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Protecting children affected by Atypical Gender Identity Organization: the comparative legal perspective

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Abstract. Some children at a very young age could feel, in the deepest realm of self-perception, to belong to the opposite sex, in spite of their absolute biological normality. According to medical literature this phenomenon is defined "Atypical Gender Identity Organization" (A.G.I.O). The DSM-5 provides different criteria for the diagnosis of gender dysphoria in children than in adults and adolescents.
It was highlighted that the variance of gender identity can be defined as the state in which gender identity is organized atypically during the psychosexual development of a child. These are cases in which children and adolescents perceive their sexual identity as inappropriate to their body and then to their biological sex. They may feel unhappy regarding their physical and sexual features and express a desire to be recognized as belonging to the opposite sex. Such situations are accompanied by difficulties from an emotional perspective, with significant behavioral suffering associated with their conditions. Medical experience shows that about 1/3 of those children affected by A.G.I.O. will be oriented to surgical intervention to change their sex, while the other 2/3 will overcome their perceived identity conforming to the biological sex during their pubertal development. After becoming adults half of the latter will have a heterosexual orientation and the other half will evolve towards a homosexual orientation. In rare cases, only after thorough psychological assessment, the international literature admits the possibility to carry out puberty blocking therapy and, subsequently, to a cross sex state.
These are the cases considered appropriate to make the choice about possible drug treatment according the guidelines of the Endocrine Society issued in 2009 and ratified by WPATH (World Professional Association for Transgender Health) in 2011. These therapies help to provide more time for both professionals and young people to better understand what to do without worries about the development of sexual characteristics of the biological sex. In this sense, the desired role allowing a smoother inclusion of affected teenager in his or her social environment.The condition of children suffering from atypical organization of gender identity directly involves the relationship between parenting choices and protection of the preeminent best interest of the child, first of all his or her mental well-being, as well as to the manifestation of consent to administration of drug therapies It must be considered that in psychiatry A.G.I.O. is still considered a mental disorder, while in theory there are those who states that it is a medical convention detrimental to the personalistic principle of self-determination.
The purpose of this paper is to analyze the comparative legal sources and case law concerning the manifestation of informed consent to medical treatment and the legal consequences related to gender change.

1. The "Atypical Gender Identity Organization".

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Recently, several news sources[1] emphasized even pre-puberty children were subjected to hormonal treatment to slow down the appearance of puberty in order to "choose" what their sex[2] or sexual orientation[3] was. Such sources do not, however, specify that there are individuals with early feeling of the deep sphere of self-perception[4], belonging to the opposite sex, despite the absolute normality in the biological sphere. According to medical literature, these children are affected with "Atypical Gender Identity Organization" (A.G.I.O.)[5]. This is a disorder that emerges from childhood when children, even at very early ages[6], highlight display "cross sex" behaviors that need to be understood and "helped in the maturation of their gender identity"[7].

Until recently there were controversies among experts about A.G.I.O. diagnosis terminology and treatments[8], and the debate is still carrying on[9].

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1 E. Day, *Transgender kids: 'Everyone was calling me Sebastian, but I knew I was a girl'*, The Guardian, April 5, 2015; J. Leake, *NHS helps children choose their sex,* The Sunday Times, November 17, 2013; H. Devlin, *Children aged 9 with gender issues can delay puberty*, The Times, May 19, 2014.

2 B. Frigerio, *Arriva in Italia il trattamento ormonale per cambiare sesso ai bambini. «Delirio di onnipotenza»*, 24 ottobre 2013, http://www.tempi.it/arriva-anche-in-italia-il-trattamento-ormonale-per-cambiare-sesso-ai-bambini#.VXFLHKZ0pcw.

3 O. Vetri, *Sospendere la pubertà per scegliere l'orientamento sessuale*, Famiglia Cristiana, 25 febbraio 2015, http://www.famigliacristiana.it/articolo/olanda-fermare-la-puberta-per-scegliere-l-orientamento-sessuale.aspx.

4 E. Schneider, *An insight into respect for the rights of trans and intersex children in Europe*, Council of Europe, Strasbourg, 2013, p. 7.

5 A. Lorenzetti, *Diritti in transito*, Franco Angeli, Milano, 2013, p. 49 n. 2; C. Manieri, S. Einaudi, *Orientamento sessuale e distubri dell'identità di genere in epoca adolescenziale*, 2014. (courtesy of the authors).

6 E. Skougard, T*he Best Interests of Transgender Children*, *Utah Law Review,* 2011, p. 1165.

7 C. Manieri, *Assistenza a soggetti in età evolutiva con "Organizzazione Atipica dell'identità di Genere" (AGIO*), (courtesy of the author) p. 2.

8 J. Drescher, P. T. Cohen-Kettenis, G.M. Reed, *Gender incongruence of childhood in the ICD-11: controversies, proposal, and rationale*, Lancet Psychiatry 2016; 3: 297–304, p. 428.

9 J. Drescher, P. T. Cohen-Kettenis, C. M. Reed, cit.

DSM 5 2013 provides different criteria for the diagnosis of gender dysphoria in children compared to adolescents and adults[10]. As far as children are involved, these criteria concern a marked inconsistency between the experienced/express and the assigned sex, of a duration of at least 6 months. This inconsistency is manifested by the presence of at least 6 of the following criteria (one of which must be Criterion A1):

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

In adolescents and adults, however, an inconsistency between the experienced/expressed and the assigned sex, with a duration of at least 6 months, must be diagnosed as manifested by at least two of the following[11]:

> "A. 1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
> 2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
> 3. A strong desire for the primary and/or secondary sex characteristics of the other gender.

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10 C. Manieri, *La Disforia di Genere: aspetti psico-endocrini*, 2015, (courtesy of the author)

11 American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, V, 2013. A different Classification is provided by International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10)-2015-WHO Version for 2015, that defines A.G.I.O. as *"A disorder, usually first manifest during early childhood (and always well before puberty), characterized by a persistent and intense distress about assigned sex, together with a desire to be (or insistence that one is) of the other sex. There is a persistent preoccupation with the dress and activities of the opposite sex and repudiation of the individual's own sex. The diagnosis requires a profound disturbance of the normal gender identity; mere tomboyishness in girls or girlish behaviour in boys is not sufficient."*, available on http://apps.who.int/classifications/icd10/browse/2015/en#/F64.2

4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
B. The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning".

Such condition is associated with significant suffering or disturbance in the social and educational environment or in other areas of functioning with an increased risk of negative responsiveness or disability. It can be isolated or associated with a "Sexual Difference Disorder"[12].

In this regard, the variance of gender identity can be defined as the state in which gender identity is organized atypically during the period of psycho-sexual development of a child[13]. These are cases where children and adolescents perceive their sexual identity as being inadequate to their body, and as a result, their biological sex. They may feel unhappy about their physical characteristics and sexual functions and express a desire to be recognized as belonging to the other gender. They prefer clothes, toys and games commonly associated with the other gender as well as friendships among people of the other gender. Such situations are accompanied by difficulties both emotionally and behaviorally with considerable suffering associated with their condition[14].

2. Assistance and treatment of A.G.I.O-Affected Children

There are three main centers in the world that have the most relevant experience in managing children suffering from A.G.I.O.: Amsterdam (formerly co-ordinated by Prof. Peggy Kettenis), London (formerly coordinated by Prof. Di Ceglie, now by P. Carmichael), and Toronto (coordinated by Prof. Zucker). The scientific research of these centers agreed in pointing to the psychological support for children with A.G.I.O. and for their families as indispensable to provide a space for re-elaborating and understanding the variant gender experience, and for incorporating it into a socio-family context promoting an egosyntonic development. These outcomes were confirmed by an internationally study promoted by Dutch scholars who first applied hormonal suspension of puberty

12 C. Manieri, S. Einaudi, id.

13 P. Valerio, I. Parisi, F. Santamaria, *Puberty Blocking During Developmental Years: Issues and Dilemmas for Gender-Variant Adelescents, Bioethical Issues, by the Interuniversity Center for Bioethics Research*, Napoli, Editoriale Scientifica, 2014, p. 144.

14 P. Valerio, I. Parisi, F. Santamaria, Puberty Blocking, id.

over a long period of time[15].

The cases dealing with these children have shown that about 1/3 of them will have a gender dysphoria experience that will require for medical-surgical adjustment, while the other 2/3 will completely overcome dysphoria at the time of puberty development, perceiving the identity of their biological sex. In adulthood half of the latter will have a heterosexual orientation and the other half will evolve towards a homosexual orientation[16].

In rare cases, after extensive psychological evaluation, international literature proposes a process of puberty blockage and of subsequent "cross-sex puberty". In these cases, it is considered appropriate to take a longer time to decide on a possible pharmacological treatment in accordance with the guidelines issued by the Endocrine Society in 2009 and ratified by the WPATH (World Professional Association for Transgender Health) in 2011. Such criteria for treating are well-defined in DSM V TR, which states that the patients should be subjects who have started puberal development (at least at stage II-III of Tanner); who are able to fully understand the meaning of the treatment and are well-supported in their family and social environment. These patients increase their gender dysphoria with the first signs of puberty, and do not show psychiatric comorbidity. They will have adequate psychological and social support during the treatment, and demonstrate knowledge and understanding of the results and risks of GnRHA treatment, cross-sex hormone treatment, and specific surgical treatment, and the risks and social benefits of sex reassignment as well[17].

The protocol treatment includes a monthly administration of GnRHA which blocks the production of puberty hormones starting from a minimum of Tanner II-III stage, generally around 12 years of age, and only after 16 years of age, there will be the administration of estradiol with increasing doses to MtF as well as testosterone to FtM, always at the same time as supportive psychotherapy, and controlling the hormonal, clinical and hematochemical parameters every 3-4 months[18].

Treatments dispensed during the first step are completely reversible, while the second step treatments are only partially reversible. Such treatments must always be carried out with

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15 A.L.C. de Vries, J.K. McGuire, T.D. Steensma, E.C.F. Wagenaar, T.A.H. Doreleijers, P.T. Cohen-Kettenis, *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment,* Pediatrics, 2014, pp. 696-704, http://pediatrics.aappublications.org/content/134/4/696

16 C. Manieri, *Assistenza a soggetti in età evolutiva*, id.

17 C. Manieri, S. Einaudi, id.

18 C. Manieri, S. Einaudi, id.

psychological and social support in the presence of a "supportive" family[19].

These therapies pursue specific goals, namely:

- "To provide more time for professionals and children to better understand what to do without the assesment of the development of puberty, allowing a deep psycotherapy investment to the children and their families;
- To prevent from sex characteristics (of the biological sex) from developing so far as to be difficult to manage and therefore disruptive to "cross" social insertion;
- To be able to live in the desired role by making the adolescent's social inclusion more fluid so as to prevent the risk of social and school exclusion, widespread among these juveniles"[20]

However, specialized medical literature does not hide fears and problems arising from undergoing such therapies, in particular diagnostic mistakes in a "fluid" time such as puberty, interference with physical development by creating abnormal conditions in cognitive and endocrine maturation, especially on statural growth and bone density, obtaining an insufficiently mature informed consent and encountering fertility difficulties[21].

3. The relevant juridical issue: treatment consent

The condition of children affected by atypical gender identity organization directly involves the relationship between parenting choices and the protection of the child's best interests, primarily for his or her well-being. Medical experience has taught that gender dysphoria can be primary when it appears during childhood or adolescence, or secondary manifested later, during adulthood.

During childhood, A.G.I.O. does not provoke physical alterations[22] and playing lets infants show their sexual identity. Indeed, kids feel their identity very early, identifying themselves as males or

19 C. Manieri, S. Einaudi, id.

20 C. Manieri, S. Einaudi, id.; I. Wilson, C. Griffin, B. Wren, *The interaction between young people with atypical gender identity organization and their peers, Journal of health psychology,* 2005 May;10(3), pp. 307-15.

21 C. Manieri, S. Einaudi, id,. S. Giordano, *Ethics of Management of Gender Atypical Organization in Children and Adolescents,* in *International Library of Ethics, Law, and the New Medicine* Volume 42, 2008, Springer Netherlands, Dordrecht, p. 258 ss.; D. A. Perkiss, *Boy or Girl: Who Gets To Decide? Gender-Nonconforming Children in Child Custody Cases, Hastings Women's Law Journal,* pp. 2014, pp. 64 ss.

22 S. Giordano, id. p. 253. However, this author emphasizes that in particular cases A.G.I.O. May occur as well as other conditions, genetic or physical, which may alter the development of the child and may cause uncertainty. In any case, patients suffering from A.G.I.O. are characterized by incongruity between sex and gender.

females independently of the gender attributed to them at birth[23], since they are disinterested in social, environmental, or family implications until puberty occurs, the social environment allows children to manifest their own inclinations through playing.

A protective environment around children is necessary, so they are able to manifest themselves. During this time, the support, observation and protection from their parents is very important, until puberty, when hormonal development inevitably overcomes playing.

However, there are cases in which the child who manifests a "deviation" from socially accepted and stereotyped gender behavior can be subjected to numerous forms of social pressure or "corrections", such as oral reprimands, punishments, psychological or physical abuse which can be carried out by parents, family members, schoolmates, educators, healthcare professionals, or strangers, even in public, which lead many authors to argue that transsexual children are not safe. Even though scientific literature is scarce at the European level, studies focusing on the experience of A.G.I.O. children confirm that such mechanisms exist and have a significant impact on both the affected children and their families[24].

As far as therapeutic treatment is concerned, child transsexuality is dealt with by experts of development of the person under a psychosexual and psychiatric perspective to understand the context in which DSM 5 emerged. This path begins with a deeper psychological analysis over a period of six months, while the personological aspect of gender identity deals with psychiatric support during at least three meetings during the same period. The psychiatrist must ensure that in the examined patient, who must be a primary transsexual, gender disorder is not confused with other psychopathology or disturbance of identity[25]. The psychiatrist represents the contraindications to the treatment that can be both physical and psychiatric as well. Indeed, the physician, an

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23 K.R. Olson, A.C. Key, N.R. Eaton, *Gender Cognition in Transgender Children, Psychological Science,* April 2015 vol. 26 no. 4 pp. 467-474.

24 E. Schneider, id.. For a recent study on the sex-reassignment in communities of Gender dysphoria/transgender adolescents, M. Sumia, N. Lindberg, M. Työläjärvi, R.Kaltiala-Heino, Current and recalled childhood gender identity in community youth in comparison to referred adolescents seeking sex reassignment, Journal of Adolescence 56 (2017) 34-39.

25 A. Prunas, D. Hartmann, M. Bini, *Disforia di genere e diffusione dell'identità: quale relazione*? In R. Vitelli, P. Fazzari, N. Rainone, M. F. Freda, *XV Congresso nazionale della sezione di psicologia clinica e dinamica, Napoli, 27-29 settembre 2013,* Fridericiana Editrice Universitaria, 2013, p. 106; P. Meyenburg, G*ender dysphoria in adolescents: difficulties in treatment,* Prax Kinderpsychol Kinderpsychiatr. 2014; 63(6), pp. 510-22.

endocrinologist, has to examine the patient at least twice, extending the medical history of the person who must be in good health, considering whether there are medical problems, especially obesity and related pathologies, which contraindicate the completion of hormonal treatment. This is a teamwork approach based on a comparison between psychologists and doctors, although doctors' opinion is not binding and they must adhere to the treatment, the eligibility of the patient to the treatment is confirmed by psychologists.

In this context, the protection of the best interest of the child is of great importance, especially about the manifestation of the consent to the administration of hormone therapy. It should be considered that in the psychiatric field the A.G.I.O. is still considered a mental pathology, while some scholars state that this is a medical convention that violates the personalistic principle of self-determination[26]. Other scholars are wondering whether, at the beginning of hormonal treatment, only parental consent or a legal authorization is needed.

Art. 315 bis, par. 3, of the civil code[27], states that children under twelve years of age, and even minors that are able to discern, have the right to be heard in all matters and procedures concerning them. Therefore, listening to the child seems to be indispensable when the judge's decision conserns a treatment of his or her affection. If his or her family supports the choice, he or she undergoes the hormonal therapy. On the contrary, if his or her parents are in conflict with each other, or with the child, the intervention of the court is required, especially if there is the urgency of the protection of the child's life, such as in cases where the child is in danger of death or threatens suicide[28].

In the Italian case law there is only one published decision made by the Tribunale di Roma, that authorized a sex reassingment surgery in the following terms: "the right to effective sexual identity is a clear specification of the broader right to health, according to article No. 32 of the Constitution. This right can be confined no longer to physical integrity alone, but to general physical and

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26 A. Lorenzetti, id., p. 31.

27 R. Pesce, *L'ascolto del minore tra riforme legislative e recenti applicazioni giurisprudenziali, Famiglia e Diritto*, 2015, p. 242; F. Tommaseo, L*a tutela dell'interesse dei minori dalla riforma della filiazione alla negoziazione assistita delle crisi coniugali*, Id., 2015, 2, 157; P. Virgadamo, *L'ascolto del minore in famiglia e nelle procedure che lo riguardano, Il diritto di famiglia e delle persone*, p. 2014, 1656; C. Ricco, Il *diritto del figlio e di ogni minore di ascolto nelle procedure e la funzione riparativa del buon ascolto, MinoriGiustizia*, 2014, p. 51; V. Di Gregorio, L'*ascolto: da strumento giudiziale a diritto del minore*, *Nuova Giurisprudenza Civile Commentata,* 2013, p. 11.

28 E. Schneider, id., p. 9, §30; p. 11, § 36 ss.

relational well-being as well. Sexual reconstruction surgery is a medical treatment aimed at achieving psychophysical integrity with the consequence, therefore, that when it is to be performed on a child, the principle of parental representation applies. The application for authorization is a complex act, that is an expression of the concurring will of the minor and that of the parent. Under the child perspective, his or her age and degree of intellectual maturity must be considered, as well as the need to protect his/her personality"[29].

4. A.G.I.O. treatment under the international and comparative experiences

The most important international sources regarding *gender issues* in transsexual minors are, on the one hand "*The Yogyakarta Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity "*[30], which is a soft law source protecting LGBTIQ people'rights; and on the other hand, the United Nations Convention on the Rights of the Child[31], which was implemented in hard law sources, such as Law 27 May 1991, No. 176 in Italy.

As regards the Principles of Yogyakarta, Article 3 seems to be of interest under this perspective. It is entitled "the right of recognition in front of the law" and states that

> "*Everyone has the right to recognition everywhere as a person before the law. Persons of diverse sexual orientations and gender identities shall enjoy legal capacity in all aspects of life. Each person's self-defined sexual orientation and gender identity is integral to their personality and is one of the most basic aspects of self-determination, dignity and freedom. No one shall be forced to undergo medical procedures, including sex reassignment surgery, sterilisation or hormonal therapy, as a requirement for legal recognition of their gender identity. No status, such as marriage or parenthood, may be invoked as such to prevent the legal recognition of a person's gender identity. No one shall be subjected to pressure to conceal, suppress or deny their sexual orientation or gender identity".*

There are no specific references to children from the reading of the text, however it seems sensible to affirm that the right to define their own sexual identity, their dignity, not to be forced into hormonal treatments or the surgical reassignment of sex, is also recognized.

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29 Tribunale di Roma Sez. I, 11 March 2011. M. G. Ruo, *Persone minori di età e cambiamento di identita' sessuale, Famiglia e Diritto,* 2012, p. 499.

30 Principles estabilished at Yogyakarta Conference from 6 to 9 November 2006 by International Commission of Jurists, International Service for Human Rights and other international committee. The Yougyakarta principles are available at http://www.yogyakartaprinciples.org/principles-en/.

31 UN Convention on the Rigths of the Child, 20 November 1989 , ratified in Italy with Law 27 May 1991, No. 176.

The New York Convention on the Rights of the Child does not contain specific rules on the subject discussed here, but it does contain provisions of immediate interest to the problems addressed by minors suffering from A.G.I.O. For instance, Article No. 7 contains important references to the right of the child to be immediately registered at birth with his or her own name, but without reference to the sexual attributes at birth. Article No. 8.1 stipulates that "1. States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference" while Article No. 12 acknowledges that "States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child". Article. No 16 protects the child from arbitrary or unlawful interferences in his or her private life in his or her family and establishes in favor of the child the right to protection of law against such interference. Finally, States Parties recognize the right of the child to enjoy the best possible state of health and to benefit from medical and rehabilitation services. They strive to ensure that no child is deprived of the right to have access to such services.

4.1. Australia

Under a comparative perspective the larger amount of legal cases concerning A.G.I.O., specifically in order to authorize hormone therapy is Australia. In cases here analyzed[32], the focus was whether the reversible hormone treatment in the Phase 1, and partially irreversible in the Phase 2, were considered both a "special medical treatment", and what were the requirements for consent to these treatments, whether the minor could be considered "competent" to express consent to the treatment to him/herself, by his/her parents, or whether this should be authorized by the judicial authority. It should be noted that each of these points were read by Australian judges under the lens of "best interest of the child". In this regard, Australian case law is consistent and has established that, in the case of agreement between all parties involved in initiating the 1st phase of reversible hormonal treatment of A.G.I.O, (i.e. the child[33], parents and health experts), no judicial authorization is

32 Re Alex: Hormonal treatment for gender identity dysphoria [2004] FamCA 297, 13 aprile 2004; Re Brodie (Special Medical Procedures: Jurisdiction) [2007] FamCA 776, 24 luglio 2007; Re Sean and Russell (Special Medical Procedures) (2010) 44 Fam LR 210, 26 ottobre 2010; Re Jamie (Special Medical Procedure) [2011] FamCA 248, Re Jamie [2013] FLC 93-547, 31 luglio 2013; Re Lucy, 2013 Fam CA 518, 12 luglio 2013, Re Jodie [2013] FamCA 62, 14 febbraio 2013, Re Colin [2014] Fam CA 449, 27 giugno 2014, Re Spencer [2014] Fam CA 310, 8 aprile 2014; Re: Jordan [2015] FamCA 175, 12 marzo 2015. In dottrina, si veda M.K. Smith, B. Mathews, T*reatment for gender dysphoria in children: the new legal, ethical and clinical landscap*e, *Medical Journal of Australia*, 2015; 202 (2), pp. 102-104.

33 (*Gillick v West Norfolk and Wisbech Area Health Authority* [1985] (1985) 3 All ER 402). N. J. Lennings,

necessary [34], even if the child undergoing therapy is orphaned and cared for by foster parents[35]. On the contrary, judicial authorization is necessary to continue the therapy at Phase 2, since it has no reversible effects[36].

Recently, the Federal Court of Australia affirmed that Kerry[37] (a MtF adolescent who at the time of making the order was aged 17 years and six months of age), Dale[38] (a FtM adolescent who at the time of making the order was 16 years of age), and Darryl[39] (a FtM adolescent who at the time of making the order was 17 years and five months of age) are competent to consent to their own medical treatment, commonly known as Stage Two treatment for Gender Dysphoria, in the form of hormone treatment.

4.2. United States of America

In the United States, there are only three reported cases[40] related to transsexual children. However, these are complex disputes whose main focus was on the separation of the parents and the custody of the children, among which there are minor children who manifested gender dysphoria. These are

Forward, Gillick: Are competent children autonomous medical decision makers? New developments in Australia, J Law Biosci. 2015 Jul; 2(2): 459–468.

34 Re Jamie [2013] FLC 93-547.

35 Re Lucy, 2013 Fam CA 518.

36 Re Brodie (Special Medical Procedures: Jurisdiction) [2007] FamCA 776, 24 luglio 2007. However, in an older case, the Family Court of Australia denied permission for Phase I and Phase II of hormonal therapy because the child would soon be of age and able to decide for himself(*Re Alex: Hormonal treatment for gender identity dysphoria [2004].*

37 Re: Kerry [2016] FamCA 970 (21 November 2016)

38 Re: Dale [2015] FamCA 473 (22 June 2015)

39 Re: Darryl [2016] FamCA 720 (26 August 2016)

40 D.A. Perkiss, id.; E. Skougard, id.

Smith v. Smith[41], Shrader v. Spain[42] and Johnson v. Johnson[43]. Family disputes would not seem to make it easier for transgender minors to face their status serenely.

US decisions concerning minor transgenders do not, as opposed to Australian ones, address the issue of informed consent, but the assignment of custody of children and, consequently, recognition of the manifestation of their gender identity. Indeed, in the cases analyzed, it is noted that judges assign the custody of minors to the parent demonstrating a negating approach by A.G.I.O.

Since these are complex disputes, they should be analyzed partially. Smith v. Smith is related to the separation of the parents of two children, one of whom is already in the early stage of a gender disorder, because that child wanted to be treated "as a girl". The mother supported her gender identity, agreed to call her "Christine", shared her experience in support groups, and took into account the beginning of hormone therapy for suspending puberty. Instead, the father treated the child as a male. In 2001, the couple divorced, and an agreement between the parents stated that the mother obtained custody of the minors, while the father was granted the right of visit. In 2004, the mother moved and enrolled Christine in a new school identifying her as a girl, and her father turned to court and obtained custody of both children, and despite the mother's appeal, the decision was confirmed in the second instance. While the first instance decision was pending, the father obtained an emergency temporary order ordering the mother to stop any treatment or consultation related to gender disorder, to stop addressing the child as "Christine" or any other female name, and stop dressing her in women's clothing. However, her mother violated that order by accompanying Christine to a swimming pool dressed as a girl. The court of first instance was very severely opposed to the disobedient mother, sanctioning her for not having shown neutrality or support for the male identity of the child and highlighting the importance of traditional gender roles [44]. Although Christine continued to refer to herself as a female, three of the five experts called for the trial, refuted the diagnosis of gender dysphoria, so the Court decided that the child was not suffering from gender dysphoria and forbidded the hormone therapy for blocking puberty. Scholars who dealt with the case severely criticized this decision by pointing out the weakness of the party's lawyer's

41 Smith v. Smith, No. 05-JE-42, 2007 LEXIS 1282 (Ohio Ct. App. Mar. 23, 2007).

42 Shrader v. Spain, No. 05-95-01649, 1998 WL 40632 (Tex. App. Feb. 4, 1998).

43 Johnson v. Johnson

44 D.A. Perkiss, id.

requests and, on the other hand, the lack of meetings between Christine and the therapist whose sworn opinion was decisive for the solution of the case. In addition, scholars highlighted the role of the first instance judge in this affair: despite the lack of specific experience in evaluating such cases, the judge supported the overwhelming prevalence of male identity on the pervasive conviction that Christine could be more certain of her gender identity as she grew. Further, by prohibiting the manifestation of her gender identity and forcing her to live with her opposing father and attending school as a male, the Court expressed the view that a minor's disfellowship may be more acceptable in society by maintaining his or her biological gender. In fact, this was a misconception, especially based on the fact that Christine at the time of the decision was 12 years old, had already entered the Tanner II pubic phase and could have benefited from the hormonal blocking treatment without taking on the male characteristics she was tired of.

Even in the case of Shrader v. Spain the custody of Nicholas, an MtF transsexual child, was awarded to the father with a negative attitude to the child's gender disorder, instead of his supporting mother. This decision was based on the circumstance that the best interest of the transgender child is to live more with his father in order to diminish his dependence on his mother, also to favor the success of psychology therapy, and to facilitate the separation of Nicholas's identity from that of his mother[45].

Finally, in Johnson v. Johnson, the co-operative approach of parents, especially of the mother, to the custody of her daughter, MtF Sarah, obtained opposite (and positive) results. Indeed, in spite of the strong differences between parents, the mother and her lawyer prepared informative materials for the judge, explaining her support for her MtF daughter. The Court therefore considered that best interest was the priority of a plan, supported by a psychologist, on the investigation of Sarah's female personality before the authorization for the treatment.

4.3. United Kingdom

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Nicholas, the parties' son, was diagnosed with gender identity disorder, a serious mental condition. The recommended treatment was for Nicholas to spend more time with his father, and to lessen his dependence on his mother. Dr. Doyle, Nicholas's psychologist, testified that he had not made as much progress in therapy as she had hoped, and that Nicholas's home environment would be important to his therapy. Dr. Otis, a psychologist who evaluated Husband, Wife, and both children, testified that Wife was unable to admit that Nicholas had a problem, and that Nicholas needed to separate his identity from his mother's. The trial court was within its discretion in deciding that, given Nicholas's gender identity disorder, it was in the children's best interest to live with their father (Shrader v. Spain, cit.).

The UK recent and published cases concern on the one hand a 17-year-old adopted FtM child [46], and on the other hand the case of a 7-year-old child, that according to his mother, suffered from gender variancy[47].

The child in the first case was adopted when he was 6 years old. His adoptive parents did not accept his gender dysphoria. In these circumstances, P (the child) came to the very clear and very firm conclusion that he no longer wished his parents to be involved in his life and does not wish them to receive any information about his day-to-day life, nor about his assessment and possible treatment at the Tavistock Clinic or other medical facilities. Under *Re C (Care: Consultation with Parents not in Child's Best Interests) [2006] 2 FLR 867* Justice Keehan agreed to his request because the facts of the case "are very exceptional, (…) he should instead focus on the competing article 8 ECHR rights of P and his parents"[48]. Because of the extreme conflict between the child and the adoptive parents, the child was admitted to a foster care center. However, it is apparent from the judgment that the adoptive parents are in contact with the Tavistock Clinic in order to be able to get close to their child and accompany him in the transition therapy.

The second case concerns a 7-year-old boy, (named "J") forced by his mother to live as a girl, because the mother is convinced that the child, who lives with her after his parents divorced in the year following his birth, suffers from gender variance; so she cares for him as if he were a female, making him wear a "pink headband and nail polish ", taking care of him like he was a girl with feminine recreational activities and planning for him to have treatment at a gender reassingment clinic. His mother manifested signs of real anxiety over this aspect of the child's welfare. The judge noted that local authorities, such as school and social services, have consistently failed to "*take appropriate action where there were strong grounds for believing that a child was at risk of serious emotional harm. It was "striking" that the local authority had moved into wholesale acceptance*

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46 PD v SD and Others [2015] EWHC 4103 (Fam)

47 J (A Minor), Re [2016] EWHC 2430 (Fam) 21 October 2016

48 A. Laing, PD v SD and Others [2015] EWHC 4103 (Fam), http://www.familylawweek.co.uk/site.aspx?i=ed159735. This author affirms that: "the ECHR and UNC[RC] show why the duty of confidence owed by a medical professional to a competent young person is a high one and which therefore should not be overridden except for a very powerful reason. In my view, although family factors are significant and cogent, they should not override the duty of confidentiality owed to the child", at [64] of Sue Axon and "Parental right to family life does not continue after the time when the child is able to make his own decisions. So parents do not have Article 8 rights to be notified of any advice of the medical profession after the young person is able to look after himself or herself and make his or her own decisions" (Paraghaph 28).

that J should be considered as a girl"[49]. In addition, the judge noted that although the mother was very well prepared for child gender dysphoria, she did not realize the child's personality and desires. Therefore, the child was entrusted to the father, with whom he has "fluorished" abandoning any reference to problems of gender disparities.

4.4 Canada

The Supreme Court of British Columbia decided a case where parents of an 11-year-old FtM child were divorced and later remarried, however with problematic issues about their child. According to the judge: "

> "What has not gone well is the relationship between the parties, particularly in respect of J.K. (the child) A.H. (his mother) has been supportive of J.K. and has helped guide him through the appointments with the various physicians and the commencement of the Lupron treatment. A.H. says that she has kept N.K. (the father) informed throughout but that N.K. has been angry and resistant to J.K.'s stated wishes. In contrast, N.K. believes that steps have been taken without his consent and again he is concerned that J.K. has not been properly assessed."

The interesting point of this judgment is the significance that the judge reserved to the child involved. Even though the child is so young, and no other child of so young age has been granted independent party status in litigation without a litigation guardian, the judge underlined that

> "while the issue concerning J.K. is focussed on his rights and determining his future, that issue nonetheless arises in the context of a broader, ongoing dispute between J.K.'s parents and I am concerned about the impact on J.K. of placing him squarely in the middle of that dispute".

The judge allowed the child to take part in the litigation, through a litigation guardian. According to the judge, "that guardian can guide J.K. through the process and help him formulate the views that he would like to put before the court. The guardian can also deal with the parties on matters relating to the litigation and provide J.K. with something of a buffer from the acrimony existing between his parents.

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49 R. English, Mother's determination that child was "gender variant" did him significant harm – Family Court, Uk Human Rights Blog, 1 November 2016.