Parental Paradox: Ethical Considerations in Supporting Parents of Transgender Youth When Politics or Faith Create a Divide

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ABSTRACT

Care for transgender and gender-diverse youth (TGD) has become a politically divisive topic, and access to care is increasingly restricted. Between 2022 and 2025, a surge in anti-trans legislation led 27 states to limit gender-affirming care for youth. Only 16 states and the District of Columbia have enacted protective "shield" laws.[1,2] In this polarized environment, pediatricians face increasing ethical and clinical challenges, particularly when parents who oppose gender-affirming care present to the clinical setting.

This article offers a framework to navigate such situations through the lenses of *care ethics* and *narrative ethics,* and emphasizes relational engagement over binary decision making. This approach allows clinicians to support both the patient's identity and the parent-child relationship.

Clinicians must recognize their moral obligations in a climate where legal constraints may inhibit care. As access becomes more limited, pediatricians must advocate for compassionate, evidence-based care while they support parents who may struggle with grief, shame, or guilt. By honoring the narratives of both TGD youth and their families and by respecting the complex interplay in the relationship between parents/caregivers and teens, clinicians can facilitate ethically sound, affirming care that minimizes harms to the teen—even amid potential legal, political, and relational conflicts.

CASE

A 14-year-old patient arrives at a primary care clinic with a mental health concern. After the pediatrician takes a few minutes to assess

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the patient's safety, the patient's mother says she thinks the mental health crisis is due to the patient's recent disclosure that they are gender diverse, and that they use they/them pronouns. It was difficult for the patient to disclose this information, and their mother admits that she and their father did not respond in a supportive way. They told their child that this was a phase, and that it would soon pass. After the teen ignored and avoided both parents for a few weeks, Mom sat down with the patient and listened to what they had been going through over the past several years, alone. Mom states that she realized their child needed her support and that she could not bear to think of them feeling alone in this world. She took her child to cut their hair and buy clothes that affirmed their identity. The patient shares that this experience made a positive difference for them.

Dad does not understand and admits he was reluctant to make efforts to try. He told the patient that he would try to call them by their affirmed name and pronoun, but often forgets and bristles when the patient corrects him. He avoids using any identifying names or pronouns in public. He has not looked at the website the patient tried to show him about gender. He is willing to come to future appointments, but did not feel it was necessary to come today because "there is nothing wrong with my kid, so why do they need a doctor?" At the visit, Mom says that she struggles because she describes herself as conservative and is part of a faith-based community that has a binary view of gender and gender roles and does not support transgender youth. She is a devout churchgoer, a youth leader, and believes that marriage is for a man and a woman. She says that she and her family have always voted for more conservative candidates who support "traditional family values." As Mom continues to talk, the patient slumps down in their chair and looks away.

Mom is fiercely protective of her family. She has turned away other family members who are not supportive, but now feels alone. She will not share her thoughts publicly because she is worried that she will lose lifelong friends. She attended a local support group for parents of LBTQIA+ kids and felt shunned because of her background. The discussion in the group turned political, and the people there expressed their anger with the current administration. She immediately shut down, felt isolated and angry, and was unable to participate. She felt that if they knew how she had voted, they would have kicked her out of the group.

In this circumstance, should the pediatrician ignore the harmful comments made by the parents, in order to build an alliance with them, with the hope that they will in turn grow to provide a supportive and affirming home environment?

The pediatrician struggles with the situation. Two issues are troubling. First, they firmly believe that the current set of restrictions on transgender and TGD patients in their state is a direct result of discriminatory policies put forth by the current legislature. They wonder if it is ever ethically permissible to bring politics into the exam room. If they do, how can they avoid alienating the patient's family? In this case, how can they validate Mom's experience at the local support group without inadvertently seeming to align with her views on politics and gender? Second, the pediatrician wants to support this teen and wants them to have the opportunity

to pursue gender treatment options, if they choose. The parents have made comments that the pediatrician knows are harmful to the evolving sense of self and belonging for TGD youth and may result in worsening mental health and alienation for an already vulnerable teen. They also recognize that teen health is closely correlated with having supportive parents.[3,4] In this circumstance, should the pediatrician ignore the harmful comments made by the parents, in order to build an alliance with them, with the hope that they will in turn grow to provide a supportive and affirming home environment?

INTRODUCTION

TGD children have become increasingly visible and politicized in recent years. From 2022 to 2024, there has been a steep increase in anti-trans bills, which makes it difficult for many gender-diverse individuals to access care across the United States.[1,2] As of June 2025, there are 27 US states that have banned gender-affirming care to TGD youth. Sixteen states and the District of Columbia have implemented and enacted shield laws: laws that protect providers who treat transgender individuals and/or families and patients who seek medical care.[2] Given this, access to a subspecialist who provides gender-affirming care can be difficult or impossible, or the wait list for an initial consultation is too long. It does not appear that these conditions will change soon, which leaves parents and TGD children in an even more precarious and vulnerable situation.

As pediatricians, the authors support the well-being of TGD children and their access to gender-affirming healthcare. TGD youth are at higher risk for major depressive disorder and suicidality than their *cisgender* peers, in part because of the stigma they face. (A cisgender person's gender aligns with their assigned sex at birth.) Multiple studies reinforce that family support is critical for the well-being of TGD youth.[3,4] Olsen and colleagues report that transgender children who have affirming families have levels of depression comparable to that of their cisgender peers.[5] Clinicians are uniquely positioned to listen to and address the concerns of patients and their families, and it is essential to support parents in caring for their transgender children.

Reports in the literature support our experiences with patients who have recently come out to their family as transgender or gender diverse: that patients often have spent years reflecting on their gender before they share this part of themselves.[6] While this revelation is not new to the patient, it is new to their family, and the family's journey to acceptance can mirror what their child may have already experienced privately. The literature reports that parents and caregivers have a range of emotional responses to parenting LGBTQIA+ youth, including grief, shame, and fear.[7-9] Thus, parents and caregivers may need to "catch up" to their child, which often requires time, space, support, and education. Parents who grew up in homes where gender identity was more rigidly defined may find it difficult to accept gender diversity. Many parents may experience negative emotions such as guilt over not recognizing their child's gender identity sooner, possible shame about their child, self-doubt over medical decisions they may have to make, and uncertainty about the future.[10] Pediatricians face the unique challenge of supporting patients in accessing gender-affirming healthcare, while they navigate their own viewpoints, which may be in opposition to the viewpoints of patients' families.

Transgender children come from all different types of families, and they may suffer constructed and avoidable harms when they are not supported in their identity. How can pediatricians navigate the ethical complexities of supporting transgender patients and their parents, especially when the family's political views differ from pediatricians' own, and when parents believe their faith community or political beliefs may cause harm to their child? How can pediatricians set aside their own biases to ensure that the relationships within the family remain positive? Are clinicians ethically obligated to provide gender-affirming care against parental wishes? Conversely, is it ethically impermissible to align with the parents and

withhold gender-affirming care to preserve a family's structure, at the risk the teen will be permanently harmed? These questions require thoughtful communication and intention to resolve the ethical tensions that may arise as a clinician simultaneously affirms the interests of the patient and the patient's family, despite positions that may be in conflict.

ETHICAL ANALYSIS

Caregivers and parents are expected to act in their child's best interests, and family support is crucial to reduce stressors and mitigate adverse health outcomes for TGD youth.[5] How can healthcare clinicians conceptualize a framework that supports families, even when the family's belief systems conflict with what the clinicians perceive to be in the interest of the TGD patient?

First, clinicians must explore the role of the family in medical decision making. Although parents are expected to act in the best interest of their child, Groll recognizes that family interests also matter.[11] That is, a decision for one member of the family, even though it might be in that individual's interest, may not be in the best interest of the family unit. What does this mean for a TGD youth who wants to have gender-affirming medical treatment, when their family is hesitant because to permit gender-affirming therapy will cause them to lose their entire network of community and support? Although it may be beneficial for the teen to receive care, it may come at a genuine cost to the entire family, including parents and siblings. This decision-making framework reinforces the need for clinicians to align with family needs, especially since family support of TGD patients mitigates adverse health and societal outcomes. It might mean that clinicians recognize that a supportive family is critically important, and so it is part of their job to support the entire family in the journey to acceptance, even if it means slowing down gender-affirming treatment plans. Groups such as the Family Acceptance Project encourage families to "focus on shared values such as love, family connections, and wanting their [children] to live a healthy happy life."[12]

Second, clinicians' *prima facie* duty is to patients and families, regardless of their own personal or moral beliefs. This tension has been explored extensively in the literature about conscientious objection. When a clinician has a moral disagreement with the gender care requested by a patient, it is imperative that the clinician understands the limits or constraints placed on the refusal of care.[13] In this case, the pediatrician believes they must care for a family whose moral values negatively impact the well-being of a vulnerable population. Even when parents' moral values are misaligned with good care, most (if not all) moral positions can be reconciled to positions that support a common goal: to prevent harm and to help the child. Can a clinician justifiably refuse to provide care to the family, or, even more troubling, deliberately exclude parents from a minor's care? Pediatricians have many patients with whom they have vast cultural, faith-based, or ideological differences, and yet their obligation remains the same: to provide compassionate, holistic, and evidence-based care, care that is centered in the context of family and community.

The pediatric ethics literature has explored the limits of parental authority for decision making, and this article cannot do justice to the rich discussion on this topic. In this case, the pediatrician recognizes that the parents act from what they see as the best interest of their child, and their actions do not subject their child to immediate, serious harm. Diekema proposed the use of what he termed *the harm principle*. That is, when a parent's decision does not serve the child's best interest and places the child in immediate, serious harm, clinicians must invoke the state to make medical decisions for the child.[14] In response to Diekema's harm principle, Gillam proposed the concept of the *gray zone of parenting*; that is, that parents often must navigate making difficult decisions for which there is no one best answer, and when their decisions may cause some degree of harm to their child.[15] This zone is a well-known space for anyone who has a raised a child.

Third, there is the evolving capacity of adolescent decision making. Although this case does not explicitly explore the adolescent's

view, the patient disclosed information to their parents, and both parties trusted the clinician with their information. Parents are trusted with legal authority to make medical decisions on behalf of their minor, adolescent child, but adolescents should actively participate in decision making using the concepts of assent and dissent, which helps them practice the difficult skills involved in decision making and reinforces the importance of their bodily autonomy.[16,17] Even though the pre-frontal cortex continues to develop in adolescence, studies validate gender-diverse adolescents' capacity to make medical decisions about their care.[18] Clinicians who care for TGD individuals must recognize not only the challenges, but also the valuable opportunities to involve young people in decision making. Even though legal barriers to accessing gender-affirming care are increasing, as are the risks for physicians who provide this type of care, pediatricians must remain committed to patients. When gender-affirming healthcare is antithetical to a family's values, it is essential that their teen is exposed to healthcare clinicians who honor the youth's voice with compassion and respect—even when, by law, the clinician is not allowed to provide care. These small but meaningful interactions provide young persons with a model of acceptance and care that they will carry with them into adulthood.

Clinicians who care for TGD individuals must recognize not only the challenges, but also the valuable opportunities to involve young people in decision making.

Wimberly argues that TGD patients face myriad healthcare disparities secondary to societal construction. These disparities require clinicians to use the lens of *virtue-based ethics* to "improve the health of the transgender individual and the character of themselves and the profession of medicine."[19] Virtue-based ethics uses a framework that is different than *utilitarianism* (utilitarianism values usefulness; for example, the outcome or consequence of caring for TGD youth provides a benefit to the patient or society) or a *deontological approach* (in which the morality of an action rests on rules, or a duty; for example, the duty of a pediatrician is to care for TGD youth). Virtue-based ethics incorporates the concepts of character and caring when a clinician is faced with an ethical dilemma. In virtue-based ethics, the provision of care centers on dignity (of the patient, the family, and the clinician). In recognizing the importance of dignity, clinicians must acknowledge the multiple intersections of faith, culture, economics, education, and community that families bring to a clinical encounter. To dismiss the values of the mother in this case as simply anti-trans diminishes her dignity and creates a wedge between the family and the care team. Eventually, disrespect can erode the trust that is critical to provide compassionate care. While the mother did not find that dignity in the support group she attended, a clinician can provide it. In more challenging cases when parents are not affirming, Howe emphasizes the importance of careproviders' setting aside their preconceived biases, and instead convey to parents an understanding that "the intensity of [their] views must come from a deep love for their child."[20] This strategy gives dignity back to a parent who struggles to reconcile their own deeply held personal and political views with the unconditional love that comes with parenthood.

This case centers around an adolescent patient and their mother, the adolescent's gender diversity, and their mother's desire to support and affirm their child while she still maintains

her community. The mother had already sought out local support groups, but felt isolated from them, given her conservative and faith-based views. A clinician may not agree with the mother's perspective, but can affirm her strong love for her child and the dignity she deserves as a parent. By affirming the patient and acknowledging their mother's support, a clinician can model acceptance of both the patient's gender identity and their family. To prevent adverse outcomes for a child, clinicians can appreciate and affirm parents' willingness to learn about their child's gender diversity.

Although ethical analyses using *principlism* or virtue-based ethics may help to navigate the ethical dilemmas of this case, the cornerstone of clinical ethics is listening to the stories of patients. (Principlism is an approach that applies principles, such as autonomy, in ethical analysis.) A *narrative ethics* approach—listening to patients' stories—is a practical way for busy clinicians to identify areas of alignment in care, especially when they must navigate disagreements—political or otherwise—in the treatment of TGD youth. Narrative ethics allows a clinician to understand the who, what, and why of a patient's decision to engage in care at a particular time. It gives context to a framework for shared decision making and re-centers the story on what matters to the family and to the teen.

As Montello eloquently describes, narrative medicine provides a process. She states, "Resolving a difficult clinical ethics case is different than solving it, different from fitting together all the pieces of puzzle. The meaning of resolution in narrative ethics [means] . . . progressing from dissonance to consonance."[21] A narrative approach has been proposed to help families move along their own path in supporting their TGD child which includes, as Klassen-Bolding describes, "understanding the cultural narrative about families and honoring the experience of individual family members," thus enabling a parent to write their own unique story of their family and family relationships.[s] The use of a narrative approach requires time and trust between an interdisciplinary team and a family to foster a deeper understanding of their values and treatment goals. It can empower an adolescent to play a greater role in authoring their own story, while it allows and recognizes the importance of parents and clinicians as co-authors of their story.

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A pediatrician's job is to listen and respond to the concerns and needs of patients and their families. Many pediatricians who provide care for TGD families have gone through, and continue to go through, a complex emotional journey—they grapple with anger and disbelief at the scapegoating of the transgender population, bristle at attacks about their work, witness the deterioration of patients' mental health, fight tirelessly to preserve access to healthcare, and fear for their personal safety and the safety of their families. At times pediatricians must navigate opposing personal viewpoints while they remain steadfast in support of their patients and place them at the center of their conversations and management plans.

IN OUR OWN PRACTICE

In our own practice, there are many families who hold faith-based sociopolitical beliefs that may be diametrically opposed to our own or to the official position statements of the American Academy of Pediatrics.[23] *Lancet Child & Adoles-*

cent Health published an editorial in 2021 that noted that "conservatives" were behind much of the legislation that would ban the rights of trans youth to access care.[24] While it feels easy to dismiss these families' viewpoints as harmful, we must recognize that we all come to the table with our own biases. This is why it is crucial that we have done our own work to recognize, manage, sort, and understand how our biases affect the care we provide. As Folkers and colleagues note, an interdisciplinary team in gender care fosters "recognition of the relational nature of ethical deliberation in clinical practice."[17] Such team collaboration brings diverse perspectives that help to counteract an individual clinician's biases and enhance decision making.

The most helpful outcome from our work with patients is that we learn to remain curious and open during our patient visits, recognizing that our patients are vulnerable in these moments. This case reminds us that transgender individuals exist in multiple intersections of race and ethnicity, socioeconomic status, education, faith, and politics, and, regardless of their background, parents can put aside their own biases to support and love their child. Parents may benefit from finding outside support, since they may be struggling with their own belief system, have lost the support of friends and family, and may feel less welcome in their own faith-based or political community. Access to and acceptance of pediatric gender-affirming care will continue to change in the current political landscape. Unfortunately, healthcare for TGD youth continues to be politicized and divisive, and our patients suffer for it. When families cannot find support, we need to recognize the sense of abandonment they may feel. It is our responsibility to incorporate a diverse network of community services in our practice, including affirming faith-based or political groups, and, in the absence of those communities, be an unwavering place of acceptance and support for the patient and their family. Finally, it is imperative that we remain steadfast in our support to provide and advocate for evidence-based, compassionate, and holistic care for TGD and their families.

We recommend the following when clinicians face parents of TGD who disagree with gender-affirming care:

1. Avoid blanket abandonment or exclusion of parents. We can apply the principles of care ethics and narrative ethics to listen for the narratives of the parent and the teen and acknowledge the deep interconnectedness of their parent-child relationship. This can help the clinician, teen, and parent develop a shared decision about gender-affirming care that honors the positions of all, rather than reduces the disagreement to a stark binary of pro or anti gender-affirming care.

2. Meet parents where they are. Listen to their narrative about their values, even if they are different than yours. Respect for the values from which parents build their opinions, thoughts, and actions builds connection, which is foundational to the care of vulnerable patients.

3. Build trust. Remember this is an ongoing, active journey. Trust does not always require big actions, but can be built by everyday little actions, like being patient, listening closely to patients and families, letting them talk without interrupting, avoiding minimizing their concerns and worries, respecting autonomy, being vulnerable, and talking directly. It also means not directly contradicting faith or politics in the exam room, but rather identifying common shared goals to build a trusting relationship. Follow through on promises and avoid offering what you cannot deliver.

4. Remain curious. Take the time to ask questions and get to know the family beyond their medical history. You might ask: Have you felt comfortable sharing your child's gender identity with anyone? How did it go when your child came out at school? How have you been managing it all? How can I help? What support do you need? Remember that families may feel overwhelmed with shame and guilt at the beginning of this journey, so creating a supportive and nonjudgmental space is essential. Be mindful of your non-verbal expressions. Be gentle and validate the emotions and worries parents have when they come to you.

5. Finally, as legal restrictions on TGD care become increasingly stringent, it is important to recognize the moral burden you bear when you navigate the societal and legal challenges to the care you provide. At the same time, it is crucial that we all continue to advocate for evidence-based, compassionate, and holistic care for TGD youth.

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