Canadian Journal of Family Law

Volume 33 | Number 1

2020

# Respecting and Protecting Transgender and Gender-Nonconforming Children in Family Courts

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# RESPECTING AND PROTECTING TRANSGENDER AND GENDER-NONCONFORMING CHILDREN IN FAMILY COURTS

**Claire Houston**[*]

*Family court judges are increasingly being asked to resolve parenting disputes involving conflict over a child's gender expression or identity. These disputes ask whether it is in the best interests of children to support their gender nonconformity, including any decision to transition to a gender different from the one they were assigned at birth. Despite more of these cases coming before family courts, judges have little guidance on how to resolve these cases in the best interests of children. Drawing on medical and social science literature and reported decisions, and applying a robust theory of children's participation rights, this article offers a number of suggestions for resolving parental conflicts over a child's gender, including hearing and placing significant weight on the views and preferences of the child, and presuming that supporting a child's gender nonconformity is in the child's best interests.*

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## INTRODUCTION

Family court judges[1] are increasingly being asked to resolve parenting disputes involving transgender or gender-nonconforming (GNC) children.[2] These cases ask whether it is in the best interests of children to support their GNC behaviour, allow children to live as a different gender, or, less commonly, permit medical interventions to align a child's body with their gender identity. In these cases, one parent—usually the mother—supports the child's gender nonconformity or decision to socially or medically transition while the other parent—usually the father—disputes the child's gender nonconformity or trans identity, and often accuses the other parent of encouraging or forcing the child to be gender variant.[3] One of the central questions in these cases therefore becomes, "is this child *really* trans?"

Family cases involving children are decided according to the "best interests of the child" standard;[4] however, determining what is in the best interests of a

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1 I use the term *family court* broadly to refer to courts that hear family matters, whether they be Unified Family Courts, provincial courts, or superior courts.

2 See Diane Ehrensaft, *Gender Born, Gender Made: Raising Healthy Gender-Nonconforming Children* (New York: The Experiment, 2011) at 9. Gender-nonconforming children are defined by Ehrensaft as those "who do not abide by the prescribed gender norms of their culture". I have purposely chosen to use the broad definition of gender-nonconforming to encompass more children.

3 The gendered nature of these conflicts is discussed below in Part VI.i.

4 *Divorce Act*, RSC 1985, c 3 (2nd Supp), s 16(8). See also e.g. *Children's Law Reform Act*, RSO 1990, c C-12, s 24(1).

particular trans or GNC child may be challenging. Trans youth are an especially vulnerable population, suffering disproportionate mental health issues—including suicidality—and social and medical transition can help these children. A child's "views and preferences" help determine what is in their "best interests",[5] and therefore a child's decision to transition deserves respect. However, not all GNC children grow up to be trans, and clinicians who work with GNC children disagree about when children should be able to decide to socially or medically transition. Parents and judges, who are legally obligated to protect children, may worry that allowing a child to transition, especially where transition involves irreversible medical treatment, will harm the child.

This article provides suggestions for resolving family law cases involving parental conflict over a child's gender. First, judges should hear and place significant weight on the views and preferences of the children at the centre of these disputes. Second, judges should focus on

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5 See e.g. *Children's Law Reform Act*, *supra* note 4, s 24(2)(b). The federal *Divorce Act* does not list a child's views and preferences as a factor in determining best interests; however, courts have considered a child's views and preferences when applying the federal best-interests standard. See e.g. Nicholas Bala, "Bringing Canada's *Divorce Act* into the New Millennium: Enacting a Child-Focused Parenting Law" (2015) 40:2 Queen's LJ 425 at 454. Amendments to the *Divorce Act*, expected to come into force March 1, 2021, enumerate a child's views and preferences as a factor in the best-interests standard. Bill C-78, *An Act to amend the Divorce Act, the Family Orders and Agreements Enforcement Assistance Act and the Garnishment, Attachment and Pension Diversion Act and to make consequential amendments to another Act*, 1st Sess, 42nd Parl, 2019, cl 12 (assented to 21 June 2019), SC 2019, c 16 (clause 12 inserts a revised section 16(3) into the *Divorce Act*).

what the child is communicating about their experience and needs rather than asking "is this child *really* trans?". Third, judges should presume it is in the best interests of trans and GNC children to support their gender nonconformity, and their decisions to socially and medically transition. Fourth, judges should attempt to balance support for a child's gender nonconformity with reducing parental conflict. Finally, gender expert evidence should not always be necessary in these cases. These suggestions are based on empirical literature about trans and GNC children, judicial approaches to the issue in reported decisions, transgender analyses of gender,[6] and an expansive view of children's participation rights.[7]

The article proceeds as follows. Part I summarizes medical and social science research about trans and GNC children and their needs. Part II sets out the legal framework for resolving parental disputes over a child's gender. Part III describes how Canadian judges have approached cases involving parental disputes over a child's gender, highlighting themes and noteworthy reasoning.[8]

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6 See e.g. Dean Spade, *Normal Life: Administrative Violence, Critical Trans Politics, and the Limits of Law* (Durham: Duke University Press, 2015). See also Paisley Currah, Richard Juang & Shannon Minter, eds, *Transgender Rights: History, Politics and Law*, 1st ed (Minneapolis: University of Minnesota Press, 2006); Julia Serano, *Whipping Girl: A Transsexual Woman on Sexism and the Scapegoating of Feminism* (Berkeley: Seal Press, 2007).

7 To a lesser extent, this paper is also in conversation with feminist theory.

8 Research was limited to Canadian common law decisions and therefore excludes decisions from Quebec.

Part IV elaborates my suggestions for resolving these cases in the future.

## I. WHAT WE KNOW ABOUT TRANS AND GENDER-NONCONFORMING CHILDREN

Medical and social science research on trans and GNC children can guide judges in making decisions in the best interests of these children. This part summarizes this research. Part IV draws upon this research summary to offer suggestions on how to resolve family cases involving parental disputes over a child's gender.

### i. DEFINING TRANS AND GENDER-NONCONFORMING CHILDREN

"Transgender" and "gender-nonconforming" have different meanings. A transgender person is one whose gender identity does not match their gender assigned at birth.[9] Trans people may identify as male or female or something else (for example, non-binary, agender, bigender, or genderfluid). Some trans people socially transition. Social transition means to live according to one's gender identity, and may involve changing names, pronouns, and appearance (that is, clothes, hairstyle, etc.).[10] Some, but certainly not all, trans people medically transition. Medical transition means accessing health care to change one's body to reflect one's gender identity.

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9 See Stephanie Brill & Rachel Pepper, *The Transgender Child: A Handbook for Families and Professionals* (San Francisco: Cleis Press Inc, 2008) at 5.

10 Diane Ehrensaft et al, "Prepubertal Social Gender Transitions: What We Know; What We Can Learn—A View From a Gender Affirmative Lens" (2018) 19:2 Intl J Transgenderism 251 at 252.

Medical transition may involve hormone therapy and/or surgical interventions.[11] For children, it may also involve puberty suppression.[12] Approximately 0.39–0.60 percent of adults identify as transgender, and approximately 1.2–4.1 percent of adolescents identify as transgender.[13]

Gender nonconformity describes behaviours and interests outside of what is considered typical for a person's assigned gender.[14] For example, a child assigned male at birth who wears dresses or plays with dolls may be considered gender-nonconforming. Not everyone who expresses gender-nonconforming behaviour identifies as transgender. Especially among children, gender nonconformity is more common than transness.[15]

### ii. GENDER NONCONFORMITY DOES NOT NECESSARILY PREDICT TRANS IDENTITY

Not all GNC children grow up to be trans adults. Gender nonconformity may indicate (future) transness, it may be a permanent expression, or it may be a phase or developmental stage. *Gender constancy*, the understanding that gender identity does not change according to gender expression, does not develop until around age six.[16] Before

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11 Elijah C Nealy, *Trans Kids and Teens: Pride, Joy, and Families in Transition* (New York: WW Norton & Company, 2019) at 106.

12 Brill & Pepper, *supra* note 9 at 204.

13 Joseph H Bonifacio et al, "Management of Gender Dysphoria in Adolescents in Primary Care" (2019) 191:3 CMAJ E69 at E70.

14 See Brill & Pepper, *supra* note 9 at 5.

15 Brill & Pepper, *supra* note 9 at 3.

16 See Brill & Pepper, *supra* note 9 at 63.

that time, children may conflate gender identity with gender expression (i.e. "I am a girl because I wear dresses"). Children who identify as a gender different from the one they were assigned at birth may not be trans, but may be expressing a preference for activities or dress associated with that gender (i.e. "I am a girl because I *like* to wear dresses"). That said, it is not uncommon for trans kids to assert their gender identity at a very young age.[17] Thus, a child assigned male at birth who says, "I am a girl", may be exhibiting a lack of gender constancy or they may be trans.

Puberty is another important turning point in gender development. For some kids, trans identity emerges with the onset of pubertal changes. For other children, puberty may be a time when gender nonconformity ends. Desistance research, a series of studies involving children diagnosed with *gender identity disorder* (GID)—what we would now call *gender dysphoria*[18]—suggests that for the majority of children (often cited as 80 percent),[19] GID desists around puberty.[20] According to these studies,

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17 See Brill & Pepper, *supra* note 9 at 16.

18 The medicalization of gender nonconformity and its effects are discussed below in Parts I.v. and IV.v.

19 See Julia Temple Newhook et al, "A Critical Commentary on Follow-Up Studies and 'Desistance' Theories about Transgender and Gender-Nonconforming Children" (2018) 19:2 Intl J Transgenderism 212 at 213 [Newhook et al, "Critical Commentary on Follow-Up Studies and 'Desistance' Theories"].

20 The desistance studies include Kelley D Drummond et al, "A Follow-Up Study of Girls With Gender Identity Disorder" (2008) 44:1 Developmental Psychology 34 at 42; Thomas Steensma et al, "Desisting and Persisting Gender Dysphoria after Childhood: A

gender dysphoria in children is more likely to predict lesbian, gay or bisexual orientation than trans identity. However, these studies have serious methodological flaws.[21] First, the inclusion criteria were broad so not all of the children included in the studies would have met the diagnosis for GID.[22] Second, the sample of children was under-inclusive. One of the clinics—the Toronto clinic—was known to discourage gender nonconformity. Parents of trans children who affirmed their children's identities may not have sought treatment from that clinic thus reducing the number of GID children in the sample.[23] Third, the authors recorded desistance too early.[24] In four of the studies, the average age at which desistance was recorded was sixteen. However, a trans identity could have been asserted later. Finally, the recorded number of "desisters" was too high. In a few of the studies, the authors counted those who did not respond to follow-up as "desisters."[25] These flaws suggest that the desistance rate among gender-dysphoric children is lower than the studies

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Qualitative Follow-up Study" (2011) 16:4 Clinical Child Psychology & Psychiatry 499; Thomas D Steensma et al, "Factors Associated With Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study" (2013) 52:6 J Am Academy Child & Adolescent Psychiatry 582; Madeleine SC Wallien & Peggy T Cohen-Kettenis, "Psychosexual Outcome of Gender-Dysphoric Children" (2008) 47:12 J Am Academy Child & Adolescent Psychiatry 1413.

21 See Newhook et al, "Critical Commentary on Follow-Up Studies and 'Desistance' Theories", *supra* note 19.

22 See *ibid* at 214–15.

23 See *ibid* at 215.

24 See *ibid* at 215–16.

25 See *ibid* at 216.

report and that relying on desistance research for clinical purposes is highly problematic.[26]

### iii. PREDICTING TRANSNESS IS PROBLEMATIC

Trying to determine which children will grow up to be trans adults is also problematic. Early research suggests there may be common features among children who persist in their trans identities.[27] For example, children who strongly and consistently assert a trans identity over a number of years are more likely to continue in that identity.[28] Similarly, gender dysphoria or gender variance that continues into adolescence is more likely to continue into adulthood.[29] However, there is no definitive way to predict which children will grow up to be trans.

More fundamentally, attempting to predict whether a child will become a trans adult assumes that gender

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26 See Newhook et al, "Critical Commentary on Follow-Up Studies and 'Desistance' Theories", *supra* note 19 at 215. See also Julia T Newhook et al, "Teach Your Parents and Providers Well: Call for Refocus on the Health of Trans and Gender-Diverse Children" (2018) 64:5 Can Fam Physician 332.

27 See e.g. Jean Malpas, "Between Pink and Blue: A Multi-Dimensional Family Approach to Gender Nonconforming Children and their Families" (2011) 50:4 Family Process 453 at 460–61.

28 See *ibid* at 461. However, this type of prediction does not account for gender conforming children who later assert a trans identity, raising further questions about the value of trying to predict which GNC children will later identify as trans.

29 Jack Drescher & Jack Pula, "Ethical Issues Raised by the Treatment of Gender-Variant Prepubescent Children" (2014) Hastings Center Report S17 at S18.

identity is fixed.[30] The trans movement has taught us that gender identity is sometimes fluid. People can move between different gender identities (and back and forth) over time. This fluidity does not diminish the significance of one's gender identity.[31] But it does raise concerns about whether it is possible to predict future gender identity with certainty.

### iv. TRANS YOUTH ARE A PARTICULARLY VULNERABLE GROUP

Discrimination and violence against trans youth are widespread and pervasive. Data from the Canadian Trans Youth Health Survey found that of the 923 participants (ages fourteen to twenty-five), two-thirds reported discrimination based on gender identity.[32] A survey of LGBTQ students by the Egale Canada Human Rights Trust found that ninety percent of trans students reported hearing

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30 See Florence Ashley, "Thinking an Ethics of Gender Exploration: Against Delaying Transition for Transgender and Gender Creative Youth" (2019) 24:2 Clinical Child Psychology and Psychiatry 223 at 227 [Ashley, "Thinking an Ethics of Gender Exploration"].

31 See Lisa Duggan, "Queering the State" (1994) 39 Social Text 1 at 9, where Duggan argues that sexual identity can be compared to religion—a belief system that can change, but is nonetheless not considered trivial or shallow. Clifford Rosky argues that gender identity, including in children, can be conceptualized similarly. See Clifford J Rosky, "No Promo Hetero: Children's Right to Be Queer" (2013) 35:2 Cardozo L Rev 425 at 502.

32 See Jaimie F Veale et al, "Being Safe, Being Me: Results of the Canadian Trans Youth Health Survey" (2015), online: (pdf): *Stigma and Resilience Among Vulnerable Youth Centre, School of Nursing, University of British Columbia* <apsc-saravyc.sites.olt.ubc.ca/files/2018/03/SARAVYC_Trans-Youth-Health-Report_EN_Final_Web2.pdf> [perma.cc/X67C-9AA3] at 2.

transphobic comments daily or weekly, and that sixty-five percent reported being verbally harassed regarding their gender.[33] More than three-quarters reported feeling unsafe at school.[34] One-third of the younger participants (ages fourteen to eighteen) in the Canada Trans Youth Health Survey reported physical violence or threats of violence in the past year, and many of the youth reported sexual harassment.[35]

Discrimination and violence may negatively impact the mental health of trans youth.[36] A recent study of trans youth in Newfoundland found that ninety percent of participants suffered depression and/or anxiety.[37] Of the younger

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33 See Catherine Taylor et al, "Every class in every school: The first national climate survey on homophobia, biphobia, and transphobia in Canadian Schools. Final Report" (2011), online: *Egale Canada Human Rights Trust* <egale.ca/wp-content/uploads/2011/05/EgaleFinalReport-web.pdf> [perma.cc/XBP5-HFNJ] at 52, 59.

34 See *ibid* at 23.

35 See *ibid* at 17.

36 See e.g. Greta R Bauer & Ayden I Scheim, "Transgender People in Ontario, Canada: Statistics from the TRANS Pulse Project to Inform Human Rights Policy" (last modified 1 June 2015), online (pdf): *Trans PULSE* <transpulseproject.ca/wp-content/uploads/2015/06/Trans-PULSE-Statistics-Relevant-for-Human-Rights-Policy-June-2015.pdf> [perma.cc/TZL6-CUTF] (the Trans PULSE study of 433 Ontarians ages sixteen and older reported that, "Contrary to the notion that depression and suicidality are primarily attributable to distress inherent to being trans, we found evidence that discrimination and violence had strong adverse impacts on mental health" at 6).

37 Julia Temple Newhook et al, "The TransKidsNL Study: Healthcare and Support Needs of Transgender Children, Youth, and Families on the Island of Newfoundland" (2018) 37:2 Canadian Journal of Community Mental Health 13 at 23.

participants in the Canadian Trans Youth Health Survey, three-quarters reported self-harm, and two-thirds said they had considered suicide in the past year.[38] Among this latter group, over a third had attempted suicide at least once.[39]

## v. THE SHIFT TOWARD GENDER AFFIRMING CARE

Trans identity and gender nonconformity have historically been pathologized. For years, medical and mental health professionals treated trans and GNC people as mentally disordered. Until 2013, the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) included "Gender Identity Disorder", defined as a "strong and persistent cross-gender identification", as a mental disorder requiring treatment.[40] This view of gender variance as pathological has stigmatized trans and GNC people.

The early pathologization of gender variance by professionals involved trans and GNC youth. Beginning in the 1960s, professionals began treating GNC boys (termed "sissy boys") in an effort to prevent perceived negative outcomes of adult homosexuality, "transvestitism", and "transsexuality".[41] These treatments involved eradicating

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38 See Veale et al, *supra* note 32 at 42.

39 See *ibid*.

40 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed (Washington, DC: American Psychiatric Association, 1994) at 532.

41 Karl Bryant, "Making Gender Identity Disorder of Childhood: Historical Lessons for Contemporary Debates" (2006) 3:3 Sexuality Research & Social Policy 23 at 26, 27.

or suppressing femininity and promoting masculinity.[42] In 1980, gender variance in children was formally pathologized with the inclusion of "Gender Identity Disorder of Childhood" in the *DSM*.[43]

Professionals have recently moved away from the view of gender variance as abnormal and toward a view of gender variance as a normal human variation. In 2010, the World Professional Association for Transgender Health (WPATH) proclaimed: "the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally diverse human phenomenon [that] should not be judged as inherently pathological or negative."[44] The most recent version of the *DSM* lists "gender dysphoria", which describes "the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender."[45] This

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42 See *ibid* at 28.

43 See American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed (Washington, DC: American Psychiatric Association, 1980) at 264.

44 WPATH, "WPATH De-Psychopathologisation Statement" (26 May 2010), online: *World Professional Association for Transgender Health* <www.wpath.org/policies> [perma.cc/2W3M-JUTS].

45 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed (Washington, DC: American Psychiatric Association, 2013) at 451.

shift in focus from transness to distress related to transness was an attempt to de-pathologize gender variance.[46]

Many professionals who work with trans and GNC children now espouse a "gender affirming" approach.[47] This approach recognizes that gender variations are not disorders; that gender presentations are diverse; that gender is a product of biology, development, and socialization; that gender is not necessarily binary and can be fluid in the moment or within an individual across time; and that pathology in GNC children (that is, depression, anxiety) is more likely a result of cultural reactions (that is, transphobia) than inherent to the child.[48] The gender affirming approach also emphasizes listening to what children are saying about their gender identity and expression and supporting them (and their parents) as they

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46 Some argue that any reference to transness as a disorder should be removed from the *DSM*. See e.g. Arlene Lev, "Gender Dysphoria: Two Steps Forward, One Step Back" (2013) 41:3 Clin Soc Work J 288 at 294.

47 Ximena Lopez et al, "Statement on Gender-Affirmative Approach to Care from the Pediatric Endocrine Society Special Interest Group on Transgender Health" (2017) 29:4 Current Opinion in Pediatrics 475. See also Jason Rafferty, "Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents" (2018) 142:4 Pediatrics 1; Michelle Telfer et al, "Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents Version 1.1" (2018), online (pdf): *The Royal Children's Hospital* <www.rch.org.au/uploadedFiles/Main/Content/adolescent-medicine/australian-standards-of-care-and-treatment-guidelines-for-trans-and-gender-diverse-children-and-adolescents.pdf>.

48 See Marco A Hidalgo et al, "The Gender Affirmative Model: What We Know and What We Aim to Learn" (2013) 56:5 Human Development 285 at 285.

explore their gender. The goal of treatment is to help children "live as *they* are most comfortable."[49]

## vi. DIFFERENT VIEWS ABOUT TREATING GENDER DYSPHORIA IN CHILDREN AND ADOLESCENTS

Medical and mental health professionals have varying views about how and when to treat gender dysphoria (GD) in children. There are three accepted "treatments" for gender dysphoric children and adolescents: counseling, social transition, and medical transition.[50] While counseling may be offered to any GNC child, and a child (usually with the support of their parents) may socially transition at any time, medical transition typically requires diagnosis or documentation of GD.[51] The main professional controversies in treating gender-dysphoric

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49 *Ibid* at 287 [emphasis added].

50 Eli Coleman et al, "Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7" (2012) 13:4 Intl J Transgenderism 165. Until quite recently there was controversy over so-called "reparative therapy", which involved clinicians attempting to suppress femininity in boys or masculinity in girls to prevent the development of trans identity. However, it is now considered unethical to try to align a child's gender identity or expression with their assigned gender. See *ibid* at 175. In 2015, Ontario amended a law so as to prohibit "any treatment that seeks to change the sexual orientation or gender identity of a person under 18 years of age." See *Affirming Sexual Orientation and Gender Identity Act, 2015*, SO 2015, c 18, s 2.

51 See Coleman et al, *supra* note 50 at 177.

children concern social transitioning before puberty and hormone therapy before age sixteen.[52]

Most professionals who work with gender dysphoric children recommend social transition, but they disagree about the timing of treatment. The WPATH Standards of Care (SOC), for example, are cautious about early social transition because of the possibility that children may wish to "transition back" to the gender they were assigned at birth.[53] Citing desistance research, they say most children cease gender nonconforming around puberty, and that early social transition could lead some children to regret this decision.[54] They cite research by Steensma and Cohen-Kettanis suggesting that transitioning back can be *highly distressing*.[55] Finally, they point to lack of evidence about the long-term effects of social transition in prepubescent children.[56]

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52 There is also some debate over whether sex reassignment surgery should be conducted on older teenagers under the age of 18. See Diane Ehrensaft et al, *supra* note 10 at 251. However, because these children are likely capable of consenting to treatment, I do not discuss this issue here.

53 Coleman et al, *supra* note 50 at 176. I borrow the term *transition back* from Kristina Olson, "Prepubescent Transgender Children: What We Do and Do Not Know" (2016) 55:3 J Am Academy Child & Adolescent Psychiatry 155 at 156.

54 See Coleman et al, *supra* note 50.

55 See Thomas D Steensma & Peggy T Cohen-Kettenis, "Gender Transitioning Before Puberty?" (2011) 40:4 Archives Sexual Behaviour 649.

56 See Coleman et al, *supra* note 50 at 176.

Professionals who support early social transition argue that delaying social transition can be harmful and that the risks of transitioning back are exaggerated. They point to new research that suggests prepubescent gender dysphoric children who choose to socially transition experience better mental health outcomes than prepubescent gender dysphoric children who live according to their assigned gender.[57] They also say there is little support for the proposition that transitioning back is highly distressing, noting that the Steensma and Cohen-Kettenis research only involved two children, and that it is not clear if these children had socially transitioned.[58]

Most professionals who work with gender dysphoric youth also support medical transition but disagree about the timing of hormone therapy.[59] Medical transition in adolescents may involve puberty suppression and/or hormone therapy.[60] Puberty suppression usually involves administering hormones at the onset of puberty to

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57 See Kristina R Olson et al, "Mental Health of Transgender Children Who Are Supported in Their Identities" (2016) 137:3 Pediatrics 2.

58 See Florence Ashley, "Gender (De)Transitioning Before Puberty? A Response to Steensma and Cohen-Kettenis (2011)" (2019) 48:3 Archives Sexual Behaviour 679.

59 See e.g. Diane Chen et al, "Advancing the practice of pediatric psychology with transgender youth: State of the science, ongoing controversies, and future directions" (2018) 6:1 Clinical Practice in Pediatric Psychology 73. Again, I am discussing puberty suppression and hormone therapy, not gender affirming surgery.

60 Again, some professionals advocate for gender affirming surgery in older teenagers. See Ehrensaft et al, *supra* note 10.

prevent the development of secondary sex characteristics.[61] Puberty suppression is described as "fully reversible" because children will proceed through the puberty of their assigned gender if hormone blockers are stopped.[62] Hormone therapy involves administering hormones to facilitate the development of secondary sex characteristics. Hormone therapy is considered "partially reversible", as certain physiological changes (such as lowered voice and fat distribution) may become permanent even though hormones are discontinued.[63] While there are health risks associated with hormone therapy,[64] most professionals who work with gender dysphoric adolescents believe that

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61 The WPATH SOC and Endocrine Society clinical practice guideline recommend puberty suppression once a child reaches pubertal stage Tanner II, which occurs around 10.5 in biological females and 11.5 in biological males. See Mickey Emmanuel & Brooke R Bokor, "Tanner Stages" (13 May 2019) online: *StatPearls, National Center for Biotechnology Information* <www.ncbi.nlm.nih.gov/books/NBK470280/> [perma.cc/5UC3-HDK5]

62 Coleman et al, *supra* note 50 at 177.

63 See *ibid* at 178.

64 Feminizing hormones may cause blood clots, gallstones, elevated liver enzymes, weight gain, and elevation of triglycerides. Masculinizing hormones may cause weight gain, acne, baldness, sleep apnea, and an increase in the volume of red blood cells. See *ibid* at 223–26. Hormone therapy may also cause infertility. See Brill & Pepper, *supra* note 9 at 215–17. While there are no conclusive studies about the long-term effects of puberty suppression, it is generally considered safe. See e.g. Brill & Pepper, *supra* note 9 at 210.

these risks are usually less serious than the risks of withholding treatment.[65]

There is debate about when hormone therapy should commence. The WPATH SOC and Endocrine Society clinical practice guidelines recommend hormone therapy once a child reaches age sixteen.[66] However, in a recent update to its guideline, the Endocrine Society acknowledges that hormone therapy may be appropriate in certain cases after a child reaches age 13.5.[67] Opponents of early hormone therapy worry about administering only partially reversible treatment to younger adolescents.[68] They are concerned about affecting permanent bodily changes on those who may later transition back to the gender they were assigned at birth and be subsequently distressed by these changes. Proponents, again, say that delaying treatment can prolong the suffering of children and place their mental health at risk. They point to a small body of research that suggests puberty suppression and hormone therapy can improve the mental health of gender

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65 See Coleman et al, *supra* note 50 at 178. See also Samuel Dubin et al, "Medically Assisted Gender Affirmation: When Children and Parents Disagree" (2019) 46:5 J Medical Ethics 295 (where the authors argue that the harm of a parent's refusal to consent to medical transition may justify child protection intervention to allow the state to consent to treatment on the child's behalf).

66 Wylie C Hembree et al, "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline" (2009) 94:9 J Clinical Endocrinology & Metabolism 3132.

67 Wylie C Hembree et al, "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline" (2017) 102:11 J Clinical Endocrinology & Metabolism 3869.

68 Chen et al, *supra* note 59 at 80.

dysphoric adolescents.[69] To counter fears surrounding desistance, they cite reports of teenagers who commenced and later abandoned hormone therapy who said the process helped them more fully explore their gender.[70]

### vii. TRANS AND GNC CHILDREN NEED PARENTAL SUPPORT

Parental support is key to the well-being of trans youth. A Trans PULSE study of trans youth from Ontario compared those with "strongly supportive" parents to those with "not strongly supportive" parents and found that "parental support of youth's gender identity and expression was directly associated with how trans youth rated their health and general well-being."[71] Specifically, youth with

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69 See e.g. Annelou LC de Vries et al, "Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study" (2011) 8:8 Journal of Sexual Medicine 2276 (which found a decrease in behavioural and emotional problems and depressive symptoms among young adolescents who took hormone blockers); Annelou LC de Vries et al, "Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment" (2014) 134:4 Pediatrics 696 (finding that young adults who received puberty suppression followed by hormone therapy and gender-confirming surgery experienced improved psychological functioning and well-being and an alleviation of gender dysphoria).

70 See Jack L Turban & Alex Keuroghlian, "Dynamic Gender Presentations: Understanding Transition and 'De-Transition' Among Transgender Youth" (2018) 57:7 J Am Academy Child & Adolescent Psychiatry 451.

71 Robb Tavers et al, "Impacts of Strong Parental Support for Trans Youth: A Report Prepared for the Children's Aid Society of Toronto and Delisle Youth Services" (2 October 2012) at 2, online (pdf): *TransPULSE* <transpulseproject.ca/wp-

strongly supportive parents were more likely to report life satisfaction, positive mental health outcomes, and higher self-esteem, and were less likely to suffer depressive symptoms and consider and attempt suicide.[72] The Canadian Trans Youth Health Survey also found that trans youth who reported high levels of parental support experienced better physical and mental health and were less likely to consider suicide.[73] Recent qualitative research involving trans youth in Quebec confirms that feeling loved, accepted and supported by family significantly improves the ability of trans youth to cope with discrimination in other spheres of life.[74]

Parents can become supportive over time. Parents, upon learning of a child's trans identity, may feel as if "their world is falling apart."[75] Some studies suggest that even the most supportive parents may grieve losing the gender identity of the child they thought they had.[76] Parents also commonly feel "a profound sense of devastation, loss,

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content/uploads/2012/10/Impacts-of-Strong-Parental-Support-for-Trans-Youth-vFINAL.pdf> [perma.cc/3QRQ-HU4C].

72 *Ibid* at 2.

73 Veale et al, *supra* note 32 at 63.

74 See Annie Pullen Sansfaçon et al, "Digging Beneath the Surface: Results from Stage One of a Qualitative Analysis of Factors Influencing the Well-being of Trans Youth in Quebec" (2018) 19:2 Intl J Transgenderism 184.

75 Brill & Pepper, *supra* note 9 at 39.

76 Shawn V Giammattei, "Beyond the Binary: Trans-Negotiations in Couple and Family Therapy" (2015) 54:3 Family Process 418 at 422. Other practitioners have also noted feelings of grief or a sense of loss among parents of trans or GNC children. See Malpas, *supra* note 27 at 457.

shock, confusion, anger, fear, [and] shame".[77] Over time, these feelings can give way to acceptance and support, especially if parents themselves are supported.[78] For many parents, truly accepting a trans child takes years.[79] Clinicians and activists advocate for helping parents through this process because of the importance of parental support to trans youth.[80]

### viii. PARENTAL CONFLICT OVER A CHILD'S GENDER IS PROBABLY HARMFUL

Finally, there is some evidence that conflict over a child's gender identity may be harmful to children. Interviews with ten American "affirming" mothers of trans and GNC children who had experienced "custody related challenges" found that nine of the mothers reported that the custody challenges had negatively impacted their children.[81] Negative impacts included harms associated with having a "rejecting" parent and court orders limiting the child's

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77 Brill & Pepper, *supra* note 9 at 39.

78 See Caitlin Ryan, "Generating a Revolution in Prevention, Wellness & Care for LGBT Children & Youth" (2014) 23:2 Temple Political & Civ Rights L Rev 331 at 337.

79 Brill & Pepper, *supra* note 9 at 40.

80 See Caitlin Ryan et al, "Family Acceptance in Adolescence and the Health of LGBT Young Adults" (2010) 23:4 J Child & Adolescent Psychiatric Nursing 205. See also Florence Ashley, "Puberty Blockers Are Necessary, but They Don't Prevent Homelessness: Caring for Transgender Youth by Supporting Unsupportive Parents" (2019) 19:2 Am J Bioethics 87.

81 Katherine A Kuvalanka et al, "An Exploratory Study of Custody Challenges Experienced by Affirming Mothers of Transgender and Gender-Nonconforming Children" (2019) 57:1 Fam Ct Rev 54.

GNC expression. Research from Australia also suggests that litigation over treatment may negatively impact trans adolescents. Parents in Australia have been required to obtain Family Court approval for treatment to facilitate medical transition for their adolescent children. In one study, parents who were preparing to seek or had sought court permission reported that the court process had increased their child's anxiety, depression, and gender dysphoria.[82] Parents said their children's mental health deteriorated as the court proceedings dragged on.[83] Parents preparing to seek court approval said that even the prospect of proceedings was taking a psychological toll on their children.[84]

## II. LEGAL FRAMEWORK FOR TRANS AND GENDER-NONCONFORMING CHILDREN CASES

In Canada, different laws guide family court judges in cases involving trans and GNC children. These include the *best interests of the child* standard for resolving parenting disputes, provincial health care consent laws, and anti-discrimination laws and decisions.

Parenting disputes are resolved according to the best interests of the child. Federal and provincial legislation list a number of factors for courts to consider in determining what parenting order will be in a child's best

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82 See Fiona Kelly, "'The Court Process is Slow but Biology is Fast': Assessing the Impact of the Family Court Approval Process on Transgender Children and their Families" (2016) 30:2 Austl J Fam L 112.

83 See *ibid* at 121.

84 See *ibid* at 122.

interests, including the child's views and preferences, although this list is not exhaustive.[85]

There is legislative support for considering gender identity and expression in a best-interests determination. In 2017, Ontario passed the *Child, Youth and Family Services Act*,[86] which governs child protection proceedings in that province. The Act directs judges to consider a child's "gender identity and gender expression" when deciding whether an order or determination would be in a child's best interests.[87] The inclusion of gender identity and gender expression in the best-interests standard in the child protection context suggests that these factors could be considered when applying the standard in cases involving parenting disputes.

In cases involving parental disputes over a child's medical transition, provincial health care consent laws may also be relevant. All provinces and territories allow "capable" minors to make treatment decisions in certain circumstances.[88] Capacity generally means being able to understand information relevant to the treatment decision, and to appreciate the reasonably foreseeable consequences of the treatment.[89] In some jurisdictions, capable minors may only consent to treatment that is in their best

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85 *Divorce Act*, *supra* note 4. See also e.g. *Children's Law Reform Act*, *supra* note 4.

86 *Child, Youth and Family Services Act*, 2017, SO 2017, c 14.

87 See *ibid*, s 74(3).

88 *AC v Manitoba (Director of Child and Family Services)*, 2009 SCC 30 [*AC*]. Wishes of incapable children should still be respected.

89 See *Starson v Swayze*, 2003 SCC 32 [*Starson*].

interests.[90] When a child is capable of consenting to treatment, treatment may be administered over the objection of the child's parent(s).[91] In cases involving parental disputes over a child's medical transition, *the child* can make the decision about whether or not to proceed with treatment.[92]

Finally, family court judges should be mindful of anti-discrimination laws and decisions, though they are not directly applicable. Federal and provincial human rights codes prohibit discrimination based on gender identity or gender expression.[93] Section 15 of the *Canadian Charter of Rights and Freedoms*, which prohibits sex discrimination, also protects trans people.[94] Finally, courts and tribunals have found that legal restrictions on trans people's ability to define their gender on official identity documents (that is, birth certificates) constitute

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90 See *Infants Act*, RSBC 1996, c 223 at s 17(3) [*Infants Act*].

91 *Ibid* at s 17(2). Treatment may also be administered without notice to parents.

92 *See AB v CD and EF*, 2019 BCSC 254 [*AB v CD 2019*], aff'd 2020 BCCA 11 [*AB v CD 2020*].

93 *Canadian Human Rights Act*, RSC 1985, c H-6, s 3(1). Kyle Kirkup, "The Origins of Gender Identity and Gender Expression in Anglo-American Legal Discourse" (2018) 68:1 UTLJ 80 at 81 ("As of 2017, every province and territory in Canada has passed explicit anti-discrimination protections for trans people . . .").

94 See *CF v Alberta (Vital Statistics)*, 2014 ABQB 237 [*CF*].

discrimination.[95] Importantly, these authorities have recognized the severe stigma faced by trans people.[96]

## III. HOW FAMILY COURT JUDGES APPROACH CASES INVOLVING TRANS AND GENDER-NONCONFORMING CHILDREN

Reported decisions involving parental disputes over a child's gender should also guide future decision-making in these cases.[97] Despite only a handful of reported decisions, these cases share similarities and certain themes. For example, judges hearing these disputes tend to favour parents who support their children's gender nonconformity; they rely on "gender experts"[98] to help resolve these disputes; and they have recognized that parental conflict over a child's gender is harmful. The approaches of individual judges are also noteworthy. Individual judges have allowed a child to consent to hormone therapy over the objections of a parent, tried to balance support for a child's GNC with reducing parental

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95 See *ibid*; *XY v Ontario (Government and Consumer Services)*, 2012 HRTO 726.

96 See *CF*, *supra* note 94 at para 46 (acknowledging that the social stigma attached to being trans is "pretty severe").

97 It would be interesting to compare parental disputes over a child's gender to parental disputes over a child's sexual orientation. Unfortunately, I have not been able to locate any such reported decisions.

98 I use the term *gender expert* to describe a professional—typically a psychologist, endocrinologist, or pediatrician—with some expertise in treating—either psychologically or medically—trans and GNC children.

conflict, and emphasized the importance of listening to the child at the centre of one of these disputes.

Family court cases involving trans and GNC children are becoming more common. Since 2007, when the first case was decided, there have been ten reported family law cases involving trans and GNC children.[99] Seven of these cases were decided between 2015 and 2019.[100]

The cases share some features. All involve a post-separation dispute over parenting responsibilities and/or parenting time. Of the ten reported cases, nine cases are domestic family law cases, and one is a child protection case. However, the child protection case began as a domestic dispute over parenting and "crossed-over"[101] into the child protection realm after a child protection agency became involved with the family due to parental conflict over the child's gender identity.[102]

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99 *AB v CD 2019*, *supra* note 92, aff'd in part 2020 BCCA 11, 2019 BCSC 1057, 2019 BCCA 297; *AB v CD and EF*, 2019 BCSC 604, [*AB v CD* (Marzari J)], aff'd in part 2020 BCCA 11, 2019 BCSC 1057, 2019 BCCA 297. One of these cases, *AB v CD and EF*, has multiple decisions.

100 A search of reported decisions was conducted using the online database Westlaw Canada. Unfortunately, the reported cases do not provide information on the race or indigeneity of the children.

101 See Claire Houston, Nicholas Bala & Michael Saini, "Crossover Cases of High-Conflict Families Involving Child Protection Services: Ontario Research Findings and Suggestions for Good Practices" (2017) 55:3 Fam Ct Rev 362.

102 *Halton Children's Aid Society v GK*, 2015 ONCJ 307 [*GK*].

In all of the cases, the parents disagree about the child's gender identity or expression; one parent claims the child is trans or gender-nonconforming, while the other parent disputes this characterization. Typically, the "affirming" or "supportive" parent is the mother and the "non-affirming" or "rejecting" parent is the father. It is common for the non-affirming parent (usually the father) to accuse the affirming parent (usually the mother) of pressuring or forcing the child to be trans or gender-nonconforming.[103] The authenticity of the child's gender expression or identity becomes an issue because the parents disagree about whether to support the child's GNC behaviour, social transition, or less commonly, medical transition. For example, by questioning if the child is *really* trans, the non-affirming parent questions the need to support the child's nonconforming gender expression or gender identity.

On the whole, judges tend to favour parents who support a child's gender nonconformity. Courts have found that parents who support a child's gender nonconformity act in the child's best interests. For example, in *Ireland v. Ireland*,[104] the first of the reported cases, the mother was awarded sole custody of two children in part because she was "clearly more understanding and sensitive to" one of the children's gender questioning than the father.[105] Similarly, judges have found that a parent's failure to support a child's gender nonconformity is contrary to a

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[103] See Brill & Pepper, *supra* note 9 at 40. Those who work with transgender youth have also noted that fathers tend to struggle more with accepting a child's transgender identity and often blame mothers.

[104] *Ireland v Ireland*, 2007 ONCJ 11.

[105] *Ibid* at para 14.

child's best interests. In *A.B. v. C.D.*,[106] Justice Marzari held that the father's consistent refusal to use the fourteen-year-old child's chosen name and pronoun was not in the child's best interests.[107]

However, support for a child's gender nonconformity alone is not determinative of parenting responsibility or time. In *J.P.K. v. S.E.*, Justice Zisman awarded sole custody to a father who argued that the mother had influenced the eleven-year-old child to identify as gender neutral.[108] There was evidence that the mother, who themselves identified as transgender, had failed to address the child's severe behavioural issues, and viewed any behavioural issue as attributable to "misgendering" rather than the child's diagnosed Attention Deficit Hyperactivity and Oppositional Defiance Disorders.[109] Justice Zisman found that the father was more likely to follow the recommendations of a gender identity expert and allow the child to freely explore their gender issues.[110] And in *Halton Children's Aid Society v. G.K.*, Justice O'Connell maintained a shared parenting regime with child protection agency supervision partly due to a finding that

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106 *AB v CD* (Marzari J), *supra* note 99.

107 *AB v CD 2020*, *supra* note 92. Justice Marzari also issued a protection order on the basis that the father's refusal to respect the child's gender identity constituted family violence. This order was set aside by the British Columbia Court of Appeal.

108 *JPK v SE*, 2017 ONCJ 306 [*JPK*].

109 *Ibid* at paras 45, 159, 187, 191, 192.

110 *Ibid* at para 184.

the mother had unilaterally decided to socially transition the four-year-old child.[111]

Judges have taken different approaches to claims that an affirming parent has pressured or forced a child to be trans or gender-nonconforming. Some judges have explicitly rejected these claims. For example, in *G.K.*, Justice O'Connell rejected the father's claim that the mother was pressuring the child to be trans to gain an advantage in the parenting dispute, saying it "strain[ed] credulity."[112] Other judges have focused on the harm of questioning the authenticity of the child's gender nonconformity. In *Davies v. Murdock*,[113] the father claimed that the mother was forcing the child to be trans, despite expert opinion to the contrary, calling her actions "child abuse."[114] In granting the mother primary residence and nearly all decision-making authority, Justice Blishen said it was "significant" that the father continued to question the child about their gender identity even when such questioning caused the child distress.[115] Still other judges have attempted to minimize the issue of influence. In *J.P.K.*, the father argued that the mother, who had recently come out as trans, had influenced the eleven-year-old child to identify as gender neutral. Justice Zisman explained that the issue of influence was not relevant to making a

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111 See *GK*, *supra* note 102.

112 *Ibid* at para 105.

113 *Davies v Murdock*, 2017 ONSC 4763 [*Davies*].

114 *Ibid* at para 122.

115 *Davies*, *supra* note 113 at para 192. In the case, Justice Blishen ordered that any decision with respect to the child's gender was to follow the recommendations of a particular gender expert.

parenting decision: "the child's decision to identify as gender neutral has been made, even if influenced by the mother, what is relevant is which parent is best able to support the child."[116]

However, other judges have expressed concern about parents encouraging children's gender nonconformity. In *Gordon v. Brown*, the mother claimed that the six-year-old child, assigned male at birth, had told her "he never wanted to be a boy."[117] In response, the mother researched a playgroup for gender creative children, but did not take the child on the advice of the court appointed assessor.[118] There was also evidence that the mother had posted a picture of the child in a dress on social media and applied polish to the child's nails.[119] By the time of trial, the child was no longer exhibiting GNC behaviour. Saying the mother's actions had been a "major thread" throughout the proceedings, Justice D'Souza found the mother's picture-posting to be "inappropriate" and the nail polish "clearly inappropriate", but said her support for the child's gender nonconformity had ceased and the child had not been harmed by her past actions.[120] In *Hawes v. Hazan*,[121] there was evidence that the mother had encouraged her eight-year-old child, assigned male at birth, to wear girls' clothing, had given them "gender

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116 *JPK*, *supra* note 108 at para 184.

117 *Gordon v Brown*, 2018 ABPC 44 at para 99.

118 *Ibid* at para 100.

119 *Ibid* at para 102.

120 *Ibid* at para 102.

121 *Hawes v Hazan*, 2009 MBQB 212.

inappropriate" gifts, and had played games with the child in which the child wore make-up and pretended to be a princess.[122] Justice Douglas found that these actions caused the child to begin to "act like a girl", and admonished the mother for contributing to the child's "sexual identification problems."[123]

Judges have recognized that forcing a child to conform to a particular gender—whether assigned or not—is harmful. In *G.K.*, Justice O'Connell explained that such coercion would amount to child maltreatment: "If the mother is forcing [the child] to be a stereotypical girl against his wishes, then this will no doubt cause him emotional harm. If the father is forcing [the child] to be a stereotypical boy against his wishes, then this no doubt will also cause him emotional harm."[124]

Judges have also signaled that parental conflict over a child's gender identity is harmful. In *Davies*, the mother, supported by experts, claimed that the nine-year-old child was gender-nonconforming, while the father disputed the child's gender nonconformity, saying the mother was forcing the child to be trans.[125] One expert described it as "an ugly situation wherein there is substantial antipathy between the parents and their disagreement seems now to be crystallized around the issue of who is right about their child's gender."[126] Justice

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122 *Ibid* at para 20.

123 *Ibid* at paras 19–22.

124 *GK*, *supra* note 102 at para 117.

125 *Davies*, *supra* note 113 at para 10.

126 *Ibid* at para 123.

Blishen highlighted different expert opinions on how the conflict over the child's gender was harming the child. One expert worried that the parents' disagreement, and especially the father's refusal to accept the child's gender nonconformity, was preventing the child from exploring their gender identity.[127] Another found that the child was "at risk for significant mental illness if the situation is not resolved."[128] In *G.K.*, the mother claimed the four-year-old child was trans while the father rejected this characterization.[129] Again, experts worried that this conflict would prevent the child from exploring their gender. Justice O'Connell found the child to be in need of protection in part because the parents' disagreement over the child's gender had created a risk of emotional harm.[130]

The high conflict nature of many of the reported decisions helps explain parental disagreement over a child's gender nonconformity. Hostility, mistrust, and poor communication are common in high conflict separations,[131] and often exacerbate parental disagreement over gender. For example, in *G.K.*, the mother claimed that she suspected the four-year-old child, assigned male at birth, was transgender for "a couple of years", but did not

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127 *Ibid* at para 118.

128 *Ibid* at para 124.

129 *Ibid at* paras 15, 19, 20.

130 *GK*, *supra* note 102 at para 91.

131 See Rachel Birnbaum & Nicholas Bala, "Toward the Differentiation of High-Conflict Families: An Analysis of Social Science Research and Canadian Case Law" (2010) 48:3 Fam Ct Rev 403 at 410. The situations discussed are not the ones involving domestic violence or severe alienation but instead what has been described as co-parenting conflict.

share her suspicions with the father until she sent him an email saying the child was female and "would benefit greatly from being able to fully transition socially to her true gender identity."[132] The father, who claimed to have no knowledge of the child's gender nonconformity, rejected the mother's characterization of the child as trans.[133] High conflict can also cause parents to become entrenched in their respective positions vis-à-vis the child's gender, as in *Davies* where the parents' conflict centred on which parent was "right" about the child's gender.[134]

Finally, conflict can lead one parent to use a child's gender identity as a weapon against the other parent. In *Watts v. Sheppard*,[135] the mother, who wanted the children to live with her, initially told one of the children, who was assigned female at birth and who was struggling with his gender identity, that the father would be angry if the child identified as male.[136] Since then, the child had socially transitioned to male with the father's support and the mother now refused to accept the child's gender identity. Justice Nicholson found the mother's actions reflected a lack of appreciation for the child's needs, saying the mother supported the child's transition only "when she perceived it as being a source of leverage against the . . . father."[137]

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132 *GK*, *supra* note 102 at paras 33–34.

133 *Ibid* at paras 16, 35.

134 *Ibid* at para 123.

135 *Watts v Sheppard*, 2016 ONSC 8062.

136 *Ibid* at para 5.

137 *Ibid* at para 18.

Judges have attempted to balance support for children's gender nonconformity with reducing parental conflict. For example, in *Davies*, Justice Blishen, rather than totally favoring the supportive parent, opted for a solution intended to reduce conflict.[138] The father in that case refused to accept the child's gender nonconformity, despite medical opinion to the contrary.[139] He claimed that the mother's supposed "campaign" to turn the child trans was child abuse.[140] Justice Blishen acknowledged that the parents' conflict caused harm to the child, who had a close relationship with both parents.[141] The judge gave the mother decision-making authority with respect to the child *except* on decisions relating to gender, with those decisions to be made according to the recommendations of a particular gender expert.[142]

*Davies* illustrates the important role gender experts play in these cases. These experts may be psychologists, endocrinologists, or pediatricians. In most cases, the child has been assessed by a gender expert before proceedings commence. These assessments typically consider whether the child is suffering gender dysphoria and whether their gender nonconformity is authentic (that is, not coerced). Thus, these assessments speak to the issue of "is this child *really* trans?" and whether the affirming parent is pressuring the child to be gender-nonconforming. Gender experts may also provide an opinion on the appropriateness

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138 *Davies*, *supra* note 113.

139 *Ibid.*

140 *Ibid* at para 10.

141 *Ibid* at para 174.

142 *Ibid* at para 192.

of social or medical transition. Judges have found a parent's failure to follow an expert's recommendation to be a negative factor in determining parenting arrangements.[143] Parents who follow expert recommendations are more likely to be seen as acting in the best interests of the child.[144]

The challenge of competing gender experts has only arisen in one case: *A.B. v. C.D. 2020*.[145] This case is also the only reported decision in which a judge has ruled on the issue of medical transition. In the case, Justice Bowden supported the child's wish to medically transition.[146] The child was a fourteen-year-old transgender boy, who began socially transitioning at the age of twelve.[147] With his mother's support, he sought assistance to medically transition.[148] A psychologist diagnosed the boy with gender dysphoria and recommended hormone therapy.[149] He was referred to a gender clinic where a pediatric endocrinologist found hormone therapy to be in the child's best interests.[150] The father refused to consent to the treatment.[151] The child commenced proceedings, asking the family court to find him capable of consenting

143 See *JPK*, *supra* note 108 at para 201.

144 See *Davies*, *supra* note 113 at para 183.

145 *AB v CD 2020*, *supra* note 92.

146 *AB v CD and EF*, 2019 BCSC 254 at para 70.

147 *AB v CD 2020*, *supra* note 92 at para 11.

148 *AB v CD and EF*, 2019 BCSC 254 at para 13.

149 *Ibid* at para 15.

150 *Ibid* at para 19.

151 *Ibid* at para 20.

to the treatment and allowing the hormone therapy to proceed.[152] The father opposed the relief sought, and secured a temporary injunction preventing the treatment until the matter could be heard.[153] While awaiting the hearing, the child's gender dysphoria worsened.[154] His endocrinologist expressed concern that delaying the treatment would place the child at risk of suicide.[155] The endocrinologist, the psychologist, and a psychiatrist all assessed the child and found him capable of consenting to the hormone therapy.[156]

Justice Bowden found the child capable of consenting to the hormone therapy and ordered the therapy to proceed.[157] In doing so, Justice Bowden preferred the child's expert evidence over that of the father. The father filed an affidavit from a doctor specializing in pediatric endocrinology, who warned of the harm of transition in adolescents.[158] The father relied on this evidence to argue for more time to assess the risks of the treatment.[159] Justice Bowden refused the father's request to delay the matter until there could be a more "fulsome hearing" on the

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152 *Ibid* at para 2; *AB v CD 2020*, *supra* note 92 at para 29.

153 *AB v CD and EF*, 2019 BCSC 254 at para 3.

154 *Ibid* at para 24.

155 *Ibid* at para 26.

156 *Ibid* at paras 29, 30.

157 *AB v CD 2020*, *supra* note 92. The British Columbia Court of Appeal upheld that portion of Justice Bowden's order finding the child capable of consenting to hormone therapy.

158 *AB v CD and EF*, 2019 BCSC 254 at para 37.

159 *Ibid* at para 35.

implications of the hormone therapy for the child.[160] Justice Bowden found the father "somewhat disingenuous" in seeking to present more evidence on the hormone therapy, saying the father was more likely "delaying proceedings as a way of preventing his son from obtaining the gender transition treatment that he seeks."[161] Justice Bowden found that delaying treatment was not in the child's best interests.[162] Numerous professionals as well as the child's mother and the child supported the hormone therapy. Justice Bowden also accepted that delaying the treatment could place the child at risk of suicide.[163]

In cases involving disputes over social transition or supporting a child's GNC behaviour, judges often follow expert recommendations to support the child in taking the lead. In *J.P.K.*, the parents brought the eleven-year-old child to a pediatrician specializing in gender identity issues.[164] The pediatrician was "not clear" about "the gender piece", and suggested that the parents "let the child express himself and wait and see what happens."[165] Justice Zisman transferred custody to the father who was found to be "more likely to just let [the child] be and explore his gender issues."[166] In *Davies*, a psychiatrist, who was also the director of the gender diversity clinic at the Children's

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160 *AB v CD* (Marzari J), *supra* note 99 at para 35.

161 *Ibid* at para 43.

162 *AB v CD and EF*, 2019 BCSC 254 at paras 50, 51.

163 *Ibid* at para 53.

164 *JPK*, *supra* note 108.

165 *Ibid* at para 75.

166 *Ibid* at para 184.

Hospital of Eastern Ontario, assessed the nine-year-old child and recommended that "[t]he decision about whether to socially transition should be up to the child."[167] The mother supported social transition while the father was opposed. Justice Blishen ordered that any decision with respect to the child's gender identity follow the recommendations of the psychiatrist. Finally, after the decision in *G.K.*, the parents agreed that neither parent would allow the child, a four-year-old assigned male, to "dress as a girl."[168] Justice O'Connell expressed concern that the provision did not accord with a gender expert's recommendation to allow the child "to express himself in a variety of different ways."[169] Accordingly, the term was amended to read: "Neither party shall unilaterally dress [the child] as a girl or force [the child] to take on certain gender roles. In the event that [the child] expresses a desire to dress as a girl, then the party in whose care [the child] is shall respect [the child's] desire to dress as a girl . . ."[170]

Finally, judges have signaled that the views and preferences of children may matter more in cases involving disputes over a child's gender than other custody and/or access cases. In most of the reported decisions, the views and preferences of children were before the court, usually presented by child protection workers or court-appointed assessors. In *N.K. v. A.H.*,[171] the eleven-year-old child applied to be added as a party to his father's application

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167 *Davies*, *supra* note 113 at para 139.

168 *GK*, *supra* note 102 at para 111.

169 *Ibid* at para 114.

170 *Ibid.*

171 *NK v AH*, 2016 BCSC 744.

seeking to prevent the child from taking medication to suppress puberty. The mother supported the child's application as well as his decision to medically transition.[172] Justice Skolrood granted the child's application and appointed a litigation guardian for the child.[173] Justice Skolrood explained that, "this case is different from the many family law cases that come before the courts in which the views of the child are sought on issues relating to guardianship and parenting time, and where those views are typically presented through third party reports."[174] According to Justice Skolrood, this case, involving a dispute over whether the child should be allowed to medically transition, was "really about J.K. [the child] and his role in determining his own future. In my view, these issues cannot be property considered without J.K.'s direct participation, nor would it be fair to J.K. for the court to attempt to do so."[175]

## IV. SUGGESTIONS FOR RESOLVING FAMILY CASES INVOLVING TRANS AND GENDER-NONCONFORMING CHILDREN

Drawing on what we know about trans and GNC children and the judicial approaches to cases involving parental disputes over a child's gender, this Part offers some suggestions for how such cases should be resolved in the future. First, judges (and parents) should listen to and place significant weight on the views and preferences of the

172 *Ibid* at para 3.

173 *Ibid* at para 53.

174 *Ibid* at para 39.

175 *Ibid* at para 40.

children at the centre of these disputes. Second, judges should focus on what the child is communicating about their experience and needs rather than trying to answer, "is this child *really* trans?" Third, judges should presume that it is in the best interests of GNC children to support their gender expression as well as their decision to socially or medically transition. Fourth, judges should attempt to balance support for gender nonconformity with reducing parental conflict. Finally, judges should neither expect nor require gender expert evidence in every case involving a parental dispute over a child's gender.

### i. RESPECT THE CHILD'S VIEWS AND PREFERENCES

Judges should hear and accord significant weight to the views and preferences of the children at the centre of these disputes. Canadian family law dictates that judges consider the views and preferences of children, where they can be reasonably ascertained, when making a decision in children's best interests.[176] Article 12 of the United Nations *Convention on the Rights of the Child*,[177] which Canada has ratified, also requires decision-makers to hear and consider children's views, and some Canadian courts have interpreted Article 12 as granting children a right to be heard in family cases.[178] Trans and GNC children's voices

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176 See e.g. *Children's Law Reform Act*, *supra* note 4, s 24(2).

177 See United Nations General Assembly Resolution 44/25, UNGAOR, 44th Session, 61st meeting, UN Doc A/RES/44/25 (1989).

178 See *BD v DLG*, 2010 YKSC 44. See also Nicholas Bala & Patricia Hebert, "Views, Preferences and Experiences of Children in Family Cases" (Paper presented at the National Judicial Institute Program on

have historically been marginalized.[179] To correct this marginalization, the gender-affirming model, now practiced by the majority of gender specialists, makes listening to GNC children a priority.[180] While all children deserve the opportunity to be heard in proceedings affecting them, our past failure to hear trans and GNC children makes listening to their voices even more important.[181]

Judges should also give significant weight to the views and preferences of children in these cases. Generally, in parenting disputes, the views and preferences of children are not determinative; however, the older the child the more weight accorded to their views and wishes.[182] But parenting disputes centering on a child's gender are different from most other parenting disputes. First, they involve a matter of identity that emanates from the child. This distinguishes them from other cases involving parental disputes over a child's identity; for example, cases about whether a child should identify with a particular race

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Judicial Interviews of Children and the National Family Law Program, Whistler, British Columbia, July 11–12, 2014).

179 See Julian Gill-Peterson, *Histories of the Transgender Child* (Minneapolis: University of Minnesota Press, 2018).

180 See Hidalgo et al, *supra* note 48 at 285.

181 Listening to and respecting the views of GNC children also accords with treating trans people as legal actors rather than legal subjects. See Samuel Singer, "Trans Justice, Trans Rights: A Multi-Instrumentalist Legal Toolkit" CJLS [forthcoming in 2020].

182 See Julien D Payne & Marilyn A Payne, *Canadian Family Law*, 7th ed (Toronto: Irwin Law, 2017) at 618–19.

or religion.[183] In those cases, the issue is whether the child should share in the identity of one parent. In cases involving a child's gender identity, usually neither parent shares the identity of the child.[184] Therefore, the issue is not whether a child should share in a parent's identity but whether a child should be supported in their own, independent identity. Because gender identity emanates from the child, the child—not the parent—is best placed to define their gender and communicate their needs with respect to gender expression and identity. This is a central tenet of the gender-affirming model of treatment. As Ehrensaft explains, "[i]f you want to know a child's gender, ask the child: it is not ours to tell but the child's to say . . . ."[185]

Second, the views and preferences of GNC children should be accorded greater weight in these cases because there is often more at stake for the child here than in other parenting disputes. Children who are not supported in their gender identity are more likely to suffer negative mental health consequences, including increased risk of suicide. Those who cannot access puberty blockers or hormone therapy may not be able to "pass"[186] as their gender

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183 See e.g. *Van de Perre v Edwards*, 2001 SCC 60; *Ali v Ansar*, 2010 ONSC 2428.

184 One exception is *JPK*, *supra* note 108, where the mother also identified as gender neutral.

185 See Diane Ehrensaft, *The Gender Creative Child: Pathways for Nurturing and Supporting Children Who Live Outside Gender Boxes* (New York: The Experiment, 2016) at 164.

186 Passing has been defined as "appear[ing] to belong to one or more social subgroups other than the one(s) to which one is normally

identity, even with later medical intervention,[187] which carries what some may perceive as a risk of being "outed" as trans and potentially subjected to discrimination and violence.[188] To borrow the logic of Justice Skolrood in *N.K.*, not respecting the views and preferences of GNC and trans children in these cases deprives them of the ability to "determin[e] their own future."[189]

### ii. FOCUS ON THE CHILD'S EXPRESSED NEEDS AND NOT "IS THIS CHILD REALLY TRANS?"

Judges should avoid getting entangled in a debate over whether a child is *really* trans. This includes trying to predict whether a particular child will later identify as trans. First, it may be impossible to answer these questions. Second, asking these questions risks promoting sexist and transphobic messages.

Trying to determine if a child is or will be trans is challenging, and may be impossible. Gender nonconformity in early childhood (below age six or so) may signal transness, it may indicate long-term gender

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assigned by prevailing legal, medical and/or socio-cultural discourses." Sinéad Moynihan, *Passing into the Present: Contemporary American Fiction of Racial and Gender Passing* (Manchester and London: Manchester University Press, 2010) at 8. Some trans people "pass" as cisgender. Passing may be motivated by a desire to avoid discrimination or to affirm one's gender identity. Alecia D Anderson et al, "'Your Picture Looks the Same as My Picture': An Examination of Passing in Transgender Communities" (2020) 37:1 Gender Issues 44 at 45.

187 Brill & Pepper, *supra* note 9 at 208.

188 Nealy, *supra* note 11 at 118; Brill & Pepper, *supra* note 9 at 208–09.

189 See *NK v AH*, *supra* note 171 at para 40.

nonconformity, or it may reflect a developmental stage. Gender nonconformity in later childhood may indicate transness, long-term gender nonconformity, or it may be a phase that passes with puberty. Children who consistently and persistently identify as a gender different from the one assigned at birth over a prolonged period of time and post-pubescent adolescents with GD may be more likely to identity as trans as adults.[190] However, gender identity can be fluid and there is no guarantee that one's gender identity will be the same at ages fifteen and forty-five.[191]

Asking whether a child is really trans also pathologizes transness. Scholars and activists have pointed out that trans kids continually have their gender identities questioned while the gender identities of cisgender children are taken for granted.[192] This skepticism communicates that there is something wrong with being trans. Parents who consistently question whether their child is *really* trans risk sending the same message. This is not only potentially harmful to their child: allowing parents to express their skepticism towards a child's GNC or trans identity in legal proceedings permits anti-trans bias to be aired in a public forum.

Focusing on whether a child is *really* trans also perpetuates problematic assumptions about parental

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190 Malpas, *supra* note 27 at 460–461; Drescher & Pula, *supra* note 29 at S18.

191 Marco A Hidalgo et al, *supra* note 48 at 285.

192 See Gill-Peterson, *supra* note 179 at 10; Newhook et al, "Critical Commentary on Follow-Up Studies and 'Desistance' Theories", *supra* note 19 at 217.

influence, especially maternal influence.[193] Parental disputes over whether a child is *really* trans often involve an accusation that the mother is pressuring the child to be trans. This accusation is familiar: until quite recently, professionals blamed mothers for their children's gender nonconformity.[194] This mother-blaming is part of a larger history of holding mothers accountable for children's "pathologies", including, not so long ago, homosexuality.[195] Feminists have critiqued mother-blaming as oppressing women by keeping them responsible for child-rearing and therefore out of the public sphere, as well as misogynistic.[196] Giving space to fathers' claims that mothers are to blame for their children's gender nonconformity risks propagating sexist ideology.

Interrogating the role of parental influence on a child's gender identity also, again, pathologizes transness. As trans bioethicist and legal scholar Florence Ashley points out, "[n]o one's experience of gender is free from

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193 For more on how mothers have been blamed for children's gender-nonconformity, see Diana Kuhl & Wayne Martino, "'Sissy' Boys and the Pathologization of Gender Nonconformity", in Susan Talburt, ed, *Youth Sexualities: Public Feelings and Contemporary Cultural Politics* 32, vol 231 (Santa Barbara: Praeger, 2018).

194 See Jake Pyne, "The Governance of Gender-nonconforming Children: A Dangerous Enclosure" (2014) 11 Annu Rev Crit Psychol 79 at 84.

195 See Paula J Caplan & Ian Hall-McCorquodale, "The scapegoating of mothers: A call for change" (1985) 55:4 Am J Orthopsychiatry 610 at 612; Paula J Caplan & Ian Hall-McCorquodale, "Mother-blaming in major clinical journals" (1985) 55:3 Am J Orthopsychiatry 345 at 348.

196 See Molly Ladd-Taylor & Lauri Umansky, *"Bad" Mothers: The Politics of Blame in Twentieth-Century America* (New York: New York University Press, 1998).

social influences."[197] This means that parents, who play a significant role in children's socialization, inevitably influence a child's gender identity. However, we do not challenge the authenticity of children's cisgender identities based on parental influence, only trans identities. The implication is that influencing your child to develop a cisgender identity is appropriate, whereas influencing your child to develop a trans identity is wrong, an implication which suggests being trans is wrong. That said, if a parent could establish that a child's gender identity (whether cis or trans) was the product of another parent's coercion, it would be appropriate to question whether that identity was authentic.[198]

### iii. PRESUME THAT SUPPORTING CHILDREN'S GENDER NONCONFORMITY PROMOTES THEIR BEST INTERESTS

Rather than attempting to resolve a dispute over whether a child is or will be trans, judges should focus on—and encourage parents to focus on—the child's best interests. This was the approach of Justice Zisman in *J.P.K.*, who said that even if the mother had influenced the child to identify as gender neutral, "what [was] relevant [was] which parent [was] best able to support the child."[199]

It is not necessary to determine whether a child is or will be trans to determine their best interests. Parental disputes over a child's gender identity ask whether it is in

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197 See Ashley, "Thinking an Ethics of Gender Exploration", *supra* note 30 at 226.

198 *Ibid*.

199 *JPK*, *supra* note 108 at para 184.

the child's best interests to support GNC behaviour, social transition, or, less frequently, medical transition. These determinations do not and cannot, given the epistemic challenges of authenticating transness, hinge on whether a child is trans.

Since we cannot know for certain a child's future gender identity, and because GNC children are usually best placed to communicate what they need with respect to gender,[200] judges should presume that supporting a child's gender nonconformity or decision to socially or medically transition is in the child's best interests.

Supporting a child's gender nonconformity is likely to be in their best interests, regardless of their future gender identity. Supporting or discouraging gender nonconformity can be harmful for trans kids.[201] Trans experience also tells us that pathologizing transness is harmful. Supporting children in expressing and exploring gender protects children who may later identify as trans. It is also unlikely to harm children who later identify as cisgender and may in fact help them. Supporting gender nonconformity in future cisgender children empowers those children to come to a gender identity on their own terms.[202]

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200 Ehrensaft, *supra* note 185 at 164.

201 See Part I.vii.

202 In addition to promoting best interests, supporting gender-nonconformity in children may also have positive social effects. If we accept—and we should—that transness is a normal human variation and not pathological, it would also be problematic to view support for gender nonconformity in cisgender children as harmful, since it would suggest there is something wrong with being trans.

Judges should also presume that supporting a child's desire to socially transition—at whatever age—promotes that child's best interests. The main risk of social transition is transitioning back: a child may later wish to revert back to a cisgender identity. However, for trans kids, denying or delaying social transition can exacerbate suffering.[203] And for kids who later identify as cisgender, transitioning back to their assigned gender may not be a bad outcome. Evidence that transitioning back is highly distressing for children is limited.[204] This is not to say transitioning back is always easy, and those who transition back also need support.[205] However, social transition and then transitioning back may enable gender exploration and help individuals realize a cisgender identity.[206]

Finally, judges should presume that supporting a child's decision to medically transition, where this decision is supported by a medical professional, is in the child's best interests. Supporting a child's decision to medically transition is consistent with giving more weight to the views and preferences of older children in family law matters. In parenting cases, judges may canvass but often give limited deference to the wishes of children ages nine and under.[207] The views of children between ten and thirteen, the age at which children may seek puberty

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203 See Part I.iv.

204 See Part I.vi.

205 See Turban & Keuroghlian, *supra* note 70 at 452, 453.

206 From a social point of view, supporting children (and adults) to socially transition *and de-transition* challenges our harmful assumptions about gender: that one is either male or female, and that gender is fixed.

207 See Payne & Payne, *supra* note 129 at 618–19.

blockers, are commonly treated as important but not decisive. For children over fourteen, typically the age at which children may seek hormone therapy, courts have recognized the importance of respecting their wishes.[208]

Supporting a child's decision to medically transition is also consistent with the law respecting children's health care decision-making. Health care consent laws allow older, "capable" children to make treatment decisions over the objections of their parents. Capable children may, depending on the law of the province or territory,[209] accept or refuse treatment. The Supreme Court has recognized that the state has less of an interest in protecting a child who accepts treatment than a child who refuses treatment, since treatment is recommended by a health care provider to promote a child's best interests.[210] A health care provider's recommendation for puberty blockers or hormone therapy, which the child wishes to accept, provides greater support for that treatment being in a child's best interests, regardless of whether the child is capable of consenting. In cases involving parental disputes over a child's medical transition, the fact that one of the parents supports the health care provider's recommendation for treatment further reduces the state's interest in protecting the child.

The risks of treatment, including that a child may later change their mind, should not prevent judges from

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208 See Payne & Payne, *supra* note 129 at 618–19.

209 For example, some jurisdictions provide that a capable minor may only consent to treatment that is in their best interests. See *Infants Act*, *supra* note 90, s 17(3).

210 See *AC*, *supra* note 88 at para 52.

supporting a child's decision to medically transition. Gender-affirming clinicians do not attempt to predict a child's future gender identity but instead treat children according to their present needs.[211] They accept that there is a risk of regret but argue that this risk is outweighed by the suffering of gender dysphoric children, which itself carries a risk of suicide.[212] They point out that puberty suppression is reversible, and that while hormone therapy can lead to permanent physical changes, these changes are largely cosmetic.[213] Clinicians also suggest that changing one's mind and stopping treatment is not always harmful. For example, Turban and Keuroghlian say that some of the few adolescents in their practice who stop identifying as trans and cease hormone therapy report that this is "not necessarily a bad outcome."[214] For example, one teenager expressed that a trial of hormones allowed her to become more comfortable in her queer, cisgender identity.[215]

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211 See Newhook et al, "Critical Commentary on Follow-Up Studies and 'Desistance' Theories", *supra* note 19 at 214 stating that "current approaches to care recommend that care providers prioritize young people's stated identities, perceptions, and needs in the present moment, as opposed to attempting to estimate the likelihood of future identity and needs." See also Julia T Newhook, "Teach your parents and providers well: Call for refocus on the health of trans and gender-diverse children" (2018) 64:5 Can Fam Physician 332. Newhook states: "our main priority is not predicting children's adult identities; it is supporting children's present and future health and well-being."

212 See Turban & Keuroghlian, *supra* note 70 at 453.

213 *Ibid* at 453.

214 *Ibid* at 452.

215 *Ibid* at 451.

### iv. BALANCE SUPPORT FOR GENDER NONCONFORMITY WITH CONFLICT REDUCTION

While supporting a child's gender nonconformity and decisions to socially or medically transition is likely in the child's best interest, so too is reducing parental conflict. Parental support is essential to trans and GNC children. We also know that parental conflict, and possibly conflict over a child's gender specifically, is harmful to children. As a result, judges should attempt to balance support for children's gender nonconformity with parental conflict reduction.

Balancing support for a child's gender nonconformity with parental conflict reduction may mean giving non-supportive parents more latitude, and more time, to voice their concerns. Most parents struggle with the realization that their child may be trans, and fathers in particular.[216] Some parents learn to accept their child's gender identity, although true acceptance can take years, and may require therapeutic support.[217] Because parents *can* become accepting and because parental support is so important to trans and GNC children, judges should consider crafting orders that give non-supportive parents space to come to terms with their child's gender identity or expression. This could mean preventing supportive parents from making unilateral decisions with respect to the child's gender nonconformity. In *G.K.*, for example, Justice O'Connell ordered that each party was to be notified by the other when the child chose to wear gender-nonconforming

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216 See Brill & Pepper, *supra* note 9 at 39–40.

217 *Ibid* at 40, 42. See also Ryan et al, *supra* note 80.

clothing.[218] And in *Davies*, Justice Blishen ordered that decisions regarding the child's gender were to be made according to the recommendations of a gender expert.[219] However, where a parent's non-support is clearly harming the child, as in *A.B.*, judges should be cautious about promoting conflict reduction at the expense of the child's well-being.

### v. GENDER EXPERT EVIDENCE SHOULD NOT ALWAYS BE NECESSARY

Gender expert evidence can be useful in cases involving trans or GNC children.[220] In the reported decisions, most gender experts were "participant experts": they had assessed the child apart from the litigation and either their notes or reports were later admitted into evidence or they were asked to give testimony about their involvement with the child.[221] These experts provided opinions on whether the child was suffering GD, whether a parent had pressured the child to be gender-nonconforming, the child's views and preferences with respect to gender, and how the child's gender nonconformity should be managed. This evidence was especially valuable because of the experts'

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218 See *GK*, *supra* note 102.

219 See *Davies*, *supra* note 113.

220 A full discussion of the admissibility of expert evidence in cases involving trans and GNC children is beyond the scope of this paper.

221 See Nicholas Bala, Kristen Normandin & Cara Senese, "Expert Evidence, Assessments and Judicial Notice: Understanding Children and the Family Context," in Harold Niman, ed, *Evidence in Family Law Cases* (Toronto: Canada Law Book, 2019), § 5:30:21.

independence: all of the experts had been jointly retained by the parents prior to litigation.[222]

"Litigation experts"—experts hired by one party to provide an opinion about a matter in dispute[223]—may also assist the court. Only one case, *A.B.*, involved litigation expert evidence, and Justice Bowden placed little weight on this evidence because neither expert had met the child and could not comment directly on the case. However, litigation expert evidence could be helpful where there is a real dispute over a child's capacity to consent to medical treatment[224] or whether medical treatment is in a child's best interests.[225] Litigation experts are less likely to assist the court in non-medical transition cases. As outlined above, it is in the best interests of children to be supported in their gender nonconformity or social transition unless there is clear evidence of parental pressure. A litigation expert who has not met the child is unlikely to be able to offer an opinion on whether the child's gender nonconformity or decision to socially transition was coerced.

Although sometimes helpful, gender expert evidence should be approached with caution. Transgender identity in children is a politically contentious issue, and judges should carefully consider a gender expert's

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222 See *Lindahl v Lindahl*, [2005] OJ No 4090 (SCJ) at para 19.

223 See Bala, Normandin & Senese, *supra* note 221, § 5:30:21.

224 For example, a litigation expert may critique another professional's capacity assessment.

225 For example, where the child has a pre-existing medical condition that makes hormone therapy particularly dangerous.

impartiality in determining whether to admit their evidence and its weight. This is especially important where the evidence is challenged. More generally, gender expert evidence may have a "minoritizing" effect: by relying on experts to determine which children should socially or medically transition, the legal system may be delineating a category of children who are *really* trans to the detriment of children who fall outside those parameters.[226]

The use of gender experts also risks pathologizing children. GNC children who are brought to a gender expert for assessment may perceive that there is something wrong with their gender expression or identity, especially if this is being communicated by one parent. In the reported cases, gender experts often saw the children several times. GD diagnostic assessments are intrusive, even if performed with care. Since the 1990s, clinicians have warned that diagnostic assessments for GD may damage the self-esteem of healthy children.[227] Judges should therefore be careful not to create an expectation that gender expert evidence is always required in these cases.

Judges may be able to rely on court-appointed assessors, Voice of the Child Reports (VCRs),[228] or their

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226 See Kirkup, *supra* note 93.

227 See Newhook et al, "Critical Commentary on Follow-Up Studies and 'Desistance' Theories", *supra* note 19 at 218.

228 Voice of the Child Reports are prepared by an independent mental health professional who ascertains and reports on a child's perspectives and preferences. They are more narrow (and less expensive) than traditional assessments. See Bala, Normandin & Senese, *supra* note 221 at § 5:40.11.

own interview of a child[229] to make a decision in the best interests of a trans or GNC child. This is especially true in non-medical transition cases where a diagnosis of GD is not required to support a child's gender nonconformity or decision to socially transition.[230] In addition to offering an opinion on GD, gender experts have informed courts about parental pressure, the views and preferences of the child with respect to gender, and how to manage a child's GNC behaviour. A competent court-appointed assessor could at least provide an opinion on parental pressure and the views and preferences of the child with respect to gender. A VCR or judicial interview could also put the views and preferences of the child before the court. Because a child's gender nonconformity or decision to socially transition should be supported absent evidence of parental pressure, information provided by an assessor, VCR, or judicial interview would likely be enough for a judge to determine which approach to managing the child's gender nonconformity would be in the child's best interests.

## CONCLUSION

A number of principles should guide judges hearing parenting disputes involving trans or GNC children. Because GNC children are often best placed to communicate their needs with respect to gender, and

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229 Judicial interviews of children in family law cases are becoming more common. See Rachel Birnbaum & Nicholas Bala, "A Survey of Canadian Judges about Their Meetings with Children: Becoming More Common but Still Contentious" (2014) 91:3 Can Bar Rev 637.

230 Most GNC children are not gender dysphoric. See Part I.ii. While social transition is a recommended treatment for GD, the decision to socially transition ultimately rests with the child and not a treatment provider. See Brill & Pepper, *supra* note 9 at 116.

because these decisions are fundamentally important to children, judges should hear and place significant weight on the views and preferences of children at the centre of these disputes. Rather than asking, "is this child *really* trans?" or attempting to predict the child's future gender identity, questions that are not only harmful but also nearly impossible to answer, judges should focus on what the child is saying they need. Judges should also presume that supporting a child's GNC behaviour or their decision to socially or medically transition is in the child's best interests. A presumption in favour of supporting gender nonconformity in children recognizes that the risks of *not* supporting gender nonconformity are greater than the risks of supporting gender nonconformity. While supporting gender nonconformity is crucial, given the importance of parental support to trans and GNC children, judges should attempt to balance support with reducing parental conflict. Finally, to avoid pathologizing gender nonconformity in children, judges should consider whether gender expert involvement is necessary. As more children identify or express as gender-nonconforming and more of these cases inevitably come before family courts, judges should keep these principles in mind in order to make decisions that both respect and protect trans and GNC children.