CENTRAL EUROPEAN UNIVERSITY

‘LET CHILDREN GUIDE YOU’:

IMPLEMENTING INTERNATIONAL HUMAN RIGHTS LAW FOR THE WELL-BEING OF TRANS* YOUTH

BY

MICAH GRZYWNOWICZ

Submitted to

Central European University

Department of Legal Studies

In partial fulfillment of the requirements for the degree of Master of Arts

Supervisors: Professor Renata Uitz and Doctor Eszter Polgári

Budapest, Hungary

2014

Abstract

Trans* youth aged 14 – 18 is a growing group of individuals who claim access to trans* specific health care. Due to the fact that they have not yet reached legal maturity, most often their parents are involved in decision-making, giving consent and communication with doctors. As it is showed in the research, this may result in situations when young persons' needs are not heard and young persons are excluded from participating in decision-making about their own health. This in practice may mean being refused necessary services, negatively impacting their well-being.

By using queer and human rights based approaches, the thesis answers the question why the respect for the right to be heard and participation in decision-making in the context of informed consent are crucial for the well-being of young trans* people. It is done by outlining relevant human rights provisions of the United Nations Convention on the Rights of the Child as well as case law of the European Court of Human Rights on the right to privacy.

Alongside the law, the intersection of various roles performed by parents, medical professionals and non-governmental organizations is argued to be instrumental in ensuring the well-being of trans* youth. The discussion is based on specific examples from Canada and the Netherlands, their legal frameworks, work of NGOs and doctors.

Recommendations to relevant stakeholders are also provided in order to contribute to the developments in the field of trans* specific health care.

TABLE OF CONTENTS

Terminology

There are various terms used throughout the thesis. They are defined below to make the text accessible and comprehensible. The reader should, however, be aware that the words might be defined or understood differently depending on cultural, political, geographical or social contexts one comes from.

Gender identity – it is one's self-identified gender.[1] It may or may not match the sex assigned at birth.[2] It is related to the personal experience of one's body, including dress, mannerism, hair, speech, and other elements creating one's identity.[3] Everyone has gender identity.

Transgender – it is a "heterogeneous group of people, [which] encompasses persons who have a gender identity which is different from the sex assigned to them at birth and people who wish to portray their gender identity in a different way to the sex assigned at birth."[4] Transgender persons also wish to, choose to, or prefer to express their gender identity in a different way than expected by the society norms based on their biological sex.[5]

Transgender is also used as an umbrella term to describe a wide range of identities, such as, for instance, transsexual, intergender, nongender, drag queens, drag kings, and many more.

Trans* Youth – it is an umbrella term which will be used for young people aged 14 – 18 who question their sex assigned at birth. Some may not identify with their gender identity, some may

[1] ANSO, Association of Nordic and Pol-Balt LGBT Student Organizations, *Students for Transgender Inclusion*,
[2] Council of Europe Commissioner for Human Rights, *Discrimination on Grounds of Sexual Orientation and Gender Identity,* Council of Europe Publishing, Strasbourg, 2011, p. 129.
[3] *Yogyakarta Principles on Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity*, 2006.
[4] Lauri Sivonen, "Gender Identity Discrimination in European Judicial Discourse" in *Equal Rights Review*, 2011:7, 11-26, p. 11.
[5] *Discrimination on Grounds of Sexual Orientation and Gender Identity,* p. 132.

wish to transition only socially and/or also medically. Some also may wish to access trans* specific medical services, such as puberty blockers or counseling. Trans* youth will be used in the thesis as a term embracing all young people that fall out of the binary gender system, those who wish to experiment with their gender expression or wish to change their gender identity.

Puberty blockers (puberty suppressors) – it is medication, which is used to stop puberty. It ensures that secondary sex characteristics do not develop and sex hormones, such as estrogen and testosterone, do not cause undesired changes in one's body.[6] The effects of puberty blockers are reversible and do not carry negative side effects.[7] They are given to young people when puberty hits, which is from the age of 10 but it is administered on a case-by-case basis because puberty is a very individual process. "The two main methods of administration are monthly injections and a surgical implant in the arm."[8] Puberty blockers should not be used for longer than four years and till the age of 16, otherwise they negatively impact the development of one's body and health, e.g. bone density or fertility.[9] After having finished the period of using puberty blockers a young person should decide, if to continue on cross-sex hormonal treatment or to allow the regular puberty kicks in[10].

Cross-sex hormonal treatment – a procedure of providing hormones to trans* persons, which would allow to develop secondary sex characteristics of the 'opposite' sex. It means that a person assigned female at birth would receive testosterone to develop secondary sex characteristics

[6]TransYouth Family Allies, Puberty Inhibitors, available at http://www.imatyfa.org/permanent_files/pubertyblockers101.html, accessed 31 October 2014.
[7] Annelou L.C. de Vires, Jenifer K. McGuire et all, "Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment" in *Pediatrics* peds.2013-2958; published ahead of print September 8, 2014, doi:10.1542/peds.2013-2958, available at http://tinyurl.com/puo362x, accessed 30 October 2014.
[8]TransYouth Family Allies, Puberty Inhibitors.
[9]Ibid. and interview with Thomas D Steensma, Ph.D. conducted by the author, 11 March 2014.
[10]Ibid.

considered male, and a person assigned masculine at birth would receive estrogen to develop secondary sex characteristics considered feminine.

Gender Creative – it is a term used mostly in Canada and the United States to describe children and young people who question their sex assigned at birth. It encompasses the lived experiences of young people who experiment with their gender and sometimes do not wish to proceed with any permanent bodily changes. The term also allows them to escape pathologizing discourse of transgender identities, which are diagnosed and treated. It is also a name of an organization in Canada, Gender Creative Kids,[11] bringing together parents, activists and medical professionals working together for the well-being of young people questioning their gender.

[11] Gender Creative Kids, http://gendercreativekids.ca.

CHAPTER 1 – Introduction

In the last few years, medical professionals dealing with trans* youth noticed a significant change in the age of their patients. The doctors in the Netherlands started to deal with people as young as 12[12] and media reported on gender non-conforming children from different parts of the world who are only 6 years old.[13] Even though gender non-conformity is not a new phenomenon in itself, both for medical system and societies, it has been mostly referred to when discussing adults. Children and youth have not received attention leaving their needs and developing identities on the margins. The changing reality, however, forces parents and care givers to re-think their approaches as well as provision of services so that they are able to cater for young people who demand trans* specific care.

Providing medical services to minors aged 14 – 18, the target group of the thesis, is far more complex than working with adults. Due to the fact that they have not yet reached legal maturity, most often their parents are involved in decision-making, giving consent and communication with doctors. This may result in situations when young persons' needs are not heard and they are excluded from participating in decision-making about their own health.

It is not sufficient to look at abovementioned issues only from a medical perspective, as it does not seem to be able to provide sustainable solutions benefiting young people. In search of a meaningful framework, it is interesting to investigate how international human rights instruments

[12] Cohen-Kettenis, P.T., Delemarre-van de Waal, H. A., Gooren, L. J. G., "The Treatment of Adolescent Transsexuals: Changing Insights" in *International Society for Sexual Medicine*, (2008) 5: 1892-1897, p. 1894.
[13] E.g. Raising My Rainbow: Adventures in Raising a Fabulous, Gender Creative Son, available at http://raisingmyrainbow.com, accessed on 4. October 2013.

can be helpful in ensuring well-being of trans* youth. A human rights based approach may be more helpful as it makes use of a broader framework outlining division of responsibilities and rights of different actors involved in young people's well-being. The thesis will attempt to answer the question why the respect for the right to be heard and participation in decision-making in the context of informed consent are crucial for well-being of young trans* people. It will also claim that the role of the parents should focus on guidance and trust in their children abilities to know what their bodies need.

The thesis will make use of human rights framework dealing with the right to health to be able to contextualize and depict processes relevant for well-being of trans* youth. The discussion will be framed within the context of health care settings as it allows for accessing necessary medical services, which may contribute to one's well-being, which is the primary focus of the thesis. For the purpose of this research "well-being" is understood as a broad concept encompassing various aspects of one's overall state of being, including physical and psychological condition. It is not always connected or dependent on health care system but is also impacted by other factors, such as, for instance, relationships with parents or caregivers, atmosphere at school, or possibility to live in one's preferred gender.

Since such an approach has not been extensively used yet, the research and discussion should provide interesting insights to the problem and hopefully conclude with innovative recommendations. Specific examples of Canada and the Netherlands will be used to make discussion and analysis more concrete and focused.

1.1 Theory

Queer theory has been chosen as a tool to conduct the analysis and discussion. It is well

suited especially because the thesis will look at various norms of legal, medical, and social systems as well as their impact on well-being of trans* young people. One of the main characteristics of queer theory is questioning of norms existing in the society. It challenges gender, sexualities, identities, (dis)abilities, and other aspects of everyday life. "One of the founding aims of queer theory is to challenge normative boundaries, between what is 'normal' and 'abnormal', 'heterosexual' and 'homosexual' and so on."[14] Queer theory is in direct opposition to heteronormativity, which

> is the assumption that everyone is heterosexual. It assumes that there are only two genders/sexes, men and women, and that men should be masculine and women should be feminine. It supposes that those two genders attract and complete each other.[15]

Hence, heteronormativity has serious consequences for everyone in the society, not only for those who break the norms and attempts to control sexuality and gender. Moreover, the claim that 'men should be masculine and women should be feminine' has various repercussions ranging from the way people are supposed to dress, to what hair style they should have, to even the fragrance of perfume they are allowed to wear.[16] In the context of human rights, heteronormativity forces existing laws to acknowledge only binary gender identities i.e., men, women, or trans people who transitioned from one gender to another. All identities falling out of the binary gender system are unprotected against discrimination and are most often invisible in the legal system.

Queer theory will be used to investigate an impact of the existing norms on well-being of trans* youth. The theory will assist in exposing norms existing in Dutch and Canadian laws, medicinal policies and practices regulating gender-related issues so that they can be questioned

[14] Hird, M., J., "Naturally Queer" in *Feminist Theory* (2004) 5:85, 85-89, p. 87.
[15] ANSO, p. 6.
[16] Ibid., p. 8.

and dismantled.

> Queer theory is definitely not restricted to homosexual men and women, but to any one who feels their position (sexual, intellectual, or cultural) to be marginalized. The *queer* position then is no longer a marginal one considered deviant or pathological; but rather multiple positions within many more possible positions – all equally valid.[17]

Moreover, the discourse presented by two scholars, Judith Butler and Susan Stryker, will draw attention to the fact that laws are based on normative approaches to gender, identities, and sexualities has serious consequences for persons falling out of the societal norms. This will serve as basis for further analysis of medical systems as well as their impact on the right to be heard and to participate in decision-making by trans* youth and their well-being. It will also help look critically at the role of parents and doctors in the process.

1.2 Queer and Gender

The meaning of the term 'queer' has moved beyond a point in which it is used merely as a means to create inclusive categories of marginalized groups. It is also used to challenge and problematize experiences such as discrimination in regards to a collective identity as opposed to simply using the term as an identification of an individual's gender identity and/or sexual orientation.[18]

> To understand gender as a historical category, however, is to accept that gender, understood as one way of culturally configuring body, is open to a continual remaking, and that "anatomy" and "sex" are not without cultural framing.[19]

What Judith Butler speaks about in the above excerpt implies that gender should not be seen as a stable construction. Due to changes in culture, politics, or beliefs, the ideas about gender evolve

[17] Dowson, T., "Why Queer Archaeology? An Introduction" in *World Archaeology, Queer Archeology*, (2000) 32:2, 161-165, p. 163.
[18] Dilley, p. 458.
[19] Butler, J., *Undoing Gender*, Rutledge, New York, 2004, p. 10.

and are re-done, re-thought, and re-applied. Consequently, mentioned "anatomy" or bodies are required to look and behave according to existing norms created by the culture, politics, and beliefs in power. Such an approach to gender will be very useful when looking at experiences of trans* youth and how they do (not) fit into the societal norms of what is expected from "real" boys and girls and their bodies.

When defining a "proper" body, those norms decide who a "proper" and "fit" human being is.

> [This] version of the "human" requires ideal morphologies and the constraining of bodily norms. (…) The norms that govern idealized human anatomy thus work to produce a different sense of who is human and who is not, which lives are livable, and which are not.[20]

Those arguments are valuable to keep in mind when discussing the intersection of law, medicine, and parental roles, as these factors appear to have control over youth's bodies. The set of written and unwritten rules on how gender is supposed to be performed and done in a society puts in focus bodies of the persons who clearly break the norms. Consequently, the system enforces the requirement to surgically "correct" their bodies in order to fit the norms of a specific gender. Discussing gender, elements connected with it[21], and legal rules regulating them from a queer perspective definitely will raise relevant questions. It challenges also the idea of who decides what a "proper" body is, who has the right to force those bodies to become what they "should be" and also as Butler herself stated, queer asks who can decide "whose lives count as lives"[22]. Those questions and remarks are especially interesting when being applied to youth, as their bodies seem not to belong to themselves but to others who have legal responsibility over them.

A queered position in social research problematizes what is known, who is the knower,

[20] Butler, p. 4.
[21] E.g., body, gender expression, gender identity, names, mannerism, perfume types, etc.
[22] Butler, p. 17.

and how knowledge has been created and distributed.[23] From this perspective, "queer" is changed into a verb, which analyzes and discusses a text in order to draw conclusions based on the relationship between sexuality, power, gender, and conceptions of insider and outsider.[24] Since the thesis deals with youth questioning norms and challenging gender binary system, queer theory and its perspectives are relevant and useful. It will make it possible to discuss and combine legal, medical, social and gender issues, and at the same time provide a comprehensive norm critical analysis of their interaction and impact on well-being of trans* youth.

1.3 Methodology

For the purpose of the thesis three methods will be used, i.e. case study and critical discourse analysis will be used jointly with interviews. Critical discourse analysis (CDA) is a type of discourse analysis looking at the structures legalizing social power abuses, dominance and inequality, which are then enhanced through text and language in the social and political contexts.[25] Critical discourse analysis underlines the methods in which structures justify, reinforce or even question the connections between power and dominance in society.[26] The approach will be greatly useful due to its focus on norms, power structures and decision-making, which are put in center of the thesis. At the same time, CDA will be used as a means of tautology of the existing laws and practices regulating access of young trans* persons to necessary services, their right to be heard and participate. It will also facilitate scrutinizing of what happens within this system.

[23] Dilley, pp. 458-459.
[24] Ibid., p. 458.
[25] Van Dijk, T., "Critical Discourse Analysis" in *The Handbook of Discourse Analysis*, eds. Hamilton, H., Schiffrin, D., and Tannen, D. Blackwell Publishers Ltd: Oxford (2001), 352-371, p. 352.
[26] Ibid., p. 353.

The method is especially attractive here as it suggests that "the power of dominant groups may be integrated in laws, rules, norms, habits, and even a quite general consensus, and thus take the forms of 'hegemony'".[27] This is definitely relevant for the thesis because it deals with regulations put in place to police bodies, identities, and decision-making possibilities of young trans* people. It will also help address norms and dominance of specific groups, which are the one to blame for conservatism of medical system and decision-makers' reluctance to cater for the specific needs of trans* youth.

Since the discussion will look at specific cased situated in contexts of Canada and the Netherlands, making the arguments more concrete and drawing conclusions easier, a case study method will be used. "The case study [will] produce the type of context-dependent knowledge,"[28] highly beneficial for the discussion. Subsequently, the case study assists in achieving pre-set goals. At the same time, the ability to limit the information to a specific context will prevent the discussion from being too general. The flexibility of the method makes it possible to draw independent conclusions, interpret or even generalize, if necessary.[29]

Interviews are used to complement desk research, which provide subjective perspectives on the topic. The interviews have been chosen also because "[they] are particularly useful for getting the story behind a participant's experiences. The interviewer can pursue in-depth information around the topic."[30] The interview is a method allowing for a closer investigation of experiences of a person or group of people as well as an opportunity for better understanding of

[27] Van Dijk ,p. 355.
[28] Flyvvbjerg, B., "Five Misunderstandings about Case-Study Research" in *Qualitative Inquiry,* (2006) 12 (2): 219-245, p. 221.
[29] Ibid., p. 229.
[30] McNamara, C., *General Guidelines for Conducting Interviews*, available at http://managementhelp.org/businessresearch/interviews.htm, accessed on 25. 03. 2014.

discussed issues. In the case of this research, gathering material through interviews was especially valuable due to scarce academic resources available as well as choosing specific contexts for analysis.

Being aware of the fact that qualitative research methods see interview-subjects as voices of "the truth", the thesis will not aim at using the gathered material as such unequivocal "facts" devoid of a specific context and its particularities. [31]

> An interdisciplinary approach to deconstructing qualitative methodology born from scientific discourse will enable a queer (feminist) poststructuralist perspective on research design/preparation, narrative collection, analysis, representation and self-reflexivity that emphasizes polyvocality and alterity in the research results instead of universality and monolithic-based inquiries. [32]

Such a deconstructed interview method will present gathered material as multi-voice and multi-perspective set of information, rather than "the truth" on the topic. It will serve as a collection of several unique stories addressing one issue of well-being of trans* youth and will be analyzed to create a mosaic of experiences and approaches, which in turn will be used to challenge existing normative legal and medical standards.

Similarly, Ferguson in his "Queering Methodologies: Challenging Scientific Constraint in the Appreciation of Queer and Trans Subjects", suggests using a concept of "narrative collection" instead of research "data" in order to emphasize that the interviews result in gathering of personal "stories" and experiences, expertise or opinions, but never dry "data".[33] Ferguson implies that such an approach, thanks to its inherently questioning character, acknowledges uniqueness of queer lived experiences and does not attempt to put them in neatly square research boxes.

[31] Ferguson, M. J., "Queering Methodologies: Challenging Scientific Constraint in the Appreciation of Queer and Trans Subjects" in *The Qualitative Report,* 2013, Vol. 18, Article 25, 1-13, p. 2.
[32] Ibid., p. 2.
[33] Ibid., p. 2.

The chosen methods complement each other as they focus on different aspects of the discussed problem. They allow analyzing the text, critically commenting on it, and also gathering reliable narratives, not as an added value to the discussion but rather as one of the main sources of knowledge. Combined with queer theory and feminist approaches, it will provide strong and comprehensive arguments for the discussion.

CHAPTER 2 – Trans* Youth

The thesis uses a human rights-based approach to challenges to the well-being of trans* youth therefore it is crucial that readers have a full understanding of who the people in focus are and what their lived experiences are. This is why this chapter will explain who trans* youth are and what specific issues readers should be aware of before proceeding with further sections of the thesis. It will be done by discussing topics, such as non-binary gender identities, mental health, and medical issues. The chapter will also provide examples from every day lives of trans* youth to demonstrate how critical access to trans* specific care is and what can happen when it is refused.

2.1 Young and Trans*

"Last year we saw 200% more referrals than ever in adolescents and children. It is a worldwide phenomenon and it is booming."[34]

There is a variety of definitions and ways to understand trans* identities. What the concept entails depends many times on the cultural and political context one comes from, and

[34] Interview with Thomas D Steensma, conducted by the author, 11 March 2014, Amsterdam, the Netherlands.

how trans* identities have been constructed by trans* community. For the purpose of the thesis 'trans*' is used as an umbrella term embracing all gender identities that question gender binary and individuals who do not identify with the sex assigned at birth. It is a very wide understanding of trans* identities but it allows for including a wide range of lived experiences.

In the context of young people, the concept of trans* is even more diverse. It seems to be constructed to focus more on the experiences and needs for experimenting with gender rather than mainly on changing one's body.

> In the case of children "[Trans]" indicates a child who identifies as the opposite gender, while a variety of other labels, such as gender-non-conforming, gender-variant, gender-creative, tomboy, tomgirl, pink boys, and princess boys are used to describe those who express their gender differently.[35]

Consequently, the thesis will include all possible variation of trans* identities experienced by young people. This means that when using the broad concept of 'trans*', it will include those young people who may not identify with their sex assigned at birth; those who may wish to transition only socially and/or also medically; and also those who may wish to access trans* specific medical services, such as puberty blockers or counseling and later maybe cross-sex hormonal treatment. In other words, the term will embrace all young people that fall out of the binary gender system and who wish to experiment with their gender expression or wish to change their gender identity permanently, or for a shorter period of time. Understanding the term 'trans*' in this context is crucial because young people belonging to any of these groups, or their parents may seek assistance from medical professionals or non-governmental organizations. Therefore, it makes them subjects of interest for this research.

[35] Jessica Ann Vooris, "Trapped in the Wrong Body and Life Uncharted: Anticipation and Identity Within Narratives of Parenting Transgender/Gender Non-conforming Children" in Fiona Joy Green and May Friedman (eds.), *Chasing rainbows: exploring gender fluid parenting practices*, Demeter Press 2013, p. 75.

2.2 Diagnosis, Puberty Blockers and "Gender Health"

"'gender health' [is] ensuring and facilitating an accepting and gender expansive (gender diverse) childhood that sees gender nonconformity as healthy"[36].

As of today, in majority of countries around the world in order for a trans* person to receive trans* specific health care, they must be diagnosed with a mental condition called gender dysphoria. According to *Diagnostic and Statistical Manual of Mental Disorders (DSM-5),*

> [f]or a person to be diagnosed with gender dysphoria, there must be a marked difference between the individual's expressed/experienced gender and the gender others would assign him or her, and it must continue for at least six months. In children, the desire to be of the other gender must be present and verbalized. This condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.[37]

What this above description does is to see trans* identities as a mental health condition, even though it acknowledges that the 'condition' is related to the way a person is perceived by others. It fails to recognize that it is not a responsibility of an individual to fit gendered and normative expectations of the society in order to be considered healthy. Moreover, any kind of support the person would be able to get to live in their preferred gender is conditioned upon the very diagnosis. Consequently, trans* youth are forced into a pathologizing diagnosis from a very early age, which frames their identity and experiences as something undesired and to be cured. It perpetuates stigma, shame and prejudice. Moreover, it also pathologizes parents who are blamed for bringing their children up in a wrong way by allowing them to experiment and live out their

[36] Diane Ehrensaft, *Gender Born, Gender Made: Raising Healthy Gender-Nonconforming Children*, New York: The Experiment, LLC, 2011 in Sandra B. Schneider, "Producing Homeplace: Strategic Sites and Liminoid Spaces for Gender-Diverse Children" in Fiona Joy Green and May Friedman (eds.), *Chasing rainbows: exploring gender fluid parenting practices*, Demeter Press 2013, p. 113.
[37] American Psychiatric Association, "Gender Dysphoria", available at http://www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf, accessed 31 October 2014.

gender identities as they wish or simply by respecting the preferred gender expressions.[38]

Having in mind the pathologizing structures of the system, it is extremely difficult to disregard the fact that such a social construct seems to be the only[39] way, for trans* youth and others to be able to live in their preferred genders. For this reason the upcoming discussion will focus on the services available within the outlined system. It should be kept in mind, however, that the author of the thesis strongly disagrees with pathologization of trans* identities and does not consider trans* individuals mentally ill. Words, such as 'treatment' or 'care' will be used as umbrella terms for services that trans* people have the need for in order to ensure their well-being, and do not carry their regular meaning of healing of a disease or condition.

One of the treatments that trans* youth have access to is puberty blockers[40], which suppress puberty occurring from around age 10. They ensure that the production of sex hormones is stopped before it results in irreversible changes in one's body. This would include development of secondary sex characteristics, such as growth of breasts and starting to menstruate or enlargement of the penis, lowering of voice and appearance of facial hair. Puberty blockers do not cause any long-lasting negative effects.[41] Quite the opposite, puberty blockers "are reversible and are used to prevent the devastating effects of developing unwanted secondary sexual characteristics".[42]

It is worth mentioning that puberty suppressors were not created for trans* specific treatment but were "developed in the 1970s (…) to suspend precocious physical maturity in

[38] Ehrensaft, pp. 46 and 48.
[39] Except from a few countries when a diagnosis is not required, such as for instance Argentina or Denmark.
[40] For detailed description refer to Terminology section, p. 5.
[41] Jennie Wood, "These Kids Are All Right, Too", *Infoplease,* available at http://www.infoplease.com/us/education/transgender-children.html#ixzz3HikRnXpx, accessed 31 October 2014.
[42] TransYouth Family Allies, Puberty Inhibitors.

children who begin showing signs of puberty as young as seven or eight."[43] The treatment was used until the children were deemed to be psychologically ready to handle puberty and its consequences.[44] It turned out to be a successful approach especially because there were no side effects, it was reversible and the puberty process would restart after six months of taking a child off the medication.[45] Due to its positive outcomes, endocrinologists working with gender non-conforming youth started to include puberty blockers into their practice.

There is significant amount of research showing its positive impact on the well-being of trans* youth.[46] Diane Ehrensaft, who is a writer and a parent to a gender non-conforming child, writes in her book *Gender Born, Gender Made*

> [i]n addition to avoiding the trauma of experiencing an unwanted puberty with irreversible results (…), providing transgender children with puberty-inhibiting drugs allows families to buy time, during which the children can grow to fuller emotional and cognitive maturity and, with help of their parents, make more informed life decisions about their gender identity and expressions and their wish to undergo drug (and perhaps later surgical) interventions to have their body match that identity.[47]

It is also explicitly admitted by doctors that the lack of this treatment would do a lot of damage.[48] "These kids can become depressed, self-mutilate or attempt suicide. The effects of the puberty-blocking drugs are reversible, giving kids time to decide if they want the permanent sex change."[49] Similarly, dr. Norman Spack, one of the doctors participating in research on the

[43] Ehrensaft, p. 142.
[44] Ibid., p. 142.
[45] Ibid., p. 143.
[46] Annelou L.C. de Vires, Jenifer K. McGuire et all, "Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment" in *Pediatrics* peds.2013-2958; published ahead of print September 8, 2014, doi:10.1542/peds.2013-2958, Available at http://tinyurl.com/puo362x, accessed 30 October 2014.
[47] Ehrensaft, p. 143.
[48] Jennie Wood, "These Kids Are All Right, Too", *Infoplease, available at* http://www.infoplease.com/us/education/transgender-children.html#ixzz3HikRnXpx, accessed 31 October 2014.
[49] Ibid.

impacts of puberty blockers stated that, "[trans] kids have a high level of suicide attempts. (…) [t]hree out of four have made very serious suicide attempts. And I've never seen any patient make [an attempt] after they've started hormonal treatment."[50] The conclusion to be drawn here is obvious. Access to puberty blockers is proven to improve quality of life of trans* youth and should be made available.

It could be seen as an investment into 'gender health' of a young generation of trans* individuals. Ehrensaft created this term in order to encourage parents to take care of their gender questioning children. According to Ehrensaft, gender health is about "ensuring and facilitating an accepting and gender expansive (gender diverse) childhood that sees gender nonconformity as healthy"[51]. What was important for her was that young people were able to explore and experiment with their identities in order to find who they really were.[52] It is an interesting concept, which could be applied to any person because everyone has a gender identity and everyone is influenced by heteronormativity. It could be also claimed that the need for medical treatment derives from oppressive heteronormativity and being forced into living in the binary gender system and not necessarily from aversion to one's body. Possibly by addressing everyone's gender health, one could question gender norms and improve situation for many, not only trans* youth and adults.

[50] Pagan Kennedy, "Q&A with Norman Spack", *Boston Globe*, available at http://www.boston.com/bostonglobe/ideas/articles/2008/03/30/qa_with_norman_spack/?page=full, accessed 31 October 2014.
[51] Ehrensaft in Sandra B. Schneider, "Producing Homeplace: Strategic Sites and Liminoid Spaces for Gender-Diverse Children" in Fiona Joy Green and May Friedman (eds.), *Chasing rainbows: exploring gender fluid parenting practices*, Demeter Press 2013, p. 113.
[52] Sandra B. Schneider, p. 113.

2.3 Different Realities

Since the medical system is based on binary gender order and assumes that there are only two genders, the models used when dealing with trans* youth perpetuate just that. In practice, it means that youth coming to use services, not only have to be diagnosed as having gender dysphoria, but also must declare wanting to live in the 'other' gender. Such an approach is problematic as it excludes a significant number of young people who do not identify with any legally recognized gender, i.e. male or female. Bastiaan France, working at TransVisieZorg, an organization providing support to trans* youth and their parents in Amsterdam, the Netherlands, noted that gender non-conforming kids, who are not transsexual have it much harder.[53] "Gender non-conforming kids have to face everything that comes with questioning gender norms on top of everything else."[54] In other words, they may be bullied because of their gender expression, they may be forced by parents into wearing clothes 'appropriate' for their assigned gender, they may be beaten up on the street for looking gay, and they may be discriminated in other places.

Moreover, focusing on the binary makes also gender-queer, or gender fluid youth invisible and their lived experiences illegitimate. Dr. Steensma, Ph.D who is a clinical psychologist at the Center for Expertise on Gender Dysphoria at the VU University Medical Center in Amsterdam, the Netherlands, expressed a wish at the end of the interview saying

> it is very very important (…) that people grow up in a culture or society where they can be whatever they are, (…) neutral, queer, X, gender dysphoric, non-gender dysphoric, a little bit gender dysphoric, whatever. I think this will result in less psychological problems and maybe also in less need maybe of certain medical procedures even. I think the biggest problem is that if society pushes someone in the binary then you get people who get regrets and say, 'if I could have chosen years ago I would have chosen only hormones and breast removal and not the genial

[53] Interview with Bastiaan Franse, 12 March 2014, conducted by the author, Amsterdam, the Netherlands.
[54] Ibid.

> surgery because the quality wasn't good enough for me and I know it doesn't say anything about my gender'.[55]

Several points may be drawn out from this observation. It touches upon the need to educate the society about gender norms and consequences of the binary gender order. It questions existing medical system, which offers merely limited services catering only to transsexuals. What dr. Steensma's testimony also does is to acknowledge the fact that the need for medical interventions might be result of heteronormative system and not necessarily of trans* people's hatred towards their bodies. It is a bold statement coming from a person working within a medical system, which is known as rather normative. There is a serious need for more discussions within health care settings addressing the binary and its negative impact on the well-being of trans* people.

Apart from challenges connected with diversity and lack of recognition of non-binary identities, there are other difficulties faced by trans* youth. In most cases, access to other services, such as surgical interventions (irreversible treatment) is available only for young people who reached legal maturity, i.e. turned 18. Franse stressed that it often causes difficulties for young people. Not only because they have to wait and cannot live in their preferred gender, but also because at the age of 18 there are other important changes happening in their lives related to transition to autonomy.[56] This includes starting university, moving out from their parents' place, looking for jobs, having their first meaningful relationships, and others. Being forced to go through physical transition on top of it contributes to higher levels of stress and more difficulties in adapting to new life circumstances.

[55] Interview with Thomas D Steensma.
[56] Interview with Bastiaan Franse.

2.4 Chapter Conclusion

This introductory chapter focused on outlining main concepts related to trans* youth, their lives and necessary services. It presented the purpose of puberty blockers and research proving their positive impact on the lives of gender non-conforming young people. It was clear that regardless of opposition, puberty inhibiting medicine contributes to better quality of life and allows for informed decision-making about future interventions and preferred gender identity. They also contribute to being exposed to less bullying and gaining higher self-esteem and self-confidence. In the light of this, it should be kept in mind that not all young trans* people identify with the 'opposite' gender but there is a number of youth that fall outside the binary gender norms. Their needs should also be catered for by the medical system. Lastly, it was mentioned that a limit age of 18 on accessing surgical intervention is problematic because it forces young people to wait and collides with other crucial developments in their lives. One solution to it that could be proposed here could include maturity assessment for accessing irreversible treatment. It was also claimed that heteronormativity plays a crucial role in how trans* youth deal with their identities. It also identified a need for addressing the negative impact of the binary gender system on the well-being of trans* youth.

CHAPTER 3 – Framework for Human Rights-Based Approach

The aim of this chapter is to outline international human rights instruments which frame a general protection of the right to the enjoyment of the highest attainable standards of health ("the right to health") for young people and how they can be applicable to trans* youth. Even though

the right to health is not the primary focus of the thesis, its framework is helpful for the analysis of human rights-based approach and how it impacts the well-being of young trans* people. While analyzing the international human rights framework, it has to be kept in mind that "[a]dolescent health is an interdisciplinary field"[57], which means that it is influenced not only by the medical establishment but also by elements such as law, parents, school, and the society at large. Consequently, it cannot be framed or analyzed only through the lenses of health care but must be looked at in the wider context and how all those elements intersect. This is also the reason why the research in the thesis focuses on well-being and not solely on health. The discussion will be approached from a perspective of the right to be heard and the right to participation in decision-making (informed consent) and right to privacy. This discussion is meant to counteract narratives adopting a medical and pathologizing approach labeling young trans* people as mentally ill.

3.1 The UN Convention on the Rights of the Child

One of the most relevant instruments for the discussion on the well-being of trans* youth is the UN Convention on the Rights of the Child (CRC) and several articles of the Convention, discussed in this section. Their importance will be strengthened by the interpretation provided by the UN Committee on the Rights of the Child in *General Comments nos. 4*[58]*, 12*[59]*,* and *15*[60]. Not only do the *General Comments* look at specific issue within the CRC, but also they clarify

[57] White Holman, C. and Goldberg, J., "Ethical, Legal, and Psychological Issues in Care of Transgender Adolescents" in *Caring for Transgender Adolescents in BC: Suggested Guidelines*, Vancouver Costal Health, Transcend Transgender Support & Education Society, and the Canadian Rainbow Health Coalition, 2006, p. B-1.
[58] UN Committee on the Rights of the Child, *General Comment no. 4 (2003), Adolescent health and development in the context of the Convention of the Rights of the Child*, CRC/GC/2003/4.
[59] UN Committee on the Rights of the Child, *General Comment no. 12 (2009), The Right of the Child to be Heard*, CRC/C/GC/12.
[60] UN Committee on the Rights of the Child, *General Comment no. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, CRC/C/GC/15.

existing interplay and interdependence of different provisions. This will provide opportunity for the reader to realize that provision of services to young trans* people should be established with application of human rights perspective.

According to Article 24 of the CRC every child has "the right to health":

> States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that *no* child is deprived of his or her right of access to such health care services.[61]

The Committee on the Rights of the Child in its *General Comment No. 15 (2013)* confirmed for the first time that access to health without discrimination included also gender identity,[62] recognizing the needs of trans* children and youth. This was a significant development in comparison with 2003 when the *General Comment No. 4 (2003)* on adolescent health and development in the context of Convention on the Rights of the Child was limited to sexual orientation among other discrimination grounds[63]. However, the text of the *General Comment No. 4* could be interpreted as indirectly addressing trans* youth regardless, as it focuses on impacts of discrimination and exclusion:

> [a]dolescents who are subject to discrimination are more vulnerable to abuse, other types of violence and exploitation, and their health and development are put at greater risk. They are therefore entitled to special attention and protection from all segments of society.[64]

The Committee also elaborated on the type of health issues that a young person should have a say in. These include

[61] UN Convention on the Rights of the Child, 1989, Article 24(1). Emphasis mine.
[62] *General Comment no. 15 (2013)*, para. 8.
[63] *General Comment no. 4 (2003),* para. 6.
[64] Ibid., para. 6.

> [w]hat services are needed, how and where they are best provided, barriers to accessing or using services, the quality of the services and the attitudes of health professionals, how to strengthen children's capacities to take increasing levels of responsibility for their own health and development, and how to involve them more effectively in the provision of services.[65]

Such an interpretation of Article 24 is extremely important when it comes to trans* adolescents as it supports the approach used by progressive doctors and supportive parents following the needs of young people.

According to the Committee on the Rights of the Child, Article 12 of the CRC stresses that the youth who are able to formulate their opinions should be given the right and opportunity to share their ideas and views if those have any impact on their health.[66] It is, however, emphasized by the Committee that those views should be taken into account "in accordance with the age and maturity of the child"[67]. Even though the age of the young person in question is crucial, the individual experience and needs related to one's body cannot be disregarded when making decisions about needed services. The *General Comment No. 15* states that the older the young people get, the bigger decision-making capacity they possess and therefore they should be allowed to be in control over their bodies.[68] Such an approach has its challenges especially in States that regulate minimum age for giving medical consent, as it does not allow for any flexibility or assessment of decision-making abilities.

When discussing health and minors, the issue of medical consent has to be taken into account. Even though the capacity of making decisions depends of the maturity of a person, the Committee stated that young people should be allowed to give their consent to certain services

[65] *General Comment no. 15 (2013)*, para. 19.
[66] Ibid., para. 19.
[67] Ibid., para. 19.
[68] Ibid., para. 24.

and not be dependent on parents or legal guardians.[69] Services that young trans* people are interested in receiving oftentimes include puberty blockers, reversible hormonal treatment. In such situations, it is sometimes difficult to obtain parental consent, which is harmful for young people. As many specialists stressed

> (…) delaying the start of treatment [for gender reassignment] (even under 16 years) has its psychological drawbacks. Some individuals who have shown a pattern of extreme cross-sex identification from toddlerhood onwards develop psychological problems, such as depression, suicidality, anorexia, or social phobias[70].

This statement goes hand in hand with the general concern expressed by the Committee, who noted that mental health problems, such as for instance "depression, eating disorders, anxiety, (…) alcohol, tobacco and drug use, (…) and self-harm and suicide"[71] were on the rise among young people.[72] Consent is quite a complex issue in the case of trans* adolescents and it will be discussed in more detail in the upcoming sections of the thesis[73].

3.2 The Right to Be Heard and to Participate in Decision-Making

The respect for the rights to be heard and to participate in decision-making are at the core when ensuring well-being of young trans* persons. This section aims at outlining the reasons for their significance as well as potential in improving access to relevant services for trans* youth, which will be done by discussing mainly the UN Committee on the Rights of the Child *General Comment no. 12 (2009)* on the right to be heard.

As mentioned before, dealing with provision of medical services to youth may be

[69] *General Comment no. 15 (2013)*, para. 31.
[70] Cohen-Kettenis, P.T., Delemarre-van de Waal, H. A., Gooren, L. J. G.,"The Treatment of Adolescent Transsexuals: Changing Insights" in *International Society for Sexual Medicine*, (2008) 5: 1892-1897, p. 1894.
[71] *General Comment no. 15 (2013)*, para. 38.
[72] Ibid., 38.
[73] Refer to pp. 30-36.

challenging due to the fact that young people are not always in the position to make their own decisions. It does not have to do so much with their capacity to understand or being able to decide rather than legal constraints imposed on them by national laws and policies regulating decision-making and connecting such decisions to specific minimum age. As a principle and according to Article 3 of the Convention on the Rights of the Child all decisions[74] are to be taken in the best interest of the child, however, there is always a question pending what constitutes the best interest and who decides on it. There seems to be a tension between the principle and Article 12 of the CRC saying that a young person should be able to express their views and be listened to.

The Committee in its *General Comment no. 12*, however, expressed very clearly that the relationship between Articles 3 and 12 should be seen as interdependent rather than contradictory. According to the Committee,

> one [Article] establishes the objective of achieving the best interests of the child and the other provides the methodology for reaching the goal of hearing either the child or the children.[75]

Moreover, alongside with hearing young people's needs and voice, there is a need for them to actively participate in decision-making. Passive listening to one's opinions does not necessarily translate into taking them into account when making final decisions. Therefore, in order to fulfill requirements of the CRC, both elements must be present at the same time.

At this stage it is crucial to understand the difference between various types of decision-

[74] According to Article 3 of CRC: "3 (1). In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.
3 (3). States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision".
[75] *General Comment no. 12 (2009)*, para 74.

making. Since the research deals with minors, it is not about autonomous decision-making, but rather participation in the process and being seen as an active partner whose voice matters. According to Harry Shier there are five different levels at which young people can participate in decision-making:[76]

> (…) first, children are listened to; second, children are facilitated in expressing their views; third, children's views are taken into account; fourth, children are involved in decision-making processes; and fifth, children share power and responsibility for decision making. [77]

What is relevant and of interest for this research is a combination of all the above-enumerated strategies. To build on the example of Articles 3 and 12, these levels of participations are interdependent and cannot function without others being disregarded. Such a strategy seems to be very accessible and inclusive as it allows for working with youth regardless of their age, as the process is adapted to their abilities and maturity.[78]

Furthermore, it should be noticed that participation requires also being able to search and access proper information in order to make informed decisions. The right to do that is guaranteed in CRC under freedom of expression in Article 13, which incorporates the freedom "to seek, receive and impart information".[79] The possibility to seek information in any shape and form is crucial especially when it comes to decision-making in health care settings. The importance of this provision should not be underestimated in the case of trans* youth, whose needs related with transition not always are met with support and understanding. This is why it is critical that they

[76] Harry Shier, "Pathways to Participation: Openings, Opportunities and Obligations: A New Model for Enhancing Children's Participation in Decision-making in line with Article 13.1 of the UNCRC" in *Children and Society*, Vol. 15, Issue 107, 2001 in Mary Donnelly and Ursula Kilkelly, "Child-Friendly Healthcare: Delivering on the Right to Be Heard" in *Medical Law Review, 19, Winter 2011, pp. 27–54*, p. 30.
[77] Ibid., p. 30.
[78] Mary Donnelly and Ursula Kilkelly, "Child-Friendly Healthcare: Delivering on the Right to Be Heard" in *Medical Law Review,* 19, Winter 2011, pp. 27–54, pp. 30-31.
[79] Ibid., pp. 32-33.

have real possibility to receive all necessary information to be able to express their needs and wishes as well as to actively and fully participate in decision-making.[80]

Active participation of young people in decision-making does not only benefit them but it also contributes to reducing levels of misunderstanding and conflicts between youth, parents and health care service providers.[81] Moreover, active participation indirectly requires parents or guardians to pay attention to developing abilities of their children and to be a part of a very dynamic process. This approach finds strong support in Article 5 of the Convention. It the light of this, parents are supposed to support and lead their children according to their developing and growing abilities.[82] Donnely and Kilkelly claim that if

> [r]ead together with Article 12, Article 5 demonstrates the gradual way in which parents' direct role in the protection of children's rights transfers to children as they acquire the maturity to take on this role for themselves.[83]

The argument is enhanced by the Committee's *General Comment no. 4* addressing decision-making specifically in the context of medical care stating that young people should be active in making decisions about their well-being.[84] In other words, evolving maturity of trans* youth should be assessed on regular basis and taken into account during consultations on accessing trans* specific health services.

[80] See e.g. European Court of Human Rights, *V.C. v. Slovakia*, Application no. 18968/07, Judgment 8 February 2012, paras. 108 – 112 and European Court of Human Rights, *A, B, and C v. Ireland*, Application no. 25579/05, Judgment 16 December 2010, paras. 264 – 267.
[81] An approach based on 'therapeutic jurisprudence' recognises the 'need for an assessment of the therapeutic impact of legal rules': see B. Winick, 'The Right to Refuse Mental Health Treatment: A Therapeutic Jurisprudence Analysis' (1994) 17 Intl JL Psychiatry 99, 100 in Mary Donnelly and Ursula Kilkelly, "Child-Friendly Healthcare: Delivering on the Right to Be Heard" in *Medical Law Review, 19, Winter 2011, pp. 27–54*, p. 34.
[82] Donnelly and Kilkelly, p.43.
[83] Ibid., p.43.
[84] *General Comment No 4 (2003),* para. 39.

3.3 The Right to Privacy and Informed Consent to Medical Care

"What consent does in this context is not to neutralise the power imbalance but to legitimise it."[85]

Having seen the importance of the rights to be heard and participation in decision-making within the context of the UN Convention on the Rights of the Child and well-being of trans* youth, this section will claim that also the respect for the right to privacy is indispensible in ensuring that young trans* people receive proper services. It will also discuss issues concerning informed consent and its impact on well-being of trans* youth using an example of the *Gillick v West Norfolk & Wisbech Area Health Authority*[86] case (the *Gillick* case). This section will also look at how informed consent relates to the right to privacy.

Maclean, who did research on the intersection of autonomy, informed consent and medical law, argues that the right to consent might have been given too much attention and weight.[87] Maclean claims that it is a flawed approach to be putting the right to consent at the same level with the right to life or bodily integrity.[88] He states that the right to consent

> is not something possessed equally by all persons within the rights-holding community. Persons who are incapable of giving or withholding consent still possess the right to bodily integrity.[89]

He strengthens this argument with saying that if there were no right to bodily integrity, there would be no obligation for obtaining a person's consent for treatment or intervention with their body.[90] It would consequently make consent procedures redundant and useless. What it also means is that the right to consent only makes sense when a person has access to other rights and

[85] Alasdair Maclean, *Autonomy, Informed Consent and Medical Law: A Relational Challenge*, Cambridge University Press, 2009, p. 133.
[86] *Gillick v West Norfolk & Wisbech Area Health Authority,* [1986] AC 112 House of Lords.
[87] Ibid., p. 121.
[88] Maclean, p. 121.
[89] Ibid., p. 121.
[90] Ibid., p. 121.

has the power to exercise them.[91] Maclean's claims are valid and should be taken into consideration when exploring well-being of trans* youth. It should be examined if the fact that minors do not always have the right to give consent due to, e.g. national laws restricting age of consent, should mean that they are not allowed to live in their preferred identities, be exposed to discrimination and worsening health conditions. If this were the case, one could argue that their right to bodily integrity would be violated.

According to the Convention on Human Rights and Biomedicine of the Council of Europe[92] (the Oviedo Convention) and its general rule on consent, no medical intervention can take place without a free and informed consent given by a patient.[93] By free and informed consent it is meant that the person in question has been provided with all necessary information about their treatment, its consequences, as well as options of care.[94] It could also be added that a person should have capacity to make decisions and support in decision-making should be given, if necessary.

When it comes to minors and their capacity to give informed consent, the Oviedo Convention states that if a young person is unable to comprehend what the treatment implies and therefore is deemed incompetent in decision-making, it is their parents' role to consent to treatment.[95] The Convention does, however, emphasize that "[t]he opinion of the minor shall be taken into consideration as an increasingly determining factor in proportion to his or her age and

[91] Maclean, p. 121.
[92] Council of Europe, Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, Oviedo 1997, available at http://conventions.coe.int/Treaty/en/Treaties/Html/164.htm, accessed 1 October 2014.
[93] Ibid., Article 5.
[94] Ibid., Article 5.
[95] Ibid., Article 6.

degree of maturity"[96]. In this way, it acknowledges provisions enshrined in Article 12 of CRC.

The above arguments create an interesting background for a discussion on the ECHR as well as existing case law of the European Court of Human Rights. Even though the European Convention on Human Rights does not explicitly mention children and young people, Article 8 safeguarding "the right to respect for private life and family life" has been used on numerous occasions to protect them.[97] What is relevant for the topic of the thesis and well reflects on prior discussion on Maclean's arguments is that

> [t]he ECtHR has recognized that the right to private life encompasses a right of autonomy[98] as well as a right to physical and psychological integrity which is not dependent on the subject's decision-making capacity.[99]

In other words, in its case law, the Court confirmed that the ability to consent is a secondary matter and should not influence negatively one's rights to bodily integrity and autonomy. For instance, in *Storck v. Germany*[100], the Court stressed that no medical intervention can be administered even if a person lacks legal capacity to give consent.[101] Court also emphasized on several occasions that "a person's body concerns the most intimate aspect of private life"[102] and should never be interfered with without informed consent. At the same time, Mary Donnelly claims that the decision in the *Storck* case gives rise to

> the basis for an approach to decision-making that looks beyond questions of capacity or

[96] Convention on Human Rights and Biomedicine, Article 6.
[97] Donnelly and Kilkelly, pp. 46-47.
[98] See European Court of Human Rights, *Pretty v United Kingdom,* Application no. 2346/02, Judgment 29 June 2002, para. 61 in Donnelly and Kilkelly, p. 48.
[99] Kilkelly, p. 48.
[100] European Court of Huan Rights, *Storck v. Germany*, Application no. 61603/00, Judgment 16 June 2005, para. 76 and Mary Donnelly, *Healthcare Decision Making and the Law: Autonomy, Capacity and the Limits of Liberalism*, Cambridge University Press, 2010, p. 220.
[101] Donnelly, p. 220.
[102] European Court of Human Rights, *Y.F. v. Turkey*, Application no. 24209/94, Judgment 22 October 2003, para. 33.

> incapacity and addresses issues of willingness, restraints and force. The decision makes it clear that the absence of capacity does not justify a treatment 'free-for-all'.[103]

The abovementioned arguments are significant in the context of well-being of trans* youth as their bodies and identities are prioritized over legal capacity to making decisions. If interpreted in such a broad way, which has not happened yet, it could potentially have serious consequences on the way trans*-specific health care is provided for youth.

It is often used as an argument in discussions concerning health care of young people that all information about it should be shared with their parents or legal guardians. It is problematic as it results in young people being deprived of privacy that all patients are entitled to. It is additionally challenging because confidentiality is seen as an important principle for the Court, which was reiterated in the cases of *Z v Finland*[104] and *MS v Sweden*[105]. Even though the two cases dealt with adults, one of the judges in the case of *the Queen on the application of Sue Axton v The Secretary of State for Health*[106] stated, referring to those very cases, that

> there is no good reason why they could not apply to protect the confidentiality of health information concerning a young person, especially because, (…) a duty of confidentiality is owed to a young person by medical professionals[107].

In the light of this, the Court claimed that the lack of privacy and compromised confidentiality have a chilling effect on patients, who may be frightened to seek assistance or treatment.[108] Such an argument is definitely valid when it comes to young people, who are not independent and

[103] Donnelly, pp. 220-221.
[104] European Court of Human Rights, *Z v Finland,* Application no. 22009/93, Judgment 25 February 1997, para. 95.
[105] European Court of Human Rights, *MS v Sweden*, Application no. 74/1996/693/885, Judgment 27 August 1997, para. 41.
[106] The Queen on the application of Sue Axton v The Secretary of State for Health (The Family Planning Association: intervening) [2006] EWHC 37 (Admin), Case No: CO/5307/2004, available at http://www.familylawweek.co.uk/site.aspx?i=ed1583, accessed 20 October 2014.
[107] Ibid.
[108] *Z v Finland,* para. 95.

very often rely on consent from their parents, not only for medical procedures but also litigation. If seeking advice or support from a medical staff by a young trans* person meant that the parents should be notified, the young person would hesitate about reaching out for help. This is especially true when legal guardians are not supportive of the child's identity.

For the purpose of further discussion it is important to look also at specificities related to consent in the context of young trans* youth in particular. The reason why it is imperative to have a better understanding of processes around consent of young people is that the possibility to give consent or not has direct consequences on controlling significant aspects of their lives. Being able to decide is especially important in the context of health care and services ensuring well-being.[109] However, making decisions within the medical setting proved to be challenging due to the fact that youth under 18 years old, which often is the age of legal maturity, were refused the right to give consent about medical matters concerning them.

A British case, *Gillick v West Norfolk & Wisbech Area Health Authority*[110], that addressed the issue of maturity and ability to give informed consent for medical treatment in 1986 turned out to have a long-standing impact on the way young people were treated within the legal system, including heath care settings. The *Gillick* judgment was seen as a breakthrough in the field of children's rights in general and when it comes to youth autonomy in particular.[111] It created a test, which would become a tool to measure if a child is competent and mature enough to make informed decisions about issues concerning their life.[112] In practice, it meant that a young person below the age of 16, if sufficiently mature, could override their parents' decisions

[109] Maclean, p. 133.
[110] *Gillick v West Norfolk & Wisbech Area Health Authority,* [1986] AC 112 House of Lords.
[111] Emma Cave, "Goodbye *Gillick*? Identifying and Resolving Problems with the Concept of Child Competence" in *Legal Studies*, Vol. 34 No. 1, 2014, pp. 103-122, p. 103.
[112] Ibid., p. 103.

on their health. It is significant in the context of trans* youth well-being, as it gives them the possibility to be in charge of their bodies and identities. This is especially helpful when parents are not supportive and wish to restrict their children's access to relevant services. Consequently, this new assessment method acknowledged "minors as independent rights-holders"[113], which was further strengthened by ratifications of CRC.

What was so critical in what *Gillick* did was that it clarified when the parental control over decision-making for young people's lives ends in the medical context:

> (…) as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.[114]

In other words, it meant that whenever a young person below 16 years old wished to obtain medical information or advice, as well as undergo treatment, they were supposed to be the primary decision maker as long as they passed the *Gillick* test of maturity.

Unfortunately, allegedly there were certain challenges that the test faced especially when attempting to address issue of 'maturity'. Prout and James claimed as early as in 1990 that not only is maturity extremely complex due to being composed of elements, such as "physical, psychological, emotional, cognitive and/or social maturity"[115], but it also is a socially constructed concept that varies depending on cultural contexts.[116] Following this argument, one would never be able to use such a universal test because of diversity of contexts that exist within a country or across the world. The case, however, was so influential that the test was applied in

[113] Cave, p. 104.
[114] *Gillick v West Norfolk & Wisbech Area Health Authority*, pp. 26-27.
[115] A Prout and A James 'A new paradigm for the sociology of childhood?' In A James and A Prout (eds) Constructing and Reconstructing Childhood: Contemporary Issues in the Sociological Study of Childhood (London: Routledge/Falmer, 1990) pp 7–33 in Emma Cave, "Goodbye *Gillick*? Identifying and Resolving Problems with the Concept of Child Competence" in *Legal Studies*, Vol. 34 No. 1, 2014, pp. 103-122, p. 109.
[116] Ibid., p. 109.

different countries regardless, e.g. in Canada and Australia.[117]

3.4 Chapter Conclusion

Having examined relevant rights in the context of the Convention on the Rights of the Child with a special focus on the right to be heard, participate in decision-making as well as the right to privacy, it can be concluded that their respect is crucial for the well-being of trans* youth. First of all, the Convention ensures that gender identity is included as one of grounds that young people cannot be discriminated against in the context of health care. Secondly, being able to express one's opinion and having it taken into account during decision-making is crucial for trans* youth to ensure receiving services that they need. It has been explicitly included in CRC and later on interpreted by the Committee on the Rights of the Child. Moreover, since consequences of decisions regarding health will leave permanent mark on a young person's life, it is critical that they are active participants in decision-making process. Similarly, the right to privacy includes the right to bodily integrity which is especially relevant in the context of trans* youth.

The chapter also closely examined issue of capacity to make informed decisions with health care settings, which is based on the *Gillick* test measuring a young person's maturity. It was proven that the *Gillick* assessment allows for flexibility and caters for different paces of mental development in young people. Limitations imposed on the age of consent create blanket restriction on consent without taking into account the individual abilities of young people in

[117] See Supreme Court of Canada, *A.C. v. Manitoba (Director of Child and Family Services)*, 2009, SCC 30, available at https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/7795/index.do, accessed 1 November 2014 and High Court of Australia, *Department of Health and Community Services v JWB and SMB (Marion's Case)*, [1992] HCA 15; (1992) available at http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/cth/high_ct/175clr218.html?stem=0&synonyms=0&query=title(175%20CLR%20218, accessed 1 November 2014.

question. Consequently, the chapter provided a legal framework which could be used for advocating for better health services available for trans* youth.

CHAPTER 4 – Consent and Related Practices in Canada and the Netherlands

The aim of this chapter is to bring all-so-far provided information and focus the discussion on well-being of trans* youth by looking at specific examples of the Netherlands and Canada. The emphasis will be on legal frameworks in these two countries, which regulate access to services for trans* youth, including age of consent of minors within the health care system. Canada and the Netherlands deal with the issues differently and it will be therefore interesting to see what approaches are used to ensure well-being of trans* youth and which can serve as an example of good practice.

4.1 Canada

Due to the fact that Canada is composed of ten provinces and regulating health care issues is within provincial competences there are some differences from one province to another in a way medical consent is dealt with.

According to Jackman and McRae, capacity to make decisions in most cases in Canada is not connected to age but rather to maturity of a person in question.[118] Provinces of Ontario, Alberta, British Columbia, Manitoba and Saskatchewan have decided not to define age limit at

[118] Michelle Jackman, MD, MSc, FRCPC; and, Andrew McRae MD, PhD, FRCPC, *Medical Decision-Making and Mature Minors*, available at http://www.royalcollege.ca/portal/page/portal/rc/common/documents/bioethics/section1/case_1_5_2_e.html, accessed 23 July 2014.

which a young person would be entitled to making decisions related to their health.[119] These provinces base their procedures on a doctrine of "mature minor",[120] which is a direct influence coming from the *Gillick* case. As it was mentioned before, the doctrine assesses how capable a person is to understand the type of medical procedures and their consequences.[121] It was argued

> that mature minors should be able to prioritise their current desire for autonomy in the same way as competent adults. This is a proposition that has been shown to be effective in Ontario, Canada, where a single test for and presumption of capacity applies to all. A competent minor can consent to and refuse medical treatment and neither parents nor the court have a power of veto.[122]

Such a flexible and individualized assessment has very concrete benefits for young people as it allows also the younger children to have the opportunity to decide and be in control over their bodies. Moreover, due to the fact that an ability to make decisions develops at various paces in different people, a decision on one's mental capacity should not be determined simply by age.

Having said that, it is worth mentioning that regardless of the general belief in individualized assessment the provinces of Québec and New Brunswick define age limits for decision-making for medical purposes in their provincial laws. The *Medical Consent of Minors Act*[123] of New Brunswick states that a person from 16 years old is treated equally with an adult who has the right to decide on their treatment as well as refuse it.[124] The Act outlines also that a person under the age of 16 is allowed to make their own decisions under condition that two

[119] Jackman.
[120] Ibid.
[121] Ibid.
[122] Cave, pp. 118-119.
[123] CanLII, *Medical Consent of Minors Act,* SNB 1976, c M-6.1, available at https://www.canlii.org/en/nb/laws/stat/snb-1976-c-m-6.1/latest/snb-1976-c-m-6.1.html, accessed 25 November 2014.
[124] Jackman.

doctors testify that the person in question is capable of understanding the treatment and its consequences for the person's well-being.[125]

At the same time in Québec, the *Civil Code of Québec* guarantees in its article 14 that a 14-year-old person has a right to give consent to treatment.[126] The only time that parental consent is required is when the treatment may risk the young person's health.[127] It is unclear how the last provision of parental involvement would impact trans* youth because it is not defined what 'health risk' entails. Therefore, in a hypothetical situation where taking puberty blockers is potentially defined as a health risk by some, parents could potentially override decision of a young person, which would have serious consequences for their mental and physical health.

In the light of the last point, it is worth looking a bit deeper at regulations about consent given by minors in Canada. There is a clear distinction in the law between 'necessary'[128] and 'unnecessary' treatments for one's health, which may become problematic in the context of trans* youth accessing services. In the case of 'necessary' treatments, young people between 14 and 17 years old can give consent and their parents do not need to be informed, unless they need to stay in the hospital for more than 12 hours.[129] When it comes to 'unnecessary' treatments, the consent procedure is similar, however, when the procedure could lead to permanent side effects or other risks, the parents must be informed and they also must give consent.[130] Such an approach raises a set of questions when it comes to trans* youth. Any surgical interventions that a young

[125] Jackman.
[126] CanLII, *Civil Code of Québec*, LRQ, c C-1991, Article 14, available at https://www.canlii.org/en/qc/laws/stat/lrq-c-c-1991/, accessed 23 July 2014 and Angela Campbell, *Contemporary Challenges in the Law of Consent* – presentation, McGill University, Faculty of Law, available at http://goo.gl/kHFycB, accessed 23 July 2014.
[127] Jackman.
[128] E.g. abortion is treated as a necessary for one's health therefore the parents do not need to be informed.
[129] Educaloi, "Medical Decisions for Children 14 to 17 Years Old", available at http://www.educaloi.qc.ca/en/capsules/medical-decisions-children-14-17-years-old, accessed 23 July 2014.
[130] Ibid.

person under the age of 18 would like to have performed in order to change their body would never be allowed by the current state of the law. Such limitations contribute to problems young trans* people face when they are unable to transition and live their lives according to felt gender identity.

It is helpful to use a first hand experience of working with trans* youth, age of consent and law. The insight was provided by Shuvo Ghosh, MD[131] working in Montreal, Québec during an interview conducted by the author. When asked about specific law or policy that he works according to when dealing with trans* youth, he said that there was no concrete document that regulated his work.

> The general method for our practice here is to follow the Hippocratic Oath, and the regulations for practicing medicine under the professional order for physicians in Québec, which is called the *Collège des médicins du Québec*.[132]

In other words, dr. Ghosh and his colleagues have a negative ethics standard, which means that they are allowed to practice 'ethically' and by generally accepted 'standards of care'. They are established either by their practice center, the larger institution like the University, the medical context of the location where they practice, like for instance "the standards of Montreal", or a provincial or nation-wide standards.[133] What is, however, included in the law is what the medical professionals are not allowed to do or what particular procedures to follow in case of specific situations, such as for instance abortion on a minor. When it comes to trans* youth and "generally accepted ethical standards of care", the Montreal gender clinic tends to use

[131] Shuvo Ghosh is a developmental-behavioral pediatrician who did medical studies and a general pediatrics residency in the USA and subsequently completed specialty fellowship training in developmental-behavioral pediatrics at McGill University/Montreal Children's Hospital. He currently runs the only pediatric gender variance program in the province of Québec, Canada.
[132] Interview with Shuvo Ghosh.
[133] Ibid.

a model similar to the one created by the government and professionals in the province of British Columbia,[134] even though there is no age limit imposed on the age of consent.

The guidelines used by VCH Transgender Health Information Program[135] in British Columbia are based on the *Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People, Version 7* (SOC) of World Professional Association for Transgender Health (WPATH).

> The overall goal of the SOC is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment.[136]

The SOC is significant for the discussion here as it not only addresses all possible medical issues faced by trans* adults wanting to undergo gender reassignment, but it also explicitly mentions youth. Children and adolescents are discussed in a separate part of the document due to specific needs and also significant differences in identity development between them and adults.[137] WPATH SOC outlines issues, such as competences of mental health professionals, social transition in childhood and adolescence, puberty blockers, cross-sex hormonal treatment and others,[138] which are fundamental for providing appropriate services for young people. Canadian approach should definitely be considered a good practice and an example for follow.

Going back to the above-mentioned discussion on age of consent, dr. Ghosh said that the

[134] Interview with Shuvo Ghosh.
[135] Transgender Health Information Program of Vancouver Coastal Health is a center providing information within British Columbia on trans* specific health care and available support, available at http://thip.vch.ca, accessed 28 October 2014.
[136] Coleman, E., Bockting, W., et all, "Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People, Version 7" in *International Journal of Transgenderism*, Vol. 13, 2011, pp. 165-232, p. 166.
[137] World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Non-Conforming People*, 2001, p. 172.
[138] Ibid., pp. 174-177.

age of 14 is indeed the time when a young person is able to request care and give consent to care in Québec. He emphasized, however, that he always hopes that it does not have to become a legal battle for the young person to receive relevant services.[139]

> (…) I work hard to include caregivers (parents or whoever has guardianship) [in decision-making]. I try to explain, include, and find ways to ensure the trans* youth feels accepted and that we are a full team rather than a patient and physician dyad only.[140]

Such an approach shows flexibility as well as seeing well-being of a trans* young person as a holistic issue, as well as it clearly drafts roles of each stakeholder relevant for the process. They will be discussed in more detail in Chapter 5[141], when the intersection of the roles of parents and care providers, as well as their impact on well-being of trans* youth will be explored.

From the analysis above it can be concluded that Canadian legal framework is patient focused and it was designed to make health care services accessible for young people and to provide opportunities for them to make decisions regardless of age. In the light of this it is crucial to look at the regulations in the Dutch system, which is very often seen as a pioneer in the field of trans* health to see if it also can serve as a good practice in the field of trans*-specific care.

4.2 The Netherlands

According to the Dutch Medical Treatment Contracts Act (WGBO)[142], dealing with all procedures related to medical treatment, it is parents who make decisions regarding a young

[139] Interview with Shuvo Ghosh.
[140] Ibid.
[141] See pp. 46-62.
[142] Rijksoverheid, Patiëntenrecht en cliëntenrecht, Rechten in de zorg, available at http://www.rijksoverheid.nl/onderwerpen/patientenrecht-en-clientenrecht/rechten-in-de-zorg, accessed 29 November 2014.

person's health.[143] To be more exact, children below the age of 12 are automatically thought to be incapable of making decisions and therefore all the power is in the hands of their legal guardians.[144] Consequently, they are deprived of a possibility to make informed decisions about their bodies and health. Older children, between 12 and 15 years old who are deemed competent, may give consent, however, it is an obligation to also obtain their parents' consent.[145] It is only young people from the age of 16 that are seen as mature enough to make independent decisions about their health.[146] Dr. Steensma adds another layer to the seemingly strict age restrictions for giving consent.

> When it comes to decisions like this, it is helpful to have a protocol but in many cases it depends on body development, psychological maturity, [and] functioning of the family. Probably you are better off with case-by-case decision model.[147]

This statement confirms that the Canadian model of maturity assessment is more beneficial than the Dutch blanket age limitation on decision-making.

Since the thesis looks at young people from the age of 14, it is crucial to comment on the Dutch age restrictions. In comparison to the Canadian system based in majority of cases on flexible approach and maturity assessments, the Dutch system seems to be quite conservative. As it was clearly stated in the Chapter 2[148] dealing with issues faced by trans* youth, it is imperative that they receive services they need as early as possible. From what can be seen in literature and

[143] Irma M Hein, Pieter W Troost, Robert Lindeboom, Martine C de Vries, C Michel Zwaan and Ramón J L Lindauer, Assessing children's competence to consent in research by a standardized tool: a validity study in *BMC Pediatrics* 2012, Vol.12:156, available at http://www.biomedcentral.com/1471-2431/12/156, accessed 25 July 2014.
[144] Ibid. and Rijksoverheid.
[145] Ibid.
[146] Ibid.
[147] Interview with Thomas D Steensma.
[148] See pp. 15-22.

media[149], young people discover their gender identities early on in their lives and therefore should be allowed to make decisions about it. For some it would include taking puberty blockers and for some it would be about seeing a psychologist or only receiving advice on transitioning socially. Such interventions are reversible and give young people time to think and decide what is best for them. This is why there should be no age restrictions imposed on giving consent, if it is related to reversible treatment. There should be, however, a maturity assessment process in place when the treatment would involve irreversible procedures.

When analyzing the Dutch law, it is clear that minors have the same constitutional rights as adults.[150] At the same time, the authority that parents have in order to protect their children should in no way negatively impact on the children rights.[151] If this is indeed so, a question should be asked what happens to young people's rights to bodily integrity, when it is the parents who decide on it and the decision is in contradiction to what a young person needs. Maclean provides a relevant comment to the posted question: "[i]f the right to bodily integrity truly belongs to the child then the parents cannot legitimately waive that right"[152].

According to the Dutch law, the older the minor is the more decision-making power they have and will be able to override the authority of their parents.[153] It is, however, problematic that children's rights when it comes to their bodies are to be implemented progressively depending on their age and maturity. It is especially troublesome in cases when legal guardians fail to give consent because a young person will be forced to wait with accessing any services or treatment

[149] E.g. Cohen-Kettenis, P.T., Delemarre-van de Waal, H. A., Gooren, L. J. G. and Raising My Rainbow: Adventures in Raising a Fabulous, Gender Creative Son.
[150] Right to Informed Consent – Minors, the Netherlands, available at http://europatientrights.eu/countries/signed/netherlands/netherlands_right_to_informed_consent_minors.html, accessed 25 July 2014.
[151] Ibid.
[152] Maclean, p. 131.
[153] Right to Informed Consent – Minors.

till they turn 16 years old.[154]

4.3 Chapter Conclusion

The chapter presented specific legal requirements concerning age for giving medical consent for young people using examples of Canada and the Netherlands. In this respect the Canadian legal system turned to be more flexible and young people-oriented as it is based on maturity assessment and a concept of 'mature minor'. If a young person is labeled as such after an evaluation, they are able to make decisions about their health. The exception to this rule in Canada is Québec with the age limit of 14 years old and New Brunswick with the age limit of 16. At the same time, in the Netherlands, according to the law, the age of consent is set at 16. There are voices, though, from the medical professionals that care for trans* youth should rather be given on case-by-case basis. It is a positive consideration because age limit is showed to be problematic in the context of trans* youth. Limitations may restrict access to necessary services and forced young people to wait, which is challenging especially when it comes to puberty blockers, which are time sensitive.

Chapter 5 – Parents, Medical Professionals, NGOs and the Well-Being of Trans* Youth

So far the thesis provided an outline of international legal framework ensuring protection of the rights of minors when it comes to decision-making and giving consent within health care settings. It elaborated specifically on the rights to be heard, participation and privacy and how

[154] Right to Informed Consent – Minors.

they impact well-being of trans* youth as well as offered a short introduction to the Dutch and Canadian legal systems regarding medical consent and assessment of maturity. Throughout the text, various stakeholders were mentioned, such as parents, medical professionals, and NGOs, who operate within a framework of the existing laws. It became clear that they have a significant impact on the well-being of trans* youth. This is why, the aim of a discussion in the last chapter is to explore the intersection of the roles all the abovementioned actors have and their influence on trans* young people. It will be argued that active involvement of all three actors is crucial as well as their duties can be performed in a flexible and supportive legal system. The chapter will, however, also involve voices which oppose the idea of providing young trans* people with possibility to access trans* specific services. It will be done in order to also show that the issue of trans* health in general and trans* youth-related matters in particular are still seen as controversial rather than as an obvious human rights question that every one agrees on.

5.1 The Role of Parents

"(...) Parental rights to control a child do not exist for the benefit of the parent. They exist for the benefit of the child and they are justified only in so far as they enable the parent to perform his duties towards the child and towards other children in the family"[155]

There are so many different roles that a parent takes on with the minute their child is born that it would not be possible to list them all. Some of them each parent has to deal with. To put it in simple terms, children need to be fed, dressed, sent to school, or taken care of, among many other things. Not all parents, however, have to address the fact that their child is questioning sex they were assigned at birth. This may cause some difficulties for guardians, simply because they live in heteronormative societies which do not prepare them for anything more than following

[155] *Gillick v West Norfolk & Wisbech Area Health Authority*, p. 8.

the clearly set norms. It is additionally challenging because it is about children or young people who are not always taken seriously when it comes to their wishes or beliefs. The way the parents deal with the process of their child questioning their gender identity has significant impact on well-being of the young person in question.

Brennan and Noggle suggested what general roles parents should have in order to ensure that their actions have always the best interest of the child in focus. They claimed that parents should assist their children in knowing their rights and they should act as "stewards" and not authoritarian decision makers.[156] Brennan and Noggle proposed three core duties that parents should fulfill, which include "(1) the duty to not violate the rights of the child; (2) the duty to prevent others from violating the rights of the child; (3) the duty to promote the interests of the child"[157] These are general recommendation, which are not specific to trans* health, however they could easily be translated into trans* context. These recommended obligations seem to be quite obvious at the first sight, however, they may become obsolete when one is unable to deal with one's child's identity. Therefore, making sure that all of them are respected by parents of trans* youth is crucial.

It is worth to unpack each duty to see how relevant they are in the context of trans* youth. The first suggested duty, from a perspective of trans* youth, would imply that parents allow their child to decide what services they need, what plan of action they would want in order to feel well in their body and identity. It would require active listening and letting the child actively participate in decision-making, even if the young person is below the legal age of consent. It would result in respecting their right to be heard, participate in decision-making as

[156] Samantha Brennan & Robert Noggle, "The Moral Status of Children's Rights, Parents' Rights, and Family Justice", *Social Theory and Practice,* Vol. 23, No. 1, pp. 1-26, 1997, p. 12 in Annette Brömdal, p. 50.
[157] Ibid., p. 50.

well as respect to their private life. The second obligation to make sure that no one violates the rights of their child would imply here that the parents communicate with the health service providers and act as advocates for their children. Many times they have decision-making power and they should use it in a way to benefit their child. Thirdly, the parents have a duty to promote the interest of their children. In this context it means that they speak about the needs of trans* youth, about non-binary identities, and do their best to educate people around them, including medical staff or other family members. It would lower a risk of bullying, discrimination and inappropriate treatment.

It was mentioned before that difficulties with accepting preferred identities by parents are caused by societal heteronormativity and presence of various norms. What could be added to this is also the fact that non-conforming gender identities are very often pathologized and seen as disorders needing medical treatment. Coppock claims that it is easier for parents to deal with a potential disorder of their child when doctors make a diagnosis because, as she says, it eliminates the stigma of disease.[158] To translate Coppock's words into the context of trans* youth, it could be said that pathologization could make it easier for parents to handle their child questioning gender identity because it would become 'only' a disease that can be cured and not a behavior challenging the norms. In the heteronormative system it is easier to explain certain behaviors to others when they can be related to psychological and/or physical health problems, rather than to openly accepting such norm-breaking actions. Moreover, very often parents are not familiar with gender identity concepts or needs that trans* youth have. Therefore, they rely on the knowledge and expertise of doctors, who supposedly have more experience and would know how to "treat"

[158] Vicki Coppock, "Medicalising children's behaviour" in Franklin, Bob (ed.) *The New Handbook of Children's Rights: Comparative Policy and Practice*, London: Routledge, 2003, pp. 139-149, in Annette Brömdal, p. 52.

their child.[159]

In Coppock's opinion, such an approach is problematic because it excludes young people from decision-making process as it is automatically assumed that the medical professionals are the ones knowing what is best for the child.[160] Consequently, the young person is left without any possibility to give their consent. The role of the parents should be to make decisions after consulting doctors with their necessary expertise but most of all, their child, who most likely has a strong opinion on the situation. Parents often are afraid of their children making mistakes and so they act controlling and authoritative. The problem with such a strategy when it comes to gender identity is that in majority of cases parents do not posses proper tools to deal with it. It is their children who go through the experience and therefore they are the right people to make decisions, even if it means making mistakes.

As stated by Franklin, making mistakes should be seen as being in the best interest of the child because they are helpful in learning what is good or bad for oneself.[161] He argued that

> a child can only mature when autonomy and decision-making is handed to it, and an excessive protection and hindering the individual's autonomy and decision-making, will lead to increased incompetence regarding its own life and its own situation.[162]

It could be added to the above argument that allowing minors making decisions before reaching adulthood is beneficial also because it is done in a safe environment. It is meant that the young person can reach for help or support of their parents or other adults who could assist in decision-making. They are not left alone with the decision and this is when an important learning process

[159] Coppock, p. 52.
[160] Ibid., p. 52.
[161] Bob Franklin, "Children's rights and media wrongs: Changing representation of children and the developing rights agenda" in Franklin, Bob (ed.) *The New Handbook of Children's Rights: Comparative Policy and Practice*, London: Routledge, 2003, pp. 22-24 in Annette Brömdal, p. 50.
[162] Ibid., p. 50.

takes place. On the contrary, if young people are not allowed by their parents to make decisions and potentially fail at it, it is flawed to expect them to be adults fully competent in decision-making.[163] The role of the parents should focus on guidance and trust in their children abilities to know what their bodies need. Moreover, since decisions about accessing trans* specific services most likely will have life-long lasting impact, it is critical that young people can take independent but informed decisions. This should also include allowing for a margin of error and even change of hearts.

Having said that, the author of the thesis is well aware that arguments relating to allowing young trans* people to make mistakes could and most probably will be used by the people who strongly oppose the possibility to access trans* specific health services by trans* youth. To counteract any negative reactions, it should be emphasized that young people who question their gender identity at an early age, seek most of the time only reversible treatment. Moreover, it was proven by a recent Dutch research conducted by a team of renowned physicians specialized in health care for trans* youth that access to puberty blockers has a very positive impact on their well-being.[164] Lack of such services, as described before, leads to depression, trauma and societal exclusion. Parents should be aware of that and make sure that the time for questioning, trying and reflection is granted.

In the light of this, it is worth to refer to words of dr. Joanne Olsen working at the Children's Hospital in Los Angeles, who during her appearance in the *20/20*[165] special "Boys

[163] Franklin, p. 50.
[164] de Vires, McGuire et all.
[165] *20/20* is an American TV newsmagazine broadcasted on abc network.

will be Girls"[166], stressed the importance of positive reinforcement and support coming from parents.[167] While emphasizing that it is crucial for parents to acknowledge diversity within gender identity spectrum and individuality of experiences connected with them, she said, "these are some kids who absolutely cannot function unless they socially transition"[168]. After this, she turned directly to parents with a very straightforward question: "would you rather have a dead son than an alive daughter because these kids have a suicidal rate that is astronomical."[169] Even though embedded in a heteronormative approach to gender identity, the comment addressed a significant issue. Similar opinion was shared also by an advocate for the rights of trans* youth, Kim Pearson, from the Trans Youth Family Allies who said that "[t]rans kids are the highest suicide risk on the planet, bar none".[170] At the same time, research conducted in Ontario, Canada focusing on impacts of parental support on the well-being of trans* youth found that

> (…) the impact of strong parental support can be clearly seen in the 93% reduction in reported suicide attempts for youth who indicated their parents were strongly supportive of their gender identity and expression,[171]

which only proves how important parental support is.

When discussing the role of parents it became clear that it is almost impossible to ensure well-being of trans* youth without involvement of other actors. It is apparent that doctors and

[166] "Boys will be Girls", Part 1/4 available at https://www.youtube.com/watch?v=u-DjtvAPOhE, accessed 2 November 2014.
[167] Jessica Ann Vooris, "Trapped in the Wrong Body and Life Uncharted: Anticipation and Identity Within Narratives of Parenting Transgender/Gender Non-conforming Children" in Fiona Joy Green and May Friedman (eds.), *Chasing rainbows: exploring gender fluid parenting practices*, Demeter Press 2013, p. 77.
[168] Ibid., p. 77.
[169] Ibid., p. 77.
[170] Ashley C., "Transgender Kids in the Spotlight for LGBT Rights" at ArtInFactMag, available at http://www.artinfactmag.com/culture-dish/transgender-kids/, accessed 30 October 2014.
[171] Travers, R., Bauer, G., Pyne, J., Bradley, K., Gale, L., Papadimitriou, M., "Impacts of Strong Parental Support for Trans Youth: A Report Prepared for Children's Aid Society of Toronto and Delisle Youth Services", Trans PULSE, 2012, p. 3, available at http://transpulseproject.ca/wp-content/uploads/2012/10/Impacts-of-Strong-Parental-Support-for-Trans-Youth-vFINAL.pdf, accessed 31 October 2014.

medical staff play significant role in the process and they may have either positive or negative impact on it, depending on what their approach is. This is why the next section will look at the role of the medical professionals, which will be enriched by statements from two doctors working directly with trans* youth. The discussion will be also strengthened by exploring the third actor identified as significant for well-being of young trans* people, i.e. non-governmental organizations.

5.2 The Role of Medical Professionals and Non-Governmental Organizations

"The role of the physician is always quite clearly to be an advocate for the patient"[172]

One could think that there is not much to discuss about the role of doctors because traditionally they are supposed to "do no harm", which does not seem to be too complex of an issue. It is, however, often forgotten that there is a lot of power and authority coming with the profession. This in turn results in situations when people often rely unconditionally on them for assistance and most importantly for providing 'the correct' treatment. In some situations, such as straightforward cases of removing appendix, operating on gallbladder or heart, leaving decisions to professionals does not carry any significant risks. They know what to do and there is no space for personal opinions of the patient, it is not up to them to keep the gallbladder or appendix or not. The power that doctors have, however, is of a great importance when it comes to trans* specific services because sometimes it may be misused.

According to dr. Shuvo Ghosh, the role of the physician is always to be an advocate for the patient.[173] He stressed also that everything that is done must follow a practice pathway of not

[172] Interview with Shuvo Ghosh.
[173] Ibid.

alienating family members or caregivers whenever possible.[174] Otherwise, in the case of dealing with minors, the situation may end up in lengthy legal battles with much time wasted.[175] What it meant by this is that the aim is to be able to receive consent for early intervention, which is crucial when it comes to supporting trans* youth. While legal procedures may take up to two or three years, puberty is completed, which defeats the whole point of starting puberty blockers in the first place.[176] Dr. Thomas D. Steensma said that for him the role of a medical professional is to guide a patient to the best treatment available.[177] "My goal is that someone who enters this clinic will go out with a better quality of life and is happy."[178]

Similarly, to dr. Ghosh, dr. Steensma admitted that he puts a lot of effort into working with parents and making sure that all parties are on the same page when it comes to the used procedures.[179] He stressed that what is the most important for him is that a young trans* person's needs are heard, taken into account, and that the person actively participates in decision-making.[180] Dr. Ghosh stated that sometimes when young people need puberty blockers, caregivers are hesitant, in which cases he tries his best to explain all the consequences of waiting too long to initiate hormone blockers.[181]

> One specific case included parents who differed on treatment approach, and although they were divorced, each had the right to parental "consent" and opinion for their 12 year-old child [Female to Male trans]. Although the mother spent more time with the child, the father had a fair amount of time with the child too and was quite upset at the thought of using male pronouns or seeing the child in a male appearance with a male name. (…) It is not easy to mediate this kind of intra-

[174] Interview with Shuvo Ghosh.
[175] Ibid.
[176] Ibid.
[177] Interview with Thomas D. Steensma.
[178] Ibid.
[179] Ibid.
[180] Ibid.
[181] Interview with Shuvo Ghosh.

> parent or child-parent conflict but it helps to know that by 14 the child has more "rights" in medical decision-making.[182]

The experience of dr. Steensma falls in line with dr. Ghosh's comment. He also said that disagreements between parents are challenging because building consensus requires time that a child does not always have when blockers are being considered.[183] What he emphasized, however, was that he would be ready to override wishes of the parents in favor of those of a young person.

> We can overrule parental decisions at least when the [adolescents] are 16 but I think when we have the same issue when the child is 14 and it is very clear, we, as a team, always decide to go with the child.[184]

He stressed, thought, that he would do everything in his power to ensure that parents are included in the process and hopefully learn to understand the needs of their child.[185]

> I try to make sure that parents make their decisions with all the known information because sometimes they make their decisions without knowing, for instance, future development or without thinking of things that can happen because of their decision.[186]

Moreover, dr. Steensma agreed that with a young person getting older, they gain more independence and space for expressing their opinions when it comes to their health.

It is interesting that dr. Steensma was so determined to follow a young person's voice, especially because in the Netherlands the age of consent is 16. When Bastiaan France, was asked about it, he admitted to be unfortunately bound by limitation of the law, which meant his NGO was unable to provide any services to young people below 16 years old without agreement from

[182] Interview with Shuvo Ghosh.
[183] Interview with Thomas D. Steensma.
[184] Ibid.
[185] Ibid.
[186] Ibid.

legal guardians.[187] Franse said that a young person could ask for support or access to one of their services, such as concealing, group meetings with peers and support with school, provided that they are 16 or have permission from their parents.[188] Such a situation is challenging because there is still a lot of fear around coming out trans* person, but Franse stated that in majority cases parents are supportive. Although he has not encountered many problematic situations, he admitted that the services are given to those who seek assistance themselves, which unfortunately translates in majority of cases into a very white Dutch audience.[189] It means that youth from other ethnic backgrounds widely present in the Dutch society like Surinam, Morocco, or Turkey do not reach out to TransVisieZorg.[190] It may be caused by many issues, such as lack of support from parents, fear of racism within trans* communities, or difficulties in accessing Amsterdam due to socio-economic status, to name a few.

What is important to stress in the discussion about the role of the medical professionals and NGOs is their cooperation and its impact. All three interviewees emphasized that it is crucial for them to have a connection with the other actors in the field. Dr. Ghosh said that he worked with community-based groups and they were creating their own foundation which would help to provide some services to trans* youth.[191] This in return would ensure that support from NGO sector and medical expertise would be accessible in one place making it much easier for the youth and their caregivers. Dr. Ghosh also said

[187] Interview with Bastiaan Franse.
[188] Ibid.
[189] Ibid.
[190] Ibid.
[191] Interview with Shuvo Ghosh.

> (…) some of these groups [working with trans* youth] contact me so they can better tailor their work to the needs of trans* youth, since we are a medical and psychological resource for the gender non-conforming community here in Québec.[192]

It is admirable that trans* NGO sector in Québec trusts the medical professionals in such a way. Historically, there used to be a lot of hostility and distrust towards the medical establishment. It was due to the fact that the medical world approach(ed) trans* identities as mental disorders which need(ed) to be cured and there was/is no consideration for the belief that there are more than two genders.

In the Netherlands, there is a certain level of cooperation between doctors and trans* NGOs, however, not as close as in Québec. Dr. Steensma thought that such a state of play could be a result of historical differences and fights regarding protocols being used by the gender clinic.[193] Even though approaches changed a lot, he concluded that those feelings still might be there, which exposes their cooperation for challenges.[194] The organizations target the gender clinic to advocate for changes in applied protocols in order to acknowledge developing trends in gender non-conforming, non-binary, and genderqueer gender identities as well as more tailored individual services. Franse from TransVisieZorg said

> what is happening now is that medical system follows the law and not changes in kids bodies. Puberty hits at the age more or less 10 and up but the law still says 12 or later, which is too late for many and leaves permanent changes. So now the [gender] clinic is looking into a possibility to follow body development instead. It is almost asking for case-by-case approach depending on individual development. But it still should be done in a bigger framework.[195]

[192] Interview with Shuvo Ghosh.
[193] Interview with Thomas D. Steensma.
[194] Ibid.
[195] Interview with Bastiaan Franse.

It is clear that the organization bases its arguments on needs coming directly from trans* youth. The approach is based on lived experience rather than on structured and pre-defined medical protocol, which doctors must follow. Dr. Steensma admitted that lived experience is a valid reason for receiving services, however, he must be convinced without a doubt that if he provides trans* specific care to a young person, he would not cause harm.[196] According to him, transitioning, even if only socially, can have a lot of unforeseen consequences for both, the young person and their parents, and they need to be well prepared for them.[197] A closer cooperation with NGOs and creating plans of action that would address both social challenges of transitioning and potential need of medical treatment could be a solution for existing discrepancies between the two communities.

Such a cooperation would be beneficial for all parties involved, most importantly trans* youth. Due to the fact that young people are still dependent on their parents, there is a high risk of them not coming-out out of fear, which could result in further stigma and/or health problems. All three interviewees stressed that it is crucial that they facilitate communication between the parents and trans* youth. A young person does not live in a vacuum and any services or treatment they would receive would be visible causing difficulties at home without a proper strategy. Instead, the young trans* person should go through the process having support from their family. This is where NGOs and medical professionals have a lot of tools to offer support and ensure well-being of trans* youth.

[196] Interview with Thomas D. Steensma.
[197] Ibid.

5.3 The Opposition

Apart from the supportive system built up from parents, medical professionals and NGOs discussed above, it would be a serious flaw not to mention the voices opposing trans* issues in general and providing trans* youth with services in particular. There have been several instances where different people expressed their discontent and even open hostility towards the idea of letting young people access puberty blockers or experiment with their gender expression or identity.

During his interview, dr. Ghosh admitted that there are overtly vocal religious groups in North America that are against the concept of 'trans*'.[198] One of such examples is Pastor Sean Harris of Berean Baptist Church in Fayetteville in South Carolina, who advised beating up children who break normative gender roles. Even though his sermon addressed homosexuality, his arguments were about gender expression and gender roles, which directly relate to trans* youth and children.[199]

> So your little son starts to act a little girlish when he is four years old and instead of squashing that like a cockroach and saying, "Man up, son, get that dress off you and get outside and dig a ditch, because that is what boys do." You get out the camera, and you start taking pictures of Johnny acting like a female, and then you upload it to YouTube, and everybody laughs about it, and the next thing you know, this dude, this kid, is acting out childhood fantasies that should have been squashed.[200]

Obviously, statements like this do not take into account the harm that it would cause to a child and what long-term consequences the child would suffer. What is in focus is norms, which

[198] Interview with Shuvo Ghosh.
[199] Cassie Murdoch, "Horrible Pastor Advocates Beating the Gay Out of Young Kids", *Jezebel*, available at http://jezebel.com/5906907/horrible-pastor-advocates-beating-the-gay-out-of-young-kids, accessed 31 October 2014.
[200] Ibid.

according to heteronormativity, every one is supposed to obey. If not, they are exposed to severe punishment. Harris also addressed breaking norms of femininity, ordering parents to correct it:

> [a]nd when your daughter starts acting too butch you reign her in. And you say, "Oh, no, sweetheart. You can play sports. Play them to the glory of God. But sometimes you are going to act like a girl and walk like a girl and talk like a girl and smell like a girl and that means you are going to be beautiful. You are going to be attractive. You are going to dress yourself up."[201]

Yet, again each of the pieces of 'advice' is based on normative approach to gender, which is harmful to everyone in the society but especially young people who are in a process of defining who they are.

Opposing voices do not only come from religious communities. There are also doctors specializing in trans* youth who prefer to take rather suppressive approach to gender identity. Dr. Ken Zucker, who is a head of the Gender Identity Service at the Centre for Addiction and Mental Health in Toronto, is a proponent of "a watch-and-wait approach [advising] parents of princessy six-year-olds to say, 'You're not a girl. You're a boy.'"[202] Zucker's infamous strategies have not been met with appraisal from the international trans* community or majority of his peers. Dr. Ghosh said

> historically we have had a Toronto-based model for the whole country and this was a negative model, but this is changing, through my clinic, the ones in Vancouver, and a few others around the country, including smaller ones in Toronto where they are challenging the old mentality.[203]

Zucker's approach was based on forcing youth who was uncomfortable with their gender identity or gender expression into going back to the roles they did not want. For instance, he repeatedly advised parents of a child assigned male at birth who clearly preferred to live in a role of a girl,

[201] Murdoch.
[202] Margaret Wente, "Transgender Kids: Have We Gone too Far?", *The Globe and Mail*, available at http://www.theglobeandmail.com/globe-debate/transgender-kids-have-we-gone-too-far/article16897043/, accessed 31 October 2014.
[203] Interview with Shuvo Ghosh.

to take away all toys, which could be labeled girly.[204] They were also supposed to do their best to "extinguish his identifications with female characters and female gender expressions"[205]. According to the mother, after employing dr. Zucker's strategy, the child "didn't want to go to school anymore. (…) It [was] very hard for him. He'll disappear and close the door, and we'll find him playing with dolls (…) and the stuff that he's drawn to"[206]. Such an approach is cruel and only perpetrates oppression that trans* people face on daily basis being forced to fit it roles that the society designed for them. There is no need to expose children and youth to it prematurely.

Another opposing perspective comes from so-called 'allies' of trans* movement. Ms. Dreger, who is a bioethicist and professor at Northwestern University's Feinberg School of Medicine in Chicago, is a self-proclaimed supporter of trans* community.[207] Even though she claims to support trans* rights, she openly expresses her 'buts' related to strategies used by trans* movement in regards to trans* youth. She argues it went too far, which also includes accusing parents of forcing their children to transition.[208] From a perspective of a trans* advocate, allies do not get to question methods and strategies used by groups they claim to support. The battles fought are not theirs and it is impossible for them to contribute with real lived experiences of the group. Allies' role is to support and assist when asked to, to provide advice if necessary and possible, to listen and follow the needs of the group they are with. However, it is not their role to challenge the needs and the real life experiences of that group, for

[204] Ehrensaft, p. 105.
[205] Ibid., p. 105.
[206] Alix Spiegel, "Two Families Gapple with Son's Gender Preferences", National Public Radio *All Things Considered*, 7 May 2008 in Ehrensaft, pp. 105-106.
[207] Wente.
[208] Ibid.

the simple reason of not being able to share this very knowledge. This is what Ms. Dreger has been doing with her accusations and misguided judgments.

There is yet another perspective which questions an early interventions available for trans* youth. It comes from within trans* community. It does not directly oppose the idea of puberty blockers or cross-sex hormonal treatment early in life but it is rather a voice expressing worry regarding the future of trans* community. Alexis Rivera, a trans* activist working at the Transgender Law Center in the United States, argued that

> [i]f medical technology keeps advancing, are we going to eradicate transgenderism? The younger the transition starts, the younger you start socializing a biological female as a boy, they're not going to have that transgender identity.[209]

Even though the argument is legitimate from the perspective of the movement, it cannot serve as an excuse to deprive young people access to the relevant treatment. It would be in direct contradiction to what the trans* community advocates for, which is non-discrimination, better quality of life, and well-being of *all* trans*, gender variant, gender non-conforming and other gender-questioning people. Moreover, as dr. Steensma stated, regardless of how good services for young people are, there will always be trans* people over the age of 18 coming out because of different stages of identity development.[210] Consequently, trans* community will always consist of young people. The responsibility of the trans* movements is in this situation to educate young generation and make sure that they embrace their trans* identities or trans* experiences and live openly and be part of the community.

What is very clear after seeing the opposition's arguments, it is that there is a complete

[209] Lauren Smiley, "Girl/Boy Interrupted", *SF Weekly*, 2007, available at http://www.sfweekly.com/sanfrancisco/girlboy-interrupted/Content?oid=2163302&storyPage=4, accessed 2 November 2014.
[210] Interview with Thomas D Steensma.

lack of any consideration for human rights of trans* youth. There is no rights language used, instead it is based on artificially constructed norms which only aim is to oppress and restrict young people, but also others in the society. Based on what Bastiaan Franse said, trans* youth must know the language of rights and know that they can have a voice to claim what they need or want.[211] In other words, there is a need for education targeting young trans* people so that they are aware of mechanisms that safeguard their access to necessary services. Such awareness raising process should also include making young people conscious of options they have when it comes to living their gender identities or gender expressions. Moreover, young trans* people should be aware of the specific roles that their parents and/or medical doctors plan in their lives in order for them to be able to exercise different levels of autonomy in decision-making. Education on the well-being of trans* youth should also target parents and medical professionals so that there is a strong commitment to designing strategies of including young people in decision-making process and providing needed care.

5.4 Chapter Conclusion

The aim of this chapter was to look at what roles parents, NGOs and medical establishment play in ensuring well-being of trans* youth. It became clear that these stakeholders are interconnected and interdependent when it comes to health of young people. It is impossible for only one of them to ensure proper services or health care for gender non-conforming youth. After analysis of the roles and consequences coming from inappropriate performance of each of them, a conclusion can be drawn that all three must act as a well oiled machine in order for the system to work and for trans* youth to receive proper services. What is crucial in the process is

[211] Interview with Bastiaan Franse.

communication between all actors but also without exclusion of young people and they should always be in the center of decision-making. Even though it has been showed that the opposition exists and attempts to undermine the efforts of the supporters, it has to be kept in mind that their arguments lacked human rights perspective. Moreover, their arguments focus on normative and oppressive discourse which aims at sustaining heteronormative gender order, no matter the cost. The opposition standpoints are deficient in merit and are not based on reliable sources.

Recommendations

The thesis explored the issue of well-being of trans* youth from using human rights-based approach. It also examined intersection of roles of parents, medical professionals and non-governmental organizations. Since such a combination of approaches has not been used before, a set of recommendations to all three mentioned stakeholders is provided below in order to contribute to the developments in the field of trans* specific health care and trans* movement as a whole.

- Human rights-based approach should be used to advocate for improvements in trans* youth-specific health care.
- The right to bodily integrity should be in focus when dealing with trans* people and not age of consent as imposed restrictions violate the right to bodily integrity. The ability to consent is a secondary matter and should not influence negatively one's rights to bodily integrity and autonomy. Everyone has the right to bodily integrity; this includes persons who are deemed incapable of giving or withholding consent to medical treatment.

- Trans* youth should be ensured that their privacy and confidentiality of their medical treatment information is secured and they are not forced to share their medical information with their parents. Respect for private life is crucial for trans* youth and the lack of privacy and compromised confidentiality have a chilling effect on patients, who may be frightened to seek assistance or treatment.
- Capacity to make decisions should not be connected with age but rather to maturity of a person in question. A young person who does not have capacity to make decisions independently should be given support in the process.
- There should be no age limitation imposed on accessing irreversible procedures, such as surgeries or cross-sex hormonal treatment. Instead, a maturity assessment process should be in place when a young trans* person would wish to access them.
- Parents should allow their trans* children to decide what services they need and what plan of action they would want to follow in order to feel well in their body and identity. The parents should ensure that no one violates the rights of their child. They should communicate with the health service providers and act as advocates for their children. The parents should speak about the needs of trans* youth, about non-binary identities, and do their best to educate themselves and people around them, including medical staff or other family members.
- The role of the parents should focus on guidance and trust in their children abilities to know what their needs are. Any decision should be taken only after consulting all interested parties, including the doctors but most of all, the child in question.
- Medical professionals working with trans* should educate themselves on issues related to lived experiences of their patients and be active and pro-active actors in ensuring the well-being of trans* youth.

- Standards of care employed to provide health care for trans* youth should follow World Professional Association for Transgender Health *Standards of Care for the Health of Transsexual, Transgender, and Gender Non-Conforming People*.
- All trans* identities, including those falling out of gender binary should be given due consideration and respect by parents, medical professionals and NGOs. Young people should be granted access to necessary services without being forced to live in one of the two binary genders.
- Medical professionals and NGOs working with trans* youth and their parents should establish close cooperation. They should create plans of action that would address both social challenges of transitioning and potential needs for medical treatment. It would also create a supportive network for young trans* people.
- NGOs and medical professionals should support the process of participation in decision-making and ensure that trans* youth's voice is heard. As professionals they should strive to educate and support parents of trans* youth as they have a lot of tools to ensure well-being of trans* youth.
- There should be an education program in place targeting young trans* people in order to familiarize them with human rights and other legal mechanisms that safeguard their access to necessary services. This should include parents and medical professionals.
- Trans* movements should invest time and resources in educating young generation about their history, experiences and culture to ensure that they embrace their trans* identities or trans* experiences as well as live openly and are part of the community.

Conclusion

A growing number of young people claiming trans* specific health care, such as puberty blockers, counseling, or cross-sex hormonal treatment forces parents, medical professionals and NGOs providing support to re-define their approaches. Due to the fact that people aged 14 – 18 have not yet reached legal maturity majority of medical decisions are made by their parents or legal guardians. This results in their access to necessary services being restricted causing serious consequences for their health and well-being. Their vulnerability in this respect is perpetuated by standing legal framework further limiting their capacity to autonomous decision-making, as well as attitudes of medical doctors and (non)existence of supportive NGOs.

Human rights instruments, such as the United Nations Convention on the Rights of the Child contains provisions fundamental for ensuring well-being of trans* youth. The right to be heard and the right to participate in decision-making are crucial for making sure that young people receive health care services properly tailored to their needs. The two provisions are interrelated and interdependent. The young person must be able to express their opinions and requests and they must be actively taken into account during decision-making process. Listening to the wishes is not enough, there has to be an active participation of the young person who is able to make decisions, either independently or with support. The respect for the right to be heard and the right to participate in decisions-making were found to be indispensible in contributing to well-being of trans* youth.

Moreover, it was established also that the right to privacy plays an important role in young trans* people's health. It was especially apparent when examining relevant case law of the European Court of Human Rights regarding the right to bodily integrity and autonomy. It is said

that the right to bodily integrity of a young trans* person should always be considered during the process of informed consent, in order to ensure that the provided treatment is done in the best interest of the child. Bodily integrity is also seen as a primary right, which cannot be overruled by someone else, even though the person in question has no (legal) capacity to make their own decisions.

The thesis also examined the roles of three main stakeholders, who were believed to have a significant impact on the well-being of trans* youth. The responsibilities of parents, medical professionals and NGOs working to support trans* youth and their parents were analyzed. It became clear that regardless of the different nature of obligations these stakeholder have towards trans* youth, it was critical that they work together, communicate with each other and create a common plan to provide the best services possible. What was found for all the actors, however, was that they all need to put the needs of young people into focus. They must ensure active participation of trans* youth in decision-making, and provide support for it where necessary.

Interviews conducted with medical professionals in Montreal and Amsterdam proved that it is fundamental for doctors to be their patients' advocate and guide them to the best service possible. It was also found that the existing legal regulations on age limit for giving consent is not always helpful for the youth and not always appreciated by the doctors. The framework does not take into account mental or bodily development of youth and provides only for a strict age focused procedures.

The research showed that there is a clear disconnection between a system providing health care for trans* youth and human rights framework. There is a need for awareness raising about human rights instruments relevant for ensuring the well-being of trans* youth, among all named stakeholders, including trans* youth. The role of human rights is not taken into account

when working with trans* youth. It creates an impression that the issues at hand should or can be dealt with only using medicalized approaches, which is a flawed method. Ensuring well-being of people by using human rights based approach has proven to be helpful in cases of other groups, such as for instance people with disabilities, and its potential for trans* youth should be investigated.

The thesis concludes with a set of recommendations to relevant stakeholders in order to contribute to the developments in the field of trans* specific health care as well as to serve a support tool for trans* movement. They were formulated to address the deficiency of the existing medical and legal systems as has been shown in the thesis.

Bibliography

Primary Sources

Civil Code of Québec, LRQ, c C-1991, CanLII, URL: https://www.canlii.org/en/qc/laws/stat/lrq-c-c-1991/.

Dutch Medical Treatment Contracts Act (WGBO), Rijksoverheid, Patiëntenrecht en cliëntenrecht, Rechten in de zorg, URL: http://www.rijksoverheid.nl/onderwerpen/patientenrecht-en-clientenrecht/rechten-in-de-zorg.

Committee on the Rights of the Child, General Comment No 4 (2003) Adolescent health and development in the context of the Convention on the Rights of the Child, CRC/GC/2003/4.

Council of Europe, Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, Oviedo 1997, URL: http://conventions.coe.int/Treaty/en/Treaties/Html/164.htm.

Medical Consent of Minors Act, (New Brunswick) SNB 1976, c M-6.1, CanLII, URL: https://www.canlii.org/en/nb/laws/stat/snb-1976-c-m-6.1/latest/snb-1976-c-m-6.1.html.

UN Committee on the Rights of the Child, *General Comment no. 4 (2003), Adolescent health and development in the context of the Convention of the Rights of the Child*, CRC/GC/2003/4.

UN Committee on the Rights of the Child, *General Comment no. 12 (2009), The Right of the Child to be Heard*, CRC/C/GC/12.

UN Committee on the Rights of the Child, *General Comment no. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, CRC/C/GC/15, 2013.

UN Convention on the Rights of the Child, 1989.

Secondary Sources

Aldersson, P., ”Young children’s health care rights and consent” in Franklin, Bob (ed.) *The New Handbook of Children’s Rights: Comparative Policy and Practice*, London: Routledge, 2003.

American Psychiatric Association, “Gender Dysphoria”, URL: http://www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf.

ANSO, Association of Nordic and Pol-Balt LGBT Student Organizations, *Students for Transgender Inclusion*, 2008.

Ashley C., “Transgender Kids in the Spotlight for LGBT Rights” at *ArtInFactMag*, URL: http://www.artinfactmag.com/culture-dish/transgender-kids/.

Brennan, S., Noggle, R., ”The Moral Status of Children’s Rights, Parents’ Rights, and Family Justice” in *Social Theory and Practice,* Vol. 23, No. 1, pp. 1-26, 1997.

“Boys will be Girls”, Part 1/4 URL: https://www.youtube.com/watch?v=u-DjtvAPOhE.

Brömdal, A., *Intersex: A Challenge for Human Rights and Citizenship Rights*, VDM Verlag Dr. Müller Aktiengesellschaft & Co. KG, 2008.

Butler, J., *Undoing Gender*, Rutledge, New York, 2004.

Campbell, A., *Contemporary Challenges in the Law of Consent* – presentation, McGill University, Faculty of Law, URL: http://goo.gl/kHFycB.

Cave, E., ”Goodbye *Gillick*? Identifying and Resolving Problems with the Concept of Child Competence” in *Legal Studies*, Vol. 34 No. 1, 2014.

Coleman, E., Bockting, W., et all, ”Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People, Version 7” in *International Journal of Transgenderism*, Vol. 13, 2011.

Cohen-Kettenis, P.T., Delemarre-van de Waal, H. A., Gooren, L. J. G., ”The Treatment of Adolescent Transsexuals: Changing Insights” in *International Society for Sexual Medicine*, (2008) 5: 1892-1897.

Coppock, V., ”Medicalising children’s behaviour” in Franklin, B., (ed.) *The New Handbook of Children’s Rights: Comparative Policy and Practice*, London: Routledge, 2003.

Council of Europe Commissioner for Human Rights, *Discrimination on Grounds of Sexual Orientation and Gender Identity,* Council of Europe Publishing, Strasbourg, 2011.

De Vires, L.C. A., McGuire K. J., et all, “Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment” in *Pediatrics* peds. 2013-2958; published ahead of print September 8, 2014, doi:10.1542/peds.2013-2958, URL: http://tinyurl.com/puo362x.

Donnelly, M., *Healthcare Decision Making and the Law: Autonomy, Capacity and the Limits of Liberalism*, Cambridge University Press, 2010.

Donnelly, M., and Kilkelly, U., ”Child-Friendly Healthcare: Delivering on the Right to Be Heard” in *Medical Law Review,* Vol. 19, 2011.

Dowson, T., “Why Queer Archaeology? An Introduction” in *World Archaeology, Queer Archeology*, (2000) 32:2, 161-165.

Educaloi, “Medical Decisions for Children 14 to 17 Years Old”, URL: http://www.educaloi.qc.ca/en/capsules/medical-decisions-children-14-17-years-old.

Ehrensaft, D., *Gender Born, Gender Made: Raising Healthy Gender-Nonconforming Children*, New York: The Experiment, LLC, 2011.

Ferguson, M. J., ”Queering Methodologies: Challenging Scientific Constraint in the Appreciation of Queer and Trans Subjects” in *The Qualitative Report,* 2013, Vol. 18, Article 25, 1-13.

Flyvvbjerg, B., “Five Misunderstandings about Case-Study Research” in *Qualitative Inquiry,* (2006) 12 (2): 219-245.

Franklin, B., ”Children’s rights and media wrongs: Changing representation of children and the developing rights agenda” in Franklin, Bob (ed.) *The New Handbook of Children’s Rights: Comparative Policy and Practice*, London: Routledge, 2003.

Gender Creative Kids, URL: http://gendercreativekids.ca.

Green J. F., Friedman, M., (eds.), *Chasing rainbows: exploring gender fluid parenting practices*, Demeter Press 2013.

Hein, M. I., Troost, W. P., Lindeboom, R., et all, “Assessing children’s competence to consent in research by a standardized tool: a validity study” in *BMC Pediatrics* 2012, Vol.12, Issue 156, URL: http://www.biomedcentral.com/1471-2431/12/156.

Hird, M., J., “Naturally Queer” in *Feminist Theory* (2004) 5:85, 85-89.

Kennedy, P., ”Q&A with Norman Spack”, *Boston Globe*, URL: http://www.boston.com/bostonglobe/ideas/articles/2008/03/30/qa_with_norman_spack/?page=full.

Jackman, M., MD, MSc, FRCPC and McRae, A., MD, PhD, FRCPC, *Medical Decision-Making and Mature Minors*, URL:

http://www.royalcollege.ca/portal/page/portal/rc/common/documents/bioethics/section1/case_1_5_2_e.html.

Maclean, A., *Autonomy, Informed Consent and Medical Law: A Relational Challenge*, Cambridge University Press, 2009.

McNamara, C., *General Guidelines for Conducting Interviews*, URL: http://managementhelp.org/businessresearch/interviews.htm.

Murdoch, C., "Horrible Pastor Advocates Beating the Gay Out of Young Kids", *Jezebel*, URL: http://jezebel.com/5906907/horrible-pastor-advocates-beating-the-gay-out-of-young-kids.

Prout, A., James, A., "A new paradigm for the sociology of childhood?' in A James, A., and Prout, A., (eds), *Constructing and Reconstructing Childhood: Contemporary Issues in the Sociological Study of Childhood*, London: Routledge/Falmer, 1990.

Raising My Rainbow: Adventures in Raising a Fabulous, Gender Creative Son, URL: http://raisingmyrainbow.com.

Right to Informed Consent – Minors, the Netherlands, URL: http://europatientrights.eu/countries/signed/netherlands/netherlands_right_to_informed_consent_minors.html.

Schneider, B. S., "Producing Homeplace: Strategic Sites and Liminoid Spaces for Gender-Diverse Children".

Sivonen, L., "Gender Identity Discrimination in European Judicial Discourse" in *Equal Rights Review*, 2011:7, 11-26.

Shier, H., "Pathways to Participation: Openings, Opportunities and Obligations: A New Model for Enhancing Children's Participation in Decision-making in line with Article 13.1 of the UNCRC" in *Children and Society*, Vol. 15, 2001.

Smiley, L., "Girl/Boy Interrupted", *SF Weekly*, 2007, URL: http://www.sfweekly.com/sanfrancisco/girlboy-interrupted/Content?oid=2163302&storyPage=4.

Spiegel, A., "Two Families Gapple with Son's Gender Preferences", National Public Radio *All Things Considered*, 7 May 2008.

Transgender Health Information Program of Vancouver Coastal Health is a center providing information within British Columbia on trans* specific health care and available support, URL: http://thip.vch.ca.

TransYouth Family Allies, Puberty Inhibitors, URL: http://www.imatyfa.org/permanent_files/pubertyblockers101.html.

Travers, R., Bauer, G., Pyne, J., Bradley, K., Gale, L., Papadimitriou, M., "Impacts of Strong Parental Support for Trans Youth: A Report Prepared for Children's Aid Society of Toronto and Delisle Youth Services", Trans PULSE, 2012, p. 3, URL: http://transpulseproject.ca/wp-content/uploads/2012/10/Impacts-of-Strong-Parental-Support-for-Trans-Youth-vFINAL.pdf.

Van Dijk, T., "Critical Discourse Analysis" in *The Handbook of Discourse Analysis*, eds. Hamilton, H., Schiffrin, D., and Tannen, D. Blackwell Publishers Ltd: Oxford (2001), 352-371.

Vooris, J. A., "Trapped in the Wrong Body and Life Uncharted: Anticipation and Identity Within Narratives of Parenting Transgender/Gender Non-conforming Children" in Fiona Joy Green and May Friedman, (eds.), *Chasing rainbows: exploring gender fluid parenting practices*, Demeter Press 2013.

Wente, M., "Transgender Kids: Have We Gone too Far?", *The Globe and Mail*, URL: http://www.theglobeandmail.com/globe-debate/transgender-kids-have-we-gone-too-far/article16897043/.

White Holman, C., Goldberg, J., "Ethical, Legal, and Psychological Issues in Care of Transgender Adolescents" in *Caring for Transgender Adolescents in BC: Suggested Guidelines*, Vancouver Costal Health, Transcend Transgender Support & Education Society, and the Canadian Rainbow Health Coalition, 2006.

Winick, B., "The Right to Refuse Mental Health Treatment: A Therapeutic Jurisprudence Analysis" in *International Journal Psychiatry* Vol. 99, Issue 17, 1994.

Wood, J., "These Kids Are All Right, Too", *Infoplease,* URL: http://www.infoplease.com/us/education/transgender-children.html#ixzz3HikRnXpx.

World Professional Association for Transgender Health, Standards of Care for the Health of Transsexual, Transgender, and Gender Non-Conforming People, 2001.

Yogyakarta Principles on Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity, 2006.

Cases

European Court of Human Rights, *Glass v United Kingdom*, Application no. 61827/00, Judgment 9 March 2004.

European Court of Human Rights, *MS v Sweden*, Application no. 74/1996/693/885, Judgment 27 August 1997.

European Court of Human Rights, *Pretty v United Kingdom,* Application no. 2346/02, Judgment 29 June 2002.

European Court of Human Rights, *Z v Finland,* Application no. 22009/93, Judgment 25 February 1997.

Gillick v West Norfolk & Wisbech Area Health Authority [1986] AC 112 House of Lords, URL: http://www.bailii.org/uk/cases/UKHL/1985/7.html.

High Court of Australia, *Department of Health and Community Services v JWB and SMB (Marion's Case)*, [1992] HCA 15; (1992), URL: http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/cth/high_ct/175clr218.html?stem=0&synonyms=0&query=title(175%20CLR%20218.

Supreme Court of Canada, *A.C. v. Manitoba (Director of Child and Family Services)*, 2009, SCC 30, URL: https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/7795/index.do.

The Queen on the application of Sue Axton v The Secretary of State for Health (The Family Planning Association: intervening) [2006] EWHC 37 (Admin), Case No: CO/5307/2004, URL: http://www.familylawweek.co.uk/site.aspx?i=ed1583.