TEENAGE GENDER AMBIGUITY: ETHICAL AND SOCIAL ISSUES

OVERVIEW

This module will explore various ethical and conceptual issues surrounding gender. Gender refers to one’s sense of being either a male or female. One’s gender is influenced by a wide variety of factors. One’s gender may be closely associated with one’s sexual anatomy, as when someone with a penis feels like a male. But that need not be the case. Gender dysphoria, for example, is characterized by a persistent feeling of severe discomfort with one’s anatomical sex. Someone who is gender-non-conforming may not feel like either a man or woman, but somewhere in between. Gender is influenced as well by society, social roles, family life, education, and other biological factors such as hormones. This module explores ethical issues that arise when teenagers specifically feel discomfort with their anatomical sex, leading to gender non-conformity or gender dysphoria. Questions include: How should physicians respond to gender dysphoria? How young is too young to begin transitioning genders? What is the role of parents when a teen seeks to transition? And what should same-sex schools do to make gender non-conforming students feel welcome? The goal of the module is to encourage informed, open dialogue regarding gender and related issues.

CONTENTS

1. Introduction to Topic
2. Physicians’ Roles in Diagnosing Gender Dysphoria and Available Therapies
3. Parental Involvement in Decision-Making
4. Policy Issues Concerning Gender Dysphoria
5. The Gender Binary: Should it Exist, and Why?
6. Conclusion
7. References and Additional Resources

LEARNING OUTCOMES

1. Define terms used in the debate and use them correctly.
2. Consider different stakeholders’ perspectives when it comes to responding to symptoms of gender dysphoria.
3. Debate policy issues specific to the transgender community.
4. Analyze the concept of the gender binary and assess its value to society.

PROCEDURES AND ACTIVITIES

This unit uses a student-centered and interactive approach to teaching. Activities are designed to allow for student participation and are marked as an individual, partner or group activity.

1. INTRODUCTION TO TOPIC

As this can be a difficult concept to grasp, the following questions serve to guide an instructor in the process of introducing gender dysphoria to a group of students who may be unfamiliar with certain terms and what they entail.

1. Has anyone you know ever felt that their identity and their body do not quite “match”?
2. Do you ever feel like the way you dress doesn’t represent who you are? Try to think of specific cases, like when you have to dress up for a formal occasion, or wear a uniform that doesn’t feel like you.
3. Have you ever wished that you could be the opposite gender?
4. Do you know what gender dysphoria is? Have you heard anything about it in the news or other forms of media?

Before discussing ethical issues surrounding gender dysphoria, it is important to get all students or discussants on the same page about terminology.
Gender identity is one's own firm sense of being a man, woman or neither. There is not yet a word in the English language for genders other than man or woman. In our society, gender is a binary choice, though this is not the case in many other cultures.

Sex refers to biological characteristics such as reproductive organs, chromosomes and hormone levels. People with male sex organs have different chromosomes and hormone levels than people with female sex organs. Some people are born with ambiguous sex organs. The term for this is intersex or hermaphroditism. Intersex individuals may nonetheless have unambiguous genders, as when an intersex individual feels like a woman.

Gender roles are the social constructs that we as a society put into place for people of different biological sexes. Stereotypical gender roles insist that women are nurturing, emotional, and caring, while men are assertive and authoritative. As such, girls generally are expected play with dolls, and boys are expected to wrestle and race trucks.

Gender-nonconforming refers to people who do not follow society's ideas or stereotypes about how they should look or act based on the sex they were assigned at birth. For example, a child is gender-nonconforming if they have a penis, but prefer to play with dolls.

Non-binary is a term used to describe societies or cultures in which gender may not be defined solely as “male” or “female,” but rather, exists on a spectrum. Binary means two choices. In non-binary societies, it is socially acceptable to take up a third gender, regardless of one’s sex. This is hard to grasp in the USA, since our culture and institutions perpetuate a binary approach to gender.

Gender dysphoria is a medical term used by doctors. It is defined as the condition of feeling one's emotional and psychological identity as male, female, or another gender identity on the spectrum to be opposite or different from one's biological sex. According to the DMS 5, the Diagnostic and Statistical Manual of Mental Disorders, gender dysphoria can only be diagnosed when observed behaviors continue for a duration of at least six months. It also manifests in behaviors such as a strong desire to be of another gender, a strong preference for cross-dressing or refusing to wear typical clothing assigned to a certain gender, a strong preference for the toys, games, or activities stereotypically used by the other gender, and a strong preference for playmates of the other gender. Only physicians or other health professionals can diagnose gender dysphoria. Since gender dysphoria is a diagnosable disease category, a diagnosis means that therapy is warranted. “Therapies” for gender dysphoria in young people include hormonal suppression to bring hormone levels in line with the desired gender. If someone with a penis feels strongly like a girl, hormone suppression therapy may suppress male hormones responsible for testicular development, voice changes, and other changes that occur during puberty.

Transgender refers to someone who has switched genders. A trans-male refers to a person who was born with female sexual anatomy, but identifies as a male. A trans-female is someone who was born with male sexual anatomy, but identifies as a woman. Trans individuals usually, but need not, use hormones to make their bodies look and feel more like the gender they identify with. They may or may not take steps, including surgery, to physically modify their sexual anatomy to look more like the anatomy of the gender they identify with.

Another important distinction to be made at the outset of this discussion is the difference between gender and sexual orientation. Gender is a person’s social and legal status as a man or woman, while sexual orientation is the term used to describe a person’s sexual desire for other people of a certain gender. Gender and sexual orientation are not synonyms! This module will focus solely on the issues of gender and gender identity.
Now that students have a better understanding of the terms relevant to this issue, survey attitudes surrounding the following questions regarding gender dysphoria:

1. Should we use behavioral signs (such as playing with dolls instead of trucks, or preferring the color pink) to determine whether or not a child feels uncomfortable with their biological sex?
2. Do these stereotypes reinforce outdated or biased beliefs about men and women?
3. Do you believe that a 10–12 year-old child who wishes to change gender or start hormone suppression therapy should be able to do so without the consent of a parent?
4. Do you believe that gender-altering treatments are warranted or ethical for children ages 10–12? If you answered no, when do you think such treatments are acceptable?
5. In your opinion, who should be able to make decisions about treatment for an adolescent? (E.g., the adolescent, a parent or other legal guardian, a medical professional, a therapist)

These, and other questions, will be discussed at length in this module.

2. PHYSICIANS’ ROLES IN DIAGNOSING GENDER DYSPHORIA AND PROVIDING AVAILABLE THERAPIES

The roles of pediatricians and endocrinologists are extremely significant in providing support and care for individuals experiencing gender dysphoria. However, there is some disagreement and uncertainty as to where these roles overlap and diverge. In addition, there is controversy surrounding both the responsibilities that such professionals have in ensuring patients’ happiness in their own skin and the steps that should be taken to diagnose and administer treatment for a condition that is, in today’s political climate, controversial.

A. Pediatricians

As medical professionals focused solely on the lives of children and their well-being, pediatricians often notice first signals of gender dysphoria and relay such information to parents or guardians of the affected individual. However, studies show that the more parents hear about childhood gender dysphoria, the more they question if their child may need to change gender. In fact, “many of the presentations in the public media concerning childhood [gender dysphoria] give the impression that a child with cross-gender behavior needs to change to the new gender or at least should be evaluated for such a change. Very little information in the public domain talks about the normality of gender questioning and gender role exploration and the rarity of an actual change” (Meyer). Because of these uncertainties and discrepancies between what is medically warranted and what is popular in the media, the burden of providing accurate medical information to concerned parents and children ultimately falls on pediatricians.

Although pediatricians are usually the first to see and discuss symptoms of gender dysphoria in children, they typically refer patients to a mental health professional for the diagnosis.

Presentation of gender dysphoria may vary greatly based on environmental and genetic factors. A pediatrician diagnosing a gender dysphoric patient and advising parents what to do must take into account these factors. It is potentially dangerous to suggest that a child has gender dysphoria when the child is simply non-conforming or exploring. Being identified as gender dysphoric can have a drastic, long-term effect on both the patient’s emotional state and their relationships with parents and loved ones. In addition, pediatricians must understand the problems that may accompany a child’s gender dysphoria—for example, abuse, posttraumatic stress disorder (PTSD), and depression can be effects of, or precede, gender dysphoria. Understanding these issues and their impact on a child’s physical, emotional, and mental health is of crucial importance to a physician.
B. Endocrinologists

Endocrinologists are medical professionals specializing in the diagnosis and treatment of children with diseases of the endocrine system, such as diabetes and growth disorders. The glands of the endocrine system produce hormones, which can affect the way individuals think, speak, sleep, eat, and function on a daily basis. As gender dysphoric patients often require hormone or puberty-suppressing treatment to present more like the gender they identify with rather than their biological sex, endocrinologists often consult and prescribe medications when a child is diagnosed with gender dysphoria.

The guidelines for practicing endocrinologists can be found in the Journal of Clinical Endocrinology and Metabolism, a journal produced by the Endocrine Society. Guidelines for specifically gender dysphoric patients include a recommendation that diagnoses of gender dysphoria are made by a mental health professional, such as a psychologist. For children and adolescents, the mental health professional should have training in child and adolescent development psychopathology. Guidelines recommend that endocrinologists should not administer either treatments involving a complete social role change (presenting oneself differently in the way one dresses or acts) or cross-sex hormones in gender dysphoric prepubescent children. In addition, guidelines recommend that physicians evaluate and ensure that patients applying to receive hormone treatment understand the reversible and irreversible effects of hormone suppression before they start these treatments. Therefore, an individual with the desire to change gender does not make the mistake of taking such extreme measures without being fully informed of the consequences of their decision.

While many of the guidelines for endocrinologists involve recommendations specifically geared toward gender dysphoric patients, guidelines must also consider the implications of treatment on adolescents and children ages 10-12 separately. Guidelines for practicing endocrinologists regarding children in this age group recommend that adolescents who fulfill eligibility and readiness criteria for gender reassignment initially undergo treatment to suppress pubertal development, such as taking GnRH (puberty suppressors). In addition, guidelines recommend that pubertal development of the desired sex be initiated at about the age of 16 years, using a gradually increasing dose schedule of cross-sex hormones, and referring hormone-treated adolescents for surgery when 1) the real-life experience has resulted in a satisfactory social role change; 2) the individual is satisfied with the hormonal effects; 3) the individual desires definitive surgical changes. Finally, and perhaps most importantly, guidelines suggest deferring surgery until the individual is at least 18 years old, meaning that an adolescent who wishes to undergo more physical changes to their sexual anatomy should not undergo surgical procedures to alter genitalia until they are at least 18. Until then, possible courses of treatment may include cross-sex steroids, GnRH, or a change of social presentation in public.

In sum, endocrinologists’ guidelines support a stepped approach to facilitating gender transitions in children. Young children may be prescribed puberty-suppressing hormones so that they do not undergo the bodily changes associated with their biological sex during puberty. Older adolescents may be prescribed cross-sex hormones to encourage the development of bodily traits associated with the desired gender. And adults over 18 may opt to undergo surgery so that their sexual anatomy and other body parts appear and function more like those of the desired gender. The next section discusses specific therapies offered to individuals based on age.

C. Available Therapies

Different types of support and therapies are available for children of different age groups and are based on the permanence and long-term effects of such treatments, as well as the perceived responsibility and decision-making capacity that is required to make life-changing choices. For example, a younger child may not have the mental capacity to make a huge treatment decision—therefore, permanent, life-changing treatments are rarely, if ever, undergone for younger children. In this section, treatments available for individuals within each age group will be explored.

For children between the ages of 1-9, treatment options are typically quite limited. This is because children at such a young age are difficult to diagnose—at times, they may seem to be simply gender non-conforming, and sentiment toward one’s gender may change by the time the child has entered puberty. Usually a child who
wishes to change gender, or exhibits some of the behaviors outlined in the DSM-5 listed above, will be referred to a child and adolescent Gender Identity Clinic (GIC). Staff at these clinics then carry out a detailed assessment of the child to help them determine what support they need. Options for support consist of the following:

- Family therapy
- Individual child psychotherapy
- Parental support or counselling
- Group work for young people and their parents
- Regular reviews to monitor gender identity development
- Changes in social presentation

Most options offered at this stage are psychological rather than medical or surgical, as the majority of children cannot be *diagnosed* with gender dysphoria until they have reached puberty and, subsequently, adolescence. Psychological support at this age is crucial, as it gives young people and their families a chance to discuss their concerns and thoughts so that they can cope with the emotional distress of gender non-conformity and dysphoria without rushing into more drastic, and possibly harmful, treatments.

**Once children reach the age of about 10-12,** they have entered puberty and are therefore viable for more medical support in changing genders, if the child still desires to change gender. At this point, they can be treated with gonadotrophin-releasing hormone (GnRH) analogues. These synthetic hormones suppress the hormones that are naturally produced by the body during puberty. GnRH analogues may also suppress puberty and help delay potentially distressing physical changes caused by the individual's body becoming even more like that of their biological sex. For example, GnRH will delay the development of breasts and the beginning of menstruation in a person who was born with female sexual anatomy but identifies as a male, and wants to present as such. GnRH is administered as a pill or in the form of injections, and must be taken regularly to function as an effective hormone suppresser. More permanent options are discussed below. It is important to note that GnRH is still fully reversible, and can be stopped at any time.

**Older teens** may be considered for additional therapies that help them to appear as the opposite gender (or no gender at all). By this age, doctors are able to make a more confident diagnosis of gender dysphoria, and steps can be taken toward more permanent hormone or surgical treatments, if the patient desires them. Cross-sex hormones may be a viable treatment for individuals in this age group who wish to transition to another gender. Hormone therapy means taking the hormones of an individual's preferred gender so as to stimulate bodily changes and transition to the desired gender. A trans-man (female to male transition) would take testosterone, or masculinizing hormones, while a trans-woman (male to female transition) would take estrogen (feminizing hormones).

**Adults** have the greatest amount of freedom in terms of therapies for a couple of reasons. First, they can consent to treatments and seek therapies on their own. They do not need parental consent to begin transitioning or seek psychological support. Second, doctors are more comfortable prescribing medications and even more invasive methods to transition genders when a patient has had a consistent desire to change genders – often several years. Since they are older, adults meet this criterion.

Some additional ways to facilitate successful gender transitions include:

- Mental health support
- Cross-sex hormone treatment
- Speech and language therapy
- Hair removal treatments
- Peer support groups
- Relatives’ support groups
- Surgery

Curriculum Integration Idea: Understanding Hormones
How do hormones work? What is the role of hormones in the development (and maintenance) of bodily traits? How does hormonal therapy affect physical characteristics? Why?

3. PARENTAL INVOLVEMENT IN DECISION-MAKING: WHO GETS TO MAKE DECISIONS ABOUT TRANSITIONING GENDERS?

As we’ve seen, there are various ways of supporting teenagers both psycho-socially and medically to facilitate gender transitions. There is disagreement, however, over when doctors should start supporting gender transitions (after all, it might be “just a phase”) and over whether parents should be involved in the decisions to start hormone therapies. Some doctors – and parents – refuse to acknowledge gender dysphoria in their teenage patients and children. Other doctors and parents are more accepting and see delaying transition as causing more harm to children who are then forced to exist in what is perceived as the wrong body.

A study done at the Endocrine Center of the Children’s Hospital in Boston surveyed adolescents who were being treated for gender dysphoria about their experience. The study found that children who did not actually receive treatment, whether for financial reasons or because their parents were not supportive, had a higher rate of psychiatric complications before receiving treatment at the hospital. In fact, 57 percent of transgender or gender-nonconforming adolescents possessed the desire to commit suicide when their families chose not to speak or spend time with them as a result of their gender dysphoria. These are dangerously high rates, and are very much related to the pain and abandonment felt by gender dysphoric or transgender youths who feel as though they are alone in this conflict. As a result of parental abandonment, many adolescents with gender dysphoria are left on the streets, and the population of homeless adolescents with gender dysphoria is rapidly increasing. According to the National Center for Transgender Equality, one in every five transgender people have experienced homelessness at some point in their lives, proving that this issue is an important factor in determining the amount of power different stakeholders should have when making treatment decisions.

A. Adolescent Autonomy

The debate over adolescent autonomy in this space refers to the debate over whether adolescents should be permitted to make decisions about treating gender dysphoria. Respect for autonomy is a bioethical principle that requires that doctor respect the choices of their patients, when those choices are fully informed and in line with the patient’s values. Autonomy refers to the capacity to make decisions that are in line with one’s values and preferences. This debate is extremely prevalent in the discussion of gender dysphoria and ethics. Those “against” adolescent autonomy argue that parents ought to make treatment decisions. Those “for” adolescent autonomy argue that adolescents are, and should be, able to make decisions to begin transitioning to another gender, even if their parents do not agree.

i. Arguments against Adolescent Autonomy

One popular argument against adolescent autonomy states that adolescents do not have the basic cognitive ability to be able to make medical decisions, including decisions surrounding therapies for gender dysphoria. In a study done by the Department of Pediatrics in Jonköping, Sweden, cognitive and decision-making abilities of children were tested by reading ability, age, and the ability to remember and understand a text. The study found that, as expected, older children had greater knowledge and cognitive abilities, as well as a heightened ability to retain information, than younger children. These results are significant because they show that a greater mental capacity directly corresponds to a greater ability to make competent decisions, meaning that younger children may not be able to give informed consent to a medical treatment. In order for a physician to legally administer a treatment, they must make sure that the patient is informed of all of the details and risks of that treatment. This is called informed consent. Informed consent requires that a patient understands proposed interventions, has weighed them against alternatives, and accepts differences. If a patient is too young to understand a procedure or the consequences of the procedure, the patient cannot provide informed consent. When patients cannot provide informed consent, physicians must obtain consent from a legal guardian. In the case of children, that is usually a parent.
Another significant argument against granting children in this age group full decision making capacity highlights the fact that as much as 52 percent of children between ages 4 and 11 are diagnosed with one or more mental illnesses at the same time they are diagnosed with gender dysphoria, such as clinical depression or suicidal thoughts (Diagnostic and Statistical Manual of Mental Disorders). These statistics force us to consider the implications and effects of these conditions on a child’s decision-making abilities. Depression, for example, could lead to a difference in the way a child makes decisions about their course of treatment and make it difficult to discern the child’s desires and preferences.

There may also be other risks associated with allowing young children to make decisions about medical treatment. For example, a child may make a decision rashly, or without considering the long-term effects of such a choice. A child may also make a decision that is largely influenced or manipulated by a parent, guardian, or other stakeholder in the child’s life. Finally, a child’s decision about treatment may differ from that of a parent or guardian, possibly creating a legal conflict that is traumatizing or difficult for the child in the long run.

Finally, the effects of puberty on a child also play a large role in determining an individual’s values and sense of identity. Puberty, and the mental and physical changes that accompany it, may have a large effect on the long-term wishes of a child. Using this logic, is puberty a “necessary evil?” Some people think it is beneficial for a child to be able to experience puberty for the emotional and physical changes it could bring to them, even if they go through puberty with gender dysphoria. Beyond this, they ask: should a child take hormones that could change their pubescent growth process if they have not yet been through puberty? The idea is that puberty may change the way the child feels about the body, so doctors should not suppress puberty even if a child wishes to undergo such treatment.

ii. Arguments Supporting Adolescent Autonomy

On the other hand, not allowing a child to make decisions ultimately disregards that individual’s desire to feel comfortable in their own skin. Should medical professionals and others be allowed to make decisions that may alter a child’s life and psychological health forever?

Not allowing a child to begin GnRH or cross-sex hormones when they are chosen by the child could have a long-term impact on the child. The child may grow up wishing that they had more decision-making power to have successfully transitioned at a younger age. Or, if parents force their child into forms of therapy that seek to reinforce the child’s biological sex (such as psychotherapy or behavioral therapy) rather than their desired gender, a child may resent the trauma of having gone through such an experience. This would cause more pain and struggle for the child in the long run. If children are permitted to make decisions for themselves, one may argue that they will be content with any decision made because it was their own decision.

In addition, it can be argued that children living with terminal or other severe illnesses may mature drastically throughout the treatment process. Thus, they may become more viable to make decisions for themselves, especially after undergoing numerous life-threatening or serious treatments. The same may be true of children living with gender dysphoria: they have unique insight into what it means to live with this affliction and may therefore be better able than those who do not feel the same way to make treatment decisions.

Instructors may consider asking students to view the issue from the perspective of an individual who has experienced the uncertainty and self-realization that comes with puberty and adolescent development, and understands how one’s physical and emotional well-being can be affected. Now, imagine how a gender dysphoric individual may feel in this situation. Can the use of hormones or puberty suppressors, be justified from this perspective? Why and how? These are valuable and relevant questions to be addressed, especially in a classroom setting.
B. Parental Involvement in Decision-Making

In this section, students will discuss the ethics of parental involvement in treatment decisions, exploring how much power parents and guardians should have over a child’s decisions and how best to determine a parent’s responsibility in making decisions for younger children.

i. Arguments against Parental Involvement in Treatment Decisions

Arguments against parental decision-making highlight the fact that most parents know little about the process of diagnosis and treatment of gender dysphoria, have little knowledge about the implications of certain decisions for treatment, and don’t know what it feels like to have gender dysphoria. On the one hand, parents may be too eager to help their children transition. A parent who simply wishes to make their child happy may authorize unnecessary measures to pacify a child wishing to change gender, and this excessive lenience could lead to starting therapies prematurely or undergoing procedures that are medically unwarranted or harmful. For example, a mother who simply wants her child to be happy may believe that undergoing hormone or GnRH treatment is the best solution to satisfy the child’s desires. Sometimes parents are too willing to do whatever it takes to make their child happy, and downplay or even ignore harmful consequences. This supports an argument against parental involvement in treatment decisions.

On the other hand, parents may refuse to accept a child who identifies with another gender. A parent who refuses to acknowledge their gender nonconforming child may alienate their child and make matters worse that way. For example, let us examine a situation involving a mother with a young boy, about 10 years of age. Her son tells her that he is unhappy being a boy and wants to be a girl. He plays with dolls, dresses in feminine clothing, and many of his friends are female. The mother, only wishing to see her son content, decides to seek medical help. However, she is opposed to surgery to physically alter a child’s genitalia. The doctor informs her that puberty blockers are administered as a transition to something more permanent, such as surgery. Unhappy with this outcome and feeling that it is against her own beliefs, she cuts her son off from these possibilities and attempts to constrain his discontent by encouraging him to behave “more like a boy.” In this case, the parent’s beliefs are placed above the psychological well-being of the child, which may present an issue in regards to the child’s welfare, possibly resulting in mental illness or, in some tragic cases, suicide. This story also describes the dangers of parents making treatment decisions for their children. In this case, the parent refused treatment, forcing their child to live with gender dysphoria instead.

Finally, having parents inexperienced or uneducated in issues surrounding gender can lead to over-exaggerating when children display gender non-conforming behaviors. There is a difference between children with gender dysphoria and children who do things that are not stereotypically associated with their perceived gender (i.e. not dressing like a boy, not playing with monster trucks or other stereotypically "male" toys, having friends of another gender). Parents who do not understand the difference between gender dysphoria and a child’s simply “being a child” and experimenting with different toys or playmates of the opposite gender may make drastic decisions about treatment based on an unfounded fear or worry that their child is gender dysphoric when in reality, the child may simply be different from other children their age and gender. This presents another possible danger of parents making treatment decisions for their children.

ii. Arguments Supporting Parental Involvement in Treatment Decisions

However, there are also many things to consider when examining the competence and ability of parents and legal guardians to make decisions for their children, as parents know their children better than anyone else and understand their children’s perspectives and opinions best. Generally, most parents have their children’s best interests in mind when making treatment decisions. It can be frustrating to feel as though one’s own child is no longer in one’s control. It is logical for someone who has taken care of, fed, bathed, and clothed a child for many years to believe that a parent should be responsible for making serious or life-changing decisions.

Group Activity
Students should read the following case study and determine which stakeholder, parent or patient, should be able to make decisions regarding treatment. Afterward, a discussion may be used to facilitate conversation about the ethical issues involved and the implications of allowing certain stakeholders to have decision-making power.

Alex, a 16-year-old who was assigned “male” at birth, was referred to a mental health specialist by a pediatrician for evaluation because of Alex’s persistent desire to be a woman and take female hormones. During childhood, Alex preferred to play with dolls, wear “women's” clothing, and keep long hair. By the age of 15 years, Alex wore nothing but “women's” clothing and adopted a new name in accordance with Alex’s gender identity. Alex's mother has never accepted her child’s behavior and has denied the gender dysphoria. Alex’s father has been mostly absent during Alex’s upbringing. Alex tells a therapist about a very strong desire to take female hormones. Dr. Guerra, the therapist, recommends regular psychotherapy and prescribes antidepressants to treat Alex’s anxiety and depression. Alex refuses to adhere to this treatment, and again asks for hormonal drugs. During the period in which Alex does not take hormones, Alex experiences unwanted bodily changes. Dr. Guerra then refers Alex to an endocrinologist, who recommends hormonal therapy, but Alex’s mother refuses to consent to the treatment.

The stakeholders involved: society, Alex, Dr. Guerra, Alex’s mother

Discussion Questions:
1) Should the endocrinologist prescribe hormones to Alex without Alex’s mother’s consent? If so, what justifications – moral and legal – support that decision?
2) How might our understanding of adolescent decision-making in other contexts (e.g., terminal and chronic illness or addiction and mental health treatment) inform our views of whether adolescents or their parent(s) should make treatment decisions relating to their gender dysphoria?
3) How could Alex’s depression and anxiety affect Alex’s decision making capacity? Is it ethically permissible to deem Alex incompetent to make decisions because of this depression?

Split participating students into four groups based on the stakeholders presented above. Ask students to respond from the perspective of their assigned stakeholder, thinking about these discussion questions from the perspective of those individuals. What ethical values does your stakeholder consider most significant? If the case study does not explicitly state these values, what can be assumed from the role of that individual in the study? How may these values affect the physical and emotional well-being of a gender dysphoric child or adolescent?

4. POLICY ISSUES CONCERNING GENDER DYSPHORIA

Given the progression of policy concerning the rights of the transgender community in recent years, many people have become more accepting of questioning individuals and people who do not identify as either of the binary genders. People are getting more and more used the to the idea that individuals may not conform to expectations about how men and women typically dress, and getting used the to idea that someone may identify with a gender opposite from their assigned sex. But the reality of allowing people to present in public as the gender they desire still challenges some people’s beliefs about sex and gender. This has led to some fierce policy debates.

A. Bathroom Laws

The implications of allowing children and adolescents to present themselves as the gender they desire challenge some people’s views on gender. Backlash against the Houston Equal Rights Ordinance (HERO) is a good example. HERO was a law proposed by Texas lawmakers to establish protections for transgender people. One section of HERO, nicknamed the “bathroom ordinance” by those who oppose it, has created significant controversy (The New York Times). The “bathroom ordinance” would have given transgender
individuals the ability to use the bathrooms of the gender they identified as. Jared Woodfill, a Houston lawyer and Texas Republican Party leader, began a campaign opposing HERO under the basis that trans-women (derisively called “cross-dressing men”) may violate or assault women in public bathrooms if trans-women were permitted to use the bathrooms of the gender with which they identified. This narrative has stretched all the way to the highest positions in government, and has prevented HERO from being made into law, even though many advocates of HERO argue that this fear is unfounded.

Another issue similar to the Houston “Bathroom Ordinance” involves the North Carolina “Bathroom Law,” a law that explicitly denies transgender individuals the right to use the bathrooms of the gender with which they identify. The law says that you must use the bathroom that corresponds to the sex you were assigned at birth. Many individuals in North Carolina argue that public safety is the justification for this law. For example, Lt. Governor Dan Forest said, “If our action in keeping men out of women’s bathrooms and showers protected the life of just one child or one woman from being molested or assaulted, it was worth it” (Fausset, Blinder).

There has been significant controversy surrounding this decision, as members of the trans community have retaliated with protests against the policies in both states. Some lawmakers say that they would be open to modifying parts of this law, and that there is some precedent for a correction. Chris Sgro, executive director of the group Equality North Carolina and one of the plaintiffs of a federal lawsuit challenging this law, will be serving on an open State House seat. He is the sole individual on the legislature who is openly gay, bisexual, or transgender, and “note[d] that the law goes beyond the issue of transgender people and bathrooms” as it “left gay, bisexual and transgender people worse off because it does not include specific protections based on sexual orientation or gender identity, and precludes towns and cities from passing their own anti-discrimination policies” (Fausset, Blinder). Furthermore, the law prohibits workers from bringing certain discrimination cases to the state court, and these claims must be filed in a federal court or with the state’s Human Relations Commission, steps that may be more costly or inconvenient for plaintiffs.

Bathroom policy debates are just one example of the many difficulties that accompany social presentation and the additional problems a child must face when they dress and present themselves as their desired gender in public. Other difficulties include opposition from those unwilling to accept the child as the gender they present themselves to be, or general refusal to allow these individuals to occupy public spaces.

Group Activity

Discussion questions:

1. How do you feel about the issues surrounding transgender individuals and bathroom use/designation?
   2. Do you believe that allowing transgender individuals to use bathrooms of the sex they identify as will indeed pose a threat to others using the same bathrooms?
   3. What ethical “dilemmas” stand out, or are most pertinent, in these issues?
   4. What do you see as the main problem in these policies?
   5. If you created a policy that was inclusive to individuals of all gender identities while also adhering to the wishes of policy and lawmakers in Houston and North Carolina, what would it be?
   6. How would your policy effect different stakeholders involved?

B. Same-Sex Schools

The issue of same-sex schools and universities and the way these institutions treat gender non-conforming individuals is a fairly recent one and has only become relevant in recent years, as the number of trans individuals attending or seeking to attend those schools has increased. A changing student body challenges the way such institutions function and even their missions. Colleges for women, for example, pride themselves on educating women leaders and role models. In focusing narrowly on educating women, do these schools
reinforce gender binaries and gender roles? Would expanding the student body to include trans students undermine their mission?

As same-sex high schools and universities consider these abstract questions, they also face real conflicts about whether and how to accommodate trans students.

At Wellesley College, a women’s university in Massachusetts, the issue manifested in a debate over whether a trans-man should be allowed to run for student council. Timothy Boatwright, who was born a woman but identifies as a male, was a student at Wellesley when this issue became prevalent. When Timothy ran for a position representing the student body at Wellesley, an Abstain campaign was created to prevent him from being elected. Many students were against the idea of a man commanding power on campus, as the majority of the student body and the institution itself places great importance in not perpetuating patriarchy. Institutions such as Wellesley wish to give women the resources and means to empower themselves and explore fields of study that are largely male-dominated. Thus, there is a large amount of attention paid to women’s rights and expectations, as well as the consequences that inevitably accompany being a woman. Many argued that it ran counter to the school’s identity and mission to see a trans-man representing the student body.

Another fellow student and trans-man, Eli, was torn when asked whether or not he felt transgender men belonged, or could be accepted by the student body at Wellesley. He said, “I don’t necessarily think we have a right to women’s spaces. But I’m not going to transfer, because this is a place I love” (Padawer). He also began to question if “Wellesley [should] draw a line [or] if a line should even be drawn” between different identities, and where that line becomes insignificant (Padawer).

Transgender men are allowed at most women’s colleges if they apply as female; however, transgender women, people who are raised male and go on to identify as women, have much more difficulty getting accepted into either all-female or all-male colleges. Certain universities have altered their policies to be more accepting toward transgender individuals—for example, Mills College in May of 2016 became the first women’s college to broaden its admissions policy to include self-identified transgender women. The school also welcomes biological females who identify anywhere on the gender spectrum. Mount Holyoke College announced a more far-reaching policy, admitting any academically qualified students regardless of anatomy or gender identity, as school officials viewed the problem as a civil rights issue. Amidst these drastic changes, Wellesley remains unsure of how to “[work] out how to be a women’s college at a time when gender is no longer considered binary” (Padawer).

**Group Activity**

Invite students to discuss the above issue in small groups, where each group presents a different argument from the perspective of a different stakeholder. One group may represent the interests of school officials at Wellesley, one group the trans-men community at Wellesley, another group the individuals identifying as women at Wellesley, and finally, a group representing the perspective of officials at schools such as Mount Holyoke, which welcomes individuals of all identities on the spectrum. Ask students to consider and respond to the following questions:

1. What are the ethical considerations to acknowledge regarding this issue?
2. What are some considerations regarding policy and the legal rights of LGBTQ+ individuals at same-sex schools or universities?
3. How might the feminist movement at colleges such as Wellesley impact individuals who identify on the gender spectrum?
4. How can policymakers eradicate the inequality between acceptance rates of transgender students in single-sex universities?
5. Why might it be difficult to “change” Wellesley’s policies and those of similar universities?
6. How can we, as individuals examining policy issues that affect LGBTQ+ individuals, reassess such regulations to be more accepting of members of the LGBTQ+ community?
C. Women’s Sports

Another important issue that has risen to the forefront in recent years is: who counts as a woman when it comes to sports? With the goal of ensuring fair play, sports associations and colleges sometimes force women to undergo gender testing if they appear to have male characteristics, such as increased muscle mass. The worry is that having “male characteristics” will give the women an unfair advantage. Individuals shown to have “male or ambiguous attributes” are sometimes barred from participating in competition.

Dutee Chand is one of India’s fastest runners. She, along many others, was tested for irregular hormone levels, and was found to have higher levels of testosterone than was “normal.” Since then, Chand has been at the center of a legal struggle that contests her disqualification and the international policy her lawyers say discriminates against athletes with atypical sex development.

Two organizations, the International Association of Athletics Federations (the I.A.A.F) and the International Olympic Committee, have “spent half a century vigorously policing gender boundaries” (Padawer), in the process humiliating athletes who are gender non-conforming and placing individuals into boxes based on their gender. However, this process totally leaves out intersex people or those with naturally aberrant hormone levels. This controversial policy, and the desire to place labels on those who do not conform to gender or sexual norms, but want to continue their passions as athletes, keeps individuals like Chand from pursuing their dreams for something that their bodies cannot control.

Group Activity

Invite students to discuss this issue together in three groups. Let one group of students represent the interests of Chand and other athletes like her who are disqualified from competition because of their hormone levels or chromosomes. Let another group represent a policymaker's perspective, and let the last group represent an I.A.A.F. representative. Debate the following questions within these groups and create a “policy” to address the issue discussed above.

Questions:
1. What is your perspective on this issue? Do you believe that organizations such as the I.A.A.F and the International Olympic Committee are unjustly disqualifying athletes from competition?
2. How can we draw a line between gender identity and biological sex in such a controversial legislative issue that could create a precedent for many future international events?

Partner Activity

As a wrap-up activity, have students find partners. The objective of this activity is to have students create a policy that, in their perspective, is just and ethical to all involved in the issue explored in topic C. Partners must devise the policy and present it to the class, explaining how it addresses multiple perspectives and issues affecting each stakeholder involved. Instructors may choose the scope of specificity in this assignment: policies may be broad and address many international organizations as a whole, or they may focus on the organizations discussed.

5. THE GENDER BINARY: SHOULD IT EXIST? WHY?

Many of the issues outlined in this module exist because of a desire to place individuals who do not conform to society’s standards into boxes, as well as to label those who are unsure so that we as a society feel more secure within our constructs. However, one must question whether or not treatment for gender dysphoria is the proper and most effective way to solve the issue and provide those affected with the resources to feel safe and secure in their own bodies. Psychologists are among those responsible for supporting those who feel that they
do not fit within society’s gender boxes—and these professionals are at the forefront of eradicating, or at the very least softening, the strict divisions of gender and the gender binary.

The American Psychological Association (APA) recently published guidelines for practicing psychologists in the United States when it comes to supporting transgender and gender non-forming people. The guidelines reinforce that psychologists have a responsibility to ensure that each gender dysphoric patient feels comfortable in their own body and is not at risk for depression, suicide, or acts of violence because of an inability to freely and easily express their gender identity. In fact, ensuring the mental health and safety of these individuals is just as important as ensuring that their physical needs are met.

According to the Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (TGNC), trans-affirmative practice is the provision of care that is respectful, aware, and supportive of the identities and life experiences of TGNC people. This practice is enacted and followed whenever a gender dysphoric or gender-questioning individual seeks psychiatric help. Some of the guidelines set in place for psychologists with TGNC patients include:

1. Psychologists understand that gender is a nonbinary construct that allows for a range of gender identities and that a person’s gender identity may not align with sex assigned at birth.

2. Psychologists seek to understand how gender identity intersects with the other cultural identities of TGNC people.

3. Psychologists are aware of how their attitudes about and knowledge of gender identity and gender expression may affect the quality of care they provide to TGNC people and their families.

4. Psychologists recognize how stigma, prejudice, discrimination, and violence affect the health and well-being of TGNC people.

5. Psychologists strive to recognize the influence of institutional barriers on the lives of TGNC people and to assist in developing TGNC-affirmative environments.

6. Psychologists recognize the potential benefits of an interdisciplinary approach when providing care to TGNC people and strive to work collaboratively with other providers.

These guidelines allow psychologists to attain a mutual understanding and acceptance of the necessary care provided to TGNC individuals—this extends not only to those who are gender dysphoric, but also, to those who are transgender or gender non-conforming and may or may not have families supporting their decisions. These guidelines are extremely important, as they hold physicians to a certain standard of care and work to eliminate any bias or discrimination against those seeking treatment. Gender dysphoric patients, especially adolescents entering or experiencing puberty, need a supportive team of professionals that they can rely on to receive emotional support without fear of judgment or misunderstanding. Such guidelines are extremely relevant to many of the issues that these adolescents face in today’s day and age.

In addition, these guidelines call for a deeper discussion regarding the effectiveness of treatments for gender dysphoria as opposed to greater leniency with gender and the gender binary. Psychologists are required to understand the significance of societal constructs and the fact that gender does indeed exist on a spectrum. However, the larger public does not seem to acknowledge or accept this view; male and female restrooms still exist, and few written applications provide the option to choose a gender other than “male” or “female.” Of course, understanding the gender binary and how universal it is, completely eradicating this system would require massive social change. It would also require a general public who is educated and willing to accept a different point of view, a different perspective. Perhaps such a future is unrealistic; still, this is an important discussion to have with students who may have very diverse views on the subject.
Explore what is meant by the statement, “Gender is a spectrum.” This can be hard to wrap our heads around. Ask students to explore what this means to them through drawing or art. Ask students to depict the gender binary, and then depict a gender spectrum. You can search for images through an online search, or leave it up to students’ interpretations. Is “spectrum” even a good metaphor for gender?

Facilitate a discussion about the existence of the gender binary discussed above:

1. Do you believe that the gender binary should exist/is necessary? Why?
2. What substantial societal changes would need to be undergone for this to be possible?
3. Do you believe that such a change can happen? In how many years? Why?

6. CONCLUSION

Teachers should invite students to return to the questions outlined in the beginning of this module. An optional reflection may be written, so that students can compare their thoughts on the issue before and after the lesson.

1. Do you believe that an individual who wishes to change gender should be able to without the consent of a legal guardian?
2. Do you believe that permanent treatments are acceptable for children ages 10–12?
3. If you answered no, when do you think such treatments are acceptable?
4. In your opinion, who should be able to make decisions about treatment for an adolescent? (Ex: the adolescent him/herself, a parent or other legal guardian, a medical professional, a therapist)
5. In general, do you believe that the policies and guidelines set in place for medical professionals interacting with gender dysphoric patients are ethical? How or why?

7. REFERENCES AND ADDITIONAL RESOURCES

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