Children with Gender Identity Disorder. A Clinical, Ethical, and Legal Analysis

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Published in 2013, Simona Giordano's book, "Children with Gender Identity Disorder[1]. A Clinical, Ethical, and Legal Analysis", is yet to receive the attention it deserves. It displays not only great insight and careful analysis of the issues involved, but also deep sensitivity and compassion. It integrates clinical, ethical and legal analysis with results from empirical research and personal testimonies and with fairy tales and literary sources. Among these are poems that highlight the frailty and vulnerability of human life – such as François Villon's *Ballade des pendus*, which Giordano calls "an allegory of the human condition, constantly at the border of mistake and death", which "reminds us that we are all dangling before a common undulating, uncertain destiny, swaying between error, virtue, and fortune" (Giordano 2013: xvi). This book, Giordano writes, is about all of us, not only as professionals or parents or friends - that is, not only because of our relation to a transgender person - but because, in fact, all of us are *in between* genders. This claim is clarified further in the book. In the first chapter, "**Transgenderism: setting the scene**", Giordano explains the main concepts that are used throughout the book. The transgender experience, and gender ambiguity in general, have always been a part of human history, but have been marginalised in deeply gender binary cultures such as Western cultures. This has led to such expressions being left out of not only Western medical practice but also linguistic development. Words such as *transsexual* and *transgender* have been coined in the English language in the 1940s and 1980s, respectively. The term *transgender* is used in this book to denote all forms of gender development that differ from the gender assigned at birth. Thus, it includes individuals who have had hormonal or medical gender reassignment treatment,

[1] At the time of the publication of this book, Gender Identity Disorder was the term still in use in the Diagnostic and Statistical Manual of Mental Disorders (DSM). It has since been replaced with Gender Dysphoria in the fifth and current version of the manual.

as well as individuals who have not but identify their own gender as *beyond* that which was assigned to them at birth.

As will become evident later in the volume, these two concepts, 'transgender' and 'transsexual' misleadingly suggest that there are two 'opposite' genders or sexes and all issues are reducible to being allowed to migrate from one to the other – this, argues Giordano, is a misunderstanding of the complexities of gender identity and gender variance (Giordano 2013: 43). For up-to-date terminology in this area see the GLAAD Media Reference Guide – Transgender Issues[1].

In chapter two, "**What is gender**", this core concept is explained and analysed from the perspectives of several disciplines such as sociology, gender studies, philosophy, clinical psychology, psychiatry, and endocrinology, and in figurative arts. In sociology and gender studies, explains Giordano, gender identity is "the recognition of the implications of belonging to one sex. The roles, behaviours, and attitudes that people may adopt and internalise, depending on whether they belong to one sex or another, reflect the expectations that a society in a given historical and geographical context has of men and women" (Gordano 2013: 12). This identity receives input from parents and society even before a child is born: the appearance of children's genitals determines how they will be received in the world, and genitals "are thought to reveal a series of relationships, preferences, and inclinations, which are assumed to be stable across the future life of the child" (*ibid.*). Gender is a normative construct that determines how individuals are expected to develop throughout their lives. Thus, rather than being biologically determined, gender in gender studies is a social construct.

This is also the chapter in which the distinction between *sex* and *gender* is explained and its (negative) implications highlighted. Biological sex comprises chromosomal sex (such as XX and XY), gonadal sex (testicles and ovaries), hormonal sex (that depends on the levels of certain hormones such as androgen), and anatomical sex (genitalia). These biological dimensions of sex are complemented by legal sex: the sex a person is considered as having in the eyes of the law. However, these dimensions do not always neatly map onto each other in every person, and are more complex than the dichotomies that have been assumed. Of these complexities, the most obvious are intersex conditions. Examples of intersex conditions are Turner syndrome, Klinefelter syndrome, congenital adrenal hyperplasia, or androgen insensitivity syndrome – these

[1] Available at http://www.glaad.org/reference/transgender (last accessed August 2015).

are briefly discussed in the chapter. Thus, to say that biological sex is clear and made of two sexes, male and female, is an inaccurate simplification: considering that all these elements of sex map out in different ways in different individuals, it would be more accurate to say, argues Giordano quoting Anne Fausto-Sterling, that there are more than two sexes in humans. (Note that intersex conditions and the transgender experience need not intersect: while intersex conditions are about the alignment of the above aspects, the transgender experience is about the mismatch between gender identity and sex assigned at birth – even if all the dimensions of sex are otherwise aligned.)

Giordano investigates some of the likely origins of the idea that only two sexes are *normal* in humans, and then points out how the idea of gender as the social interpretation of biological facts (sex) relies on the expectation that sex is easy to identify and that its various aspects are (supposed to be) congruent. This, argues Giordano, suggests that the relationship between sex and gender is reversed: "rather than seeing gender as a construction based on biological sex, we should perhaps think of sex (the dichotomous sex) as a construction based on implicit norms related to gender" (Giordano 2013: 18). Furthermore, the expectation from gender studies that gender can be "moulded" by upbringing has had clinical implications which Giordano discusses in the next chapter.

Chapter three, "**Gender identity development**", presents and analyses the main theories of gender development, and the clinical and normative (often harmful) implications that these have had. The theories that Giordano discusses here are grouped together in the biological model (or *essentialist* model; according to which gender identity is mainly determined by biological forces), the social model (or *constructionist* model; gender role and gender identity are mainly social constructs), and the biosocial model (sex and gender result from an interaction between the biological and the social). Four more theories are also reviewed, though more briefly: the sociobiological theory, Freud's psychoanalytic theory, the cognitive-developmental theory, and the gender-schematic processing theory.

Clinical practice has been heavily influenced by the social model of gender development (Giordano 2013: 39). For decades, children with ambiguous genitalia at birth (that may result from conditions called DSD: Disorders of Sex Development) have been "corrected" surgically and then raised in one of the two genders with the expectation that they will conform to the gender assigned. Such expectations have

sometimes had tragic consequences, such as in the case of David Reimer who was raised as a girl after his penis was accidentally severed when he was a baby, never conformed to the assigned gender, and committed suicide in 2004.

Gender identity, explains Giordano, is an aspect of personal identity; it is, in Giordano's own words, "the result of a complex interplay of various factors: social, biological, and perhaps of other natures as well (historical, cultural, cognitive, and so on). The perception of our own gender (like the perception of other elements of ourselves) may also depend on various personal elements, including cognitive responses (*who one thinks one is*), affective responses (*who one feels one is*), and volitional responses (*who one wants to be*). All these factors combine themselves in a unique way in each individual to create the person that each feels and thinks one is and wants to be. In this sense, being a part of a gender minority is as uncomplicated (or as complicated) as being a 'straight' woman or man. All the processes of gender development are equally complex (or simple), equally unique, and equally legitimate" (Giordano 2013: 32).

In chapter four, "**What is 'Gender Identity Disorder'? Tales of people in between**", Giordano explains gender variance, its incidence, prevalence, and aetiology, and relies on adapted fairy tales as well as real life case histories to illustrate a range of experiences of children with gender variance. Gender dysphoria (previously "Gender Identity Disorder" in the DSM) is the "discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)" (WPATH in Giordano 2013: 57). In this chapter, Giordano reviews some of the risks to transgender people arising from, for example, the lack of availability of medical interventions. She discusses the three dimensions of gender dysphoria: the psychological, the physical and the social dimension, and the hardships that accompany it, which include guilt, secrecy, fear, humiliation, isolation, rejection, discrimination, violence, bullying, physical and sexual abuse, recurrent threats to self-esteem, heightened risk of homelessness, substance abuse, depression, and suicide. How serious these risks are depends on how accommodating of gender ambiguity a society is.

Giordano explains that early transition intervention is preferable as it is much more likely to achieve the changes that the person seeks, some of which become simply out of reach as she has matured physically (Giordano 2013: 59-60). This is complicated by the fact that some children do not persist in gender dysphoria as they age (one

solution for which, reversible treatment, is explored in the next chapter). Furthermore, what type of intervention is in order is often seen as depending on what the cause of gender dysphoria seems to be, and if it is psychological or endocrinological. The problem with looking for the causes of gender dysphoria is that often this is a pursuit for *what went wrong* – which is "to assume that something has actually gone right in other cases, and this is not necessarily a sound assumption" (Giordano 2013: 67). There does not need to be *something wrong* with a person's gender identity for her to need medical assistance to allow her to understand her identity and express her own self.

Chapter five, "**Available treatments for transgender children and adolescents**" makes an overview of treatments, including "combined approaches" which she evaluates as most promising. Treatments for children with atypical gender identity have included behavioural therapy (aimed at reducing cross-gender identification), psychological therapies (often also aimed at reducing cross-gender identification), and medical therapies. Combined interventions involve three stages: wholly reversible treatment (such as suspension of puberty), partly reversible treatment (such as the administration of masculinising/feminising hormones), and irreversible treatment (reassignment surgery) at a later age. So far, results of reassignment surgery have been promising: body dissatisfaction decreased significantly, and cases in which the person wants to revert to the sex established at birth are rare. Reassignment surgery does not however suit every person's needs, and some may simply not be comfortable with having to make an abrupt *either or* choice between genders (Giordano 2013: 89).

Chapter six, "**Ethical issues surrounding treatment of transgender minors**", deals with the main ethical objections to medical treatment of children with gender variance. These are that (1) to initiate such treatments is akin to playing god or playing with nature, (2) gender variance is a social, not a medical problem, and should thus not be treated with medical means, (3) experimental treatment is unethical, and (4) children lack competence to consent to such treatments. Giordano rejects these arguments one by one. Playing god is something medicine does all the time, and whether something is natural or in line with nature does not determine whether it is the right or the wrong thing to do. Social change may well be in order if we are to improve the lives of children with gender variance, but social change alone will not always suffice, and does not resolve the need for medical treatment: at least in some cases, the suffering experienced by transgender individuals can only be assuaged with medical intervention. Lastly,

experimental treatment may *sometimes* be unethical, but it is not unethical in principle. And while health professionals should not expose children to unnecessary harm, they also have a moral responsibility to mitigate harm that already exists or is foreseen, if they can – especially if the risks from *not receiving the treatment* outweigh the likely risks of the treatment.

Giordano further discusses the ageism implicit in setting age limits for access to treatment. Current guidelines have until recently or are still recommending 18 as the minimum age of eligibility for surgical intervention in cases of gender dysphoria. However, to refuse treatment because of age alone not only reduces the capacity to benefit from treatment (see Chapter four), but is also unjust and discordant with the principles of the duty of care that health professionals otherwise abide by. The same, argues Giordano, is the case for the requirement of Real Life Experience: that one experiences life as *the other* gender for at least a certain period, usually 12 months, before access to surgery is granted. The problem with this expectation is that it only makes sense if there are only two genders, and one can experience one *or* the other – whereas gender and sex expressions are much more varied than that. In this way, the requirement that they adhere if not to the sex assigned at birth, then to *the other*, reinforces the very strict gender divide that is causing the suffering. It also, argues Giordano, increases the risks of abuse, ridicule, and stigma, by demanding that one "masquerades" as the other sex. While we should be cautious before taking irreversible measures, we also have to avoid causing more suffering and, in the end, this will depend on the circumstances of each particular case. This is why Giordano argues that any decisions should be taken on a case by case basis, in each therapeutic relationship.

Chapter seven, "**The treatment of minors with gender dysphoria: legal concerns**", focuses on analysis of the UK context. Even when transgender children and adolescents have the capacity to consent to treatment, Giordano recommends that, in the case of experimental treatments, consent should also be sought from their legal guardians. Health professionals have an obligation to share the relevant information with their patients and act in their patients' best interests, and give adequate weight to their views. In this chapter we also find discussions of the meaning of consent, the relation between consent and information, legal capacity to consent for treatment or participation in research, refusal of treatment, consent and mental illness, the role of the

family, the determination of best interests, the health professionals' duty of care, causation, and foreseeability of consequences.

Gender minorities, writes Giordano, share many difficulties with other types of minorities, in their journey towards acceptance. "**Epistemological issues relating to transgenderism**" (in particular the classification of gender variance as pathology, as a *disorder*) are discussed in chapter eight. Unless there are

"sound reasons to consider gender variance as a mental illness, its inclusion in psychiatric manuals risks being not only a conceptual mistake, but also a moral wrong done to those affected. (…) Gender identity is one of the most important, intimate, and private aspects of who we are. Gender identity like sexual orientation concerns nobody else except for the person him/herself. Considering gender diversity as a mental disorder may be, to use Marcuse's epithet, a form of 'repressive tolerance'" (Giordano 2013: 141).

The three epistemological reasons for classifying gender variance as a mental disorder that Giordano discusses in this chapter are (1) the fact that it is associated with extreme distress and impairment, (2) the fact that the condition seems to be psychological in nature, and (3) the fact that it deviates from 'normal species functioning'. However, argues Giordano, the first condition is also fulfilled by other types of suffering that we do not classify as mental illnesses, such as mourning. To experience distress, she continues, is *adequate* when confronted with adversity – and individuals with gender variance can face a great deal of adversity. Should clear somatic causes of gender variance be discovered, in some senses this might make life easier for them. Until then, argues Giordano, the apparent lack of somatic causes does not mean that the causes are psychological. Furthermore, the labelling of gender dysphoria as a mental illness contributes to the stigma of living with gender variance.

There may be pragmatic, rather than epistemological, reasons to retain the diagnosis: for example, doing so might make it more likely that support and treatment are offered (this is also the justification given for the inclusion of gender dysphoria in the current version of the DSM[1]). In reality, not only does this diagnosis not give access to publicly funded treatment (in the UK) for all medical interventions necessary (this will largely depend on regional budget), but also it is not a condition for treatment being provided. A classification as a syndrome rather than a disorder might fulfil the same

[1] See Gender Dysphoria Fact Sheet, at www.dsm5.org/documents (last accessed August 2015).

role. According to Giordano, medical "treatment should be offered based on need and prognosis, not based on nosology or on the classification of the sort of condition one has" (Giordano 2013: 149). This argument is developed in this and the following chapter. It is a controversial position for those who see medicine's role as that of treating or curing illnesses, and not otherwise of relieving suffering in general. Giordano offers a variety of examples for why such a narrow understanding of medicine is not in fact mainstream, and medicine is often used to supress or counter normal functioning, or to alleviate psychological suffering: such are contraception, treatments for age related conditions, or breast reconstruction after mastectomies. To this add the conceptual difficulties encountered in the effort to define 'illness' or 'normality', and the reduction of psychiatric illnesses to psychiatric solutions (and thus excluding other forms of treatment, such as surgery).

If is often assumed that determining whether a condition has biological causes clarifies the question of whether medical treatment should be offered. In chapter nine, "**Should gender minorities pay for medical treatment?**" Giordano argues that whether gender variance has biological causes is a different question than whether transgender individuals have a right to medical treatment. She here explores two parallel scenarios in which gender variance is no longer classified as a disorder. One scenario supports the claim that any medical treatment should therefore be funded by the individuals seeking it. The other scenario supports the claim that treatment should be offered when it is likely to reduce severe suffering – including when this suffering is caused by atypical gender development. The alternative outcomes of the two scenarios are dramatically different for transgender people.

Transgender people, writes Giordano in her conclusion, are gender nomads, and trying to impose binary gender assumptions onto them is "not only a form of abuse towards the individual concerned, but a way of silencing a diversity that enriches humankind" (Giordano 2013: 170). Instead of trying to prevent or suppress gender variance, we should celebrate it as an expression of a human search of authenticity and being true to oneself, and we should respect it for what it is. Whatever the causes of gender variance, she writes, they are, "so far as we can tell, the same as the causes of all gender identities: people are who they are, and they develop through extremely complex pathways that are unique to them" (*ibid.*).

We should all reflect on the way in which we think about gender and on how the societies we live in treat gender minorities, concludes Giordano. This book can help boost this reflection and discussions on this topic. It helps that it is written in a very approachable language, with minimal academic jargon and with examples from movies and literature, and it clarifies ethical, legal, and medical issues. One may disagree with one or another of Giordano's arguments, and we are as yet only learning to explore these issues: it may well be that new evidence and new treatment possibilities will warrant different recommendations. Nevertheless, this book is a good introduction and I hope it will accompany many explorations of this topic.

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