concerns were part of the court’s consideration in the case of *Re Kelvin*.

In 2017, Australia repealed the requirement for court authorization before an adolescent may receive stage 2 gender-affirming hormones in the case of *Re Kelvin*, and the country now allows a minor to be provided with gender-affirming care where the minor is found to be *Gillick* competent and where the treatment is therapeutic. Courts determined that where the treatment by use of gender-affirming hormones is therapeutic and the minor is found to lack *Gillick* competency, court authorization will still not be required for gender-affirming hormones. Instead, the minor may receive gender-affirming hormones even where there is no finding that the minor is *Gillick* competent so long as the parents provide consent for the treatment and the parents and medical provider agree to the method of treatment. Court authorization will only be required for an adolescent’s treatment of gender-affirming hormones where there is dispute or controversy as to the treatment, for instance where the parents and medical providers disagree.

The ruling in *Re Kelvin* was affirmed in the case of *In Re Imogen*. *Re Imogen* further clarified the rule guiding gender-affirming care for minors in finding that people under eighteen may receive gender affirming care beyond a social transition where the

\[138\] *Id.*
\[139\] *Id.*
\[140\] *Id.*
\[141\] *Id.*
\[142\] *Id.*
\[143\] *Id.*
\[144\] *Id.*
\[145\] *Id.*
\[146\] *Id.*
\[147\] *Re Imogen* (No. 6) [2020] Fam CA 761.
parents, medical provider, and the adolescent are in agreement as to the care.\textsuperscript{148} If the adolescent desires stage 2 hormone treatment, the parties must not dispute the \textit{Gillick} competence of the adolescent, the diagnosis of gender dysphoria, or the treatment plan.\textsuperscript{149} The majority opinion in \textit{Re Imogen} determined that psychotherapeutic treatment as the sole form of treatment is risky and not backed by sufficient evidence to be a proven treatment.\textsuperscript{150}

Australia’s view of gender-affirming care for minors varies in a significant way from most European countries and the United States. Australia’s guidelines value the mental health of the minor and attempts to provide gender-affirming care so long as it is in the best interest of the minor. Under the finding that psychotherapeutic treatment is not adequate care for many adolescents with gender dysphoria, Australia views puberty blockers and hormone therapy as a necessary treatment with many benefits. Australia has found that there are greater benefits for a minor with gender dysphoria to be treated with puberty blockers and gender-affirming hormones than psychotherapeutic treatment. Australia has expanded access to gender-affirming care for minors, citing a priority for the minors’ current and future distress.

VI. Other Countries

A. Japan’s Approach

The law in Japan has generally not given much recognition to the rights of transgender individuals. Japan has neglected to recognize the fluidity of sexuality and gender, thus resulting in laws that severely restrict transgender individuals to socially, physically, and legally transition. In 2004, Japan enacted the Gender Identity Disorder Special Cases Act.\textsuperscript{151} For transgender individuals’ gender identity to be legally recognized, this act requires transgender individuals to undergo gender reassignment surgery and have no functional reproductive glands.\textsuperscript{152} Additionally, this act has required

\begin{itemize}
  \item \textsuperscript{148} \textit{Id.}
  \item \textsuperscript{149} \textit{Id.}
  \item \textsuperscript{150} \textit{Id.}
  \item \textsuperscript{151} Gender Identity Disorder Special Cases Act, Act No. 111, art. 2 (2003).
that the individual cannot have underage children or be married, and must be at least eighteen years of age.\textsuperscript{153}

The Supreme Court in Japan used outdated and offensive concerns, such as concerns that transgender men could become pregnant and that any program of allowing gender transitions “may cause confusion in society,” to uphold this law in the years since its enactment.\textsuperscript{154} The Supreme Court, however, showed progress in its recognition of transgender individuals in October of 2023 by ruling a portion of this act to be unconstitutional.\textsuperscript{155} The court struck the requirement of sterilization for transgender adults seeking to legally transition.\textsuperscript{156} This requirement violated Japan’s constitutional guarantees of freedom from invasion into individual’s bodies against their will.\textsuperscript{157} Advocates of the sterilization requirement continue to argue that the absence of sterilization may confuse society and allow men posing as transgender women to invade women-only bathrooms.\textsuperscript{158}

Japan’s step towards positive gender-affirming care and legal recognition of transgender individuals is just one small piece of a much bigger picture. The Gender Identity Disorder Special Cases Act is still enforced and after the Supreme Court’s recent decision, still states that a legally recognized transgender individual in Japan cannot be under eighteen years of age, be married, have underage children, or have genitals resembling those of their biological sex.\textsuperscript{159}

The Gender Identity Disorder Special Cases Act in Japan also creates great hurdles for transgender adolescents. As stated in the Act, individuals under age eighteen are without legal recognition for their transgender identity, even if the adolescent meets all other requirements of the act.\textsuperscript{160} Teenagers in Japan report that the mandated sex reassignment surgery for legal gender recognition pressured them to undergo sex reassignment surgery before

\begin{itemize}
\item \textsuperscript{153} Id.
\item \textsuperscript{154} Id.
\item \textsuperscript{155} Anthony Kuhn, \textit{Japan’s Supreme Court Hands Down a Landmark Transgender Rights Decision}, NPR (Oct. 25, 2023), https://www.npr.org/2023/10/25/1208448169/japan-transgender-rights-supreme-court
\item \textsuperscript{156} Id.
\item \textsuperscript{157} Id.
\item \textsuperscript{158} Id.
\item \textsuperscript{159} Id.
\item \textsuperscript{160} Kuhn, \textit{supra} note 155.
\end{itemize}
adulthood to allow them to attend university or apply for jobs according to their gender identity.\footnote{Kyle Knight, Rights in Transition: Making Legal Recognition for Transgender People a Global Priority, HUMAN RIGHTS CAMPAIGN (2016), https://www.hrw.org/world-report/2016/country-chapters/africa-americas-asia-europe/central-asia-middle-east/north-0.}

Further, there is little discussion in Japan of the gender-affirming care treatments for adolescents with gender dysphoria. Many schools in the country enforce strict male/female school uniform policies that often do not allow children to change uniforms without a diagnosis of Gender Identity Disorder.\footnote{Id.} Junior high and high school students have reported experiencing extreme anxiety due to a requirement of the diagnosis.\footnote{Id.} This has led to an increase in both quantity and length of school absences, and has increased the amount of dropouts among preteens and teens.\footnote{Id.} These policies do not allow a social transition by the adolescent to explore their gender identity. Japan's approach to gender-affirming care and legal gender recognition is outdated, discriminatory, and coercive in prohibiting legal gender recognition for anyone under the age of eighteen.

\subsection*{B. Middle Eastern Countries}

Countries in the Middle East have enacted laws restricting and banning access to gender-affirming care and legal gender recognition.\footnote{Colin Stewart, In 5 Middle Eastern Nations, Gender-Affirming Health Care Is Illegal, ERASING 76 CRIMES (Aug. 2, 2022), https://76crimes.com/2022/08/02/in-5-middle-east-nations-gender-affirming-health-care-is-illegal/.} These laws are influenced by conservative religious views and the countries' narratives of protecting societal values.\footnote{Id.} For example, in 2003, Egypt banned doctors from providing gender-affirming care and allowed legal gender recognition and appropriate healthcare only for individuals with intersex characteristics.\footnote{Id.} This has caused a spike in underground surgeries where ill-equipped clinics provide risky surgeries and care and the sources of hormones are unknown.\footnote{Id.}
The country of Turkey has continued to further these narratives of protecting societal values by placing restrictions on transgender individuals. Article 41 of Turkey’s constitution provides that the family is the foundation of Turkish society. The Constitution grants the State of Turkey the authority to take any measure deemed necessary to protect this foundation and ensure the “peace and welfare of the family, especially the protection of the mother and children.”

The Constitutional Commission of Turkey’s Grand National Assembly approved Bill No. 2/4779 in 2023, which, if passed, would amend Article 41 of the Constitution to implement a more concrete definition of marriage to mean a union only between a man and a woman. Further, this amendment would define family as consisting only of a man, a woman, and children. Turkey’s president recently stated that he did not “recognize LGBT” and made a vow to combat “perverse” trends that threaten to destroy the institution of family. Bill No. 2/4779 is just one attempt to stifle the rights of transgender individuals within Turkey.

Transgender individuals in Turkey are viewed as having a psychological illness which many psychologist and psychiatrists in the country attempt to cure. Gender reassignment surgeries are allowed by law and stated in Article 40 of the Turkish Civil Code with several conditions, including that the individual must be eighteen years of age, cannot be married, and must be infertile. The Turkish government heavily supervises sex-reassignment surgeries by allowing them in a very limited number of hospitals throughout the country.
Under the belief that transgender identity is an illness, Turkey does not provide much protection for socially transitioning transgender individuals. Although doctors and physicians may legally assist adolescents in socially transitioning or providing other gender-affirming care, not including sex-reassignment surgeries, these physicians are severely shamed for providing such gender-affirming care to minors. Turkish physicians have studied the benefits of gender-affirming care for minors who experience gender dysphoria and treat patients according to those findings; however, many Turkish citizens and groups attack this form of treatment, alleging that the doctors are performing sex-reassignment surgery and hormone therapy on children.

Turkish physicians stated concerns for transgender adolescents in their attempts to combat the lack of access to treatment by taking unprescribed hormonal medication. These physicians were concerned that inappropriate hormone use can be problematic for transgender adolescents by possibly deteriorating their overall health and potentially leading to physical and mental problems. With the restrictions enforced by Turkish officials that limit the number of clinics authorized to provide gender-affirming care, an increase in the number of adolescents taking unprescribed hormonal medication threatens the country of Turkey. In a recent study, Turkish physicians found that an increase in healthcare centers for transgender adolescents could increase parental awareness about gender dysphoria and increase access to treatment.

VII. Medical Professionals’ Opinions

Medical professionals in many regions agree that gender-affirming care for minors is important and should be provided,
whether that care is a social transition, puberty-blockers, or hormone treatment. Medical associations such as the World Professional Association for Transgender Health (WPATH), the Endocrine Society, the American Medical Association, the American Academy of Pediatrics, and the American Psychiatric Association have all supported gender-affirming care for transgender youth as medically necessary care.

WPATH is a multidisciplinary professional association that operates on an international scale with a stated mission to promote care, education, research, public policy, and support in transgender health that is evidence-based. As one of the leading institutes for transgender health, WPATH provides a standard of care for health care professionals to provide the safest and most effective care in treating transgender adults and adolescents. WPATH’s standard of care supports the use of a patient-centered care model in the use of gender-affirming interventions, allowing for a holistic approach to address the patient’s social, mental, and medical health needs with importance placed on the affirmation of the adolescent’s gender identity. WPATH encourages gender-affirming interventions in the form of puberty suppression, hormone therapy, and gender-affirming surgeries. In this model, WPATH’s standards encourage gender-affirming intervention based on the needs of the individual patient and strongly discourage reparative or conversion therapy for individuals experiencing gender dysphoria.

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188 Id.

189 Id. at S7.

190 Id. at S100.

191 Id. at S7.
WPATH explains that pubertal suppression does not cause permanent damage to the adolescent’s reproductive functions.\textsuperscript{192} There are risks, however, in the case of invasive procedures that may have permanent effects on the adolescent.\textsuperscript{193} WPATH cites to the Dutch approach about the general appropriate care for certain ages, that pubertal suppression can be considered at age twelve, gender-affirming hormone treatment can be considered at age sixteen, and gender reassignment surgery can be considered at age eighteen.\textsuperscript{194} The WPATH standards suggest that gender-affirming hormone treatment may be initiated prior to age sixteen to avoid prolonged pubertal suppression.\textsuperscript{195} The concern is that prolonged pubertal suppression at a time of peak bone mineralization can lead to decreased bone mineral density.\textsuperscript{196}

Generally, these standards of care implemented by WPATH are followed by many medical professionals. There has, however, been an increase in countries breaking away from the WPATH standards of care and instead following gender-affirming care standards developed by their own leading physicians. The creation of these new standards of care is partially due to the rise in adolescent patients seeking gender-affirming care in the form of puberty blockers and gender-affirming hormones.\textsuperscript{197} This spike in patients has caused a number of countries to question the appropriateness of the WPATH model and has prompted a push for more research into these drugs.\textsuperscript{198}

Part of the concern among these countries is the permanency of the treatment, often citing to the potential bone health concerns of delaying puberty.\textsuperscript{199} Many doctors believe transgender adolescent patients will recover from the loss of bone density once they are off the puberty blocker; however, two recent studies found that for many patients. Their bone density does not rebound after coming off of puberty blockers and their bone density is often lesser

\textsuperscript{192} Id. at S157.
\textsuperscript{193} Id. at S65.
\textsuperscript{194} Id.
\textsuperscript{195} Id.
\textsuperscript{196} Id.
\textsuperscript{198} Id.
\textsuperscript{199} Id.
than that of their cisgender peers.\textsuperscript{200} The lack of sufficient bone density may lead to a heightened risk of debilitation fractures at an age earlier than normal and risks greater harm for patients with already weaker bone density.\textsuperscript{201}

Although the medical community may partially disagree on the timing of treatment in the form of medication and surgery, medical professionals agree that acceptance and affirmation is key to gender-affirming care and addressing the concerns of the transgender adolescents’ health and safety.\textsuperscript{202} Legislation that prohibits gender-affirming care in the form of puberty blockers imposes greater discomfort on transgender and gender-nonconforming youth and fosters discrimination by individuals uneducated on the issue of gender-affirming care and its positive effects. It is important for transgender individuals to have a supportive backing of family, friends, medical professionals, and their community.

\section*{VIII. Recommendations and Conclusion}

On an international scale, transgender and gender-nonconforming adolescents commonly experience transphobia and stigmatization. The implementation of transphobic policies furthers this stigmatization and prevents transgender adolescents from receiving necessary medical care. These policies create a further divide between the already vulnerable minor group of transgender individuals and the remainder of society and can lead to discrimination, marginalization, and hate crimes against transgender individuals.\textsuperscript{203} This can cause what is known as minority stress.\textsuperscript{204} Minority stress increases rates of depression, suicidality, and self-harm in transgender and gender-nonconforming adolescents.\textsuperscript{205} Given these increased rates of suicidal ideation,\textsuperscript{206} government agencies and lawmakers must use their authority to ensure the protection of transgender adolescents.

\begin{flushright}
\textsuperscript{200} \textit{Id.} \\
\textsuperscript{201} Twohey & Jewett, supra note 197. \\
\textsuperscript{202} Coleman, supra note 187. \\
\textsuperscript{203} Id. at S6. \\
\textsuperscript{204} Id. \\
\textsuperscript{205} Id. \\
\textsuperscript{206} See supra text at note 9. \\
\end{flushright}
The passing of legislation allowing gender-affirming care to minors illuminates a debate between the balancing of outdated morals and science. Policymakers must be careful to align new legislation with the best interests of transgender adolescents and the recommendations and research of medical professionals. Government authorities should allow room for medical professionals to determine the best treatment for transgender youth. Implementing policies that are discriminatory and based on outdated beliefs and principles is detrimental to the care of these adolescents. Legislation that is based on the idea that transgender individuals suffer from a mental illness or are “deviants,” as believed by Turkey’s president, does not align with fundamental human rights. Criminalizing the treatment of such individuals to promote the overall care and safety of the individual is against public policy and leads to greater issues such as back alley gender-affirming treatment, marginalization, and the increase of a divide between a vulnerable class and the majority of society.

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