Protecting Transgender and Gender Nonconforming Children and Adolescents in Iowa Child Custody Proceedings

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TABLE OF CONTENTS

I. INTRODUCTION

Gender nonconforming persons appeared in recorded history as early as Ancient Egypt.[1] Around the world, indigenous groups have "long had the language to describe gender diversity," and some "cultures recognized and embraced three or more gender identities"[2] For example, many North American Native communities "traditionally revered" gender nonconforming people.[3] Native American societies use the term "Two Spirit" to refer to individuals "who were born with masculine and feminine spirits in one body."[4] Two Spirit members of the community often "performed highly respected spiritual, medical, and economic roles."[5]

Over the last 100 years, the understanding of gender in Europe and the United States "has undergone tremendous change."[6] At the turn of the twentieth century, health professionals regarded gender variance as "one of the most diseased forms of homosexuality."[7] Sexologist Magnus Hirschfield became one of the main voices refuting that gender diversity was a subset of same-sex attraction.[8] In the 1930s, Hirschfield conducted some of the first gender-affirming surgeries for transgender individuals.[9] The fierce advocacy of transgender individuals and health professionals supporting affirmative

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[1] TRANSGENDER MEDICINE: A MULTIDISCIPLINARY APPROACH 3 (Leonid Poretsky & Wylie C. Hembree eds., 2019) (ebook) [hereinafter TRANSGENDER MEDICINE].

[2] *Id.* at 4.

[3] Maia Sheppard & J. B. Mayo, Jr., *The Social Construction of Gender and Sexuality: Learning From Two Spirit Traditions*, 104 SOC. STUD. 259, 262 (2013).

[4] *Id.*

[5] *Id.*

[6] TRANSGENDER MEDICINE, *supra* note 1, at 9.

[7] *Id.* at 5.

[8] *Id.*

[9] *Id.*

care led to a more accurate and deeper understanding of gender in the late twentieth century.[10] With access to the internet, gender diverse people organized online communities and formed groups to influence medical and social policy, and to expand society's understanding of gender to include non-binary and gender fluid identities.[11]

The twenty-first century brought increased awareness to the necessity for supporting transgender and gender nonconforming ("TGNC") children and adolescents.[12] Parents may not have the same idea of what is best for their TGNC child, and in cases where parents are separated or divorced, a non-affirming parent may attempt to take advantage of a court's ignorance in order to receive a more favorable custody arrangement.[13] Often, non-affirming parents accuse their affirming ex-partners of forcing a transgender identity upon their child.[14] Because these custody disputes quite frequently turn into a battle of experts, the case law involves only children of parents with financial means to bring such a case.[15] The parent with more funds will then often gain the more favorable custody arrangement.[16]

There are few public cases involving custody of TGNC children across the United States, and no Iowa appellate court has yet heard such a case. However, Iowa case law does include other major issues that arise in custody battles, such as immunizations. The reasoning from Iowa's custody cases involving immunizations can provide a legal framework for a judge to apply in custodial arrangement proceedings involving TGNC children and adolescents.

As the medical and psychological communities continue to gain a deeper understanding of gender identity and expression, experts overwhelmingly support the use of affirmative care for TGNC children, adolescents, and

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[10] *Id.*

[11] *Id.* at 6.

[12] Laura Edwards-Leeper, *Affirmative Care of TGNC Children and Adolescents*, *in* AFFIRMATIVE COUNSELING AND PSYCHOLOGICAL PRACTICE WITH TRANSGENDER AND GENDER NONCONFORMING CLIENTS 120 (Anneliese Singh & Lore M. Dickey eds., 2017) (ebook).

[13] Katherine A. Kuvalanka et al., *An Exploratory Study of Custody Challenges Experienced by Affirming Mothers of Transgender and Gender-Nonconforming Children*, 57 FAM. CT. REV. 54, 55 (2019).

[14] *Id.* at 61.

[15] *Id.* at 64.

[16] *Id.* at 65.

adults.[17] An individual's sense of self is prioritized over societal standards.[18] Due to health professionals' opinions and evidence demonstrating affirmative care is in the best interests of children and adolescents for their long-term mental health and quality of life, Iowa courts must order an arrangement most assured to provide the youth with affirmative care when determining custodial arrangements involving TGNC children and adolescents.

Part I of this Note will discuss the terminology and definitions relevant to TGNC individuals and describe the diagnosis of Gender Dysphoria ("GD"). Part II involves the range of treatment and support options for TGNC children, adolescents, and adults, while Part III examines the limited case law in custody cases involving TGNC children and adolescents. To evaluate the understanding of child custody and TGNC individuals in Iowa, Part IV looks at Iowa case law in child custody where immunization is an issue to understand the reasoning used for major health decisions. Part V argues that because of public policy and modern science, courts should grant health care decision-making and physical care to affirming parents.

II. TERMINOLOGY AND DEFINITIONS

Gender is complex and it is important to be aware of the terminology and definitions relevant to TGNC individuals. The chart in Part A discusses the terminology concerning TGNC individuals and corrects misconceptions such as gender identity and sexual orientation being the same. Part B looks specifically at the terminology for TGNC children and adolescents and explains why it may vary depending on age. Part C defines Gender Dysphoria, the medical diagnosis given to some TGNC individuals. It also discusses the precursor to Gender Dysphoria, Gender Identity Disorder, and why the medical and psychological communities changed the terminology. Finally, Part D examines the diagnostic criteria for Gender Dysphoria and clarifies that questioning gender identity or being gender variant is not the reason for a diagnosis.

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[17] *See, e.g.,* MICHELLE FORCIER ET AL., PEDIATRIC GENDER IDENTITY: GENDER-AFFIRMING CARE FOR TRANSGENDER & GENDER DIVERSE YOUTH v–vi (Michelle Forcier et al. eds., 2020) [hereinafter PEDIATRIC GENDER IDENTITY]; Eli Coleman et al., *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People*, 13 INT'L J. TRANSGENDERISM 165, 173–74 (2012).

[18] Edwards-Leeper, *supra* note 12, at 123.

A. Terminology

Gender Identity	A person's "internal, deeply held sense of their gender."[19] Some people identify on the gender binary (either as a man or a woman), while other people identify off the binary, such as those who are non-binary or genderqueer.[20]
Gender Expression	Gender expression describes a person's "external manifestations of gender, expressed through a person's name, pronouns, clothing, haircut, behavior, voice, and/or body characteristics."[21] While society may label these manifestations as either ". . . masculine or feminine . . ." the understanding of what is feminine and masculine changes and varies.[22]
Transgender	A transgender person's gender identity is different than the sex designated to them at birth, and they often ". . . seek to align their gender expression with their gender identity . . ."[23]
Transition	Transitioning is different for each person.[24] There are several different types of steps a transgender person may take to have their gender identity align with their gender expression.[25] This includes personal decisions, such as telling one's peers, using a new name and pronouns, and dressing

[19] *GLAAD Media Reference Guide – Transgender*, GLAAD, https://www.glaad.org/reference/transgender [https://perma.cc/YBP6-7V8D].

[20] *Id.*

[21] *Id.*

[22] *Id.*

[23] *Id.*

[24] *Id.*

[25] *GLAAD Media Reference Guide*, *supra* note 19.

	differently.[26] It also could include medical decisions such as hormone therapy or gender confirmation surgery.[27]
Gender Nonconforming/Gender Diverse/Gender Variant[28]	A gender nonconforming person identifies or expresses themselves in a way that is unconventional with their sex assigned at birth.[29] The term "gender nonconforming" does not cover one specific description.[30] Some transgender people also identify as gender nonconforming, however, not all gender nonconforming people are transgender.[31]
Nonbinary/Genderqueer	A non-binary or genderqueer person has a gender identity and/or gender expression off the binary and "may define their gender as falling somewhere in between man and woman, or they may define it as wholly different from these terms."[32]
Pronouns	It is important to use the correct pronouns for transgender and gender nonconforming persons.[33] The correct pronouns are the ones aligning with a person's gender identity.[34] Some non-binary people use the singular *they*[35] for their pronouns.[36]

[26] *Id.*

[27] *Id.*

[28] AFFIRMATIVE MENTAL HEALTH CARE FOR TRANSGENDER AND GENDER DIVERSE YOUTH: A CLINICAL GUIDE 5 (Aron Janssen & Scott Leibowitz eds., 2018) (ebook) [hereinafter AFFIRMATIVE MENTAL HEALTH CARE].

[29] *Id.*

[30] *Id.*

[31] *Id.*

[32] *GLAAD Media Reference Guide*, *supra* note 19.

[33] *Id.* at 16.

[34] AFFIRMATIVE MENTAL HEALTH CARE, *supra* note 28, at 5.

[35] If it is known that an adolescent or adult has transitioned, this Note will use the correct pronouns aligning with their gender. If the pronouns are unknown or are being used to refer to a gender nonconforming child, this Note will use the singular "*they*" to avoid assigning a gender to an individual.

[36] *GLAAD Media Reference Guide*, *supra* note 19.

Sexual Orientation	Sexual orientation is different than gender identity. A person's sexual orientation regards their "enduring physical, romantic, and/or emotional attraction to another person."[37]

B. Gender Nonconforming Children and Adolescents

Because puberty is a pivotal point for gender identity development, many experts believe it is problematic to use the term transgender for prepubertal children.[38] Not all gender variant children become transgender adolescents.[39] Most children begin to develop a gender identity "in early childhood and become solidified [in that gender identity] by adolescence."[40] Current data suggests that most gender nonconforming children will not persist with their nonconformance into adolescence or adulthood.[41] It is also possible for an individual to not be gender nonconforming as a child, but later become gender variant or develop as gender nonconforming after going through puberty.[42]

C. What is Gender Dysphoria?

In 1987, the Diagnostic and Statistical Manual of Mental Disorders 3 ("DSM-3") addressed gender identity of children and adolescents for the first time.[43] The diagnosis was atypical gender identity disorder ("GID"), and this label persisted until 2013.[44] The criteria to diagnose GID focused on gender expression and a child who identified with their sex designated at birth could still be diagnosed with GID.[45] As the stigma of TGNC persons decreased

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[37] *Id.*

[38] Shervin Shadianloo & Richard R. Pleak, *Mental Health Issues in Caring for the Transgender Population*, *in* TRANSGENDER MEDICINE, *supra* note 1, at 115.

[39] *Id.*

[40] Edwards-Leeper, *supra* note 12, at 120.

[41] Oksana Hamidi & Todd B. Nippoldt, *Biology of Gender Identity and Gender Incongruence*, *in* TRANSGENDER MEDICINE, *supra* note 1, at 40.

[42] Shervin Shadianloo & Richard R. Pleak, *Mental Health Issues in Caring for the Transgender Population*, *in* TRANSGENDER MEDICINE, *supra* note 1, at 115.

[43] Tonia Poteat et al., *History and Prevalence of Gender Dysphoria*, *in* TRANSGENDER MEDICINE, *supra* note 1, at 10.

[44] *Id.*

[45] *Id.* at 10–12.

and health professionals gained more understanding about gender identity, there was a push for a change to a non-pathologizing diagnosis for TGNC children, adolescents, and adults.[46]

Although the necessity of mental health evaluations and psychiatric diagnoses is controversial amongst Lesbian, Gay, Bisexual, Transgender, and Queer ("LGBTQ") advocates,[47] the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM-5") still includes a diagnosis for transgender individuals because it is necessary for medical insurance coverage.[48] To help reduce the stigma that gender diverse individuals face, the American Psychiatric Association ("APA") "replace[d] the diagnostic name 'gender identity disorder' with 'gender dysphoria'. . ." in the DSM-5.[49] A health professional may diagnose a person with gender dysphoria if the person identifies with a gender different than the one assigned to them at birth.[50] The DSM-5 recognizes that "a trans identity in and of itself is not pathological."[51] Rather, the diagnosis is focused on the "presence of clinically significant distress" resulting from gender variance.[52]

D. Diagnosing Gender Dysphoria in Children and Adolescents

Before the APA released the DSM-5 in 2013, "the diagnostic criteria focused more on stereotypical, binary gender expression as opposed to gender identification."[53] The focus on gender expression led to overbroad results. Even a child who identified with their sex assigned at birth could fall under the GID diagnosis if, for example, they were "a natal male who identifies as a boy who happens to prefer girls as friends [and] enjoys girls' toys."[54]

The DSM-5 instead focuses on gender identity and "does not presume that a person whose identity does not align with their sex at birth has a gender identity that does align with a binary identity of female or male."[55] It is

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[46] Edwards-Leeper, *supra* note 12, at 122.

[47] TRANSGENDER MEDICINE, *supra* note 1, at 13.

[48] *Gender Dysphoria*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Gender-Dysphoria.pdf [https://perma.cc/BK2S-HK97].

[49] *Id.*

[50] Jack Turban, *What is Gender Dysphoria?,* AM. PSYCHIATRIC ASS'N (Nov. 2020), https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria [https://perma.cc/9GVE-CSC8].

[51] TRANSGENDER MEDICINE, *supra* note 1, at 12.

[52] *Gender Dysphoria*, *supra* note 48.

[53] TRANSGENDER MEDICINE, *supra* note 1, at 10.

[54] *Id.* at 12.

[55] *Id.*

possible for a child or adolescent to be gender variant but "not meet diagnostic criteria for GD."[56] This is the case when a youth does not identify as cisgender and does not experience the requisite "distress or dysfunction as a result of their identity."[57]

III. THERAPY AND GENDER NONCONFORMING PERSONS

As understanding of TGNC individuals evolved, professionals and amateurs developed several approaches to therapy. Part A discusses the difference between the therapeutic approach and affirmative care. Part B discusses conversion therapy and Part C examines the mental health risks for LGBTQ children and adolescents and how affirmative care helps alleviate those risks. Part D reviews barriers TGNC individuals face in the health care system and the limited data on STIs in TGNC individuals.

A. The Therapeutic Approach vs Affirmative Care

In the era of GID, "gender experts" had two main approaches to therapy for gender diverse individuals: therapeutic[58] and affirmative care.[59] For more than thirty years, Dr. Kenneth Zucker led The Centre for Addiction and Mental Health's ("CAMH") Family Gender Identity Clinic.[60] From the mid 1970s to 2012, Zucker's clinic evaluated 570 children ranging from the ages of two to twelve.[61] The clinic used the therapeutic approach and attempted to make a child comfortable with their assigned gender.[62] As part of this approach, Zucker encouraged parents of his clients to forbid any toys, dress, or play that is not traditionally associated with the child's gender assigned at birth.[63] For example, he directed parents of a child assigned male at birth to

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[56] AFFIRMATIVE MENTAL HEALTH CARE, *supra* note 28, at 6.

[57] *Id.*

[58] Kenneth K. Zucker et al., *A Developmental, Biopsychosocial Model for the Treatment of Children with Gender Identity Disorder*, 59 J. HOMOSEXUALITY 295, 369 (2012).

[59] Alix Spiegel, *Two Families Grapple with Sons' Gender Identity: Psychologists Take Radically Different Approaches in Therapy*, NAT'L PUB. RADO (May 7, 2008, 4:00 PM), https://www.npr.org/2008/05/07/90247842/two-families-grapple-with-sons-gender-preferences [https://perma.cc/AN4R-G2HX].

[60] Molly Hayes, *Doctor Fired from Gender Identity Clinic Says He Feels Vindicated After CAMH Apology, Settlement*, THE GLOBE & MAIL (Oct. 7, 2018), https://www.theglobeandmail.com/canada/toronto/article-doctor-fired-from-gender-identity-clinic-says-he-feels-vindicated/ [https://perma.cc/932E-7WAA].

[61] Zucker et al., *supra* note 58, at 369.

[62] Spiegel, *supra* note 59.

[63] Edwards-Leeper, *supra* note 12, at 121.

get rid of the child's Barbies and Polly Pockets, forbid the child from pretending to be a female character, and cease the child's time spent with female playmates.[64] He warned the parents that their child's feminine behaviors were "dangerous to a kid with gender identity disorder," and believed the child was at risk of being rejected by other children.[65] The therapeutic approach claims to be most concerned with avoiding a child feeling like an outcast or being bullied by peers for not conforming to stereotypical gender ideas.[66] Zucker's clinic has since closed and the therapeutic approach is no longer as popular.[67]

Although affirmative care is now mainstream in the medical and psychological fields, Zucker's approach is still relevant. In response to accusations that Zucker practiced conversion therapy, CAMH investigated Zucker's clinic and fired him in 2015.[68] The CAMH investigation found that Zucker's method subjected children to intensive assessment.[69] However, in a 2018 settlement, "CAMH apologized to Zucker and agreed to pay him more than half a million dollars."[70] Zucker insists his approach is not conversion therapy because, while he attempts to make children "accept their birth sex," he claims that he supports people transitioning "if they continue to experience gender dysphoria into adolescence."[71]

Supporters of the affirmative approach also recognize that society has a long way to go to understand and accept gender variance, but maintain that trusting that an individual can define themselves is imperative for the individual to achieve "long-term psychological health and quality of life."[72] The affirmative care approach understands that the traditional binary idea of gender is inaccurate and that there are a wide variety of gender identities and expressions.[73] Health professionals who use this approach help family members understand how to best support the person who is gender nonconforming stay true to themselves, and also provide assistance in how to cope with bias and ignorance in society.[74] Psychologist Diane Ehrensaft is

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[64] Spiegel, *supra* note 59.

[65] *Id.*

[66] *See id.*

[67] *Former CAMH Psychologist Defends His Work at Youth Gender Identity Clinic*, CBC (Oct. 9, 2018), https://www.cbc.ca/news/canada/toronto/former-camh-psychologist-dr-kenneth-zucker-defends-his-work-1.4856371 [https://perma.cc/UQH9-F68P] [hereinafter *CAMH Psychologist*].

[68] Hayes, *supra* note 60.

[69] *Id.*

[70] *CAMH Psychologist*, *supra* note 67.

[71] *Id.*

[72] Edwards-Leeper, *supra* note 12, at 123.

[73] *Id.*

[74] *See id.*

an example of a health professional who uses the affirmative approach.[75] She explains to parents who seek her help for their gender variant child or adolescent that the child does not need a "cure."[76] This approach advises that a gender nonconforming person should only seek medical or mental health help if the person is experiencing some sort of ancillary disorder like anxiety or depression.[77]

Affirmative care for transgender adults is not the same as for gender nonconforming children and adolescents.[78] Because "childhood, adolescence, and adulthood are unique developmental stages," the treatment must be different for each stage.[79] For children, affirmative care is "a child's opportunity to live in the gender that feels most real or comfortable to that child and to express that gender with freedom from restriction, aspersion, or rejection."[80] Gender identity is still "fluid and forming" in childhood, and the child needs "space for growth and change" to avoid being "box[ed] . . . into a gender with which they might not ultimately identify."[81] With both children and adolescents, affirmative care "help[s] the individual recognize various ways of experiencing gender—as male, female, or somewhere in between/something else."[82] Affirmative care "include[s] helping the individual figure out how to navigate a world that still applies a gender binary to many aspects of life."[83] The approach also requires helping children and adolescents "develop tools for dealing with teasing and bullying," and also "provid[es] resources in the way of groups and other LGBTQ friendly organizations."[84]

Transitioning and medical interventions such as hormone treatment or puberty blockers are also a part of affirmative care. Some supporters of the approach are unsure on whether children should transition because of the low amount of gender dysphoric children who persist in their

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[75] Spiegel, *supra* note 59.

[76] *Id.*

[77] *Id.*

[78] Edwards-Leeper, *supra* note 12, at 123.

[79] *Id.*

[80] *Id.* (quoting Marco A. Hildalgo et al., *The Gender Affirmative Model: What We Know and What We Aim to Learn*, 56 HUM. DEV. 285, 286 (2013)).

[81] *Id.* at 124–25.

[82] *Id.* at 125–26.

[83] *Id.* at 126.

[84] Edwards-Leeper, *supra* note 12, at 125–26.

nonconformance to the sex assigned at birth to them after puberty.[85] However, those who support early transition point to TGNC adolescents who believe "their childhood was wasted due to not being able to live as their 'true' gender."[86] For adolescents experiencing early stages of puberty, affirmative care can often include "gonadotropin-releasing hormone analogs (GnRHA), commonly referred to as puberty blockers."[87] Puberty-blocking "medications do not alter the patient's pubertal development . . . and are completely reversible."[88] Many health professionals are comfortable with providing puberty-blocking medication for young TGNC adolescents because it is seen as "'buying time' for the adolescent to continue sorting out their gender identity without the added stress of their body changing."[89] Hormone treatments are another option for adolescents who are at least sixteen years-old.[90]

Affirmative care also may require a health professional to "go against the wishes of the parents."[91] Parental skepticism is particularly strong if the family believes in "more traditional gender roles or with late-onset adolescents."[92] Despite the difficulty created by parents unable to accept their child's identity, affirmative care encourages health professionals to work with such parents.[93] Working with the parents gives a care provider a better picture of the child's life and also provides an opportunity to educate the parents.[94] TGNC children and adolescents have the healthiest long-term outcomes when they have parental support, so helping that child feel validated and heard by their parents is a critical aspect of affirmative care.[95]

B. What is Conversion Therapy?

Conversion therapy "is any attempt to change a person's sexual orientation, gender identity, or gender expression."[96] It is also referred to as "reparative therapy," and involves "a range of dangerous and discredited

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[85] *Id.* at 126–27.

[86] *Id.* at 126.

[87] PEDIATRIC GENDER IDENTITY, *supra* note 17, at 191.

[88] *Id.* at 192.

[89] Edwards-Leeper, *supra* note 12, at 129.

[90] *Id.* at 130.

[91] *Id.* at 131.

[92] *Id.*

[93] *Id.*

[94] *Id.*

[95] Edwards-Leeper, *supra* note 12, at 131.

[96] *Conversion Therapy: What is Conversion Therapy?*, GLAAD, https://www.glaad.org/conversion therapy?response_type=embed [https://perma.cc/PHK9-MA54] [hereinafter *Conversion Therapy*].

practices."[97] Groups in support of conversion therapy often use terms seemingly "harmless at first glance," like "sexuality counseling," or "promoting healthy sexuality."[98] The methods used include "shaming, emotionally traumatic or physically painful stimuli to make their victims associate those stimuli with their LGBTQ identities."[99] So far, twenty states passed laws to protect minors from conversion therapy.[100] The American Psychological Association and the American Psychiatric Association, as well as dozens of other organizations, denounce the use of conversion therapy.[101]

C. Mental Health of TGNC Youth

LGBTQ youth are at a high risk for mental health issues.[102] LGB children and adolescents "experience stress associated with society's stigmatization of homosexuality and of anyone perceived to be homosexual."[103] The youth in these "sexual minorities" also experience "internalized homonegativity or homophobia."[104] Transgender children and adolescents also "experience substantial amounts of prejudice, discrimination, and victimization," and stigma related to gender expression affects cisgender and transgender gender nonconforming individuals.[105] LGBTQ youth reported "lower levels of parental closeness and increased rates of parental abuse and homelessness."[106]

Transgender children and adolescents "have higher rates of depression, suicidality and self-harm, and eating disorders compared with their peers."[107]

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[97] *The Lies and Dangers of Efforts to Change Sexual Orientation or Gender Identity*, HUM. RTS. CAMPAIGN, https://www.hrc.org/resources/the-lies-and-dangers-of-reparative-therapy [https://perma.cc/5V85-RKCM].

[98] *Conversion Therapy*, *supra* note 96.

[99] *Id.*

[100] Brooke Sopelsa, *Virginia Becomes 20th State to Ban Conversion Therapy for Minors*, NBC NEWS (Mar. 3, 2020, 3:45 PM), https://www.nbcnews.com/feature/nbc-out/virginia-becomes-20th-state-ban-conversion-therapy-minors-n1148421 [https://perma.cc/4CX3-54S3].

[101] *Conversion Therapy*, *supra* note 96.

[102] Stephen T. Russel & Jessica N. Fish, *Mental Health in Lesbian, Gay, Bisexual, and Transgender (LGBT) Youth,* 12 ANN. REV. CLINICAL PSYCH. 1, 465 (2016).

[103] Sabra L. Katz-Wise et al., *Lesbian, Gay, Bisexual, and Transgender Youth and Family Acceptance*, 63 PEDIATRIC CLINICS N. AM. 1012, 1011–25 (2016).

[104] *Id.*

[105] *Id.*

[106] *Id.*

[107] Maureen D. Connolly et al., *The Mental Health of Transgender Youth: Advances in Understanding,* 59 J. ADOLESCENT HEALTH 489, 489–95 (2016).

They also overwhelmingly "experience family rejection or lack of support, linked with negative mental health outcomes, such as self-harm and suicidality."[108] Gender nonconforming children and adolescents "are at increased risk for abuse by caregivers, as well as peer victimization and bullying . . ."[109] Gender nonconforming males often face more stigma than nonconforming females.[110] One study discovered that parents typically "welcomed gender nonconformity among their daughters, but had mixed reactions to their sons' gender nonconformity . . ."[111] Parents with sons were accepting of their sons having an interest in cooking, "but had negative reactions" to their sons wearing dresses.[112]

Family support and acceptance of LGBTQ children and adolescents is linked with "less depression, less substance abuse, and less suicidal ideation and behaviors."[113] Parental support of transgender individuals is especially "protective against depression and associated with having a higher quality of life."[114] Also, more parental acceptance is "associated with a greater likelihood of having an affirmed identity than struggling with one's identity."[115] Studies taken from 2011 to 2016 found that "[g]ender-affirming medical therapy and supported social transition in childhood have been shown to correlate with improved psychological functioning for gender-variant children and adolescents."[116]

D. Access to Health Care and Sexual Health

In addition to the mental health risks, "[TGNC] youth reported significantly poorer health, lower rates of preventative health checkups, and more nurse office visits than cisgender youth."[117] Specifically for transgender adolescents, access to "pubertal blockers and cross-sex hormone treatments" is burdened by high costs that insurance companies most often will not cover.[118] Also, TGNC adolescents residing in the Midwest have difficulty

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[108] Emily Pariseau et al., *The Relationship Between Family Acceptance-Rejection and Transgender Youth Psychosocial Functioning,* 7 CLINICAL PRAC. PEDIATRIC PSYCH. 268, 267–77 (2019).

[109] Katz-Wise et al., *supra* note 103, at 1015.

[110] *Id.*

[111] *Id.*

[112] *Id.*

[113] *Id.* at 1019.

[114] Katz-Wise et al., *supra* note 103, at 1019.

[115] *Id.* at 1018.

[116] Connolly et al., *supra* note 107, at 489.

[117] TRANSGENDER MEDICINE, *supra* note 1, at 30.

[118] *Id.* at 31.

accessing gender clinics because they are primarily on the West Coast or in the Northeast.[119]

Access to health care for TGNC individuals is further burdened by the lack of training and confidence in many current medical professionals in caring for TGNC people.[120] A 2011 study examined 176 medical schools in the United States and Canada, finding "a median of 5 h[ours] was dedicated to teaching content related to LGB and transgender health but 33% of medical schools reported 0 h[ours] . . . during clinical years."[121] A different study in 2016 of "mid-Atlantic endocrinologists" found that "only 20% were 'very' comfortable in discussing gender identity."[122] A 2015 study found only 47.1% of physicians "felt confident" in providing transgender medical therapy to adolescents.[123]

There is limited data for sexually transmitted infections ("STIs") in TGNC individuals.[124] Local and federal agencies often "do not collect data on gender identity" and categorize transgender people inaccurately, "such as transgender women being categorized historically as men who have sex with men."[125] There are limited studies suggesting transgender women have a higher risk of contracting HIV, with a higher risk for Black transgender women.[126] Due to "factors such as homelessness, poverty, mental health issues, and substance use," as well as "fear of drug-drug interactions between hormones and antiretroviral therapy," transgender women diagnosed with HIV "are less likely to adhere to antiretroviral medicines."[127]

IV. IOWA CHILD CUSTODY

Before diving into the relevant cases for this Note, this section provides a basic rundown of Iowa child custody law. Part A explains what Iowa law says about custody, physical care, and modification of custody and care. Part B presents the Iowa immunization cases providing the framework to

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[119] *Id.*

[120] *Id.*

[121] *Id.* at 28.

[122] TRANSGENDER MEDICINE, *supra* note 1, at 27.

[123] *Id.* at 31.

[124] *Id.* at 84.

[125] *Id.*

[126] *Id.* at 60.

[127] TRANSGENDER MEDICINE, *supra* note 1, at 60.

demonstrate Iowa courts' commitment to science when seeking what is in a child's best interest.

A. Joint Legal Custody, Joint Physical Care, and Modification in Iowa

To understand the Iowa legislative scheme regarding child custody, it is first relevant to define the various custody arrangements. Iowa defines "legal custody" or "custody" as "an award of the rights of legal custody of a minor child to a parent."[128] These "rights and responsibilities . . . include but are not limited to decision making affecting the child's legal status, medical care, education, extracurricular activities, and religious instruction."[129] When a court orders "joint legal custody . . . neither parent has legal custodial rights superior to those of the other parent."[130] "Physical care," involves "the right and responsibility to maintain a home for the minor child and provide for the routine care of the child."[131] This means that a parent with physical care "maintains the primary residence and has the right to determine . . . details associated with routine living, including such things as what clothes the children wear, when they go to bed, with whom they associate or date, etc."[132] Parents with "joint physical care," are entitled to at least "shared parenting time with the child, maintaining homes for the child, [and] providing routine care for the child."[133]

In determining child custody and arrangements, Iowa courts' main concern is what is in the best interest of the child.[134] The best interests of the child is determined by weighing eleven factors.[135] The ultimate goal in

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[128] IOWA CODE § 598.1(5) (2016).

[129] *Id.*

[130] *Id.* § 598.1(3).

[131] *Id.* § 598.1(7).

[132] *In re* Marriage of Hansen, 733 N.W.2d 683, 691 (Iowa 2007).

[133] IOWA CODE § 598.1(4).

[134] *Id.* § 598.41.

[135] *Id.* § 598.41(3). The eleven factors are:

> (a) Whether each parent would be a suitable custodian for the child, (b) Whether the psychological and emotional needs and development of the child will suffer due to lack of active contact with and attention from both parents, (c) Whether the parents can communicate with each other regarding the child's needs, (d) Whether both parents have actively cared for the child before and since the separation, (e) Whether each parent can support the other parent's relationship with the child, (f) Whether the custody arrangement is in accord with the child's wishes or whether the child has strong opposition, taking into consideration the child's age and maturity, (g) Whether one or both of the parents agree or are opposed to joint custody, (h) The geographic proximity of the parents, (i) Whether the safety of the child, other children, or the other parent will be

weighing the factors is to provide "maximum continuous physical and emotional contact . . . with both parents."[136] If one parent interferes or harms the opportunity for the child's relationship with the other parent "without just cause," the court may consider that "harmful to the best interests of the child."[137]

The Iowa legislature created a presumption in favor of joint legal custody.[138] If a court decides not to grant joint custody, it must be because of "clear and convincing evidence . . . that joint custody is unreasonable and not in the best interest of the child."[139] There is not a presumption for joint physical care:[140]

> [T]he court may award joint physical care to both joint custodial parents upon the request of either parent . . . If the court denies the request for joint physical care, the determination shall be accompanied by specific findings of fact and conclusions of law that the awarding of joint physical care is not in the best interest of the child.[141]

If a court decides not to grant joint physical care, it will "choose a primary caretaker who is solely responsible for decisions concerning the child's routine care," and then normally grant "visitation rights" to the other parent.[142]

If a court finds that joint physical care is not in the best interest of the children, the primary physical care giver should be "[t]he parent who can administer most effectively to the long-term best interests of the children and place them in an environment that will foster healthy physical and emotional lives."[143] The court must base its physical care determination on "what is best

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> jeopardized by the awarding of joint custody or by unsupervised or unrestricted visitation, (j) Whether a history of domestic abuse . . . (k) Whether a parent has allowed a person custody or control of, or unsupervised access to a child after knowing the person is required to register or is on the sex offender registry as a sex offender under chapter 692A. *Id.*

136 *Id.* §598.1(1).

137 IOWA CODE §598.1(1); IOWA CODE § 598.41(1)(c).

138 IOWA CODE § 598.41.

139 *Id.* § 598.41(2)(b).

140 *In re* Marriage of Hansen, 733 N.W.2d 683, 692 (Iowa 2007).

141 IOWA CODE § 598.41(5)(a)–(b).

142 *Hansen*, 733 N.W.2d at 691.

143 *In re* Marriage of Walton, 577 N.W.2d 869, 871 (Iowa Ct. App. 1998).

for the *child*," and not "upon perceived fairness to the *spouses*."[144] If only one parent is awarded physical care, the parent must support the child's relationship with the other parent.[145] The Iowa Supreme Court enumerated some "nonexclusive" factors to consider when determining care, including "(1) [c]ontinuity, stability, and approximation; (2) 'the ability of the spouses to communicate and show mutual respect'; (3) 'the degree of conflict between parents'; and (4) 'the degree to which the parents are in general agreement about their approach to daily matters.'"[146] How the court should weigh those factors is dependent on "the specific facts and circumstances of each case."[147]

Due to "the fundamental policy that 'once custody of children has been fixed it should be disturbed only for the most cogent reasons,'" there is a "heavy burden" that must be met in order to modify a court's initial custody order.[148] The guiding principles for modification were established in *In re Marriage of Frederici*:

> To change a custodial provision of a dissolution decree, the applying party must establish by a preponderance of evidence that conditions since the decree was entered have so materially and substantially changed that the children's best interests make it expedient to make the requested change. The changed circumstances must not have been contemplated by the court when the decree was entered, and they must be more or less permanent, not temporary. They must relate to the welfare of the children. A parent seeking to take custody from the other must prove an ability to minister more effectively to the children's well being.[149]

Iowa courts modified orders where shared-care arrangements became "unworkable."[150] There are twelve factors a court must consider when determining whether there has been a "substantial change in circumstances" to warrant a modification.[151]

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[144] *Hansen*, 733 N.W.2d at 695.

[145] *Id.* at 700.

[146] *In re* Marriage of Heitman, No. 15–0631, 2016 WL 742816, at *4 (Iowa Ct. App. Feb. 24, 2016) (quoting *Hansen*, 733 N.W.2d at 696–99).

[147] *Id.* (quoting *In re* Marriage of Williams, 589 N.W.2d 759, 761 (Iowa Ct. App. 1998)).

[148] *In re* Marriage of Hoffman, 867 N.W.2d 26, 32 (Iowa 2015).

[149] *In re* Marriage of Frederici, 338 N.W.2d 156, 158 (Iowa 1983).

[150] Thorpe v. Hostetler, 949 N.W.2d 1, 6 (Iowa Ct. App. 2020).

[151] IOWA CODE § 598.21C(1)(a)–(i).

B. Custody Battles Concerning Immunizations

In 1988, *Lambert v. Everist* brought the question of immunizations in child custody before the Iowa Supreme Court. Because immunizations "have a proven record," the Iowa Supreme Court held the pro-immunization father could better provide for the child's long-term needs.[152] Subsequently, the Iowa Court of Appeals faced the issue in *Rodgers v. Clark* and *In re Marriage of Asefi*.[153] Each time the court ruled for the parent supporting immunizations.[154] Both cases also brought up the issue of religious objections to immunizations.[155] In *Rodgers*, the court decided the mother who supported immunizing her children had the religious decision-making power as well, so the father could not use his religion to argue against vaccinating the children.[156] The court in *Asefi* found that the father's true reasons for objecting to vaccinations were not religious.[157]

1. *Lambert v. Everist*

After James Lambert and Sarah Everist separated, the trial court granted the parties joint legal custody of their daughter, Laural.[158] The court granted Sarah primary physical care and James appealed.[159] The court of appeals affirmed the lower court's decision and James appealed to the Iowa Supreme Court, requesting it award primary physical care to him.[160]

One of the parties' main disagreements was over the appropriate health care for their daughter.[161] Sarah preferred "nonconventional or 'natural'

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[152] Lambert v. Everist, 418 N.W.2d 40, 43 (Iowa 1988).

[153] *See* Rodgers v. Clark, No. 06-0802, 2007 WL 108486, at *2 (Iowa Ct. App. Jan. 18, 2007); *In re* Marriage of Asefi, No. 12-1787, 2013 WL 4011156 (Iowa Ct. App. Aug. 7, 2013).

[154] *Rodgers*, 2007 WL 108486, at *4; *Asefi*, 2013 WL 4011156, at *5.

[155] *Rodgers*, 2007 WL 108486, at *2–3; *Asefi*, 2013 WL 4011156, at *4.

[156] *Rodgers*, 2007 WL 108486, at *3.

[157] *Asefi*, 2013 WL 4011156, at *4.

[158] Lambert v. Everist, 418 N.W.2d 40, 40 (Iowa 1988).

[159] *Id.*

[160] *Id.*

[161] *Id.* at 42.

medicine"[162] and thought "immunizations were not healthy for children."[163] She refused to allow James to immunize Laural.[164]

The Iowa Supreme Court considered this case a close call because both parents were dedicated to providing Laural with appropriate care and she had "grown and developed well" under the arrangement up to that point.[165] It ultimately decided that James could "minister more effectively to the long-range interests" of the child.[166] The court came to that conclusion because James supported conventional schooling and had "a job and regular income."[167] Furthermore, the court found "it significant[ly] in his favor that James insisted upon immunizing Laural even over Sarah's wishes."[168] It stated, "[w]hatever the benefits of nonconventional or 'natural' medicine . . . *immunizations have a proven record*. The fears of our parents caused by childhood diseases such as poliomyelitis are unknown to modern couples because of immunization programs."[169] The court granted physical care to James and stated Sarah should have visitation rights.[170]

2. *Rodgers v. Clark*

Amy Rodgers and Jeffrey Clark never married, but during their relationship, they had two children together.[171] The parties separated in 2002 and "a paternity decree was entered in Maine . . . incorporat[ing] the parties' stipulation to joint legal custody, with Amy having primary physical care."[172] The stipulation allowed Amy control over the religious decisions, while granting Jeffrey control over decisions about non-emergency medical care.[173] Specifically, the stipulation stated, "[i]n no event shall Mother have the right to consent to the immunization of the children."[174]

Amy moved to Iowa with the children and, in November 2004, filed for modification.[175] She sought "sole legal custody of the children, an increase in

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[162] *Id.* at 43.

[163] *Id.* at 41.

[164] *Lambert*, 418 N.W.2d at 41.

[165] *Id.* at 43.

[166] *Id.* (quoting *In re* Marriage of Winter, 223 N.W.2d 165, 166 (Iowa 1974)).

[167] *Id.*

[168] *Id.*

[169] *Id.* (emphasis added).

[170] Lambert v. Everist, 418 N.W.2d 40, 43 (Iowa 1988).

[171] Rodgers v. Clark, No. 06-0802, 2007 WL 108486 (Iowa Ct. App. Jan. 18, 2007).

[172] *Id.*

[173] *Id.*

[174] *Id.*

[175] *Id.*

Jeffrey's child support obligation, and a specific visitation schedule."[176] She also regretted agreeing to not immunize the children and asked for the modification to cancel that provision.[177] Iowa public schools require parents to have their children immunized unless "a physician finds the immunization would be injurious to the child's health," or "a child's parent may submit an affidavit 'stating that the immunization conflicts with the tenets and practices of a recognized religious denomination of which the applicant is an adherent or member.'"[178] Amy claimed that Jeffrey did not "have any religious beliefs . . . prohibit[ing] immunization, and that he improperly signed the exemption cards in Iowa."[179]

The court eliminated the immunization provision because it was "clearly against the public policy of Iowa."[180] Because the stipulation gave Amy "the right and responsibility for all religious decisions," the court held only she could "determine whether the religious exemption for immunizations should apply."[181]

3. *In re Marriage of Asefi*

Megan and Sadegh Asefi divorced in August 2011 and "[t]he stipulated dissolution decree granted the parties joint legal custody and joint physical care."[182] The parties grew up following different religions and their child's immunizations were a point of contention even before the divorce.[183] For religious reasons, Sadegh did not agree with the recommended immunizations and delayed the immunization schedule by "research[ing] each [immunization] before it was administered and . . . sign[ing] a waiver declining immunizations."[184] Sadegh then objected to the child receiving a "'catch-up' schedule of shots."[185]

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[176] *Id.*

[177] Rodgers v. Clark, No. 06-0802, 2007 WL 108486, at *1 (Iowa Ct. App. Jan. 18, 2007).

[178] *Id.*

[179] *Id.* at *3.

[180] *Id.*

[181] *Id.* at *4.

[182] *In re* Marriage of Asefi, No. 12-1787, 2013 WL 4011156, at *1 (Iowa Ct. App. Aug. 7, 2013).

[183] *Id.*

[184] *Id.*

[185] *Id.*

Megan filed an application for modification in February 2012, because of, among other things, the disagreement over immunizations.[186] Sadegh did not agree with Megan over any vaccines until she filed for the modification.[187] The court determined that Sadegh did not have religious reasons for refusing immunizations for the child, but rather "doubts the physicians and their recommendations for combined shots."[188] As "the party seeking the change in physical care," Megan had to show she would "provide superior care."[189] Sadegh stalling the child's immunization schedule concerned the court because the child would not be "properly inoculated for his eventual enrollment in school."[190] Because "Megan's view on immunization and health [was] more 'mainstream,'" the court found she could provide the child with superior care.[191]

V. CHILD CUSTODY CASE LAW INVOLVING GENDER NONCONFORMING CHILDREN

There is limited available case law involving TGNC children in custody disputes in the United States. This section summarizes three cases involving disputes where parents disagreed on the care of their TGNC child. Decided in Ohio in 2007, *Smith v. Smith* took place in the context of GID and medical professionals less accepting of gender fluidity.[192] The court admitted there were "severe limitations in using the judicial system to resolve [such] complex and possibly controversial childrearing and childhood mental health issues," but granted the non-affirming father sole custody.[193] Decided in California in 2009, *Johnson v. Johnson* also took place in the context of GID.[194] However, the child's non-affirming parent in that case was slightly more accepting of the child's gender identity.[195] Using a best interest of the child analysis, the judge appeased both parents by ordering the child to attend therapy with a gender expert as well as religious counseling recommended by the father.[196] Decided in Alaska in 2014, *Kristen L. v. Benjamin W.* is the only case of the

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[186] *Id.* at *1–2.

[187] *Id.* at *2.

[188] *In re* Marriage of Asefi, No. 12-1787, 2013 WL 4011156, at *4 (Iowa Ct. App. Aug. 7, 2013).

[189] *Id.*

[190] *Id.*

[191] *Id.*

[192] Smith v. Smith, No. 05 JE 42, 2007 WL 901599, at *1 (Ohio Ct. App. Mar. 23, 2007).

[193] *Id.* at *12.

[194] Erika Skougard, Note, *The Best Interests of Transgender Children*, 2011 UTAH L. REV. 1161, 1163 (2011) (citing Johnson v. Johnson, No. RF09-463371, at 1 (Super. Ct. of Calif. Cnty. of Alameda Oct. 10, 2009)).

[195] *Id.* at 1196.

[196] *Id.* at 1197.

three taking place in the context of GD.[197] It is also the only of the three where the affirming father attained custody, but that is primarily attributed to the mother's physical and emotional abuse of her gender nonconforming child.[198]

A. Smith v. Smith

As part of the dissolution of marriage, the court designated the mother, Victoria Smith, as the residential parent of both children.[199] The court granted the father, Kevin Smith, visitation, but he rarely saw the children until he filed a motion to be designated the residential parent in 2004.[200] Kevin filed this motion in response to Victoria's plan to move to Niles, Ohio and enroll their eldest son "in a new school as a girl under the name Christine."[201] Under a temporary order, the court forbade Victoria from addressing the child as Christine or allowing the child to wear girl's clothing.[202] The court prohibited both parents from seeking treatment or counseling for the child.[203]

As early as age two, the child showed a tendency towards "female clothing."[204] By age four, Victoria allowed the child to "dress in girl's clothes and told him he could be a girl someday."[205] Victoria concluded the child had GID "based on internet research and support group information."[206]

At the trial court level, the case quickly became a battle of the experts.[207] In September 2004, the court issued a temporary judgment order requiring that the child received counseling, and prohibited the child from wearing "girl's clothes," going by a "girl's name," or using she/her pronouns.[208] The judge ordered that the child could not "attend transgender support groups

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[197] Kristen L. v. Benjamin W., No. S-15302, 2014 WL 2716842, at *1 (Alaska June 11, 2014).

[198] *Id.* at *2.

[199] Smith v. Smith, No. 05 JE 42, 2007 WL 901599, at *1 (Ohio Ct. App. Mar. 23, 2007).

[200] *Id.* at *1–2.

[201] *Id.* at *1.

[202] *Id.*

[203] *Id.*

[204] *Id.* at *2.

[205] *Smith*, 2007 WL 901599, at *2.

[206] *Id.*

[207] *See id.* at *3.

[208] *Id.* at *5.

and was to become 'disassociated with that lifestyle.'"[209] The court stated that it would reach a final judgment after the parents and child had psychological evaluations.[210] In August 2005, the court incorporated the temporary order from September 2004 and awarded Kevin as the sole residential parent.[211]

The appellate court affirmed the lower court's decision and stated that Victoria could file her own modification order "should the circumstances change; for instance, on the onset of puberty for the older child or a more clear and concise medical diagnosis."[212]

B. Johnson v. Johnson

The parents in this case ultimately allowed their child to transition from male to female.[213] The child was designated as male at birth, and she began to express feelings that she was a girl at a very young age.[214] In response to those feelings, the child's mother took her to a therapist who diagnosed her with GID.[215]

The point of contention for the parents was that the mother wanted to use affirmative care while the father preferred the therapeutic approach.[216] When this dispute first went to court, the mother asked to be given "a phased plan (which involved the guidance of a psychologist) to allow [the child] to explore her female identity before making a decision."[217] The mother provided the judge with educational materials about TGNC individuals and affirmative care.[218] She also "consulted with the father about [the child's] treatment and made efforts to develop cooperative solutions."[219]

The judge focused on "traditional best interests factors . . . evaluat[ing] the parents' fitness, relationships, and communication with [the child], and considered [the child's] wishes."[220] The court ordered the child to continue to go to therapy "with a qualified expert on childhood gender issues" and for

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[209] *Id.*

[210] *Id.* at *5–6.

[211] *Smith*, 2007 WL 901599, at *6.

[212] *Id.* at *12.

[213] Skougard, *supra* note 194, at 1195.

[214] *Id.* at 1196.

[215] *Id.*

[216] *Id.* at 1195.

[217] *Id.* at 1196.

[218] *See id.* at 1195–96.

[219] Skougard, *supra* note 194, at 1196.

[220] *Id.* at 1197.

both parents to be involved in the decision making.[221] The judge also permitted the father to take the child to religious-based counseling, but required both parents to obtain information from an organization advocating for affirmative care.[222]

C. Kristen L. v. Benjamin W.

After divorcing in 2012, Kristen and Benjamin shared legal custody of their sons and Kristen had primary physical custody.[223] Although assigned male at birth, their youngest child "engaged in feminine behaviors."[224] In June 2013, upon the children's arrival for their summer visit with Benjamin, he "noticed bruises on the younger child."[225] The child told Benjamin that Kristen and her husband caused the bruises and Benjamin took both children to see a counselor.[226] Both children told the counselor Kristen caused the bruises and the youngest child said "she should have been born a girl and that she was born in the wrong body."[227] The older child informed the counselor that Kristen had said "gays are sick and it's sick for [the younger child] to play with girl toys."[228] Due to the counselor's concern that Kristen was abusing the children, after two visits the counselor "filed a mandatory report with California's Child Protection Service (CPS)."[229]

The court found that "Kristen's domestic violence and inability to deal with [the] transgender issue" qualified as a substantial change of circumstances.[230] It held that Benjamin should have "sole legal and primary physical custody of the children . . . with Kristen having limited unsupervised visitation in California and potential unsupervised visitation in Alaska."[231]

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[221] *Id.* at 1197.

[222] *Id.*

[223] Kristen L. v. Benjamin W., No. S-15302, 2014 WL 2716842 at *1 (Alaska June 11, 2014).

[224] *Id.*

[225] *Id.*

[226] *Id.*

[227] *Id.*

[228] *Id.*

[229] *Kristen L.*, 2014 WL 2716842, at *1.

[230] *Id.* at *2.

[231] *Id.*

VI. IOWA COURTS MUST PRIORITIZE A TGNC CHILD OR ADOLESCENT'S ACCESS TO AFFIRMATIVE CARE WHEN DETERMINING CHILD CUSTODY AND PHYSICAL CARE ARRANGEMENTS

Examining the limited public case law of custody battles involving TGNC children and adolescents provides an opportunity to look closely at the solutions previous courts decided. *Smith, Kristen L.,* and *Johnson* discuss different approaches to, and understandings of, therapy and care for TGNC youth. The cases help illustrate possible solutions to custody battles involving TGNC children and adolescents, and why prioritizing affirmative care in future cases will be in a child's best interests.

As *Smith* was decided in 2007, the court in that case considered the diagnosis criteria of GID from DSM-4. The order in *Smith* sounds similar to the therapeutic approach taken by Dr. Zucker. The judge in *Smith* was concerned about the child conforming to traditional gender norms.[232] Rather than allowing the child to explore their gender identity, the judge ordered that the child was "not to be encouraged or permitted to wear girl's clothes" and "not permitted to go by a girl's name or be referred to as 'she' or 'her.'"[233]

The *Kristen L.* case demonstrates the risk TGNC children and adolescents face, even from their own parents. The child in *Kristen L.* experienced mental and physical abuse from their mother because of their gender nonconformity.[234] As a result of this abuse, the court granted physical care and sole legal custody to the father and granted the mother unsupervised visitation in the father's home state.[235] The *Kristen L.* case is an example of an affirming parent being granted decision making powers over a TGNC child's well-being. Yet despite the abuse of the mother, the court still granted her unsupervised visitation and said there was a possibility of the children visiting the mother in Alaska unsupervised in the future.

The *Johnson* case is the best example of a solution for a TGNC child when separated parents disagree over the care the child needs. The judge in *Johnson* admitted that the court was not qualified to deal with TGNC issues.[236] Rather than deciding what sort of mental care the child should have or what clothes the parents should allow her to wear, the judge focused on "traditional best interests factors," and came up with a solution comparable to affirmative care.[237] From "evaluat[ing] the parents' fitness, relationships, and communication with [the child], and consider[ing] [the child's] wishes," the judge ordered the parents to continue the child's therapy with a qualified

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[232] Skougard, *supra* note 194, at 1189.

[233] Smith v. Smith, No. 05 -JE -42, 2007 WL 901599, at *52 (Ohio Ct. App. Mar. 23, 2007).

[234] *Kristen L.*, 2014 WL 2716842, at *1.

[235] *Id.*

[236] Skougard, *supra* note 194, at 1196.

[237] *Id.*

expert and for the parents to get information from groups supportive of TGNC individuals.[238]

The Superior Court of California, County of Alameda decided *Johnson* in 2009 with direction from DSM-4 and GID criteria. Now, the medical and psychological communities have a better understanding that being transgender or gender nonconforming is not pathological. Now, health professionals understand there is a spectrum of gender, and even for those people who have a masculine or feminine identity, there is no one way to be masculine or feminine. Society wants to hold onto old traditional ideas of gender identity and expression, and this battle between tradition and science is likely to come up in Iowa custody battles as it did in the state courts in the cases discussed above.

Part A of this section discusses the status of conversion therapy in Iowa. Both Republicans and Democrats are working to limit or ban the use of conversion therapy in Iowa, demonstrating Iowa's public policy is moving towards protecting LQBT youth from such harmful, so-called therapy. Focusing on mental health concerns and the medical and psychological community's preference for affirmative care, Part B argues that affirmative care is in a TGNC child or adolescent's best interest. Part C quickly mentions the potential problems with religion and TGNC child custody cases.

A. Iowa is Heading Towards Protecting Children and Adolescents from Conversion Therapy

The Iowa legislature has yet to protect LGBTQ children and adolescents from conversion therapy, but both parties are working towards a bill to achieve that goal. In February 2020, the Iowa House tabled a Republican-sponsored bill to "ban health care providers from administering the widely discredited practice of 'conversion therapy.'"[239] Supporters of protecting LGBTQ youth from conversion therapy believed the bill did "not have enough strong protections."[240] The bill would not protect a minor from conversion therapy from "a clergy member or a religious counselor who is

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[238] *Id.* at 1196–97.

[239] Ian Richardson, *19 States Ban 'Conversion Therapy' for Minors; After an Iowa House Bill Fails to Advance, the State is Unlikely to Become the 20th This Year*, DES MOINES REG. (Feb. 19, 2020, 12:57 PM), https://www.desmoinesregister.com/story/news/politics/2020/02/19/bill-banning-conversion-therapy-fails-advance-iowa-house-lgbtq/4805324002/ [https://perma.cc/B3FU-AH85].

[240] Katarina Sostaric, *Iowa Conversion Therapy Ban Bill Tabled; Effort Could Continue Next Year*, IOWA PUB. RADIO (Feb. 19, 2020, 7:28 PM), https://www.iowapublicradio.org/state-government-news/2020-02-19/iowa-conversion-therapy-ban-bill-tabled-effort-could-continue-next-year [https://perma.cc/82XY-E9KZ].

acting in a pastoral or religious capacity, or a parent or grandparent of a minor who may also be a health care professional but is acting as a parent."[241]

There were mixed feelings about the measure being tabled.[242] The Family Leader, a conservative Christian group, was happy to see the measure put on hold because of their concern that such a law would "punish[] mental health professionals who discourage children from trying to transition from one gender to another."[243] Iowa Safe Schools believed the bill was not going far enough to protect LGBTQ children.[244] The group's executive director explained that a bill would need to label conversion therapy as child abuse as well as provide protection for LGBTQ children and adolescents in foster care.[245]

Iowa legislators on both sides of the aisle are working towards protecting children and adolescents from conversion therapy. By allowing conversion therapy, Iowa puts its LGBTQ youth population at risk for poor mental health and hurts Iowa families.[246] Although a bill has not yet passed and there is still disagreement about what such a bill should actually include, the intention of the legislators to ban conversion therapy should be in the mind of an Iowa court deciding custodial arrangements involving a TGNC youth.

Conversion therapy is the extreme of a non-supportive approach for a TGNC individual, but other variations of non-support are also harmful, as seen by the mental health statistics of TGNC youths experiencing family rejection. Many LGBTQ advocates labeled Dr. Zucker's therapeutic approach as conversion therapy. Even though CAMH has since apologized, it is reasonable to see how forbidding a child from the toys, clothes, and playmates of their choice could lead to the child feeling a sort of shame. For example, even with a "gender-neutral approach . . . accept[ing] gender-neutral behavior, dress, and toys but explicitly disallow[ing] cross-gender identification . . . may still reject the child's true gender, having potentially negative consequences."[247]

There are several factors a court must consider when determining what custody arrangement is in a child's best interest, and the determination varies case to case.[248] In a custody case with TGNC children and adolescents, those

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[241] Richardson, *supra* note 239.

[242] *Id.*; Sostaric, *supra* note 240.

[243] Richardson, *supra* note 239.

[244] Sostaric, *supra* note 240.

[245] *Id.*

[246] *See So-Called "Conversion Therapy" and LGBTQ Youth Mental Health*, THE TREVOR PROJECT (Aug. 27, 2021), https://www.thetrevorproject.org/resources/guide/so-called-conversion-therapy-and-the-lgbtq-youth-mental-health/ [https://perma.cc/E327-3QGH].

[247] Kuvalanka et al., *supra* note 13, at 67–68.

[248] IOWA CODE § 598.41(3).

factors are still weighed, but a TGNC receiving affirmative care and affirmative support should be paramount when weighing each of the factors. The priority must be to give space to a TGNC child or adolescent to explore their identity and expression. Just as Iowa judges sided with science regarding immunizations, so should they prioritize facts over traditional views of gender to protect public health and Iowa children.

B. Affirmative Care is in the Child's Best Interest

TGNC youth face serious mental health risks and affirmative care demonstrably alleviates those risks. The purpose of this section is to first address the mental health concerns and explain why it is a public health crisis. In addition to the mental health problems TGNC individuals face, they of course face barriers to all healthcare. This section discusses the discrimination TGNC patients experience from healthcare providers and the importance of having affirming physicians. This section then examines what Iowa courts discussed when deciding immunization child custody cases and how they consistently sided with science and the dominant understandings of medical health professionals when determining custody.

1. Mental Health Concerns

To protect TGNC youth in child custody proceedings, judges must be aware of the mental health implications of certain custodial arrangements. Even if the legislature has not yet passed a bill to protect LGBTQ youth from conversion therapy or provide them more protections, the mental health status of LGBTQ youth is a public policy crisis of which judges should be aware. As previously discussed, TGNC youth experience high rates of depression, anxiety, and suicidal thoughts, and affirmative care has proven to correlate with improved psychological health for TGNC youth.[249] When a transgender youth experiences "better family communication" or "family satisfaction," the adolescent reports "less severe depressive symptoms, fewer anxiety symptoms, and better self-esteem."[250] Affirmative care encourages family connection and correlates with improved long-term health in TGNC children and adolescents.[251]

Because a TGNC child or adolescent faces an elevated risk of mental health issues, it is imperative that a court order a custody arrangement where that youth will have access to the most support. The individual needs to be

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[249] Connolly et al., *supra* note 107, at 489.

[250] Pariseau et al., *supra* note 108, at 268.

[251] Connolly et al., *supra* note 107, at 489.

able to explore their gender identity and expression, and a court ordering shared care or health care decision making to a parent who denies the youth that freedom, puts the child or adolescent at risk for poor mental health. The mental health risks of TGNC youth are a public health problem. TGNC children and adolescents experience high rates of suicide, substance abuse, and homelessness. It is best for the children, and for the state of Iowa, to make sure TGNC children feel affirmed in their identity.

2. Primary Care Physicians

Along with being aware of the mental health risks TGNC children and adolescents face, judges in child custody proceedings also must be aware of the barriers TGNC individuals face with sexual healthcare. TGNC youth need medical providers who affirm their identity and are willing to provide them with appropriate care. Historically, TGNC patients have "experienced oppression and incompetence in medical settings."[252] A 2016 study reported that 55.1 percent of TGNC adolescents reported having to educate their healthcare providers about TGNC healthcare.[253] Additionally, TGNC adolescents report "high rates of providers using insulting language or denying their [TGNC] identities."[254]

Many TGNC individuals do not even feel safe telling their doctor their gender identity. Twenty-one to thirty-eight percent of TGNC adults reported concealing their gender identities from their healthcare provider.[255] It is critical for TGNC adolescents to have a primary care physician ("PCP") with whom they feel comfortable sharing their social history.[256] To properly assess risk factors and "support safe sexual activity," a doctor needs to know the specific sexual activities of their patient.[257]

TGNC individuals need access to healthcare providers who are willing to discuss sex education which is broader than cisgender heterosexual intercourse. When a judge is deciding the care of a TGNC child, choosing to grant a non-affirming parent that decision-making power puts the child or adolescent at risk for having a PCP who is likewise non-affirming of that identity and inadequate to ensure the eventual sexual safety of that child or adolescent. The medical community is already lacking in confidence and training, and so a TGNC youth needs to have a parent that is willing to find an affirmative care provider who will adequately meet the youth's needs.

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[252] TRANSGENDER MEDICINE, *supra* note 1, at 70.

[253] *Id.*

[254] *Id.*

[255] *Id.* at 71.

[256] *Id.* at 84.

[257] *Id.* at 83.

Besides being the most beneficial for the individual TGNC child or adolescent, a judge choosing an affirming parent to ensure the child or adolescent receives adequate affirming sexual healthcare is protecting public health. As specifically transgender women face higher rates of HIV, ensuring that children and adolescents receive the appropriate care can help combat those high rates. Additionally, as mentioned previously, local and federal agencies fail to even make proper categories for TGNC individuals to have accurate data to understand the STI risks for those populations.[258] The TGNC communities are underserved by the medical profession and a judge granting healthcare decision-making power to a non-affirming parent further exacerbates the problem of insufficient care for TGNC individuals. The more affirming the parents are when fighting for their child to receive proper sexual healthcare, the more these issues will be brought to society's attention, and the more solutions will be created to ensure TGNC people are seen by the medical community and that their healthcare risks are properly considered.

3. Affirmative Care is Superior Care

Looking at the case law concerning custody battles about immunizations, the Iowa courts favored relying on science and conventional medicine. The issues immunizations raise in custody cases are analogous to custody cases involving TGNC children and adolescents. Custody battles over immunizations usually involve one parent siding with science while the other parent either disbelieves the science or cites religious reasons. In cases involving TGNC children and adolescents, often one parent wants to be affirming of the child's identity while the other parent is insistent on traditional binary gender norms despite the medical and psychological communities' findings, or because of that parent's religion.

In *Lambert*, the Iowa Supreme Court granted the decision-making power regarding the child's health to the father who supported immunizations. The court asserted that immunizations had "a proven record."[259] Later, in *Asefi*, an Iowa District Court granted the physical care to the mother because she could provide the child with "superior care."[260] The court considered her views on immunizations to provide superior care because they were more "mainstream."[261] Likewise, affirmative care has a proven record. Different studies conducted over seven years have shown that affirmative care

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[258] TRANSGENDER MEDICINE, *supra* note 1, at 84.

[259] Lambert v. Everist, 418 N.W.2d 40, 43 (Iowa 1988).

[260] *In re* Marriage of Asefi, No. 12-1787, 2013 WL 4011156, at *5 (Iowa Ct. App. Aug. 7, 2013).

[261] *Id.* at *4.

improves long-term psychological health for TGNC children and adolescents.[262]

As previously discussed, family support is critical for TGNC youth and affirmative care provides families with support and connects them with groups to create understanding and acceptance within a family. The Iowa statutory scheme supports granting children the maximum physical and emotional relationship with each parent.[263] Affirmative care encourages health professionals to work with parents to ensure a TGNC child or adolescent can continue to have a relationship even with a parent who is non-affirming. Trying to educate a parent about the benefits of affirmative care is more beneficial for a child's health than forcing ignorant and biased views upon that child. The expansive variations of child custody arrangements provide a court with the opportunity to balance how to best affirm a child's identity while also ensuring the child has the most beneficial relationships with their parents.

Enforcing traditional gender stereotypes in a child custody arrangement should be left in the past with cases like *Smith*. Looking at the recommendations by most health professionals, a court should consider it against a child's interest to give health care decision making power and physical care to a non-affirming parent. This is not to say that a court must totally cut off the relationship between a TGNC child or adolescent and a non-affirming parent. A court can still grant a non-affirming parent time with their child like the court did in *Kristen L.* It simply makes the most sense with physical care considerations that the parent who will provide a home where a child feels the safest to be themselves is the home most likely to "foster [a] healthy physical and emotional li[fe]."[264]

Also, giving physical care and health care decision making to the affirming parent will prevent stress for a child. Some of the factors an Iowa court can consider when determining physical care is the communication between parents and their agreement on daily matters.[265] The California court in *Johnson* decided that both parents would be part of the decisions with their TGNC child and allowed the father to take the child to therapy with traditional gender ideas.[266] The judge in *Johnson* tried to get the best of both worlds by having the child go to supportive and non-supportive therapy, but this may not have been best for the child. When parents disagree on their child's identity, the court should grant physical care and accompanying decision-making power to the parent affirming. Custody determinations are

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[262] Connolly et al., *supra* note 107, at 489.

[263] IOWA CODE § 598.41(1).

[264] *In re* Marriage of Walton, 577 N.W.2d 869, 871 (Iowa Ct. App. 1998).

[265] *In re* Marriage of Heitman, No. 15–06311500631, 2016 WL 742816, at *4 (Iowa Ct. App. Feb. 24, 2016) (quoting *In re* Marriage of Hansen, 733 N.W.2d 683, 696–99 (Iowa 2007)).

[266] Skougard, *supra* note 194, at 1197.

supposed to consider the best interests of the *child*, not the *parent*.[267] And in *Johnson*, the court could have ordered the child to go to affirmative therapy and kept the father-daughter relationship intact by granting the father parenting time.

C. A Note on Religion

As seen in the three Iowa child custody cases about immunizations this Note has examined, Iowa provides a religious exception for the public-school immunization requirement. Often, a parent who is against their TGNC child seeking affirmative care may cite religious reasons for this belief. Specifically, when immunizations go against the core "tenants and practices" of a parent's religion, the child may be excluded from required immunizations.[268] Religion is likely to be a reason a parent would be against affirming the identity of their TGNC child or adolescent and would be used to prevent that youth having affirmative care.

The problem of religion came up in both *Rodgers* and *Asefi*. A previous court order granted the mother in *Rodgers* the religion decision-making power and therefore the father could not assert a right to prevent the children from being immunized.[269] The court in *Asefi* determined from the evidence that the father was truly suspect of the science behind immunizations rather than opposing for religious reasons.[270]

In *Johnson*, because of religious reasons, the father wanted to take the child to religious-based counseling that did not follow a supportive approach for TGNC individuals. The court allowed the father to take the child to counseling at a "religious institution" he "did not have any prior affiliation with . . . nor any history of religious practice."[271] Further, "[t]he counselor was a lay volunteer with no formal training in counseling from any religious or secular institution."[272] Like in *Asefi,* the father in *Johnson* appears to not actually have intense religious reasons. It seems the father actually disagreed with his child's identity and the science backing affirmative care, rather than having a core tenet or practice of his religion in conflict with his child's identity.

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[267] IOWA CODE § 598.41(1).

[268] Rodgers v. Clark, No. 06-0802, 2007 WL 108486, at *3, n.1 (Iowa Ct. App. Jan. 18, 2007).

[269] *Id.*

[270] *In re* Marriage of Asefi, No. 12-1787, 2013 WL 4011156, at *45 (Iowa Ct. App. Aug. 7, 2013).

[271] Skougard, *supra* note 194, at 1197 n.289.

[272] *Id.*

An entire other Note could be written regarding when a court determines a parent has a genuine religious belief against a TGNC child or adolescent's identity. In the limited discussion provided here there is only space to question whether a court should grant a parent religious decision-making power when that parent's beliefs conflicts with their child's identity. As with health care decisions, it is likely in a TGNC child or adolescent's best interest to grant the religious decision-making power to the affirming parent.

VII. CONCLUSION

TGNC children and adolescents are at risk for family rejection, bullying, mental health problems, substance abuse, and homelessness. When determining child custody arrangements, courts must consider modern medical and psychological understanding of gender and support for an individual's exploration of that gender identity and expression. Not only is affirmative care the best option for TGNC youth, it is also the best option to promote healthy family connections. Just as Iowa courts have sided with the scientific community when determining immunizations in child custody cases, they should side with the scientific community in determining healthcare decision-making powers of separated parents disagreeing over the appropriate care for their TGNC child or adolescent. When a custody case involves an affirming and non-affirming parent, the arrangement should grant healthcare decision-making power and physical care of the TGNC child to the affirming parent.