Trans-Children[1]: Between Normative Power and Self-Determination[2]

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Summary

People who do not conform to sex and/or gender norms often encounter reactions of shock and/or bewilderment. Not conforming to dominant representations of sex and gender through the mere act of being one's self seems to provoke defensive reactions, including rejection, shaming, and even physical violence, in others – reactions that are rooted in the aggressor's fears and/or insecurity about their own sex/gender. This type of reaction indicates that firmly entrenched sex/gender norms continue to prevail in society. In the medical profession, which has wide-reaching normative power, not meeting certain normative sex/gender-related representations has been declared pathological. This process of pathologizing an individual includes a number of different treatments, which are currently the subject of controversial debate throughout the medical profession as a whole and within its individual disciplines. The people actually affected by such pathologizing are often excluded. Their perspectives and voices, particularly those of children, receive scant, if any, notice.

1 | Children whose sex and gender (German: Geschlecht; French: sexe/genre) assigned at birth deviates from their sex/gender related self-perception (in German: geschlechtliche Eigenwahrnehmung; in French: auto-perception sexuée/genrée) and sex/gender-related self-determination (in German: geschlechtliche Selbstbestimmung; in French: auto-détermination sexuée/genrée), their sex/gender identity (in German: Geschlechtsidentität; in French: identité sexuée/genrée) and/or their sex/gender expression. The author wishes to point out that in French (unlike in German and English) the term 'identité sexuée' comprises a further distinction which suggests a bodily dimension of identity. Here, it should be noted that the author uses the term 'trans children', because it encompasses the widest possible spectrum of possibilities. The use of this term does not preclude how the children themselves want to be addressed, because only they can give a reliable answer to whether and with which term they feel themselves best described.

2 | Original version in German.

The Experience of Trans Children in the Health Care System – An Excerpt

Children who defy the sex/gender-related representations of Western cultures and instead seek acknowledgement by their parents and the wider environment of their sex/gender-related self-positioning[3,4] are often confronted with a number of problems: Lack of knowledge and the confidence to support these children (RADELUX II 2012: 15, 17, 23), particularly on the part of professionals and parents, negative reactions of adults whose sex/gender binary-based expectations have been destabilized (Voß[5]), pathologization[6] of people whose sex/gender identity[7] deviates from cultural norms (Schneider 2014), conflation with intersexuality[8] (Baltes-Löhr;[9] Groneberg[10]) and sexual orientation,[11] more precisely, homosexuality (Drescher/Cohen-Kettenis/Winter 2012: 568). In an example of the kind of experience reported by parents, the mother of a 16-year-old trans daughter with Trans-Kinder-Netz e.V. (TRAKINE), a German association organized by and for the parents and significant others of trans children, shared the following:

"My first step was to ring the [University Hospital Muenster's Clinic for Child and Adolescent Psychiatry, author's note]. I gave them the background info – that gender identity disorder may be the issue – and asked whether they had experience in this area. This question was answered unreservedly in the affirmative and I then made an appointment. […] But once there [my child and I, author's note] were disappointed – the psychologist told us that she had not dealt with such a case previously. After talking with my child, the psychologist told me that my teenager had serious depression and also suicidal thoughts […]. Panicking that he could actually harm himself, I then also contacted the LWL University Child and Adolescent Psychiatry Clinic in Hamm. He was then treated on a weekly basis as an outpatient for depression. They couldn't help us with the other issue."[12]

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3 | In French: l'auto-positionnement sexuée/genrée; in German: geschlechtliche Selbstverortung.

4 | The author uses this term to denote sex/gender-related self-determination (German: geschlechtliche Selbstbestimmung; French: auto-détermination sexuée). It includes the physically sexed self-perception (German: geschlechtliche Selbstwahrnehmung; French: auto-perception sexuée).

5 | See chapter by Heinz-Jürgen Voß in this volume.

6 | Mechanism by which people whose physical, mental and/or social characteristics do not correspond to any norms are considered and declared sick by physicians.

7 | Yogyakarta-Principles (2006): Definition of gender identity: "[…] each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth", p. 6.

8 | Biological specificities in the differentiation of sex, in which people with intersex bodies in different ways exhibit deviations from the standard sexes, whether female or male. See description of the German Federal Association of Intersexual People; URL: http://www.intersexuelle-menschen.net/intersexualitaet/ [31.12.2013].

9 | See Christel Baltes-Löhr's chapter: 'Always gender – always different'.

10 | See chapter by Michael Groneberg.

11 | Yogyakarta-Principles (2006): Definition of sexual orientation: "[…] each person's capacity for profound emotional, ability to be affectionate with [in place of affectional in the original text, author's note] and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender or more than one gender.", p. 6.

12 | TRAKINE: Report. URL: http://www.trans-kinder-netz.de/pdf/Mutter_eines_16_jaehrigen_Transmaedchens.pdf [16.08.2013].183 (in German).

Some families assume a high burden to find appropriate medical treatment for their child, as the following report shows:

"We have to travel from Bodensee [Lake Constance in southern Germany, author's note] to the university clinic in Hamburg, which of course takes a great toll, both physically and financially. Specialists who believe that development should progress naturally, and who don't try to cure something that can't be cured, still aren't available in our area. This type of approach, which we consider appropriate for our child, is only available in Hamburg."[13]

Staff changes can also lead to the threat of halting already commenced hormone treatment to delay puberty, and this can pose another stress:

"The hormone blockers [puberty-delaying hormones, author's note] gave him a stability that allowed him to consider starting anew in a different school, where no one knew him. Consequently, his social anxiety decreased significantly. When the endocrinologist rang us to say that they intended stopping our child's treatment, our son was devastated, because without the blockers a new start was impossible. The nightmare scenario of having to go through female puberty, which could have negatively affected his future physical development as an adult man, was a setback that saw him unable to imagine being accepted at the new school suggested to him. He felt like his difference would once again single him out and he would be in the same boat as at the current school, which he had attended since childhood, and where he felt victimized."[14]

These anecdotes, along with many other reports and life experiences, demonstrate the need for a different approach by the medical profession to trans children and their families. Medical intervention has to prioritize the needs of these children and their families. The social mandate of the health care system should be to improve their quality of life. Examination of how sex/gender is understood within medicine can give some clues as to how this can be achieved.

The medical perspective on sex/gender

That human sex and gender is constituted as a binary seems to be an unshakable tenet of the medical profession, despite the fact that it is neither demonstrated by scientific evidence, nor borne out by closer observation of individuals (Voß[15]). Sex as well as gender cannot be subdivided into just two variations that can be considered strictly independent of each other on the level of biology, psychology

13 | Trakine: Report. URL: http://www.trans-kinder-netz.de/pdf/Lenas_Mutter.pdf [14.02.2014].
14 | Intersex & Transgender Luxembourg a.s.b.l. (previously Transgender Luxembourg, 2012): Field report.
15 | See chapter by Heinz-Jürgen Voß in this volume.

or sociology. Instead, humans tend to traverse the range between the two ends of the spectrum on all three levels. Despite this diversity, in most societies, a child is assigned to either the group girl or boy at birth according to their genitalia. Anyone whose characteristics defy the assumed unambiguousness is in danger of being declared sick and made unambiguous by physicians – who claim for themselves the definitional sovereignty for the terms 'disease' and 'need for treatment'. (Fausto-Sterling 1993: 23; Woweries[16]).

How a person will come to position themselves in terms of sex/gender – i.e. which sex and/or gender, if any, an individual considers themselves as belonging to or identifies with or which sex/gender identity they develop – cannot be predicted at birth. Not only the experiences of trans children, but of intersex children as well, testify to this (see Woweries[17]). Cultural sex/gender related representations vary and a number of more or less prescribed possibilities for sex/gender transition (physical and social/in terms of an individual's relationship to themselves and/or their relationship to their surroundings) are known (see Baltes-Löhr[18]). Not all cultures fall back on the concept of sex/gender binarism and the mechanism of pathologization to rationalize the existence of people with characteristics that fall outside of the sex/gender binary and to "rescue" the latter (see Rauchfleisch 2012: 187; Schneider 2014). According to Langer/Martin (2004: 4), scientifically validated criteria for distinguishing between normal and pathological sex/gender identity or gender behaviour do not exist. Existing scientific data do not suffice to empirically answer whether a diagnosis of pathological sex/gender identity disorder can be attributed to a psychological disorder, a physical disorder of some other genesis, or is in fact even a disorder at all (Cohen-Kettenis/Drescher/Winter 2012: 573). Additionally, the categorization of transsexualism as a psychological disorder is increasingly being questioned (Alessandrin 2013: 57; Becker 2012: 26; Rauchfleisch 2012: 23).

The need to stop considering transsexuality as a pathology (see Sigusch 2011: 286) and especially as a psychiatric disease (Becker 2012: 26-27) is to some extent recognized in psychiatry and across medical disciplines. The solutions proposed in this context continue to emphasize the importance of making a hormonal treatment and surgical reassignment available as part of the health insurance system (Becker 2012: 27; Cohen-Kettenis/Drescher/Winter: 573; Rauchfleisch 2012: 35). Notwithstanding these advances, steps backward can also be observed, for instance the fact that psychiatry has for the first time become anchored in the discussion around reimbursement. In some circles the role of

16 | See chapter by Jörg Woweries. 'Who has a disorder? Who gets to decide?'
17 | See chapter by Jörg Woweries: 'Intersex – medical measures on the test bed'.
18 | See chapter by Christel Baltes-Löhr: 'Always gender – always different'.

psychiatry is actually being given new emphasis in terms of approving health insurance coverage for sex/gender transition measures. For example, a ministerial decree[19] passed in January 2014 introduced a diagnosis of "syndrome of gender dysphoria", which cannot be scientifically proven, and at least one year of "psychiatric treatment" as prerequisites for health insurance coverage of medical treatment. These and other inappropriate prerequisites are making[20] transition more difficult, particularly for minors, and could lead to human rights violations and contravention of the rights of children.

Another aspect of the medical discourse is its difficulty in distinguishing between sex/gender identity and sexual orientation. Although not the subject of scientific study to date, empirical data[21] gathered via observations in our self-support group show that many trans people of all ages consider and experience their sex/gender identity as separate from their sexual orientation. Despite this, health care professionals pose the question of sexual orientation almost as a matter of course. One reason for this is the prevailing assumption that trans people do not accept their own homosexual orientation and repress it (Korte 2008; Rauchfleisch 2012: 22). Becker (2012: 30) writes of seamless transitions between homosexuality and transsexuality. The extent to which sexual orientation is problematized by professionals (Becker/Möller/Schweizer 2013: 267 ff.) and researchers (Hill et al. 2007: 68), despite the minimal role it plays in the issues faced by many trans people, is astounding. It stands in stark contrast to the lack of reliable data on the sexual orientation, sex/gender identity, and the relationship between these two factors for the population as a whole, which is assumed to be heterosexual and cis-identified.[22]

The paradigm of the sex/gender binary includes the paradigm heteronormativity, according to which individuals are heterosexual by default. Following on from this is the assumption that a trans person simply wants to transition in order to live as a heterosexual. Such hypotheses exclude people who pursue homosexual or bisexual relationships after transition (Rauchfleisch 2012: 66), and those who identify as asexual or pansexual,[23] but who did not identify as heterosexual prior to transition.

Moreover, the diverse terms and definitions along with their inconsistent use and the varying manifold translation between languages, is only given cursory mention. Understanding and definition of terms such as transsexualism,

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19 | Mémorial. Official gazette of the Grand Duchy of Luxembourg. A – N° 232, 30.12.2013. Caisse nationale de santé – Statuts. Annex: "Modifications des statuts de la Caisse nationale de santé Comité directeur du 11 décembre 2013", Point f; page 4301. "Chirurgie plastique à visée esthétique et dysphorie de genre", 1° g) f. URL: http://www.legilux.public.lu/leg/a/archives/2013/0232/a232.pdf [06.01.2013].

20 |Transitioning to another gender role, which can also lie outside of the sex/gender binary.

21 | Author's observation (2009-2012) in the self-support group of Transgender Luxembourg.

22 | Congruence of the sex/gender assigned at birth that matches the sex/gender-related self-determination.

transsexuality, sex/gender variance and sexual identity vary (see Schneider 2014). This complexity contributes to a social definition of sex/gender that is culturally circumscribed at a number of levels and the frequent interchanging of sex/gender with sexual orientation, which causes additional confusion and frequently feeds into a lack of or mistaken understanding of trans people.

Experiences of parents contacting health-care professionals

Some children realize at a very early age that the sex/gender assigned to them at birth does not match their sex/gender-related self-perception. In some cases, these children communicate this self-awareness to their parents. For example, this conversation between a mother and her 5-year-old child: "Why didn't you give me a girl's name when I was born?" The mother answered: "Because you were born with a willie." To which the child replied: "Yes, but inside I'm a girl, in my heart and in my head. Even when I was first born I already had a girl's heart, I just wasn't able to tell you."[24] Thinking that they are being understanding, parents often assume their child is going through a phase. For example, the parents of a child assigned as boy at birth, might indulge their child's wish to wear a dress at home, but insist on trousers when going out, because they assume their child is a boy. Parental fear that their child will be excluded, bullied or physically harmed is another key reason for why they do not want their child leaving the house like that. Other parents admonish or sanction their child or administer corporal punishment in the name of child rearing, hoping that this will make their child begin behaving normally again (Brill/Pepper 2011: 88/89; RADELUX II 2012: 13). Some teenagers report that their parents label their wish to change the gender role as a fad, with the unstated reproach that "following every fad that comes along is unnecessary."[25] If this phase goes on too long and/or becomes too intense, parents frequently start to worry, especially if they start comparing their child to other children of the same age. The suspicion that a child does not conform to their assigned sex/gender can often throw a family in disarray. Some seek out medical help or therapy to find out what has happened to their child and how the child can become normal again. Very few parents at this stage already recognize that their child is not sick, but is simply not conforming to society's sex/gender norms. Pressure from the family's environment, childcare workers, teachers or school authorities can also lead parents to impose corrective mea-

23 | Ability of a person to feel intensely emotionally and sexually drawn to a person independently of sex and/or gender, and to enter trusting and sexual relationships with these. This includes individuals outside of the sex/gender binary (see Nieder 2013).

24 | TRAKINE: Report. URL: http://www.trans-kinder-netz.de/pdf/Mutter_von_Lisa.pdf [07.01.2014].

25 | Intersex & Transgender Luxembourg a.s.b.l. (2013): Field report.

sures, punishments, or, at the very least, to ignore the so-called non-conforming behaviour. Parents become alarmed and seek help particularly when psychological problems appear, such as difficulties in social interaction, eating disorders, self-harm (Carmichael/Parkinson/Skagerberg 2013), depression or suicidal tendencies (HES/MAG 2009), including in early childhood (Lüthi/Fuchs 2013), which often arise when the child attempts to repress their sex/gender-related self-perception and/or experiences of social rejection, punishment and corrective measures (Ehrensaft 2012; D'Augelli/Grossmann 2007; McBride 2013: 52; RADELUX II 2012: 15). For example, this mother's experience:

"One night Karl tried to cut-off his willy under the shower with a plastic knife from the general store." Karl: "Then I'll grow a vagina. There really is a fairy that can cast a spell to turn me into a real girl. I want long hair and a vagina, and then I'll always wear proper girls' clothes […] I get sad when I see my willy. I don't want it, when will it be gone?"[26]

Moreover, society usually puts parents under a great deal of pressure to normalize the child, which generally puts the relationship between parent and child under extreme pressure (Hill/Menvielle 2009: 255-256). Physicians and psychologists often seem ill-equipped for the needs and problems of trans children. For example, parents have reported poor understanding on the part of physicians, some of who have been known to suggest the parents are responsible for their child's possible trans identity (McBride 2013: 57; Hill/Menvielle 2009; Schneider 2013). Examples include the following reactions and statements: "He [The physician, author's note] phoned and accused me of rearing the child into schizophrenia, of being a great danger to the child, and that child welfare services should be informed."; "I've never heard of anything like this."; "This type of thing doesn't exist!"; "The child needs a good clip around the ear!". One child and adolescent therapist said: "It's just a phase. And don't forget your child is from a broken home!"[27] If divorce actually does play a causal role in possible trans identity, one would expect a significantly higher number of trans people in the general population. Countries with a higher divorce rate like Luxembourg[28] would therefore have more trans children than countries with lower divorce rates.

26 | TRAKINE (2012): Report by a 6-year-old trans girl. URL: http://www.trans-kinder-netz.de/pdf/Mutter_von_Lisa.pdf [27.12.2013].

27 | TRAKINE presentation at a public information event on transsexuality, 04.12.2013, in Magdeburg, Germany. URL: https: //www.facebook.com/events/669464496419434/ [05.01.2014].

28 | The divorce rate in Luxembourg in 2010 was by 60%. URL: https://www.allianz.at/v_1353506042000/privatkunden/media-newsroom/news/aktuelle-news/pa-download/20120213_chart_eu_vergleich.pdf [17.08.2015].

The phases of professional supervision of trans children and trans adolescents

The points at which families generally seek professional help from the health care system can be categorized in three specific phases of a minor's life:

- Support in deciding whether a child should socially transition during childhood, including at (pre-)school and in the wider community.
- Prior to the start of treatment with Gonadotropin releasing hormone agonists (GnRh agonists) to delay puberty (Wüsthof[29]).
- Prior to irreversible medical intervention for adolescents and adults (so-called cross-sex hormone therapy and surgical reassignment).

Time and again health care professionals are required to decide whether and how to lend support to a family.

Medical approaches

The demand for hormone treatment and surgical reassignment increased in the 1950s, when public personalities like Christine Jorgensen[30] (1952), Coccinelle and Bambi[31] (1958-1960) publicized their transitions by means of medical intervention in the media. In the 1960s, somatic psychiatrists, endocrinologists and surgeons engaged in heated debates, in particular with psychiatrists and psychologists, about the most appropriate approach to transsexuality. Researchers focused on so-called feminine boys, with the intention of treatment as a form of early prevention and as a way to solve the problem of transsexuality in adulthood (Bryant 2006: 26).

What is the best treatment for a child is currently a subject of controversial debate in medicine, including in terms of the revised Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA, 2013) in May 2013, and the latest version of the ICD, which is scheduled for publication in 2017. According to the APA (2011), consensus has only been found for the perspective that the main goal of psychotherapy is "to optimize the psychological adjustment and well-being of the child [diagnosed with GID (replaced by the term gender dysphoria in May 2013)]". No agreement has been found regarding the following key questions:

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29 | See chapter by Achim Wüsthof.

30 | Biography.com: 'Christine Jorgensen Biography. Film Actor/Film Actress, Singer (1926–1989)'. URL: http://www.biography.com/people/christine-jorgensen-262758 [08.09.2015].

31 | Champenois, S. (2013): 'Bambi', douce trans. Libération. URL: http://www.liberation.fr/ecrans/2013/06/04/bambi-douce-trans_952833 [08.09.2015].

- Reduction of atypical behaviours regarding sex/gender norms.
- Prevention of transsexuality, particularly hormonal and/or surgical intervention (Meyer-Bahlburg 2002; Zucker 1990).

Can the above be regarded as acceptable goals of psychotherapy and in line with the physician's professional code of ethics?

Further questions that remain to be answered by society include: Should the normalization of the child's self-perception and those behaviours that do not meet cultural sex/gender stereotypes and norms as a goal of medical treatment be considered an ethically sound approach? Should deciding such questions even be the domain of medical professionals or indeed professionals of any other discipline?

Many professionals consider sex/gender-related self-positioning and behaviour that does not conform to sex/gender norms as something requiring treatment or at least changing. But an increasing number of professionals are adopting a different perspective that accords the unconditional recognition of an individual's sex/gender-related self-positioning (Riley et al. 2013), often expressed as a preferred first name of choice, a pivotal role in their therapeutic approach.

Overall, the handling of trans children in medicine encompasses various approaches, of which several are divided below into the categories normalizing, avoiding and affirmative. Due to limited space, the approaches highlighted and described in terms of aims, methods and evaluation have been selected, because they have a key influence on the lives of children and their families.

Normalizing approaches

In normalizing approaches, the attempt is made to adapt a person's perception of his or her own sex/gender, that is, a person's identity, to the cultural system of the sex/gender binary, with the goal of seeing the person remain in the gender role assigned to them at birth. The underlying assumption is that the person displays a deviation from sex/gender norms that requires treatment, which, however, varies depending on culture and time. Here, the needs expressed by the individual play a secondary role, while maintaining the binary sex/gender norms is of primary importance in this approach (Lev 2004: 331; Raj 2002: 3.1.2.).

Methodologically, a number of treatment approaches can be identified[32], including different types of psychotherapy, such as behavioural therapy and psychoanalysis, but also other techniques used in psychiatry, like electroconvulsive therapy[33] (ECT) and pharmacotherapy (Lev 2004: 321), all of which have the same aim, upholding the sex/gender binary.

32 | Also known as rehabilitative, conversion, corrective, reparatory or aversion therapy.
33 | Report received by the author in December 2013, on the use of ECT in the case of a minor in France in 2009.

Some therapists recommend in-patient treatment in child and adolescent psychiatric centres lasting several months. The mother of a trans girl described a consultation with a senior physician at a well-known German university clinic:

"He tried to convince me that Dominique can only be saved if she was removed from her parents for a long time as an in-patient." Other statements by the physician included: "What are 1.5 years of your child's life compared to the rest of his life, the life of the boy", and added: "The contact between child and parents needs to be severed for a lengthy period, so that the child can be broken at a point in time judged appropriate by experts and then rebuilt."[34]

It should be noted that 'broken' in the quote above referred to the child's sex/gender identity. In light of the fact that a scientific basis for such a corrective approach is completely lacking, the suggested treatment is astounding, as is the notion of secluding a child in a psychiatric institution for 1.5 years without parental contact. Other authors recommend that parents ignore behaviours that do not conform to sex/gender norms, and that they encourage the child to develop sex/gender-stereotypical behaviours, which seem to correspond to the sex/gender the child was assigned at birth. In particular, Meyer-Bahlburg (2002) advises the public, including parents, to bring the child into more contact with children assumed to be of the same assigned sex/gender. Parents should also minimize contact with family friends with children of the opposite assigned sex/gender and to create new acquaintances with children of the supposedly same sex/gender. Within this context, the author particularly suggests that fathers should maintain more contact with their supposed sons – despite the fact that such a measure has not been proven to have any positive effect on the sex/gender related self-positioning of a child. This recommendation is based on the assumption that a child will alter his or her behaviour to that typical of the assigned sex/gender of those children they are surrounded with (see Bosinski 2013). However, according to Steensma (as discussed by Becker/Möller/Schweizer 2013), psychosocial aspects (including the quality of the relationships with peers) have no influence on the duration of gender dysphoria.

Other measures include systematic contradictions whenever a child expresses themselves in a way or exhibits behaviour that does not correspond to sex/gender norms. For example, a trans girl reported the following about her consultations with a physician:

"My every word was squashed down. For example, I expressed my anxiety that my hair growth would increase, that I have so many pimples and such bad acne. His answer was, and I quote: 'But other

34 | Intersex & Transgender Luxembourg a.s.b.l. (2013): Field report.

boys also have pimples.' [...] I also expressed my fear of developing more masculine features; that my body would continue to develop, because you can't reverse that. To which he replied: 'Yes, that's true.' I was scared of looking like Arnold Schwarzenegger in a dress. He also said: 'At sixteen puberty has been completed, you can't become more of a man.' When I said that a boy at school had fallen in love with me, because he thought that I was a girl, his response was: 'He's gay.' It was hideous. I felt completely undermined; I wasn't permitted to disagree with anything, my point of view was in no way accepted. He tried to convince me of the opposite of whatever I felt and said. I had the constant impression that they were trying to dissuade me from my path. My perceptions were stifled before they could even be fully expressed; the seeds of my self-understanding were destroyed."[35]

This type of process hardly seems indicative of a respectful patient-doctor relationship and does not comply with medical ethics.

In parallel to the approaches above, other forms of treatment under debate for children include outcome-neutral and supportive approaches (Becker/Möller/Schweizer 2013: 273; Meyenburg/Richter-Unruh 2012). Elaborating on this topic, Meyenburg writes: "The point of psychotherapy is not to eradicate sex/gender-atypical behaviour and corresponding wishes, but to explore whether a life in the biological sex is not possible after all." Drawing upon his findings that some girls had problems returning to the female gender role, Steensma (2011: 16) cautions against socially transitioning from the assigned sex/gender any earlier than shortly before puberty. These problems are not specified, including whether and to which extent factors like misogyny played a role. In terms of today's insights, medical techniques that attempt to maintain sex/gender norms, the ongoing lack of support for timely social transition, including at pre-school and primary school age, or the prevention of such a transition, should be considered to be normalizing approaches and, in light of the lack of scientific evidence, be viewed critically.

Scientific demonstration of significantly positive results in terms of the actual life situation of those affected are lacking for all approaches, as are long-term studies. No evidence exists that behavioural patterns or identities that do not correspond to sex/gender norms can be cured or repaired. To date, all evidence[36] suggests that a person cannot be retrained in terms of their sex/gender identity. In their review of two investigations that attempted to realign sex/gender identity (and moreover, sexual orientation), Zucker and Bradley (1995), arguably advocates of normalizing approaches, found little evidence that the goals of the study had been met. Not only is it impossible to change a person's sex/gender iden-

35 | Intersex & Transgender Luxembourg a.s.b.l. (2013): Report of a person of their experience at age 16.
36 | See experiences of psychotherapists, such as those of Peter Keins, as well as reports of the parents association TRAKINE.

tity. Sex/gender stereotypes are even reinforced (compare Langer/Martin 2004). Several authors consider normalizing approaches as psychologically damaging for children by lowering feelings of self-esteem, causing or increasing fear, depression and suicidal tendencies (Ehrensaft 2012; Hill et al. 2007; Mallon/DeCrescenzo 2006; Raj 2002; Rauchfleisch 2012). Moreover, Langer and Martin (2004) refer to the paper by Burke (1996), which discusses children damaged by treatment for Gender Identity Disorder of Childhood (GIDC). Professionals working with care givers[37] have described mothers contacting them to report the suicide of their child after such treatment. Such corrective treatment has also been described as 'brutal' (Mallon/DeCrescenzo 2006: 221) and 'unethical' (APA 2011; Nieder 2012: 16).

In light of the evidence that normalizing treatment approaches have damaging effects, clinical studies of how adults experienced undergoing such gender normalization approaches during childhood, including their potential damaging effects, are urgently needed (Lev 2004: 329). In contrast to Steensma's observations discussed above, a clinical study by Ehrensaft (2012: 354) observed no negative effects of re-transition when the environment of the individual was accepting. Strikingly, the approach of Steensma and Meyenburg again implicitly prioritizes maintaining sex/gender norms over the needs actually expressed by children. Children are not given the space to explore and claim for themselves a path of personal development, which might include transition during early childhood.

Avoiding approaches

These approaches are characterized by non-reaction to requests, frequently from parents, of how to respond to behaviour by a child that is interpreted as not conforming to sex/gender norms. Parents do not receive an answer to their request for help. The best they can hope for is an admission of ignorance from physicians and psychologists. This is often connected with the perception that non-reaction will not cause any damage, that a life will take its natural course. A discussion about the possible negative consequences of such non-reaction, considering that the families continue to be exposed to the dangers of social marginalization, corrective and punitive measures, discrimination and – even the children – verbal and physical violence, without any protection. This approach cannot be considered neutral. The lack of acceptance of a child's sex/gender-related self-perception or self-positioning, or their sex/gender identity, can have serious consequences for the child's emotional stability and their ability to form relationships with others. Consequently, no decision or recommendation to families by professionals can be considered neutral at any point.

37 | Intersex & Transgender Luxembourg a.s.b.l. (28.09.2013): Field report.

Similarly, letting teenagers live through the physical development of puberty cannot be considered a neutral decision (Giordano 2008). Firstly, the physical changes of puberty increase the suffering of trans minors, which can lead to mental health issues, including thoughts of suicide; and secondly, the risk of verbal and physical violence increases, if the teenager does not meet sex and gender norms, because the despised physical changes during puberty are irreversible, that is, cannot be undone.

Affirmative approaches

In affirmative approaches, a child's sex/gender-related self-perception and self-positioning are accepted unconditionally. The child is supported according to their currently expressed needs and encouraged to explore their sex/gender identity. The expression of their sex/gender-related self-perception and self-positioning is explicitly affirmed. This can include social transition in early childhood which is increasingly being facilitated for children (Ehrensaft 2012; Hill et al. 2010; Lev 2004; Menvielle 2012; Möller et al. 2009; Torres Bernal/Coolhart 2012). Social transition at an early stage can often reduce psychological trauma like fear, depression and suicidal tendencies (Ehrensaft 2012; Rauchfleisch 2013). Key to this approach is the concept of intervening in the hostile, marginalizing [transphobic, author's note] environment, instead of individualizing the problem [of culturally based sex/gender norms, author's note] (Ehrensaft 2012; Hill et al. 2010; Lev 2004: 332, 346; Mallon/DeCrescenzo 2006; Menvielle 2012; Pirelli Benestad 2012; Raj 2002). In contrast to the approaches described above, this approach expressly states that a sex/gender identity that deviates from cultural norms is not pathological (Menvielle 2012: 363). At the same time, hormone treatment (delayed puberty and so-called cross-sex hormone treatment) is considered part of the affirmative approach. For more information about this methodology, see Wüsthof[38] and Spack et al. (2012). Giordano (2008) has described positive results using this approach. For many minors, this type of treatment has shown a significant improvement of emotional and psychological well-being (see Wüsthof[39]) and quality of life.

Apart from these considerations, the question arises under which conditions a child's desire for hormonal treatment (GnRh inhibitors or so-called cross-sex hormones) can or should be met, or more specifically, which criteria should be applied in this decision. General agreement on this question seems to include a high degree of suffering, suicidal tendencies, long-standing difference between the experienced and assigned sex/gender. Some therapists call for proof

38 | See chapter by Achim Wüsthof in this volume.
39 | Ibid.

of failed non-hormonal treatments prior to the start of hormone therapy (Becker 2012: 31) and wish to see hormone treatment viewed as a last resort that should only be prescribed after the completion of psychosexual development (also known as somatosexual pubertal development) (Korte et al. 2008), because the latter could be impeded, including in terms of the development of sexual orientation. According to critics, solid scientific evidence is lacking for any of the discussed approaches – be it for normalizing or avoiding approaches. This includes the affirmative approach, which however seems to have less detrimental effects than the others.

Making mature psychosexual pubertal development a precondition for transition is less than convincing considering the lack of scientific evidence regarding hormonal effects on various aspects of sexuality and sexual development and the reality of lifelong learning and ongoing experiences. Moreover, the approach ignores and discriminates against teenagers living asexually. Whether and to what extent the development of forms of sexual orientation are hindered, leading to impairment of developmental potential, seems to be more based on speculation guided by agenda, than on scientific insight. The high degree of mental and emotional stress placed on teenagers seems to not be an argument for early intervention with GnRh agonists for the proponents of normalizing and avoiding treatments. It should be noted that not all professionals support scientifically unproven hypotheses such as those described above. However, the one-sided emphasis in the debate surrounding the diagnosis of transidentity on the dangers of misdiagnosis, at the expensive of a supportive treatment with few side-effects, is surprising. This imbalance fails to meet the needs of those in question – young people suffering significantly under the consequences of puberty.

Whichever decision is reached regarding the type of treatment – it has to be based on a transparent and objective basis, i.e. it should prioritize the articulated (and not presumed) needs of the child or teenager, and be based on scientific proof that the applied methods will have a positive impact on the child or teenager.

The fear of medical misdiagnosis

One frequent topic of discussion is which young people should be allowed access to transition and by which means. Legal professionals limit professional liability for their decisions regarding applications for name or civil sex/gender status changes by drawing on medical opinions that certify something that cannot be scientifically proven. Medical professionals and psychologists fear making a wrong decision when it comes to approving treatment, in particular at what is

considered a young age (Preuss 2013 in Becker/Möller/Schweizer). The consequences of declining a person's wish for sex/gender transition are not discussed, with a few exceptions (Schneider 2013). Any ethical questions and concerns regarding the rights of children or human rights in general are discussed outside of the health care system, seemingly without playing a role in the medical decision-making process. This blinkered approach on the part of the health care system is unjust to children and adolescents. Similarly, the health care system must be released from its questionable role as the guardian of culturally specific sex/gender norms that serve to maintain sex/gender stereotypes. Unconditional recognition of and respect for an individual's sex/gender-related self-awareness and positioning are essential components of medical approaches in a health care system that prioritizes the needs of the individual.

Summary

The right to carry a name and to wear the clothing of the so-called opposite sex/gender, an essential part of an individual's self-determination, is claimed today even as it was a century ago (Becker 2004). Despite the fact that today's possibilities of hormonal and surgical intervention have brought other considerations to bear, insistence on this right rarely meets with acceptance, particularly in the case of children. However, along with the right to sex/gender-related self-determination as well as self-representation, this demand is, on the one hand, a core element of an individual's interaction with society at large and, on the other, vital to a person's self-image and self-esteem. The right to self-determination is not only a central tenet of any ethical considerations and many human (and children's) rights conventions, but also central to a person's emotional and mental well-being. Denying an individual this right impedes their ability to interact with their environment, their understanding of themselves, and ultimately, their sense of self-worth. Consequently, respecting an individual's right to self-determination, including how they position themselves with regard to the binary sex/gender order – without any form of pathologization – is imperative. Medical professionals should take the right of trans children and adolescents to self-determination seriously, not only by validating how an individual expresses their self-awareness, but also by responding to their needs as expressed, without placing hurdles in their path. Concrete examples include the right of an individual to be addressed by their given name of choice, both verbally and on paper.

Moreover, this should be possible on request, without the need for a court ruling, medical certification or other professional input. Professional input, in so far as desired and requested by trans people and/or their families, must abstain from disparaging or discriminating against the individual. This is not only a central tenet in ethical standards, but is also necessary to halt the common spiral of self-loathing, psychosomatic complaints and social marginalization caused by transphobia.[40] A key element is recognizing a person's sex/gender-related self-positioning in terms of law, jurisdiction, medicine and the education system. One possible measure could be reforming the legal framework governing 'sex/gender status' by optional registration of sex/gender, if at all, at birth, and altering of registered sex/gender at a later date on application to the appropriate bureaucratic authority, without medical input and court ruling. Such measures would ensure that the legal framework surrounding transition is no longer dependent on empirically unproven concepts of sex and gender, but instead solely prioritizes the rights of children and human rights in general. Moreover, decision-making by both medical and legal professions should take into account the possible consequences of denying a person's desire for transition as a matter-of-course. A legal framework that is particularly important with regard to children is the Argentinian law on gender identity,[41] particularly Article 12, which allows children to be addressed by their first name of choice, as well as the corresponding pronoun. Specifically, it says in this act: "Whenever requested by the individual, the adopted first name must be used for summoning, recording, filing, calling and any other procedure or service in public and private spaces". Discussion about scrapping the category of sex or gender in law and jurisprudence in Germany and other political and social spheres has to continue. The needs of the individual, instead of maintaining binary sex/gender norms, must become the priority of the health care system.

On a political level, medicine should be released from a certain responsibility, because when it comes to sex/gender-related self-determination, the only reliable criterion is the individual's own assessment of the stability of this assignment, and in how far this self-assignment is accurate and serious. The attempt to formulate objective expertise or to promote the notion of stable sex/gender identity beyond reasonable doubt as prerequisite for a name change, change of sex/gender in the birth register or for medical interventions like hormone treatment and surgery is doomed to failure and also risks maintaining further human rights violations.

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40 | This includes discrimination against people who do not meet cultural sex/gender norms.

41 | Global Action for Trans*Equality (GATE) (2012): Argentina Gender Identity law. Article 12 – Dignified treatment. URL: http://tgeu.org/argentina-gender-identity-law/ [14.08.2015].

For this reason, the option of changing one's sex/gender status and legal given first name easily and independently of input by health-care professionals is crucial. What is needed are pragmatic solutions that harm nobody, that conform to international conventions on the rights of children and human rights in general, and above all, that do justice to the children themselves.

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