

Connecticut College

Digital Commons @ Connecticut College

Philosophy Honors Papers

Philosophy Department

2021

Listening to the Transgender Child's Voice: Navigating Parent-Child Conflicts Regarding Gender-Affirming Care

Halle Paredes

Connecticut College, hcp721@gmail.com

Follow this and additional works at: <https://digitalcommons.conncoll.edu/philhp>



Part of the [Philosophy Commons](#)

Recommended Citation

Paredes, Halle, "Listening to the Transgender Child's Voice: Navigating Parent-Child Conflicts Regarding Gender-Affirming Care" (2021). *Philosophy Honors Papers*. 15.

<https://digitalcommons.conncoll.edu/philhp/15>

This Honors Paper is brought to you for free and open access by the Philosophy Department at Digital Commons @ Connecticut College. It has been accepted for inclusion in Philosophy Honors Papers by an authorized administrator of Digital Commons @ Connecticut College. For more information, please contact bpancier@conncoll.edu.

The views expressed in this paper are solely those of the author.

**Listening to the Transgender Child's Voice: Navigating Parent-Child
Conflicts Regarding Gender-Affirming Care**

An Honors Thesis presented by

Halle Cottle Paredes

to the Department of Philosophy

Connecticut College

May 2021

Advisor: Lindsay Crawford

Contents

Acknowledgements.....ii

Chapter 1: Introduction.....1

Chapter 2: The Best Interest View: Exploring Justifications for Parental Authority.....7

 Introduction7

 Overview of Paternalism and the Best Interest View8

 Premise A9

 Premise B11

 Epistemic Injustice and Testimonial Injustice.....13

Chapter 3: A Harm-Based Argument Against Sole Parental Authority in PBT Decision-Making Conflicts17

 Introduction17

 Best Practices for Pediatric Transgender Patients19

 Parent/Child Clinical Disagreements and the Best Interest View.....22

 Traditional Harm-Based Argument for Parental Rejection.25

 Testimonial Injustice and Children Experiencing Gender Dysphoria.....29

 Epistemic Objectification and its Harm to Trans Youth.....35

 Conclusion.....37

Chapter 4: A Positive Argument for Pediatric Autonomy in PBT Decision-Making Conflicts.....39

 The Positive Argument.....39

 Responding to Objections – Premise 2.....41

 Responding to Objections – Premise 3.....44

 Responding to Objections – Premise 149

 Responding to Objections – Premise 450

 Conclusion51

Chapter 5: Conclusion.....52

 Overview of Central Arguments52

 Further Work53

References.....57

Acknowledgements

First and foremost, I would like to thank my incredible thesis advisor, Professor Crawford, for her consistent and unrelenting support during this thesis process, as well as the entire Philosophy Department (Professor Turner, Professor Pessin, Professor Vogel, and Professor Feldman) for challenging and championing me throughout my study of philosophy. I feel so lucky to have had the privilege of learning from you.

I must also thank my on-campus family, including my friends, teammates, coaches (Eva and LC), and career advisors (especially Dot and Deb) for reminding me of all I'm capable of and cheering me on throughout my four years at Connecticut College. You have taught me so much—be it in the classroom, in the boathouse, and everywhere in between—and though I'm devastated to be parted from you, I am confident that I am leaving Conn a better person because of you.

I'd also like to thank my friend Eve—I'm so grateful that your critical and argumentative nature finally came in handy.

I would like to thank my entire family, especially my adoring parents, for their unwavering guidance, patience, and love. I'm so grateful for your unyielding support of my pursuits, even those that fell outside your purview. The parts of myself I love the most were built by you. When I was most alone I had you by my side, and I'm so lucky to have a life and a family filled with so much resilience and warmth. Thank you for reminding me of all I'm capable of, even when I forget. Through dark challenges and exciting triumphs, I cannot thank you enough for your steadfast encouragement and love. Though I'll be an ocean away next year, you should know I would not be able to do so without your unconditional love and support.

Finally, I want to thank my Nana, my Tita, and my Lola. *Though we be parted wide and far a moment's space*, the power of your kindness, love, and strength sustains me each day. As I grow older, I'm learning how much of a privilege it was to grow up with you three as my role models. Your commitment to family, medicine, academia, and kindness has provided me with a lifetime of inspiration. Though haven't gotten to spend enough time with you all recently (though, no amount of time could ever be enough), I hope you know I think of you all each day.

CHAPTER 1: INTRODUCTION

The political landscape in the United States (not to mention globally) has historically and continuously aimed to restrict the rights of transgender people. Major news stories regarding harmful legislation tend to center around “bathroom bills” prohibiting people from using restrooms that align with their gender identity; restrictions to athletic participation for trans people; and failures to properly eradicate systemic biases against trans people that hinder their employment and access to equitable and appropriate medical care. These legislative barriers in the United States are accelerating in frequency, with 2021 being a record-breaking year for anti-transgender legislation at state levels.¹ These consistent and unrelenting attacks on the rights of transgender and gender-questioning people pose serious threats more seriously to children within this population.

Though President Joe Biden signed an executive order extending federal protections against discrimination for LGBTQIA+ people on his first day in office,² many states are continuing to enact harmful legislation that further restricts the rights and freedoms of transgender children and adults. More recently, Arkansas passed a bill on Monday, March 29, 2021 that comprehensively bans access to gender affirming care for trans youth in the state. Its acronym is “SAFE”, which stands for Save Adolescents from Experimentation.³ This piece of legislation, pushed by Republican lawmakers, is the first of its kind to be approved in the United States, and is being condemned as one of the most dangerous and extreme legal acts against trans

¹ Krishnakumar, Priya. “This record-breaking year for anti-transgender legislation would affect minors the most.” *CNN*, 15 April 2021. <https://www.cnn.com/2021/04/15/politics/anti-transgender-legislation-2021/index.html>

² The White House. 2021. “Executive Order on Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation.” *The United States Government*. Accessed 3 May 2021, www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-preventing-and-combating-discrimination-on-basis-of-gender-identity-or-sexual-orientation/.

³ Arkansas SAFE Act of 2021. House Bill 1570, Arkansas 93rd General Assembly. Accessed 4 May 2021. <https://legiscan.com/AR/text/HB1570/2021>

youth across the country by Chase Strangio, deputy director for transgender justice at the American Civil Liberties Union LGBT & HIV Project.⁴ Even its name stands to reinforce harmful perceptions of gender identity, by reinforcing the corrosive idea that that children must be protected or kept “safe” from exploring their gender, and face danger when physicians provide gender-affirming care. This bill prevents trans children under the age of 19 from receiving any gender affirmation care, threatening felony penalties for any physicians who provide care that is incongruent with the restrictions laid out in this act.

One treatment prohibited under this wide-reaching bill is the provision of puberty-blocking hormonal therapy, also known as PBT. PBT is mainly used to pause pubertal development into one’s sex assigned at birth and proves helpful to children experiencing gender dysphoria who seek further gender-affirming measures as they explore their gender identity. The SAFE act aims to fully ban and restrict medical support for gender-questioning children, regardless of a physician’s or a parent’s consent, until the child turns 18. This restriction of care not only harms children in Arkansas, it also significantly sets back LGBTQIA+ rights by reintroducing dangerous and incorrect perceptions of gender identity into legal and societal dialogue.

Every day, transgender and gender-questioning children face harmful attacks from both social and political angles that threaten their ability to embrace their gender identity. One important element of care that children with gender dysphoria need access to is PBT. As mentioned earlier, PBT provides necessary hormonal assistance to children as they approach puberty and experience a disconnect between their gender identity and their body’s biological

⁴ Yurcaba, Jo. “Arkansas passes bill to ban gender-affirming care for trans youth.” *NBC News*, last modified 29 March 2021, accessed 20 April 2021. <https://www.nbcnews.com/feature/nbc-out/arkansas-passes-bill-ban-gender-affirming-care-trans-youth-n1262412>.

development. The present medical system in the United States maintains that children in medical contexts cannot provide consent until age 18; until then, they must defer to their parents or guardian's medical decision making on their behalf. Though this system may normally operate well, as parents are able to understand the nature of medical situations and risk assessments for non-identity bearing medical procedures like well-visits, medical procedures, or vaccinations (though vaccine restriction is another politically charged issue, in and of itself), deferring to parental consent has the potential to harm children when parents are unable or unwilling to listen to a child's perspective regarding identity-based care. Receiving gender-affirming hormone treatment involves factors deeply personal and most apparent to the child experiencing gender dysphoria. This deferral of autonomy to parents imposes serious barriers for children accessing care. When put in the position to comprehensively deny PBT to their children, parents are not always equipped with the best tools to make these informed decisions on behalf of their child. Biases, denial, and misunderstandings or interpersonal barriers within parent/child relationships stand to complicate their ability to make choices that reflect their child's best interest. In this thesis, I will argue that children requesting PBT should have comprehensive autonomy over these medical decisions.

This thesis will begin, in **Chapter 2**, with an exploration into the basis of parental authority over their children. I examine the "best interest view," outlined in Robin Downie and Fiona Randall (1997),⁵ which offers two main premises that guide parental autonomy over their child's medical care and interests. The premises are: (A) that children are incapable of understanding their best interests and, conversely, (B) that parents can know and act in their

⁵ Downie, Robin and Fiona Randall. 1997. "Parenting and the Best Interests of Minors." *The Journal of Medicine and Philosophy*; *J Med Philos* 22 (3): 219-231. doi:10.1093/jmp/22.3.219.

child's best interests. I then take time to unpack and provide objections to each of these premises. Regarding Premise A, I question the assumption that children are incapable of understanding their best interests by raising commonplace situations in which children are awarded the latitude to conceive of and act upon their own interests. When tackling Premise B, I attack the view that parents are always able to know of and act in accordance with their child's interests by raising instances in which parent's judgements about their children is clouded by their own experiences. In this vein, I examine the psychological phenomena called "ambiguous loss," in which parents grapple with feelings of loss when their children do not fulfill the idealized plans that parent's set for them. I argue that parents are not necessarily the absolute source of levelheadedness that they are often assumed to be. Following an exploration of these premises, I provide an introduction to the concept of *epistemic injustice*. Epistemic injustice is a specific, epistemic harm incurred by a knower when their credibility is not provided sufficient weight by a hearer. Epistemic injustice is revisited later in the thesis, however its introduction in this chapter serves to point out the significance of epistemic harm in the discussion of surrogate decision making.

Chapter 3 focuses more closely on the application of parental autonomy to cases when children with gender dysphoria request PBT and their parents refuse. The chapter begins with an overview of the best medical practices for transgender or gender-questioning children. Following a summarization of The World Professional Association for Transgender Health (WPATH)'s "Standards of Care for the Health of Transsexual, Transgender, and Gender Non-Confirming People," as well as a review of other resources to understand the diagnostic criteria and nature of gender-affirming care, I begin to apply the "best interest view" to instances of parent/child disagreements regarding gender-affirming care. I revisit the phenomenon of ambiguous loss as it pertains to a parent grappling with feeling like they "lost" their daughter or son when their child

comes out and explores their gender identity. Drawing on Jeni Wahlig (2015)⁶, I will argue that parental judgement cannot always be upheld as levelheaded when making decisions regarding their child's gender affirmative care.

Chapter 3 then presents a negative, harm-based argument against sole parental authority in these medical decision-making contexts. Heavily integrating Maura Priest (2019),⁷ I explore the harms incurred by transgender children and children with gender dysphoria when they are denied access to care and rejected by their parents. These harms include, but are not limited to, mental illness, homelessness, and epistemic harm. This chapter more closely analyzes the incidence of epistemic injustice and uniquely applies one type of epistemic injustice, *testimonial injustice*, to the experience of children with gender dysphoria who advocate for medical resources and are rejected by their parents. I argue that when children share their gender identity with their parents and request PBT but face resistance from their parents, children's capacity as a knower is significantly harmed as a result of epistemic objectification and other secondary consequences of mishandling their voice.

The final substantive chapter of this thesis, **Chapter 4**, pivots to provide a positive argument in favor of providing children who request PBT with greater decision-making authority over their access to gender affirmative care. My four-premise argument combines the position of a child's epistemic agency with their decision-making capacity to conclude that children with gender dysphoria are best positioned to determine whether PBT would be in their best interest. My argument is subsequently qualified and clarified through the consideration of relevant

⁶ Wahlig, Jeni L. 2015. "Losing the child they thought they had: Therapeutic suggestions for an ambiguous loss perspective with parents of a transgender child." *Journal of GLBT Family Studies*, 11(4), 305–326. <https://doi.org/10.1080/1550428X.2014.945676>.

⁷ Priest, Maura. 2019. "Transgender Children and the Right to Transition: Medical Ethics when Parents Mean Well but Cause Harm." *American Journal of Bioethics; Am J Bioeth* 19 (2): 45-59. doi:10.1080/15265161.2018.1557276.

objections. I focus primarily on two objections. The first raises the incidence of people identifying as transgender during their childhood but discontinuing their gender transition. This phenomenon, called “desistance,” is not without controversy, as critics argue against its general use due to its implication of a gender binary.⁸

The second primary objection I focus on is the objection that providing children with greater autonomy in medical contexts may introduce a “slippery slope” in the approach towards medical decision-making and pediatric autonomy. In this case, I argue that my argument only goes so far to advocate for pediatric autonomy in medical contexts that bear on procedures or treatments inextricably linked to a child’s identity. Therefore, I will provide a principled boundary to halt any concerns regarding the lengths with which my argument can be taken to permit more radical or irresponsible instances where children can consent/dissent to medical practice. I also take time to address objections I found to be less significant to my argument, in which I argue that children are still best *epistemically positioned* to know what is in their best interest despite the fact that they may not be fully abreast of the medical or clinical background that influences their decision. In this vein, I further clarify that my argument only stands to influence situations in which children receive support from their care providers (on diagnostic or clinical grounds), but resistance from their parents.

Chapter 5 of this thesis concludes with a summary of each chapter, along with some insights regarding the potential for further work to be done to examine this issue with a more nuanced or deeper lens.

⁸ While I acknowledge the weight this term holds, for the sake of the objection within this paper, I use this term to argue that children who may explore their identity and decide against further gender affirmative treatments would still benefit from the temporary and reversable pubertal pause that PBT would provide.

CHAPTER 2: THE BEST INTEREST VIEW: EXPLORING JUSTIFICATIONS FOR PARENTAL AUTHORITY

I. INTRODUCTION

This chapter examines a common argument that accords parents decision-making authority when it comes to determining their child's care, followed by a brief introduction to epistemic injustice. That argument, which I will refer to as the *best interest view*, is grounded in the idea that parents are best positioned to act in their child's best interests. Robin Downie and Fiona Randall (1997) articulate this argument by drawing attention to two core premises.⁹ These two premises are: (A) that children are incapable of understanding their best interests and, conversely, (B) that parents can know and act upon their child's best interests. Following an outline of the best interest view, I will examine and argue against both premises.

I will then provide a basic overview of epistemic injustice, a form of injustice one experiences in one's capacity as a knower. One more specific type of epistemic injustice is testimonial injustice, in which a knower's testimony is accorded insufficient credibility. Throughout this thesis, I will provide a novel way to use these phenomena to examine the harms of parental interference and the suppression of a child's voice in medical decision-making. I am most interested in cases where children and parents disagree about a course of care or treatment options that stand to bear most heavily the child's identity formation. As such, I will focus on the children falling within the adolescent age-group (more specifically, children aged 10 and older) as a young population undergoing an integral period of maturity growth and identity formation. Later in this thesis, I will examine instances in which children who are exploring or questioning

⁹ Downie and Randall (1997), 219–231

their gender identity and decisions regarding access to gender affirmation care to deepen my exploration into identity-related medical decision-making. Throughout this chapter, however, I will provide a more general analysis and exploration of parental authority over their children in healthcare settings.

II. OVERVIEW OF PATERNALISM AND THE BEST INTEREST VIEW

Understanding how parental rights are grounded is integral to understanding why parents serve as the default medical proxies of their child in the first place. I would like to explore the relevance of *paternalism*, one relevant philosophy through which parental rights over children can be considered. Paternalism asserts that parents possess inherent authority over their offspring's decisions and behaviors to promote the most good for the aforementioned child. The best interest view serves as one argument that utilizes paternalistic ideas to defend its premises, which are as follows: (A) that young children do not know their own best interests and (B) that parents do know their young children's best interests. These premises are outlined by Downie and Randall (1997), in which they dissected the foundational claims central to parental control in favor of promoting greater latitude for their children's exercise of autonomy.¹⁰

In order to support Premise (A), a deficit in a child's knowledge and understanding needs to be established. Age and immaturity are cited as major factors disqualifying children's voices and autonomy. The lack of fully developed psychological faculties prevents the child from being fully autonomous until, supposedly, they progress to an age that confirms their freedom and independence. A child's lack of fully developed faculties renders them incapable of balancing their interests sufficiently; their lack of autonomy invalidates their opinions or beliefs.

¹⁰ Downie and Randall (1997), 222

Premise (B), on the other hand, states that, though children are unable to make their own decisions, their parents are generally knowledgeable enough to know of their child's best interests and are able to make decisions accordingly. Parents, as persons with full agency, sufficient knowledge, and assumed maturity, are expected to know their child most intimately, and therefore are best positioned to know their child's best interests. They are capable of exercising sound judgement and contemplation to act properly in accordance with what is "right" for their child. Regardless of a child's assent or dissent to a decision, parents are granted comprehensive trust in judgement over decisions made in the best interest of their child.

III. PREMISE A

One argument supporting Premise A of the best interest view argues that children, because of their youth, are too immature to comprehend their best interests and act on them with a sufficient understanding of the consequences and permanence of these choices. I would like to argue, on the contrary, that children's self-knowledge and emotional intuition are often more developed than we give them credit for. Children are agents who actively experience and interpret the world around them. As they repeatedly encounter both positive and negative consequences, children are able to develop a sense of permanence and an understanding of how their actions affect themselves and others around them. Their identities are not formulated in isolation; external relationships provide children with opportunities to learn from others and formulate beliefs central to their experiences as a person.

These identity-forming social situations culminate in deepening emotional maturity and intelligence. Although they may be younger than 18, the generally accepted marker of maturity and autonomy, a child or adolescent's distance from that benchmark does not invalidate their

present possession of these abilities. Though the timeframe in which a child may possess sufficient self-awareness and autonomy will change for children at different levels of maturity or growth, it would be unfair to make the blanket claim that all children or adolescents are unable to perform this calculus in a sufficient way.

Of course, there are instances in which adolescents improperly assess risks prior to enacting certain behaviors. Though it is understood that children will not always make decisions with optimal risk-assessment or foresight, I think that the significance of certain medical decisions that specifically pertain to a child's identity formation is one area in which they may be more reliable in their decision making. This thought will be revisited throughout Chapter 3 and Chapter 4 of this thesis, but it is important to note that the missteps teenagers or children might take in assessing the relative risk and reward of certain decisions in other areas are different from the assessments of risk and reward of decisions that are pertinent to the situations that are discussed in this thesis.

Another argument supporting Premise A is that children are not used to making large-scale decisions that ultimately shape their developing identity in the long run. However, as we examine accepted opportunities in which children exercise their decision-making capacities, it becomes clear that children frequently make decisions that accumulate in large, identity-forming ways. By providing children with the autonomy to decide on things as trivial as what sport they would like to play, adults are providing children with the opportunity to act in ways that influence their identity and sense of self. By providing children with the ability to design the way they present themselves aesthetically, as well (including through their clothing choices and other modes of self-expression), children are actively exercising self-knowledge and putting forth a representation of their identity to present to their peers and the external world. These are

consistent applications of calculated, identity-driven decision making that we readily provide to children. Therefore, it would be misleading to claim that children are entirely unable to make decisions and act in their best interest solely because they have never done so in official, more structured instances. The accumulation of these choices primes children to understand their identity, allowing for the ability to graduate to greater crossroads and opportunities to determine and act on their interests and desires.

IV. PREMISE B

Premise B maintains that parents are best positioned to know and make decisions in a child's best interest. Arguments for this premise typically attempt to prove that parents are more capable of acting level-headedly. Parents can, for example, tune out temporary feelings of emotional discomfort or strife to maintain focus on the decision at hand. The argument operates on the assumption that children, by comparison, allow fleeting, distracting feelings or thoughts to affect their cognition in ways that lead them to lose track of the important choice at hand. In the previous section, I defended the view that children are more emotionally mature than we may give them credit for. In conjunction with detailing the emotional capacity of children, the incidence of parents operating with bias similar to the perceived flaws attributed to children must also be addressed to further disprove Premise B. Here I will argue that parents, more often than is typically acknowledged, operate with biases that affect their ability to make decisions in their child's best.

Some emotional experiences of parents culminate in bias that complicate claims asserting parent's relative emotional competence in making sound decisions for their children. Parents commonly create a robust narrative of their child's future, including expectations for a child's

behavior and identity. For example, when children are young, some parents may fantasize about teaching them violin in the hopes they will grow up to become a virtuoso so they can proudly attend their recitals. Others hope their children will follow in their footsteps or pursue completely different identity forming interests. When their children actually grow up and share their interests and intentions for themselves, it may feel disheartening for parents to watch their children diverge from their imagined and intended path. In some instances of strong identity disconnects between children and parents, parents may have feelings akin to grief or loss as their children stray away from their idealizations.

A psychological phenomenon known as “ambiguous loss” has been applied to help understand the experiences of parents with children whose identities or interests fall in discord with what was imagined for them. Pauline Boss (2016) helps define and contextualize ambiguous loss as unresolved or unverified feelings of grief in which the object of loss is “psychologically missing but physically present.”¹¹ Though the concept originated as a concept to help understand the experiences of spouses of soldiers deployed for military service, it is now also applied to other relationship-dynamic changes, such as divorce, immigration, or adoption.

When tasked with understanding a child’s best interest, parents may exercise an opportunity for control to steer their child towards their own, idealized versions of their child rather than catering to the actual interests or needs of their child. Ambiguous loss plays a role in parent decision making by providing parents with a dichotomous choice, in which they can further act to impose their idealization onto their child to prevent the loss they feel of that ideal or address a child’s actual desire that may contradict the wants parents have for them. Especially when these decisions surround changes to a child’s identity, such as medical decisions regarding

¹¹ Boss, Pauline. “The Context and Process of Theory Development: The Story of Ambiguous Loss,” *The Journal of Family Theory & Review* 8 no. 3 (September 2016).

behavior-changing medications or other medical interventions, a parent may be unable to separate the necessity for that intervention with the unwanted consequence of a departure from their desired narrative.

Ambiguous loss provides significant evidence to support an argument against the claim that parents are always best positioned to make decisions in their child's best interest. The difficult experience of ambiguous loss complicates a parent's ability to make decisions for their children as sound as we might like to assume. Though we may intend for parents to act with levels of neutrality or clear-headedness in ways children may not be able to, parents themselves experience a form of emotional hardship that has the potential to interfere with their objectivity when making decisions for their children.

V. EPISTEMIC INJUSTICE AND TESTIMONIAL INJUSTICE

There exists another reason to reject the assumption that parents are better positioned to know what's in the child's best interests. As mentioned earlier in the discussion about children's emotional maturity, parents' own perceptions of their child and subsequent determinations of their child's best interest may be shaped by biases against their child's maturity. As explored in the previous section, the experience of ambiguous loss exemplifies instances in which parents grapple with feelings of loss when they realize their child diverges from their previously imposed idealizations or expectations. As a result of these biases, a parent's consideration of their child's voice may be diminished or belittled. In failing to accord their child's testimony sufficient credibility, they stand to harm their child in an epistemic way. The wrongdoing within this dynamic is called *testimonial injustice*, a type of *epistemic injustice*.

Epistemic injustice is a distinct harm inflicted on someone based on their capacity as a knower.¹² Miranda Fricker (2007) explores one mode in which persons can be harmed in their capacity as a knower – they can be harmed as *testifiers*. This is known as testimonial injustice. This field of study examines the circumstances and conditions that need to be met for a hearer to believe the testimony of a speaker.¹³ Testimonial injustice, as Fricker outlines, occurs when a speaker is not accorded sufficient credibility. Often this credibility deficit is triggered by prejudicial bias against a speaker's race, age, gender, or sexual orientation. This concept is identified by Fricker as a *negative identity-prejudicial stereotype*.¹⁴ A contemporary example of this type of testimonial injustice, Fricker explains, is the incidence of Black people fighting against doubt when articulating their negative or biased interactions with law enforcement officers, based on existing racial bias.

Fricker outlines the harms of testimonial injustice in terms of primary and secondary harms. The primary harm resulting from epistemic injustice is the wrong *intrinsic* to a speaker's being accorded insufficient credibility. This wrong can be understood in terms of *epistemic objectification*. Epistemic objectification occurs when a hearer views a speaker as a mere *source of information*, rather than an *informant*.¹⁵ Someone who is treated merely as a source of information is incapable of actively interpreting or engaging with the knowledge they possess and share. Viewing speakers as mere things, capable only of providing sources of information, complicates their ability to be considered rightfully as an equal, epistemic agent, and serves to

¹² Fricker, Miranda. 2007. *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford: Oxford University Press.

¹³ McKinnon, Rachel. 2016. "Epistemic Injustice," *Philosophy Compass* 11, no. 8. <https://doi.org/10.1111/phc3.12336>.

¹⁴ Fricker (2007), 35

¹⁵ Fricker (2007), 133

deprive speakers of respect and community that is typically afforded to reliable informants, further othering and objectifying the speaker.¹⁶

Secondary harms are those that occur as consequences of the credibility deficit. Fricker distinguishes two dimensions of these secondary harms: *practical* and *epistemic*.¹⁷ Practical secondary harms from testimonial injustice encompass the tangible setbacks or challenges facing a speaker when their testimony is afforded insufficient credibility. Fricker uses the example of testimonial injustice occurring in a courtroom setting, culminating in a plaintiff receiving a ‘guilty’ verdict facing a daunting sentence or hefty fine. The other type of secondary harm caused by testimonial injustice is epistemic. This may look like a speaker’s losing confidence in their beliefs or their ability to justify these beliefs, imposing long-term doubt in or hindrances to their epistemic agency. Secondary harms of testimonial injustice ultimately hold a broader impact or hindrance on a person’s life, by either inflicting concrete impediments or imposing pervasive concerns regarding their own internal perceptions of their capacity as a knower.

When a child shares deeply valuable information that reflects personal aspects of their identity, and experiences a credibility deficit, stands to incur the harms distinctive of testimonial injustice. One type of information that I am referencing and will explore further in this thesis is the instance of children sharing testimony in regard to their gender identity. In Chapter 3, I will explore these harms to support an argument in favor of providing children greater authority over identity-based decisions made in their best interest specifically regarding access to medical tools that assist them in their gender identity exploration. By exploring the experiences of children experiencing gender dysphoria seeking PBT in the face of parental rejection and resistance, I will advocate in favor of greater decision-making latitude for children. To do so, I will employ a

¹⁶ Fricker (2007), 134

¹⁷ Fricker (2007), 48

more detailed approach to explore epistemic harms experienced by children experiencing gender dysphoria in these situations, while also defending a harm-based argument against paternalism.

CHAPTER 3: A HARM-BASED ARGUMENT AGAINST SOLE PARENTAL AUTHORITY IN PBT DECISION-MAKING CONFLICTS

I. INTRODUCTION

In this chapter, I will discuss conflicts between parents and trans children in medical decision-making situations regarding a child's gender-affirming care. I begin this chapter by providing clinical background information about diagnostic criteria that make children eligible for medical treatments for gender dysphoria, as well as the gender-affirming medical interventions that are available to these patients. Though options for gender-affirming care vary in their degree of invasiveness, those offered to pediatric patients are typically limited to less invasive or permanent options, including psychological support and endocrine/hormonal treatments.

The following chapters in this thesis will primarily examine the decision for adolescents to embark on puberty-blocking hormonal therapy (PBT) to assist with their gender affirmation. The reversible nature of PBT provides a greater opportunity to provide pediatric patients with more latitude in exercising their autonomy over their identity-bearing medical choices. Because these children must fall within a certain age group for PBT to be most effective, the window for these puberty blockers to sufficiently pause their sex development is slim. The time-sensitivity of these decisions, therefore, pose unique and pressing circumstances. PBT provides children with the opportunity to further explore their gender identity, combined with psychological counseling and socialization, without the pressure or influence of feeling trapped in a body advancing towards a gender they feel uncomfortable with. Not only is it generally important to preserve the wellbeing of children experiencing gender dysphoria, but it is also paramount that a child's

mental health stay as centered as possible to maintain that child's eligibility to receive gender-affirming treatment in the future.

Following a clinical introduction to gender-affirming care, I will explore the general nature of parent-child disagreements regarding the use of PBT. One common argument in favor of parental decision-making draws on Premise B from the Chapter 2, holding that parents are best positioned to foresee potential harm and protect their children from harm. However, parents often inflict lasting harm on their children unknowingly in response to their child's gender identity and exploration. Parents often inflict harm without being aware of it, and they frequently fail to agree on what constitutes significant harm to their children (i.e., mental health and epistemic harms versus physical, medical harms), which would effectively invalidate an argument that claims that parents are the most qualified to recognize and reduce harm on behalf of their children.

In addition to outlining a traditional harm-based argument against giving parents sole decision-making authority in these contexts, I believe the phenomenon of epistemic injustice can be applied in novel ways to provide insight into a distinctive type of harm in these conflicts. Testimonial injustice, a specific form of epistemic injustice, can be used as a framework to support arguments in favor of allowing children to have greater control over their medical care. Children are harmed when their voices are not accorded proper credibility and weight by their parents due to biases held against their gender identity or age. Fricker (2007) lays the groundwork to understand the nature of testimony sharing and the dynamic between speakers and hearers. In this chapter, I will apply Fricker's work to the instances of children diagnosed with gender dysphoria being denied authority in PBT decision making by their resistant parents to further argue against total parental authority in these clinical contexts. Testimonial injustice

supplies a unique lens to examine how harmful it can be when children's testimony regarding their body and their interests are discredited based on assumptions that they are too young or too biased to exercise sound judgement.

II. BEST PRACTICES FOR PEDIATRIC TRANSGENDER PATIENTS

The focus of the remainder of this work will examine parent-child conflicts regarding PBT administration. However, it is important to first understand the best practices regarding gender-affirming treatment options available to patients, specifically adolescents, who experience gender dysphoria and who request medical interventions to affirm their gender identity.

There are different waves of gender-affirming steps that patients can advance through as they embrace their gender identity. The process begins with a diagnosis or discovery of gender dysphoria, the feeling that their sex assigned at birth conflicts with their gender identity. The DSM V diagnostic criteria used to diagnose children with gender dysphoria requires that children must express at least 6 months of discomfort with one's gender experience as their gender assigned at birth.¹⁸ Other diagnostic cues include changes in gender expression and presentation through a strong rejection of typically masculine or feminine clothing, toys, or activities, and a significant dislike of their sexual anatomy. For adolescents and adults, gender dysphoria diagnostic cues advance into more pointed desires to align more closely with the primary and secondary features of another gender. Specifically for adolescent patients, this involves the desire to prevent anticipated developmental changes that advance biological features associated with their sex assigned at birth. The World Professional Association for Transgender Health (WPATH)'s "Standards of Care for the Health of Transsexual, Transgender, and Gender Non-

¹⁸ American Psychiatric Association. 2013. Diagnostic and statistical manual of mental disorders: DSM-5. Arlington, VA: American Psychiatric Association.

Confirming People” advises mental-health experts to examine how this expression of gender discomfort pervades a patient’s emotional and intellectual functioning, as well as their relationships with peers.¹⁹

Options to assist patients in their gender transition span across a variety of different treatments, varying in their degree of permanence and invasiveness. One level includes changing one’s gender expression in cosmetic or aesthetic ways and adopting pronouns that align most closely with their gender identity. Psychotherapy or counseling can assist with a patient's gender exploration and cosmetic measures like hair removal, breast binding, or genital tucking. These are examples of less invasive and less permanent steps that are often taken by patients as they affirm their gender identity through presentation.²⁰

A further step to be taken to assist with gender affirmation for trans patients is hormone therapy. These treatments aim to masculinize or feminize the body, or, for patients in the pertinent age group, delay the natural biological development into their sex assigned at birth. For adolescents, hormone therapy can vary in permanence. Fully reversible hormone therapy for adolescent patients consists in what are commonly known as “puberty blockers.” As patients approach the ages of 10 or 11, their bodies begin to develop secondary sex characteristics, which include facial hair growth and breast development.²¹ Puberty blockers are gonadotropin-releasing hormone (GnRH) analogues, delivered by monthly injection, that act to suppress the development of secondary sex characteristics. For those assigned male at birth, GnRH analogues reduce voice-deepening, limit genitalia growth, and prevent the growth of facial hair.

¹⁹ World Professional Association for Transgender Health. 2012. “Standards of Care for the Health of Transsexual, Transgender, and Gender Non-Confirming People.” 7th ed.

https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English2012.pdf?_t=1613669341

²⁰ The World Professional Association for Transgender Health (2012), 16

²¹ Mayo Clinic. n.d. “Pubertal blockers for transgender and gender diverse youth” Accessed 7 February 2021. <https://www.mayoclinic.org/diseases-conditions/gender-dysphoria/in-depth/pubertal-blockers/art-20459075>.

Conversely, those assigned female at birth would experience a delay in menstruation and breast development after receiving GnRH analogues. GnRH analogues only pause puberty; when a patient stops taking GnRH, puberty resumes.²² The timing of providing puberty blocking treatment to stop the growth of secondary sex characteristics is integral to preserving a child's wellbeing as they navigate their gender dysphoria and desired next steps.²³ Because PBT is newer to the arsenal of treatment options for trans children, its long-term effects are relatively unknown. Despite its impermanence, the main risks that PBT poses to a child's health include compromised fertility and barriers to bone mineralization, according to one study examining the treatment's long-term effects.²⁴

Partially reversible hormonal therapies to advance gender affirmation are aimed at masculinizing or feminizing the body. For male-to-female patients, hormones aimed at minimizing the production of androgen, the male sex hormone, are provided prior to taking doses of estrogen to decrease the body's production of testosterone and induce feminization.²⁵ Conversely, female-to-male patients begin taking testosterone to masculinize their body.²⁶

For adult patients seeking gender affirmation, a more invasive and permanent step towards gender transition can include surgical interventions. Options for surgical sex reassignment range in detail and can vary in functional and cosmetic significance, but include hysterectomies, oophorectomies, vaginectomies, and chest reconstruction for female-to-male

²² Mayo Clinic. n.d. "Pubertal blockers for transgender and gender diverse youth." Accessed 7 February 2021. <https://www.mayoclinic.org/diseases-conditions/gender-dysphoria/in-depth/pubertal-blockers/art-20459075>

²³ Lambrese, Jason. 2008. "Suppression of Puberty in Transgender Children." *Journal of Medical Ethics* 34 (8):580-584. <https://journalofethics.ama-assn.org/article/suppression-puberty-transgender-children/2010-08>.

²⁴ Giovanardi, Guido. 2017. "Buying Time Or Arresting Development? the Dilemma of Administering Hormone Blockers in Trans Children and Adolescents." *Porto Biomedical Journal; Porto Biomed J* 2 (5): 153-156. doi:10.1016/j.pbj.2017.06.001.

²⁵ Mayo Clinic. n.d. "Feminizing Hormone Therapy." Accessed 7 February 2021. <https://www.mayoclinic.org/tests-procedures/feminizing-hormone-therapy/about/pac-20385096>.

²⁶ Mayo Clinic. n.d. "Masculinizing Hormone Therapy." Accessed 7 February 2021. <https://www.mayoclinic.org/tests-procedures/masculinizing-hormone-therapy/about/pac-20385099>.

patients and tracheal shaves, breast augmentations, facial feminization, or penile inversion vaginoplasty for male-to-female patients.²⁷

III. PARENT/CHILD CLINICAL DISAGREEMENTS AND THE BEST INTEREST VIEW

As explored in the previous section, puberty-blocking treatment (PBT) is most effective if taken prior to or early in pubertal development. As a trans child's body begins to develop secondary-sex characteristics that are incongruent with their gender identity, the onset of puberty often inflicts harmful blows to their mental health and wellbeing. It is imperative that these treatments be administered as early as possible, when clinically indicated. Given the young age of children receiving this treatment, parental consent is necessary prior to the administration of any intervention. For children seeking PBT, their relationship with unsupportive parents, who possess the sole authority over care they feel is necessary, is a challenge. Though in a perfect world these discussions would be collaborative between parent and child, parents are in a position to quickly override a child's voice and delay PBT against a child's expression of need.

In the next section, I will explore several arguments echoing the best interest view, sketched in Chapter 2, that support parents having authority over a child's medical care in the context of starting PBT. One such argument is that parents are able to make decisions more informed than their child, unbiased by the child's own emotional strife accompanying their gender dysphoria. Those opposed to allowing young pediatric patients to start endocrine treatment argue that prepubescent children and young adolescents might be advocating for gender affirmation medical treatments with a fervor guided by their need for psychological

²⁷ University of Michigan Medicine. n.d. "Gender Confirmation Surgery." Accessed 7 February 2021. <https://www.uofmhealth.org/conditions-treatments/transgender-services/gender-confirmation-surgery>.

wellbeing (as opposed to conformed and certain gender identity). Understandably, the psychological wellbeing of a child experiencing gender dysphoria is fragile. Many such children experience psychological disorders like depression, anxiety, and attention-deficit disorders at higher relevant frequencies than their cisgender counterparts.²⁸ During puberty, children whose bodies are developing into a gender they are uncomfortable with may feel a loss of control that could be focused and harnessed through PBT, therefore gender affirmation therapy could serve as a “quick fix” for the psychological discomfort they feel, questioning the authenticity of their gender identity. Therefore, an argument would follow that children are too emotionally biased to properly identify, with confidence, their gender dysphoria and should not be afforded greater latitude in these decisions over their parents, who may approach these choices with less emotional drive.²⁹

Though concerns regarding a gender-dysphoric pediatric patient’s soundness of judgement are important to consider, I argue against the presupposition that parents are inherently better suited to make these medical judgements, given their reduced emotional attachment to the issue. Revisiting the concept of ambiguous loss, parents of trans children can acutely experience feelings of loss or grief as they get accustomed to the change in their child’s gender presentation. Not only do parents of transgender children experience compounded grief for the loss of their daughter/son, but they also grapple with the loss of normalcy they attributed to having cisgender children.

²⁸ Davio, Kelly. “Transgender and Gender Nonconforming Youth More Likely to Experience Mental Health Disorders.” *American Journal of Managed Care*. Accessed 3 May 2021. <https://www.ajmc.com/view/transgender-and-gender-nonconforming-youth-more-likely-to-experience-mental-health-disorders>.

²⁹ It is important to note that not all gender-questioning children continue to seek further gender-affirming interventions. Many children who experience gender dysphoria decide, after sufficient exploration, and decide to live on as the gender they were assigned at birth. These incidents are important to the discussion of pediatric authority in PBT decision making, however they will not be addressed in the remainder of this chapter. The next chapter of this thesis will further explore instances in which children undergo PBT and decide to discontinue medical interventions in greater depth as it pertains to my argument.

Wahlig (2015) uses the framework of ambiguous loss to examine the process of grief and acceptance parents experience. Her work found that the anticipation of a shift in family dynamic away from their former, cisnormative structure serves as a source of discomfort for parents in this position.³⁰ When a child comes out to their parents regarding their newly disclosed gender identity, parents may grapple with the loss of these ideas and fantasies tied to the future of their relationship with their children. Additionally, parents may interpret their child's gender transition as the loss of their cisgender child, as opposed to the recognition of that child's gender identity. Though the child is still physically present, their change in gender presentation can be interpreted by parents as losing their child and being introduced to a new person.

Ambiguous loss is newly being used to define the relational and dynamic tension experienced in family systems of trans children, but it serves as a helpful way to classify and understand how parents conceptualize the experience of having a trans child. *Ambiguous Loss as a Framework for Interpreting Gender Transitions in Families* by Jennifer McGuire details the psychological or physical detachment that parents often embody, including relational distancing or attempting to delay a child's transition. These behaviors serve as a response to their own experience of ambiguous loss.³¹ The levels at which ambiguous loss tends to be felt depends on the cisnormativity that guides parents and family dynamics generally, however this phenomenon is experienced even by supportive and accepting parents as they prepare to embark upon this change.

The psychological experiences of parents facing ambiguous loss in response to their trans child's attempt at gender confirmation serves as a major problem when these agents have sole

³⁰ Wahlig (2015), 305–326

³¹ McGuire, Jenifer K., Jory M. Catalpa, Vanessa Lacey, and Katherine A. Kovalanka. 2016. "Ambiguous Loss as a Framework for Interpreting Gender Transitions in Families: Ambiguous Loss in Gender Transition." *Journal of Family Theory & Review* 8 (3): 373-385. doi:10.1111/jftr.12159.

authority over their child's medical treatment. Therefore, the incidence of ambiguous loss and its impact on a parent's attitude towards their child's transition minimizes the argument that parents are best suited to act in their child's best interest when deciding to receive PBT. Parents, no less than children, undergo challenges that will impede their ability to make these complex decisions based on their psychological experience. Utilizing a child's emotional struggle to discount their testimony and voice over their care, as Premise A of the best interest view implies, does not sufficiently prove that parents should, in turn, possess total authority in these circumstances.

IV. TRADITIONAL HARM-BASED ARGUMENT FOR PARENTAL REJECTION

In this section, I plan to dive deeper into the harms that occur when children are denied a voice in PBT medical decision-making. In order to understand the importance of providing children with a voice in PBT medical decision-making situations, we must understand the harm they endure when their self-advocacy is silenced and disregarded. By utilizing a traditional harm-based argument, I will explore the impact parents have over their trans children when they use their platform as both caregiver and principal decider, to withhold care from their child.

Priest (2019)³² defends a traditional harm-based argument outlining the serious harms trans children experience when they face rejection and resistance from their parents. Priest notably explores the high incidence of homelessness within the trans community. Many trans people, adolescents included, are forced out of their homes due to complete withdrawal of support from their family, cornered into choosing whether to continue living in a household that forbids them from expressing their gender, or leaving behind their family and any type of financial support they receive to embrace their gender identity. Other studies have shown that

³² Priest (2019), 45-59

financial stress is often cited by trans people as a challenge they experience as a result of their gender identity, one that often forces many into homelessness or sex work to support themselves.³³ Priest also raises concerns about high rates of suicide among trans youth. In her work, Priest cites two major studies that show that trans youth who receive support from their parents are 82% less likely to commit suicide.³⁴

Priest's attempt to highlight the serious harms of unsupportive parents during a child's transition is compelling and important. Homelessness and suicide are serious dangers that plague the trans community. However, I think it is worthwhile to add to Priest's discussion of the more drastic harms and explore more universal common experiences trans youth face that threaten their wellbeing.

First, it is important to note the prevalence of non-suicidal self-injury (NSSI) and suicidal ideation among trans youth. Studies have shown that trans youth diagnosed with gender dysphoria experience NSSI and express suicidal ideation at higher rates than their cisgender counterparts.³⁵ Additionally, when examining how trans children describe their own mental health, a Canadian study found that 70% of their participants whose parents strongly support their gender identity report positive mental health, in contrast to only 15% of those whose parents were not supportive.³⁶ Studies that examine how to better support trans people experiencing NSSI and suicidal ideation directly cite the importance of greater support and

³³ Singh, Anneliese A., Sarah E. Meng, and Anthony W. Hansen. 2014. "'I Am My Own Gender': Resilience Strategies of Trans Youth." *Journal of Counseling and Development* 92 (2): 208-218. doi:10.1002/j.1556-6676.2014.00150.x.

³⁴ Trans Pulse. 2012. "Impacts of Strong Parental Support for Trans Youth." Accessed 3 May 2021. <https://transpulseproject.ca/research/impacts-of-strong-parental-support-for-trans-youth/#:~:text=The%20most%20significant%20differences%20show,to%20those%20without%20strong%20parental>

³⁵ Marshall, Ellen, Laurence Claes, Walter Pierre Bouman, Gemma L. Witcomb, and Jon Arcelus. 2016. "Non-Suicidal Self-Injury and Suicidality in Trans People: A Systematic Review of the Literature." *International Review of Psychiatry (Abingdon, England); Int Rev Psychiatry* 28 (1): 58-69. doi:10.3109/09540261.2015.1073143.

³⁶ Trans Pulse (2012)

dialogue between them and their support systems. If the importance of a present and validating support network is a clear way to better support this population, then the lack of such interpersonal connection, let alone the experience of blatant rejection, clearly stands to seriously harm these children.

Other difficulties trans children may experience and negatively internalize are changes to their intimate familial relationships. Damage to intimate connections at home can occur as parents distance themselves from their child, in both covert and more nuanced ways, as they come to terms with their child's gender variance. This type of withdrawal may be as seemingly innocuous as parents connecting less with their child than they would have prior to their child coming out, like resisting from engaging in small-talk, or more frequently avoiding eye contact with their children, for example. Children desire connectedness and validation from their parents, and a marked change or withdrawal of such connection ultimately poses harm to the child. Especially during a sensitive and vulnerable time for this population, children may identify and internalize a parent's change in behavior as a negative response to their self-advocacy and identity in much more acute ways than one might assume. These withdrawals and forms of parental rejection pose serious strains to a child's relationship with their parents, as well. It is important to note, from present literature and social survey data, that even perceived ambivalence from parents towards a child's gender identity poses a negative effect on a child's mental health.³⁷ Parents may not know that they are doing this, or they may justify their coldness by explaining that they need time to properly process this change and, as explored earlier, grapple with their ambiguous loss independently before they deem themselves able to engage

³⁷ Catalpa and McGuire (2018), 88-103

with their child about it. However, it becomes clear that putting distance in the relationship between parent and child can cause lasting and damaging harm.

Parents' lack of effort in attempting to normalize their child's gender identity can also present as harmful rejection.³⁸ Some examples of ways parents can make such an effort include, but are not limited to, using a child's proper pronouns, respecting a child's name change, and supporting or engaging in their child's gender presentation. Parents who avoid leaning into these changes and opportunities to show their support or outwardly ignore these desires deepen a child's concern regarding their own self-knowledge and the acceptability of their personhood. It is important to note that facing rejection from parents can introduce harmful elements of self-doubt that take a toll on a child's psychological well-being, regardless of a child's own certainty of their gender identity. Children are conditioned to take behavioral cues and direction from their parents based on the important role parents play in a child's overall identity formation. Providing a "cold shoulder" or a change in routine by ignoring or acting coldly towards a child also serve as nonverbal, subtle clues of disappointment, with the goal of motivating a child to rectify their behavior in an attempt to return normalcy to the relationship.

When these types of nuanced social behaviors start to appear once a child communicates their gender variance, children can internalize this behavior as a rejection or as a signal that they have done something wrong. Mimicking interpersonal responses reserved for shaping bad behavior, parental coldness in response to a trans child's identity imposes harm and complicates their own self-knowledge and places barriers that muddle their ability to seek PBT or other medical treatment. Based on the mental-health struggles trans children often already experience, finding coldness when they may need comfort and acceptance inflicts harm that permeates their

³⁸ Catalpa and McGuire (2018), 88-103

daily-routine and seriously strains their identity formation, mental health, and familial relationships over time. As a child experiences these types of harms at home, it is understandable that conversations regarding how a child can seek medical intervention to support their transition may be stressful and difficult to handle. If a child attempts to advocate for themselves in this way, despite meeting such resistance, and is met again with parental rejection, despite their medical need and qualification for PBT, even more harm can be done.

On the note of harms resulting from interpersonal relationship dynamics enacted by parents, it is important to note here, too, that parents are commonly viewed as harm-reducers for their children. Their role as decision-makers is often defined by their unique ability to foresee and mitigate risks to their children. These ideas are central to another argument defending Premise B of the best interest view, as some purport that parents are positioned to act to reduce harm for their children. However, throughout this chapter's exposition of harms inflicted by parents, it is clear that parents themselves are unknowing sources of harm for their children. Therefore, the argument that parents should be sole decision makers for their children in these cases, on the grounds that they are best able to identify, understand, and prevent risk to their children, proves insufficient to defend exclusive parent authority over PBT decisions for their children.

V. TESTIMONIAL INJUSTICE AND CHILDREN EXPERIENCING GENDER DYSPHORIA

As discussed in Chapter 2, testimonial injustice born from negative identity-prejudicial stereotypes affects populations who already experience broader social prejudice based on gender,

race, or sexuality.³⁹ Though not initially included in Fricker's recent work, her framework of testimonial injustice is being extended to the frequent prejudicial stereotyping of children's testimony. Michael D. Burroughs and Deborah Tollefsen (2016) state that prejudicial stereotypes held against children include considering them as incompetent, untrustworthy, frequently exaggerating, and especially suggestible.⁴⁰ Havi Carel and Gita Györfy (2014) also note that children are more vulnerable to epistemic injustice due to differing epistemic abilities during various developmental stages.⁴¹ Trans children, as a population, are likely to experience these identity-prejudicial credibility deficits, in response to prejudicial biases against their identity as both a child and transgender person. Identity-prejudicial credibility deficits provide hearers with leverage to discredit the value of a child due to biases against their age and sexuality. Throughout this section, I plan to explore the intersecting prejudices that trans children experience which may interfere with their ability to receive adequate credibility.

When children come out to their families as trans and request medical therapies to affirm their gender identity, they may be met with skepticism from parents who question the certainty and permanence of the child's newly presented gender. Parents may feel as though their child could not possibly be trans (as they had not exhibited any behavior that adult typically associated with transgender people), and therefore reject that child's testimony. This response, for example, exemplifies the potential for parents to carry their preexisting biases against trans people with them into decisions regarding whether to accept their child's testimony. When parents quickly write off a child's "coming out" as a phase, or question their assuredness, they operate what

³⁹ Burroughs and Tollefsen (2016), 359-377

⁴⁰ Burroughs and Tollefsen (2016), 359-377

⁴¹ Carel, Havi and Gita Györfy. 2014. "Seen but Not Heard: Children and Epistemic Injustice." *The Lancet* (British Edition); *Lancet* 384 (9950): 1256-1257. doi:10.1016/S0140-6736(14)61759-1.

Burroughs and Tollefsen call “childism.”⁴² Due to the notion that children are immature and impressionable, their testimony is often invalidated and given less credibility than an adult’s testimony would be when sharing information of a similar kind.

As I previously explored, children with gender dysphoria often experience rejection and doubt when advocating for their needs, expressing the severity of their gender dysphoria, or the legitimacy of their gender identity. Prejudicial views regarding the emotional and intellectual capabilities of children may cause parents to view a child’s expression of their gender identity as invalid, branding their emotional and gender struggle as a scapegoat for other social or identity challenges a child may be facing. However, children who express gender alignment with their sex assigned at birth rarely face testimonial injustice or criticism as they lean into their gender identity. Daughters assigned female at birth and who continue to identify and present as female seldom experience skepticism when they express alignment with their sex at birth. The testimony provided by trans children, on the other hand, is frequently discredited and subject to resistance from their parents. When they share discomfort with their sex assigned at birth, adults may voice fears that this shift in identity must be temporary or misguided. This asymmetry between cis-gender and trans children compoundedly imposes barriers to trans children receiving the gender-affirming medical care they need, while withholding validation integral to their psychological health and development.

Much of the present literature regarding the incidence of testimonial injustice experienced by children explores the harms of testimonial injustice that children undergo in the context of sharing information developed in relation to encounters with others, or experiences of external events. Burroughs and Tollefsen explore these experiences of testimonial injustice by

⁴² Burroughs and Tollefsen (2016), 359-377

extensively analyzing the conditions and considerations surrounding the use of children as witnesses in criminal investigations and trials. They note that, despite copious empirical evidence suggesting that children aged 6 or older are as accurate in recalling events and no more suggestible than adults when questioned appropriately, negative prejudicial stereotypes continue to brand children as unreliable testifiers.⁴³ This insight into how adults impose bias onto the testimony of children regarding memory or event recollection supplies helpful insight to understand the unique nature of testimonial injustice that trans children encounter.

I would like to build upon Burroughs and Tollefsen analysis of children's experience as testifiers to provide further evidence as to the severity of the epistemic harm incurred by trans children. Due to the unique testimony shared by trans children, I believe that trans children stand to encounter deeper, more nuanced forms of these harms. Unlike memory testimony sharing, in which observations of external events can be shared and verified to some degree, voicing one's identity and accompanying personal and intimate experiences is a different type of testimony.

A child's internal experience of their gender identity is often all-encompassing and only fully apparent by the agent experiencing this. The testimony shared by children regarding their internal experience and gender identity is solely provided by the child and cannot be sourced or affirmed elsewhere, unlike the utilization of children's memories in criminal cases where facts they provide can be corroborated or shared with others. For example, a child who reports that they saw a blue car run a red light at an intersection and hit a pedestrian can be cross-checked using CCTV footage or supporting statements from other witnesses. If a child were to report that they were feeling hurt by the actions of a peer, however, there is no way to verify this statement other than by using the information provided by the child. It's impossible to justifiably disagree

⁴³ Burroughs and Tollefsen (2016), 359-377

with a child expressing their emotions, because they are the only agent who are experiencing that sadness and, thus, they are the sole person who can confirm these feelings. Even if, as a hearer, the cause of this strife seems trivial, and that the child's reaction seems disproportionate, it would be harmful to the child to invalidate their pain and tell them that they cannot be feeling that way.

In a similar way, parents learn directly and exclusively from their child about their gender identity and experience with gender dysphoria, and are therefore fully reliant on their child's testimony to understand and accept this testimony. The child's expression of their identity, too, is rooted deeply within themselves. Therefore, the rejection of identity-based testimony for children experiencing gender dysphoria is a compounded and unique harm that is incurred in response to parental rejection in these instances. Due to the complex and deeply uncomfortable nature of gender dysphoria for a child, the harms incurred by children experiencing testimonial injustice in these cases may present a serious challenge for this population.

The testimony shared by children regarding their long-term, compounded experience of their gender identity is information of a sensitive matter. Gender identity is complex and deeply individualized. Two components include the internal experience of gender and the external expression of gender. One may experience gender dysphoria within themselves but refrain from embodying this change in their gender presentation. Building off of Fricker's initial framework, Burroughs and Tollefsen echo Fricker's discussion of two important characteristics that make a credible testifier: competence and sincerity.⁴⁴ Competence surrounds a speaker's perceived knowledge regarding what they're testifying about, and sincerity pertains to confidence in a speaker's moral trustworthiness as it influences their testimony.⁴⁵ In cases of children with

⁴⁴ Burroughs and Tollefsen (2016), 359-377

⁴⁵ Fricker (2007), 76

gender dysphoria, their competence is called into question regarding their age and mental health. Questioning the sincerity of a child's testimony, on the other hand, serves to specifically invalidate the voices of these children in a unique way. When children share their gender dysphoria, their sincerity can be undermined and questioned regarding the history of their gender presentation, among other factors. Parents may deem a child's credibility deficient because they had never noticed abnormal behavior on behalf of their child that might signal their gender identity. This line of discrediting oversimplifies the complex intersections between gender identity and presentation, as they do not mutually guarantee each other. Branding a child as insincere because a parent does not believe their child fits the stereotypical trans archetype is one way in which trans children uniquely experience testimonial injustice.

In healthcare, persons are likely to experience testimonial injustice due to perceived emotional instability and cognitive unreliability.⁴⁶ Children with gender dysphoria are especially subject to these beliefs. As explored in the Section IV, trans children often experience resistance or criticism regarding their confidence in their effort to seek gender-affirming treatments, due to concerns about the mental and emotional stresses they may be experiencing in tandem with their gender dysphoria. It is important to note, as well, that even if the concerns raised by hearers regarding the credibility of a speaker's testimony are ultimately correct, the harms experienced by the speaker due to the hearer's invalidation remain.⁴⁷ This presents as significant in the discourse regarding fears of trans children "desisting," reverting back to their gender assigned at birth after undergoing the gender-affirmation process. It is important, then, to recognize that

⁴⁶ Havi, Carel, Ian James Kidd. 2014. "Epistemic Injustice in Healthcare: A Philosophical Analysis." *Medicine, Health Care, and Philosophy; Med Health Care Philos* 17 (4): 529-540. doi:10.1007/s11019-014-9560-2.

⁴⁷ Carel and Kidd (2014), 529-540

children should be approached responsibly and with sensitivity when regarding their testimony and gender identity.

VI. EPISTEMIC OBJECTIFICATION AND ITS HARM TO TRANS YOUTH

Previously, I explored the influence of rejection on children with gender dysphoria. In a deeper sense, testimonial rejection hinders both the social and intrapersonal health of a person. It is known that children formulate much of their social identity through comparison with their peers.⁴⁸ The social comparison trans children experience as they witness their peers sharing testimony without resistance can provide a blow to their self-perceived competence and self-knowledge. Over time, the continuous doubt and skepticism these children face when sharing their testimony can diminish their sense of self and confidence in their introspective capabilities. Burroughs and Tollefsen state that a consequence of rejecting the testimony of children is that the development of their epistemic virtues and intellectual self-confidence are undermined, ultimately complicating one's identity as a reliable testifier.⁴⁹ Negative self-perception and loss of confidence in one's own intellectual abilities are two secondary, epistemic harms that children experiencing testimonial injustice can experience.

As outlined in Chapter 2, a speaker stands to incur both primary and secondary harms when they experience testimonial injustice. Earlier in this chapter, I outlined harms experienced by trans children that fall into the class of Fricker's secondary harms, or those that may occur as a consequence of testimonial injustice. These include homelessness or suicide, as Priest outlined in her piece, or residual mental health challenges following rejection or inability to access gender

⁴⁸ Boivin, Michel and Guy Bégin. 1989. "Peer Status and Self-Perception among Early Elementary School Children: The Case of the Rejected Children." *Child Development*; *Child Dev* 60 (3): 591-596. doi:10.2307/1130725.

⁴⁹ Burroughs and Tollefsen (2016), 359-377

affirmation PBT. In this section, I will dive deeper into epistemic objectification as the primary harm of testimonial injustice.

Epistemic objectification, according to Fricker, is the primary harm of testimonial injustice. Fricker (2007) defines epistemic objectification as the act of undermining a speaker's testimony and views them merely as a source for information rather than a being capable of possessing and engaging with knowledge; demoting them from "subject" to "object".⁵⁰ Aidan McGlynn (2020) outlines seven ways in which epistemic objectification operates. Miranda Fricker's description of epistemic inertness is one mode in which agents are harmed, in which the objectifier views the speaker as lacking epistemic agency.⁵¹ Using Martha Nussbaum (1995) as a guide,⁵² McGlynn identifies many further forms that epistemic objectification might take.

For children with gender dysphoria, there are two additional forms of epistemic objectification that are relevant to consider. The first is "denial of autonomy," whereby the objectifier treats the speaker as lacking in autonomy and self-determination. In the case of trans children, this is exemplified by parents who discredit a child's testimony regarding their gender identity and desire to receive PBT because they view their child as beings who are incapable of the contemplation and perspective necessary to make these decisions.

Another form of epistemic objectification is "ownership," in which the objectifier treats the speaker as being owned by another.⁵³ While "denial of autonomy" plays on a child's perceived immaturity and incompetence relative to their age, "ownership" supports notions that parents should possess autonomy over their child's desires. In both forms of objectification, the

⁵⁰ Fricker (2007), 133

⁵¹ Fricker (2007)

⁵² Nussbaum, Martha C. 1995. "Objectification." *Philosophy & Public Affairs* 24 (4): 249-291. doi:10.1111/j.1088-4963.1995.tb00032.x.

⁵³ McGlynn (2020), 831-845

capabilities of trans children to utilize their autonomy and express reflections on their self-knowledge are hindered. When trans children attempt to share their experience of gender dysphoria and gender identity and continuously face belittlement or rejection from adults, children can develop diminished confidence in their ability to know themselves. This self-doubt can pervade their social relationships and can inflict lasting harms to their emotional health and social wellbeing.

This primary harm not only acts to objectify and invalidate the epistemic agency of the knower, but also sets them apart as atypical and “other.”⁵⁴ This discreditation of a person’s epistemic agency isolates them from a greater social group and inflicts a deep sense of rejection onto the speaker. Though testimonial injustice can often inflict harm in interpersonal relationships and encounters, this phenomenon doubles as a method in which social or community powers assist in the experiences of discreditation and invalidation of agents being harmed.⁵⁵ In these instances, the capacity of children with gender dysphoria as epistemic agents capable of sharing testimony is objectified and rejected by the same cis-normative community that similarly inflicts acts of prejudice or exclusion on them in in practical, social ways (such as complicating their ability to use public restrooms). Interpersonal exercises of testimonial discreditation can be reinforced on greater social scales, amplifying the harms and entangling testimonial injustice in inescapable social dynamics.

VII. CONCLUSION

⁵⁴ McGlynn (2020), 831-845

⁵⁵ Wanderer, Jeremy. 2012. "Addressing Testimonial Injustice: Being Ignored and being Rejected: Addressing Testimonial Injustice." *The Philosophical Quarterly* 62 (246): 148-169. doi:10.1111/j.1467-9213.2011.712.x.

Testimonial injustice provides a novel lens to understand the harms incurred by children experiencing gender dysphoria when they advocate for gender-affirming treatment against their resistant parents. In this chapter, I aimed to examine arguments, developed using the best interest view, that are used to uphold parental autonomy in pediatric gender-affirming care contexts. After questioning the soundness of claims regarding parent's general competence over their children and expectation of harm reduction, I led into a discussion of the traditional harm-based argument advocating for greater latitude for children over their medical decision making in identity-based care contexts. My focus on these harms aimed to underscore the damage that can be done when children experiencing gender dysphoria are rejected by their parents and withheld opportunities for affirming treatment for their gender identity. The population of children and adolescents are especially vulnerable, as their age and the natural process of puberty itself poses a harm to them, as they lose control and actively develop into a gender they feel disconnected with. In this chapter, I outlined the fragile position that children experiencing gender dysphoria are in and how imperative it is that comprehensive parental authority be questioned, as the decisions parents make may not always be done in a child's best interest.

CHAPTER 4: A POSITIVE ARGUMENT FOR PEDIATRIC AUTONOMY IN PBT DECISION-MAKING CONFLICTS

I. THE POSITIVE ARGUMENT

Throughout this thesis, I have presented a mainly negative argument against parents having sole decision-making authority when their children request PBT. In this section, I will provide a positive argument that children should have this decision-making authority. I argue for the maximization of pediatric autonomy in PBT medical contexts due to the reversibility and impermanence of PBT, along with the harms that parental involvement poses to children in these cases.

When making medical decisions that stand to affect some aspect of a child's identity, the child should be the primary decision-maker. As explored in the Chapter 3, deferring to parents when a gender dysphoric child voices their need for PBT has the potential to inflict serious harms, both epistemic and physical, on a child. Children experiencing gender dysphoria who may identify as trans are the most knowledgeable of their gender identity and thus are best positioned to determine whether PBT would be useful to support them through further identity exploration.

My argument, when broken down into concise premises, is as follows:

1. A child is epistemically best positioned with respect to their own gender identity, compared with anyone else.
2. If S is epistemically best positioned with respect to some aspect of their identity, then S is epistemically best positioned to determine whether doing X (where X affects S's identity) would be in their interest.

3. A child with gender dysphoria is epistemically best positioned with respect to whether or not taking PBT would be in their interest.

4. Decision-making authority with respect to whether or not doing X (where X stands to affect S's identity) would be in S's interest ought to fall to whoever is epistemically best positioned with respect to whether or not doing X (where X stands to affect S's identity) would be in S's interest.

C. The child with gender dysphoria ought to have decision-making authority with respect to whether or not taking PBT would be in their interest.

By establishing a child's epistemic positioning and ability to determine actions that fall within their best interests, this argument attempts to clarify that children are therefore better positioned than their parents might to make the decision to receive PBT based off of their gender identity and epistemic experiences. This is an argument on which the epistemic position the child is in regarding their gender identity justifies their decision-making authority in these cases. I would like to clarify, however, that my argument solely applies to PBT decision making. I will continue to explore this thought in further sections within this chapter, however I want to make it clear that I am not advocating for children to have total autonomy over their medical care. For example, children voicing their dissent over vaccinations or other necessary practices for more trivial reasons like avoiding discomfort does not apply to my argument— I am only defending a child's autonomy in pertinence to identity-based decisions. I will revisit this concept in Section IV of this chapter. I feel that PBT is circumstance unique from others due to the extent with which it intersects with a child's identity formation.

Another caveat to my argument that will be expanded upon in later sections relies on its exclusive use for PBT and no other gender-affirming medical treatment. Though there are further options for gender-affirming treatment, including the use of estrogen or testosterone, these treatments are not as easily reversible, and therefore requiring deeper certainty about one's gender identity and plan to transition. PBT, as a more neutral and reversible intervention, supplies that necessary intermediate option before further gender-affirming care, if a child were to pursue further action. If a child were to decide that they would like to seek further gender affirmation interventions following the administration of PBT, further medical consultation and even parental discussion could warrant that choice. But due to the more serious nature of those other treatments, I consider them exempt from this discussion.

The remainder of this chapter will consider and respond to objections to the premises of my argument. Though I focus primarily on objections to premises 3 and 2, objections to all premises will be considered. By utilizing case studies and considering objections, I plan on further clarifying and qualifying my argument to support the conclusion that children experiencing gender dysphoria ought to have decision-making authority with respect to whether or not taking PBT would be in their interest.

II. RESPONDING TO OBJECTIONS – PREMISE 2

Let's now consider objections to premise 2 of my argument, which reads "If S is epistemically best positioned with respect to some aspect of their identity, then S is epistemically best positioned with respect to whether or not doing X (where X affects S's identity) would be in their interest." As mentioned in the earlier section, my argument regarding pediatric patients receiving greater autonomy for PBT decision making does not necessarily apply to other medical

decisions. When supported by physicians who are familiar with the child and provide medical approval, children should have greater autonomy solely when medical interventions pertain to their identity, because they are best positioned to know their best interest.

Some objectors may claim that children, though they may formulate needs and desires based on their identity, are not necessarily *best* positioned to act on these interests. They may argue that this premise gives way for a “slippery slope” in which children are provided greater latitude in decision-making settings, wherein children could refuse essential medical treatments such as vaccinations or medications. Though this concern is understandable, my argument as laid out in this thesis solely applies to medical decisions that stand to affect a child’s identity. This “slippery slope” type of objection is invalid when applied to my argument, because I am solely endorsing children’s decision-making autonomy when such decisions hold significant weight over a child’s identity and when parents or other decision-making proxies are unable to best understand a child’s need. The caveat of “identity based” epistemic positioning is integral to providing a principled end to the slippery slope.

Requesting medical interventions to support a child’s gender identity exploration or affirmation is unique from other essential medical services due to the deep, epistemic and secondary harms and dangers that accompany inaction (as outlined in Chapter 3, Sections IV and V). If a child were to dissent to receiving something like an essential vaccine or medical procedure despite parental consent and medical necessity, the needs and benefits of vaccination and grounds with which they may argue with this treatment are likely less entangled with epistemic or identity factors than a child with gender dysphoria. Children dissenting due to feelings of fear, anticipation of discomfort, or other factors should be validated and heard,

however the depth and severity of need that these expressions of dissent may not provide as compelling leverage that a gender dysphoric child may have.

One could argue that medical issues, like essential medical care that a child fundamentally disagrees with, may be a case in which a child's identity is at risk for changing, in which case my argument and premise 2 may be of use. Let's say there is a child who has begun to gravitate towards and identify closely with the "anti-vax" movement. Their parents disagree and are in favor of vaccines. An objector may try to argue that my second premise would permit this child the autonomy to refuse essential vaccinations, as they are the best epistemically positioned to understand how receiving a vaccine might weigh upon their identity.

However, I would push back against this claim. While there may be structural similarities between the anti-vax child and the child with gender dysphoria, the harms and potential outcomes are very different. In Chapter 3, I attempted to explore an in-depth analysis of the harms experienced by gender dysphoric children when they do not receive PBT, or when they face rejection when attempting to embrace or explore their gender identity. Those harms provide a clear outline of the importance of providing children who request PBT with decision-making authority. In the anti-vax case and other similar cases where medical decisions may hold more ambiguous but clear weight on a child's identity, the consequences that may arise on either end of the spectrum of action—either providing this behavior-altering treatment or withholding it—must be analyzed to a similar degree. However, I believe that due to the unique and widely pervasive harms that transgender or gender dysphoric children experience, my argument suits PBT delivery and does not apply to other medical treatments or interventions. Additionally, the allegiance to a specific identity group like "anti-vaxxer" is very different from a child's gender identity. For a child to question their gender identity involves both psychological, social, and

identity-based factors that culminate in their need for medical support as they navigate this transition. As explored earlier in this thesis, the nature of gender dysphoria is unique from other medical disagreements due to gender's deep intertwinement with a child's identity and the serious harms resulting from inaction or rejection in response to these identities.

To conclude, some may object to premise 2 of my argument, "if S is epistemically best positioned with respect to some aspect of their identity, then S is epistemically best positioned with respect to whether or not doing X (where X affects S's identity) would be in their interest," on the grounds that this presents a slippery slope: children would then have the authority to consent or dissent to treatments because they may view some action as in their "best interest," when they may be misled or incorrect. I am exclusively endorsing this claim as it pertains to PBT decision-making in cases where children with gender dysphoria are attempting to receive gender-affirming, necessary care. I am not, at this point, supporting greater pediatric autonomy in pertinence to other medical situations, in which their dissent or assent may be valid but are less attached to a child's unique, epistemic positioning and identity formation. As outlined earlier, there are some circumstances that prove to be a little more ambiguous when compared against my argument, such as the use of pharmaceutical treatments for mental health or behavioral diagnoses that stand to influence a child's identity or personality. Though further consideration and thought needs to be done regarding these types of grey areas, I continue to argue that these instances are unique from and do not hold weight over the delivery of PBT for gender dysphoric children.

III. RESPONDING TO OBJECTIONS – PREMISE 3

This section will consider objections to premise 3 of my argument, which states that “a child with gender dysphoria is epistemically best positioned with respect to whether or not taking PBT would be in their interest.” One might be skeptical of accepting this premise, citing that a high percentage of children who identify as transgender or experience gender dysphoria do not continue to identify as trans later in life. Therefore, an objector may say that, because many children diagnosed with gender dysphoria do not continue to fully identify as transgender or receive further gender affirmation treatment, children are not best positioned to determine whether PBT would be in their best interest.

Integral to the discussion of childhood gender dysphoria is a phenomenon often referred to as “desistance,” the occurrence of children whose gender dysphoria does not continue into adolescence or adulthood. I would like to acknowledge that this term carries controversy and criticism, due in part to its enforcement of gender binaries, which will be addressed within this section. However, the term is often brought up by objectors to access to gender-affirming care for pediatric patients experiencing gender dysphoria, so, for the purpose of this discussion, I will refer to it in this section. In order to fully address claims made in opposition to premise 3, it is important to understand the significance and incidence of desistance within this population.

Much of the research regarding desistance and persistence (the terminology used to describe lasting experiences of gender dysphoria) is controversial, as some clinicians say it misrepresents gender identity; using language like “persistence” or “desistance” reinforces gender binaries. Academic studies of these phenomena are heavily influenced “by changing cultural norms, the self-perceptions of children and the ways that researchers interpret them.”⁵⁶

⁵⁶ Brooks, Jon. “The Controversial Research on 'Desistance' in Transgender Youth.” *KQED*. Last modified 23 May 2018, accessed 22 February 2021. <https://www.kqed.org/futureofyou/441784/the-controversial-research-on-desistance-in-transgender-youth>.

Nonetheless, the incidence of children whose gender dysphoria does not persist into adulthood presents a potential argument against awarding children with greater autonomy over their gender-affirming medical care.

One controversial study that is commonly cited in the desistance debate is Thomas D. Steensma et al. (2013). Steensma et al.'s piece recognizes prior data collected that found persistence rates varied by study between 2% to 27%.⁵⁷ Through informational interviews, Steensma found that desisters reported their gender discomfort gradually decreasing between the ages of 10 and 13. Steensma et al.'s study identified three factors associated with increasing or decreasing feelings of gender dysphoria: a child's social environment, sexual orientation, and feelings towards puberty.⁵⁸

Regarding the influence of a child's social environment, many participants reported that between the ages of 10 and 13, a natural social distance between females and males increased. This "social distance" phenomena described by Steensma et al. describes the division that occurs in childhood between social groups, where children begin to gather more closely with peers of the same sex and engage less frequently with peers of the opposite sex. This social event often pushes children towards more gendered interests or hobbies as well. For persisters, this caused an increase in their pre-existing preferences for friends whose gender mirrored the gender they identified with, resulting in deeper discomfort with their gender role. Desisters found themselves taking up gender-typical interests and ultimately felt a greater affiliation with their sex assigned at birth.⁵⁹

⁵⁷ Steensma, Thomas D et al. 2013. "Factors associated with desistance and persistence of childhood gender dysphoria: a quantitative follow-up study." *Journal of the American Academy of Child and Adolescent Psychiatry*. vol. 52 no. 6: 582-90. doi:10.1016/j.jaac.2013.03.016

⁵⁸ Steensma (2013), 582-590

⁵⁹ Steensma (2013), 582-590

Sexual orientation was also cited as a factor influencing these participant's gender dysphoria. Several desisters reported the "disappearance" of their gender dysphoria following their first experience of falling in love and a developing awareness of sexual attraction. Persisters in this study all reported attraction to members of their sex assigned at birth. Steensma et al. conclude that as children come to understand the genders they feel sexual attraction to, their gender identity responds in turn. According to Steensma et al., desisters, experiencing attraction to the sex opposite their sex assigned at birth, use this cue as evidence of their cis-gender identity, while persisters, feeling attracted to those of their sex assigned at birth, feel further clarity regarding gender dysphoria and continue to identify as trans. Though this pattern was present in this study, it is important to note that being transgender does not imply any specific sexual orientation. One's gender identity is not synonymous with their sexual orientation.

Finally, when discussing attitudes towards puberty, Steensma et al. found that both persisters and desisters experienced anxiety prior to and during the early stages of puberty. Children who were identified as persisters found puberty to be extremely distressing and felt a strong desire to seek further gender affirmation interventions. Desisting children did not report experiences of severe distress in anticipation of puberty and found that, though some felt insecure, they viewed their secondary sex characteristics as favorable.⁶⁰

Steensma et al.'s study is highly controversial, in part due to their admittance of participants into their study who did not fit updated DSM diagnostic criteria for gender dysphoria diagnosis (some participants may have been "subthreshold" for a gender dysphoria diagnosis). The study also relied on questions that many have identified as leading or potentially problematic questions, such as "Are you a boy or a girl?" Critics have voiced their concern with using lines

⁶⁰ Steensma (2013), 582-590

of questioning that enforce a gender binary, believing that gender dysphoric children may struggle to answer such a straightforward question as they attempt to integrate the gaps in personal and cultural understanding of gender dysphoria along with language barriers (this study was conducted in the Netherlands). Additionally, the study fails to address gender as a fluid spectrum and approaches many of their participants and results with a binary lens, failing to leave room for those who may identify as non-binary or gender nonconforming.

Though desisting is an important factor that should be considered when discussing access to PBT for trans youth, I do not necessarily believe that the incidence of desistance is critical enough to bar pediatric autonomy in PBT decision-making. My argument to provide children with greater authority during PBT decision-making circumstances accounts for the potential for a child to change their mind and potentially desist. Especially when such revelations surround their gender identity, which can be deeply intertwined with social and intrapersonal factors, a child's gender identity exploration is a fluid and personal process. Self-discovery often requires trial and error, and general decisions made during childhood are often subject to change or evolve over the course of a child's lifetime. Because PBT is impermanent, as reviewed in Chapter 3, it can serve as a helpful tool for clinicians to provide some respite for gender dysphoric children prior to more permanent or invasive gender affirmation medical interventions. PBT provides pediatric patients experiencing gender dysphoria with a "pause" prior to further sexual development. If a child enrolls in PBT and decides to desist, they are able to halt PBT and resume puberty to continue to further develop their sex assigned at birth. If a child's gender dysphoria persists after PBT, they are able to consider further gender affirmation treatments. Providing children with greater latitude in these medical contexts gives children the opportunity to explore gender-

affirming treatment options while eliminating instances in which children may experience testimonial injustice, as mentioned in Chapter 3.

IV. RESPONDING TO OBJECTIONS – PREMISE 1

Finally, we will examine objections posed to the first premise of my formal argument. Premise 1 states that a child is epistemically best positioned with respect to their own gender identity, compared with anyone else. Some may push back against this claim by arguing that parents are actually more knowledgeable of a child's identity and can better synthesize a child's identity and needs to better act in their child's interest. However, I would like to discuss the important and unique dynamics that pervade decisions made by cisgender parents on behalf of their trans or gender-questioning children.

Often, parents are able to directly understand or empathize with the concerns or fears that their children may express regarding medical care. Parents themselves, in cases of vaccination or medical procedure, have the experience and knowledge to sympathize and understand their child's perspective. Parents of gender dysphoric children who have not experienced the pain and discomfort that their children are undergoing as they request medical affirmation treatment are unable to epistemically position themselves to adequately determine the severity of need and benefit of this treatment in a comparable way.

Further objections to this premise might question whether care providers might be better positioned to make these decisions for children if parents cannot be. Though care providers and physicians are better positioned from a *medical* standpoint, I still hold that children are uniquely capable of accurately recognizing and sharing their epistemic needs. That is not to say that a child who experiences gender dysphoria and requests PBT, but who does not meet the clinical

markers of eligibility (which were outlined in Chapter 2 of this thesis), should unequivocally receive PBT despite physician's denial. So long as a physician is withholding PBT for strictly medical reasons and not because of bias they hold against children with gender dysphoria, my argument permits physicians to deny or postpone PBT to children. Although children are not positioned to veto clinical or diagnostic barriers to care, they are still epistemically best positioned with respect to their gender identity.

As explored in the Chapter 3, the epistemic gravity with which identity-based or identity-forming choices are made hold serious weight that stands to incur harm when their needs and interests are overridden by other agents. Therefore, children experiencing gender dysphoria are the better positioned over their parents in specific cases in which a child's identity is the central reason they are requesting this treatment.

V. RESPONDING TO OBJECTIONS – PREMISE 4

Premise 4 of my positive argument attempts to connect a child's decision-making authority with their epistemic positioning by stating that "decision-making authority with respect to whether or not doing X (where X stands to affect S's identity) would be in S's interest ought to fall to whoever is epistemically best positioned with respect to whether or not doing X (where X stands to affect S's identity) would be in S's interest." Objections to this premise may include the argument that children cannot possibly be "best" positioned to make serious medical decisions in ways their parents or adult guardians can, as children are unable to adequately foresee and act properly with respect to a decision's future impact.

But children are frequently provided the latitude and opportunity to control their gender expression in non-medical ways, including using a new name, changing their pronouns, and

presenting themselves through their clothing. These means of “socially transitioning,” as some call it, are impermanent and guided by a child’s identity and determination of need. PBT pushes this social transition one step further, as a way to afford them more time to explore their gender identity without the pressure of puberty and biological development.

Because PBT is impermanent, I believe it operates in a similar way. Though PBT is obviously more serious and complex of a process than changing pronouns or gender presentation, children who pursue in PBT receive medical supervision and accompanying support. In order to receive PBT in the first place, children must be diagnosed with gender dysphoria and receive medical and social support to address any pre-existing medical or psychological conditions that could interfere with their treatment. With physician supervision, PBT can provide helpful and often necessary respite for children exploring their gender identity. Their requests for and consent to treatment should be viewed as a sufficient to make them eligible for this low-risk, high reward treatment. It is important to be weary of the risks and potential harms that accompany the parental voice in these cases.

VI. CONCLUSION

Throughout this chapter, I presented a positive argument in favor of providing children experiencing gender dysphoria with greater decision-making authority when they request PBT. My argument aims to establish a connection between the child’s epistemic position to know what is in their best interest as it pertains to their identity and their decision-making authority. In this section, I explored potential objections to each of the four premises. I explored instances of “desistance” and halting concerns regarding “slippery-slopes” to further qualify my argument in favor of pediatric autonomy in the decision-making process.

CHAPTER 5: CONCLUSION

I. OVERVIEW OF THE CENTRAL ARGUMENTS

As mentioned in Chapter 1, the current social and political landscape in the United States has persistently and relentlessly disenfranchised transgender and genderqueer people. Hindering their access to basic resources such as bathroom use, participation in athletics, and (of utmost importance in this thesis) medical care constitute serious attacks against this vulnerable population. The SAFE Act, among many others of the same kind, is one example of legislation that specifically targets children whose gender identity does not fall within the cisnormal boundaries most commonly accepted in our present-day society. Throughout this thesis, I have argued in favor of greater decision-making autonomy for children with gender dysphoria who qualify for and request PBT, but who are denied access by their parents or guardians who possess sole authority over their child's medical care.

This thesis began with an exploration into the nature of parental authority. In looking at why parents or guardians are generally tasked with making decisions and providing consent for their children, I examined the "best interest view," which rests on two central premises: (A) that children are incapable of understanding their best interests and, conversely, (B) that parents can know and act in acting upon their child's best interests. I dedicated sections to exploring both premises and objecting to these claims, often referring to or expanding on work done by Downie and Randall (1997), who argue in favor of pediatric autonomy.

Following this general dive into the best interest view, I began to apply the best interest view to the issue of children who experience gender dysphoria and who request PBT. Chapter 3 began by presenting basic information regarding best practices and diagnostic criteria for transgender children. I then defended a negative argument against granting parents sole authority

over their child's care when children request PBT and their parents refuse to accede to those requests. By exploring concepts like "ambiguous loss" and a traditional harm-based argument against granting parents sole decision-making authority, Chapter 3 aimed to reject claims that parents are better positioned to make decisions about gender affirmation treatment on behalf of their child with gender dysphoria. Chapter 3 then segues into a novel negative argument that rests on the epistemic harms that children experience when their voices are discounted in medical decisions that hold serious weight over their identity. Drawing on the framework provided in Fricker (2007), I argued that parent-child disagreements over care that stands to profoundly influence a child's identity, in the way that gender dysphoria and PBT do, can inflict deep epistemic harms on children.

Chapter 4 of this thesis aimed to defend a positive argument for the view that children should possess greater decision-making authority in PBT medical decision-making, concluding that children with gender dysphoria ought to have decision-making authority with respect to whether or not taking PBT would be in their interest. I dedicated sections to objections to each of the premises within the four-premise argument, considering issues objectors tend to raise in these debates.

II. FURTHER WORK

This thesis provided a comprehensive dive into medical decision-making for gender dysphoric children requesting puberty blocking therapy (PBT). I laid out both positive and negative arguments that support pediatric authority for medical decision making in these situations. Based on my conclusions, further work could be done to explore whether these arguments could be applied to gender-affirming treatments that are less-reversible or more invasive, including but

not limited to hormone therapies to feminize or masculinize the body, or sex reassignment surgeries. Unlike PBT, these measures would require much deeper certainty in a child's judgement and decision-making capabilities, due to the relative permanence of the procedure. I would be inclined to assert that this argument remains relevant to less invasive gender-affirming methods that would be more challenging but capable of reversibility, like estrogen or testosterone hormone therapy. However, I am much more reluctant to extend my work to afford for pediatric autonomy when serious things like surgery are introduced into the conversation. In this case, I think that permanence and irreversibility serve as prominent obstacles that significantly rely on a patient's ability to understand permanence and make life-long and costly medical decisions. Despite this hesitation about permanence, the dive into the persistent harms that rejection or withholding access to care poses on children experiencing gender dysphoria leaves me feeling unsatisfied with the solution of mandating these children to sit in their discomfort and wait until their experience gets worse or develops before they are permitted to receive the interventions they seek.

More work should be done to examine how one's epistemic position can be strengthened over time to reach the necessary certainty that would allow for more permanent interventions. This more general question could provide further insight into the development of one's epistemic agency as it pertains to their ability to make lasting decisions about their identity and interests. Though it is relatively clear that as one ages, their epistemic agency and capacities as knowers are strengthened, I think it would be valuable to investigate what specifically contributes to the gradual increase in autonomy. Furthermore, more work could be done to examine what might qualify a teenager, in this case, to exercise absolute authority over all aspects of their gender-affirming care. Essentially, one might be interested in examining the how a child, teen, or

adolescent's epistemic agency can be strengthened over time as it pertains to medical decision making. I believe that the arguments provided in my thesis extend solely to identity-based medical decisions for children, and that permanence and gravity of certain medical decisions would have to correlate with a child's relative age and, therefore, possession of autonomy.

I think that the significance of testimonial injustice in cases where children are ineligible to make identity-based medical decisions should be further examined. In these cases, it seems that the harms of testimonial injustice as outlined in Chapter 3 would be outweighed by the risk of harm that results from permitting a child to act autonomously in specific medical contexts. I am interested in how the degrees of harm can be rationalized in the terms of testimonial injustice in these medical contexts, and I look forward to future work that might elucidate this conflict in a clearer, more generally applicable way.

Finally, in a broader sense, I would like to explore whether the arguments presented in this thesis apply to other areas of pediatric autonomy. In Halle Paredes (2019),⁶¹ I began an exploration into how pediatric autonomy and assent weighs on decisions made by parents to withhold prognostic and diagnostic information from their terminally ill children. I argued that withholding this information fails to meet a standard of care for these patients, and that age-appropriate information should be conveyed to the patient regardless of their age. I hope to see how my arguments for pediatric autonomy in contexts where children are deciding to pursue PBT might connect with my earlier work examining end-of-life care and information sharing. I think that the notion of epistemic harm or objectification would be worth analyzing in these cases, as well. Can persons experience any type of epistemic harm or injustice if they are completely excluded from dialogue?

⁶¹ Paredes, Halle. 2019. "The Littlest Voice: Ethical Considerations in Maintaining Patient Respect Through Communication During Pediatric End-of-Life Care," *Duke Journal of Medical Ethics* 1, no. 1

This thesis provided the important foundations integral to many contemporary issues in bioethics and health policy discussions, and I look forward to continuing this dive into pediatric autonomy and epistemic agency as it applies to their experiences in health care.

Bibliography

- American Psychiatric Association. 2013. Diagnostic and statistical manual of mental disorders: DSM-5. Arlington, VA: American Psychiatric Association.
- Arkansas SAFE Act of 2021. House Bill 1570, Arkansas 93rd General Assembly. Accessed 4 May 2021. <https://legiscan.com/AR/text/HB1570/2021>.
- Ashley, Florence. 2019. "Puberty Blockers are Necessary, but they Don't Prevent Homelessness: Caring for Transgender Youth by Supporting Unsupportive Parents." *American Journal of Bioethics*. 19 (2): 87-89. doi:10.1080/15265161.2018.1557277.
- Boivin, Michel and Guy Bégin. 1989. "Peer Status and Self-Perception among Early Elementary School Children: The Case of the Rejected Children." *Child Development*. 60 (3): 591-596. doi:10.2307/1130725.
- Boss, Pauline. 2016. "The Context and Process of Theory Development: The Story of Ambiguous Loss." *Journal of Family Theory & Review*. 8 (3): 269-286. doi:10.1111/jftr.12152.
- Brooks, Jon. "The Controversial Research on 'Desistance' in Transgender Youth." KQED. Last modified 23 May 2018, accessed 22 February 2021. <https://www.kqed.org/futureofyou/441784/the-controversial-research-on-desistance-in-transgender-youth>.
- Burroughs, Michael D. and Deborah Tollefsen. 2016a. "Learning to Listen: Epistemic Injustice and the Child." *Episteme*. 13 (3): 359-377. doi:10.1017/epi.2015.64.

Carel, Havi and Gita Györffy. 2014. "Seen but Not Heard: Children and Epistemic Injustice."

The Lancet (British Edition); Lancet. 384 (9950): 1256-1257. doi:10.1016/S0140-6736(14)61759-1.

Carel, Havi and Ian James Kidd. 2014. "Epistemic Injustice in Healthcare: A Philosophical

Analysis." *Medicine, Health Care, and Philosophy; Med Health Care Philos* 17 (4): 529-540. doi:10.1007/s11019-014-9560-2.

Catalpa, Jory M. and Jenifer K. McGuire. 2018. "Family Boundary Ambiguity among

Transgender Youth." *Family Relations* 67 (1): 88-103. doi:10.1111/fare.12304.

Davio, Kelly. "Transgender and Gender Nonconforming Youth More Likely to Experience

Mental Health Disorders." *American Journal of Managed Care*. Accessed 3 May 2021.

<https://www.ajmc.com/view/transgender-and-gender-nonconforming-youth-more-likely-to-experience-mental-health-disorders>.

Downie, Robin S. and Fiona Randall. 1997. "Parenting and the Best Interests of Minors." *The*

Journal of Medicine and Philosophy. 22 (3): 219-231. doi:10.1093/jmp/22.3.219.

Fricke, Miranda. 2007. *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford: Oxford

University Press.

Giovanardi, Guido. 2017. "Buying Time Or Arresting Development? the Dilemma of

Administering Hormone Blockers in Trans Children and Adolescents." *Porto Biomedical Journal.* 2 (5): 153-156. doi:10.1016/j.pbj.2017.06.001.

Krishnakumar, Priya. "This Record-Breaking Year for Anti-Transgender Legislation would Affect Minors the Most." CNN, last modified 15 April 2021, accessed 20 April 2021, <https://www.cnn.com/2021/04/15/politics/anti-transgender-legislation-2021/index.html>.

Lambrese, Jason. 2008. "Suppression of Puberty in Transgender Children." *Journal of Medical Ethics* 34 (8):580-584. <https://journalofethics.ama-assn.org/article/suppression-puberty-transgender-children/2010-08>.

Marshall, Ellen, Laurence Claes, Walter Pierre Bouman, Gemma L. Witcomb, and Jon Arcelus. 2016. "Non-Suicidal Self-Injury and Suicidality in Trans People: A Systematic Review of the Literature." *International Review of Psychiatry*. 28 (1): 58-69. doi:10.3109/09540261.2015.1073143.

Mayo Clinic. n.d. "Feminizing Hormone Therapy." Accessed 7 February 2021. <https://www.mayoclinic.org/tests-procedures/feminizing-hormone-therapy/about/pac-20385096>.

Mayo Clinic. n.d. "Masculinizing Hormone Therapy." Accessed 7 February 2021. <https://www.mayoclinic.org/tests-procedures/masculinizing-hormone-therapy/about/pac-20385099>.

Mayo Clinic. n.d. "Pubertal blockers for transgender and gender diverse youth." Accessed 7 February 2021. <https://www.mayoclinic.org/diseases-conditions/gender-dysphoria/in-depth/pubertal-blockers/art-20459075>.

- McGlynn, Aidan. 2020. "Objects or Others? Epistemic Agency and the Primary Harm of Testimonial Injustice." *Ethical Theory and Moral Practice*. 23 (5): 831-845.
doi:10.1007/s10677-020-10078-z.
- McGuire, Jenifer K., Jory M. Catalpa, Vanessa Lacey, and Katherine A. Kivalanka. 2016. "Ambiguous Loss as a Framework for Interpreting Gender Transitions in Families: Ambiguous Loss in Gender Transition." *Journal of Family Theory & Review*. 8 (3): 373-385. doi:10.1111/jftr.12159.
- McKinnon, Rachel. 2016. "Epistemic Injustice," *Philosophy Compass* 11, no. 8.
<https://doi.org/10.1111/phc3.12336>.
- Nussbaum, Martha C. 1995. "Objectification." *Philosophy & Public Affairs*. 24 (4): 249-291.
doi:10.1111/j.1088-4963.1995.tb00032.x.
- Paredes, Halle. 2019. "The Littlest Voice: Ethical Considerations in Maintaining Patient Respect Through Communication During Pediatric End-of-Life Care," *Duke Journal of Medical Ethics* 1, no. 1
- Priest, Maura. 2019. "Transgender Children and the Right to Transition: Medical Ethics when Parents Mean Well but Cause Harm." *American Journal of Bioethics*. 19 (2): 45-59.
doi:10.1080/15265161.2018.1557276.
- Singh, Anneliese A., Sarah E. Meng, and Anthony W. Hansen. 2014. "'I Am My Own Gender': Resilience Strategies of Trans Youth." *Journal of Counseling and Development*. 92 (2): 208-218. doi:10.1002/j.1556-6676.2014.00150.x.

- Steensma, Thomas D et al. 2013. "Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study." *Journal of the American Academy of Child and Adolescent Psychiatry*. vol. 52 no. 6: 582-90.
doi:10.1016/j.jaac.2013.03.016
- The White House. "Executive Order on Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation." *The White House*, last modified 21 January 2021 accessed 20 April 2021, www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-preventing-and-combating-discrimination-on-basis-of-gender-identity-or-sexual-orientation/.
- Trans Pulse. 2012. "Impacts of Strong Parental Support for Trans Youth." Accessed 3 May 2021.
<https://transpulseproject.ca/research/impacts-of-strong-parental-support-for-trans-youth/#:~:text=The%20most%20significant%20differences%20show,to%20those%20with%20strong%20parental.>
- University of Michigan Medicine. n.d. "Gender Confirmation Surgery." Accessed 7 February 2021. <https://www.uofmhealth.org/conditions-treatments/transgender-services/gender-confirmation-surgery>.
- Wahlig, Jeni L. 2015. "Losing the child they thought they had: Therapeutic suggestions for an ambiguous loss perspective with parents of a transgender child." *Journal of GLBT Family Studies*. 11(4), 305–326. <https://doi.org/10.1080/1550428X.2014.945676>.

Wanderer, Jeremy. 2012. "Addressing Testimonial Injustice: Being Ignored and being Rejected: Addressing Testimonial Injustice." *The Philosophical Quarterly* 62 (246): 148-169.
doi:10.1111/j.1467-9213.2011.712.x.

World Professional Association for Transgender Health. 2012. "Standards of Care for the Health of Transsexual, Transgender, and Gender Non-Confirming People." 7th ed. Accessed 20 April 2021.
https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English2012.pdf?t=1613669341

Yurcaba, Jo. "Arkansas passes bill to ban gender-affirming care for trans youth." NBC News, last modified 29 March 2021, accessed 20 April 2021.
<https://www.nbcnews.com/feature/nbc-out/arkansas-passes-bill-ban-gender-affirming-care-trans-youth-n1262412>.