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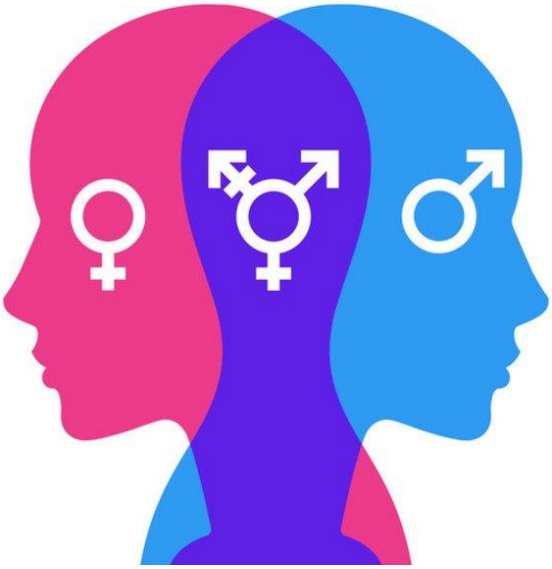
EXPERT OPINION

Might Gender-Affirming Support for Transgender Youth Constitute Child Abuse?

Elisa Reiter and Daniel Pollack | February 23, 2022

Texas Attorney General Ken Paxton disputes the American Medical Association, the American Psychiatric Association, the American Academy of Pediatrics, and the position that those respective organizations have taken in support of individualized care of children who experience gender dysphoria.



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Texas Attorney General Ken Paxton disputes the American Medical Association, the American Psychiatric Association, the American Academy of Pediatrics, and the position that those respective organizations have taken in support of individualized care of children

who experience gender dysphoria. Such individualized care could include treatments such as hormone therapy and puberty blockers.
On Feb. 18, 2022, Paxton issued Opinion No. KP-0401, regarding "Whether certain medical procedures performed on children constitute child abuse (RQ-0426-KP)." The focus of his inquiry:

"Whether facilitating (parents/counselors) or conducting (doctors) medical procedures and treatments that could permanently deprive minor children of their constitutional right to procreate, or impair their ability to procreate, before those children have the legal capacity to consent to those procedures and treatments, constitutes child abuse."

In the Executive Summary of Opinion No. KP-0401, he concludes that:

"Based on the analysis herein, each of the 'sex change' procedures and treatments enumerated above, when performed on children, can legally constitute child abuse under several provisions of chapter 261 of the Texas Family Code."

- These procedures and treatments can cause "mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning." TEX. FAM. CODE § 261.001(1)(A)
- These procedures and treatments can "caus[e] or permit the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning." Id. § 261.001(1)(B).
- These procedures and treatments can cause a "physical injury that results in substantial harm to the child." Id. § 261.001(1)(C).
- These procedures and treatments often involve a "failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child[,]" particularly by parents, counselors, and physicians. Id. § 261.001(1)(D).

AG Opinion No. KP-0401 was issued in response to two letters of inquiry:

1. The first from Hon. Matt Krause, chair, House Comm. on Gen. Investigating, to Hon. Ken Paxton, Tex. Att'y Gen. at 1 (Aug. 23, 2021), https://www2.texasattorneygeneral.gov/opinions/opinions/51paxton /rq/2021/pdf/RQ0426KP.pdf ("Request Letter");
2. The second from Hon. Jaime Masters, Comm'r, Tex. Dept. of Family & Protective Servs., to Hon. Greg Abbott, Governor, State of Tex. at 1 (Aug. 11, 2021), //gov.texas.gov/uploads/files/press/Response_to_August_6_2021_OOG_Letter_08.11.2021.pdf (on file with the Op. Comm.).

In the Diagnostic Statistical Manual of Mental Disorders, 5th Ed., gender dysphoria in children is defined as:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1):

1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typically masculine clothing and a strong resistance to the wearing of typical feminine clothing.
3. A strong preference for cross-gender roles in make-believe play or fantasy play.
4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
5. A strong preference for playmates of the other gender.
6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
7. A strong dislike of one's sexual anatomy.
8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

Texas Family Code Section 261 defines abuse as:

(1) “Abuse” includes the following acts or omissions by a person:

(A) mental or emotional injury to a child that results in an observable and material impairment in the child’s growth, development, or psychological functioning;

(B) causing or permitting the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child’s growth, development, or psychological functioning;

(C) physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident or reasonable discipline by a parent, guardian, or managing or possessory conservator that does not expose the child to a substantial risk of harm;

(D) failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child.

Paxton concludes that:

1. To the extent that these procedures and treatments could result in sterilization, they could deprive the child of the fundamental right to procreate, which supports a finding of child abuse under the Family Code.
2. The procedures and treatments … can constitute child abuse under the Family Code.

In support of this opinion, Paxton contends that the Texas Legislature has defined child abuse broadly, and further, that each of the procedures

and treatments used to treat gender dysphoria can constitute abuse under Texas Family Code § 261.001 (1)(A), (B), (C), or (D).

Texas Family Code 261.101 includes failure to make reasonable efforts to stop physical injury that could harm a child. Does Paxton's position mean that anyone who treats a child for gender dysphoria could—and should—be accused of child abuse? Texas Family Code Section 261.101 (a)-(b) mandates that professionals (doctors, lawyers, mental health professionals, teachers, and others engaged in practices requiring state licensure or certification) must report suspected abuse within 48 hours of receiving information of suspected child abuse. Moreover, the professional may not delegate the duty to report to a third party. A professional is defined, for purposes of that section as:

"An individual who is licensed or certified by the state or who is an employee of a facility licensed, certified, or operated by the state and who, in the normal course of official duties or duties for which a license or certification is required, has direct contact with children. The term includes teachers, nurses, doctors, day-care employees, employees of a clinic or health care facility that provides reproductive services, juvenile probation officers, and juvenile detention or correctional officers."

Changing gender identity is a formidable decision, involving not only a child's family of origin, but potentially, if a child has been removed from the care of their parents, by the Texas Department of Family Protective Services, the agency ordered to provide care for the child.

Prior to the release of DSM-V, the American Psychiatric Association issued a statement as follows:

"Respecting the Patient, Ensuring Access to Care. DSM not only determines how mental disorders are defined and diagnosed, it also impacts how people see themselves and how we see each other. While diagnostic terms facilitate clinical care and access to insurance coverage that supports mental health, these terms can also have a stigmatizing effect. DSM-5 aims to avoid stigma and ensure clinical care for individuals who see and feel themselves to be a different gender than their assigned gender. It replaces the diagnostic name 'gender identity disorder' with 'gender dysphoria,' as well as makes other important clarifications in the criteria. It is important to note that gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition."

In that same APA Statement, the American Psychiatric Association concluded that:

"Part of removing stigma is about choosing the right words. Replacing 'disorder' with 'dysphoria' in the diagnostic label is not only more appropriate and consistent with familiar clinical sexology terminology, it also removes the connotation that the patient is 'disordered.' Ultimately, the changes regarding gender dysphoria in DSM-5 respect the individuals identified by offering a diagnostic name that is more appropriate to the symptoms and behaviors they experience without jeopardizing their access to effective treatment options."

Does Opinion KP-0401 eliminate the right of a parent, a conservator, or of an agency to facilitate care for transgender children in Texas? Has Texas has joined the ranks of states like Tennessee and Arkansas? In

Arkansas, a federal judge placed a new law, seeking to ban doctors from providing treatment to minors for gender dysphoria, on hold while that law is being challenged in court. The Texas Pediatric Society sent a letter to Jaime Masters, commissioner of TDFPS, on Aug. 16, 2021, noting in pertinent part that "1.8% of children and adolescents identify as transgender, and an additional 1.6% are questioning or gender diverse." Those children are identified as being "particularly at risk of feeling unsafe and reporting suicidal ideations—over 50 percent have suicidal ideations and one third attempt suicide." The Texas Pediatric Society contends that:

"Medical care for transgender children and adolescents is evidence-based and has proven effectiveness. Guidelines for appropriate treatment have been carefully developed and endorsed by the American Academy of Pediatrics, the American College of Obstetrics and Gynecology, the Pediatric Endocrine Society, the American College of Physicians, World Professional Association for Transgender Health, and the American Psychological Association. The decision of whether and when to initiate gender-affirmative treatment is personal and involves careful consideration of risks, benefits, and other factors unique to each patient and family. These are medical decisions reached in consultation between the patients and their parents. The process involves repeated psychological and medical evaluation, with the participation and consent of a child's or adolescent's parents. Gender-affirming care for children and adolescents with gender diversity or gender dysphoria begins with social affirmation. Before puberty, there is no medical or surgical treatment that is used at all."

In a September 2020 article in The Legal Intelligencer, Daniel Pollack concluded:

"At birth, a child's eventual sexual identity is unknown. Of course, time is finite, but there is no reason for a politically imposed rush to judgment. Like many other medical conditions, a watch and wait approach—wisely—may last for months or years. It enables the child and parents to have a better feel for what the future may hold, and this moderate approach preserves the rights of everyone."

Slowing down may help children really get to know about their unknown.

Does Paxton have more in mind than slowing the clock? Only time will tell.

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