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Introduction

Case histories

1. Jan Morris

I was three or perhaps four years old when I realized that I had been born into the wrong body, and should really be a girl. I remember the moment well, and it is the earliest memory of my life.

I was sitting beneath my mother’s piano, and her music was falling around me like cataracts, enclosing me as in a cave. The round stumpy legs of the piano were like three black stalactites, and the sound-box was a high dark vault above my head [...] On the fact of things it was pure nonsense. I seemed to most people a very straightforward child, enjoying a happy childhood. I was loved and I was loving, brought up kindly and sensibly, spoiled to a comfortable degree [...] by every standard of logic I was patently a boy. I was named James Humphry Morris, male child. I had a boy’s body. I wore a boy’s clothes [...] (Morris, 1974, pp. 1–2)

2. James

James was referred to the Gender Identity Development Service at the age of 8 years. At the assessment interviews, he said that since the age of 4 or 5 he had very much wished he were a girl. He had been secretly dressing up in his mother’s clothes. He liked to play with dolls and cuddly toys and fantasised that he was a mother feeding them. He played weddings and liked to be in the role of the bride. At school he wanted to play with girls and avoided rough-and-tumble play or other activities with boys (Di Ceglie, 2000, p. 460)

3. Mark

Mark, aged 16 years, presented a gender identity disorder of a transsexual type. He hated his male body intensely. Socially isolated and in despair, he had attempted suicide. Since the age of 3 or 4 years he had felt that he was a girl [...]
4. Jerry

(My mother) went to the trouble of finding two identical dresses—one for me and one for my sister. My sister loved hers. I didn’t. Mother put the dress on me, I took it off. My mother put it one me again and I took it off. She tried again and again, and I took it off again—only this time I cut it up with scissors. (Kotula, 2002, pp. 92–94)

These are four stories of children with atypical gender development. Different nomenclature applies to the experience of atypical gender development. The DSM-IV utilises the term Gender Identity Disorder (GID) (DSM-IV-TR, 2000). In this paper, I will use the term Atypical Gender Identity Organisation (AGIO), first suggested by Domenico Di Ceglie (Di Ceglie, 1995, chapter 2).

There are no agreed international guidelines on the treatment of children and adolescents with AGIO. Different countries adopt different approaches. This paper offers a contribution to the establishment of guidelines that are coherent with ethical and legal principles accepted in the UK and worldwide. New guidelines for treatment of children and adolescents with AGIO are needed for at least four reasons:

1. to remove the inconsistencies between the approaches recommended by health care professionals across different countries and also by different associations and colleges in the UK;
2. to remove the inconsistencies between the way minors with AGIO are treated, as compared with children suffering from other conditions;
3. to ensure that treatment of minors with AGIO is not only clinically, but also ethically appropriate;
4. to allow health care professionals to safely exercise the clinical judgment to undertake the course of action which is in the child’s best interests.

Focus will be on the entitlement to receive treatment. For reasons of space and consistency, this paper will not consider the issue of whether treatment should be publicly funded. The defence of the entitlement to be treated and definition of clear guidelines is, however, preliminary to any further discussion of how treatment should be funded.

In the first part of the paper, I will summarise what AGIO is and how it manifests. This should help non-specialist audiences to become familiar with the problem.

In the second part, I will focus on ethico-legal issues surrounding treatment of children and adolescents with AGIO. I will outline available interventions for AGIO, their risks and benefits, and I will argue that it is possible, either for an adult or for a competent child, to give valid informed consent to treatment for AGIO. This implies that AGIO (whether or not it should be considered as a mental illness) does not ipso facto entail incompetence to decide about treatment.