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Judicial child abuse: The family court of Australia, gender identity disorder, and the 'Alex' case

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Synopsis

In April 2004, the Family Court of Australia made the decision that a 13-year-old girl, said to be suffering from gender identity disorder (GID), should be treated as a boy and embark upon a course of female hormone treatment to suppress menstruation. The treatment is expected to change to the administration of male hormones at 16, and surgery after she reaches 18. This decision is in line with a developing trend internationally to normalise the phenomenon of sex reassignment. I shall argue that gender identity disorder is a social construction created by the medical profession, and that it is culturally and historically specific. By imposing a diagnosis and treatment that will cause irreversible changes to an adolescent underaged girl's body, this decision should be seen as judicial child abuse rather than an enlightened decision in the child's best interests.
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In 2004, Chief Justice Nicholson of the Australian Family Court made the decision that treatment for gender identity disorder should begin in the case of a 13-year-old girl, 'Alex', who wanted to be a 'boy'. Although the court clearly thought it was making a progressive decision, and some commentators agreed, it was controversial for several reasons. This article offers a feminist critique of the judgement, arguing that the diagnosis of gender identity disorder is ideologically constructed to serve the needs of male dominance. The diagnosis of GID relies upon traditional ideas about appropriate gender roles and is mired in historical notions of how homosexuals are really persons with the brain of one sex in the body of another. These ideas are well represented in the 'Alex' case. I shall argue that the judgement constitutes judicial child abuse because the diagnosis and treatment, rather than being in her best interests, will lead to irreversible changes in the girl child's body that will harm her physical and mental health and are likely to lead to social and emotional isolation.

Gender identity disorder

The medical diagnosis that is the foundation for the extension of drug and surgical treatment to younger and younger patients is that of gender identity disorder (GID). In the 'Alex' case, it is not completely clear whether the court saw itself as dealing with GID in childhood or GID in adulthood. Nicholson preferred to use the word 'dysphoria' instead of 'disorder' when referring to GID. GID in childhood is diagnosed by medical professionals when children are brought to them by worried parents. The objective of the doctors is usually to put the child back onto what is seen as the correct gender track. Prevention is the preferred treatment rather than sex reassignment hormones and surgery. In adult GID, the situation is different. The adults usually self-diagnose and approach doctors requesting hormone and surgical treatment. The 'Alex' case is on the cusp between these two forms. It concerns a child but a child old enough to be seen by the court as being able to contribute to a decision about her own treatment

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and one who demands, as an adult GID aspirant would, sex reassignment. It is indicative of a recent tendency towards starting sex reassignment treatment of young people at early stages in their adolescence in countries such as the Netherlands (Cohen-Kettenis & van Goozen, 1997).

The diagnosis of childhood GID follows old-fashioned notions of what constitutes appropriate behaviour for those assigned to the sex classes of male and female. The criteria used by the court for establishing that 'Alex' has GID are those set out in the US Diagnostic and Statistical Manual (DSM). These are quoted in the transcript thus:

> . . . repeatedly stated desire to be, or insistence that he/she is the other sex; in boys, preference for cross-dressing or simulating female attire; in girls, insistence on only wearing stereotypical masculine clothing; strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex; intense desire to participate in the stereotypical games and pastimes of the other sex; strong preference for playmates of the other sex. (Family Court of Australia, 2004, p. 27)

Feminist critics of such notions of traditionally gendered expression have long argued that they are socially constructed with the political purpose of creating and maintaining a sexual difference which is essential to male domination and female subordination (e.g. Kaplan & Rogers, 2003; Wittig, 1996).

Gay and lesbian critics of the idea of GID point out that it can be used as a new way of targetting and controlling homosexuality. Thus Shannon Minter says, "*The great majority of children treated for GID grow up to be lesbian, gay, or bisexual*" (italics in original) (Minter, 1999, p. 10). A small percentage grows up to be transsexual. Such critics argue that the diagnosis of GID now serves as a replacement after lesbian and gay activists forced the removal of homosexuality as a form of mental disorder from the US Diagnostic and Statistical Manual in 1973. In 1980, 'gender identity disorder' was added.

In the late nineteenth century, sexologists proclaimed that homosexuals were biological mistakes who naturally contained characteristics of one sex within the body of another. Havelock Ellis' case studies in *Sexual Inversion*, for instance, show men saying they liked women's clothes in childhood and consider themselves to have the brains of women in the bodies of men (Ellis, 1913). These negative portrayals of homosexuality as a biological mistake were rejected in the 1970s by gay liberationist and feminist scholars and activists (Gay Revolutionary Party Women's Caucus, 1992 (1st published 1972); Walter, 1980). Lesbian feminists were fiercely critical of the notion that lesbians were essentially, or wanted to be 'men', and rejected all forms of butch/femme role-playing (Abbott & Love, 1972). Nineteenth century sexological arguments and understandings about female brains in male bodies and vice versa are alive and well, however, in the present medical literature on transgenderism.

Background to the case and basis for the decision

Evidence given in the 'Alex' case shows that she identifies as a boy and has suffered considerable distress from the fact that this was not accepted by those around her. It is this distress that forms the foundation for the decision that 'Alex' should be treated as a boy. She was born overseas and an only child. Most significantly, she was raised as a boy by her father in her earliest years. To the extent that such treatment can lead to the degree of serious distress from which 'Alex' suffered, this should perhaps be understood as a form of parental child abuse. This is not to suggest that children raised by enlightened parents who refuse gender stereotypes should be seen as subject to abuse. The rejection of such stereotypes is likely to strengthen girls. But the raising of children in a stereotypical gender which is culturally attributed to a body different from their own, and which may make them self-harm and desire to lose body parts, is of a very different order.

'Alex' said that her parents fought and that she felt rejected by her mother at an early age. An uncle lived in the family home and 'Alex' described him thus, "crazy, he'd fight with me". An uncle, perhaps the same one, is described by 'Alex' as having tried to "touch" her in a sexual way but had not proceeded to do so. Her father died when she was 5 or 6 years old and this was a devastating loss for 'Alex' who had "spent almost all of his (sic) waking and sleeping time with his (sic) father" (Family Court of Australia, 2004, p. 14). They slept in the same bed and bathed and showered together though, "None of the evidence suggests any sexual advances by the father towards Alex". Her father taught her "karate and to punch and to kick and to be self-protective". He taught her to "pee like a boy" (Family Court of Australia, 2004, p. 24). Her cousin said that 'Alex's' mother had dressed her in boy's clothes when she was little and 'Alex' said that her father "had tried to make [him] (sic)

like a boy since [he] (sic) can remember" (Family Court of Australia, 2004, p. 22).

A few years after the death of the father, 'Alex's' mother married a man who brought them to Australia. When 'Alex' was 10, a child protection alert was made. At this time, her mother said she did not want to see 'Alex' again. Grounds for the protection alert included the fact that the mother and step-father had taken 6 months to enroll 'Alex' in an English Language School, that 'Alex' was very aggressive to other students, that she had tried to kill her step-brother and harmed a younger child, and that she slept in her own bedroom while the mother and younger step-children slept in a locked bedroom to prevent 'Alex' from entering. At that time, a doctor's report said that 'Alex's' identification as a boy, which included such behaviours as using only the boys' toilets at school, was the result of incomplete mourning for her father and her mother's rejection. 'Alex' was placed with her aunt. In 2002, she was, according to the primary school principal, experiencing suicidal thoughts. Social worker, Ms R, said 'Alex' was threatening to kill herself because she "wasn't a girl and didn't want to be a girl" (Family Court of Australia, 2004, p. 21).

The permission of the family court was necessary in the 'Alex' case because sex reassignment "was not considered a treatment for a 'malfunction' or a 'disease'" and contained an irreversible element and 'significant risk' (Spriggs, 2004, p. 319). On these grounds, it fell into the legal category of "special medical procedures" which require court authorization when carried out on children. In the 'Alex' case, Nicholson states that, in accordance with the UN Convention on the Rights of the Child, decisions concerning children must be made on the basis of what is understood to be in the child's best interests. He explains that the Convention also requires that 'Alex' must be heard and her wishes considered. Nicholson stated that the evidence given by experts in the court "does not establish that Alex has the capacity to decide for himself (sic) whether to consent to the proposed treatment" but he has "uncontroverted evidence" that the proposed procedure was "entirely consistent with Alex's wishes" and the expert evidence "as to the best interests of Alex accords with those wishes" (Family Court of Australia, 2004, p. 46). He says that, "The evidence speaks with one voice as to the distress that Alex is genuinely suffering in a body which feels alien to him and disgusts him, particularly due to menstruation" (Family Court of Australia, 2004, p. 57). The decision that Alex should be treated henceforth as a boy and started on treatment which would lead to irreversible effects before the age of 18, caused considerable, and mostly negative, reaction in the media.

Reaction to the case

There was considerable immediate media reaction to the decision. Few responses supported the decision and those that did were from medical experts and transgender support groups that considered the decision to be an enlightened one. Merle Spriggs in the *Medical Journal of Australia* discussed some of the ethical issues raised by the case and decided that "the net benefit eclipses concerns about competence, autonomy and the appropriateness of the intervention" (Spriggs, 2004, p. 319). The male-to-female (MTF) lawyer and transsexual rights activist, Rachael Wallbank, wrote in *Australian Children's Rights News* that the Alex decision did not go far enough (Wallbank, 2004). The case was flawed in even entertaining the notion that transsexualism (Wallbank's preferred term) was a form of mental illness, as expressed in the concept of GID, rather than a biological condition and a form of intersex. Wallbank considers that the 'Alex' case and the submissions of the Human Rights and Equal Opportunities Commission to the court failed in not showing recognition of "the essential need of an individual who experiences transsexualism to affirm his or her innate (sic) sex by undergoing conclusive sex affirmation procedures (including surgery)" (Wallbank, 2004, p. 31). The surgery must be "funded by the state".

Most responses, however, were critical. Bio-ethicist Nicholas Tonti-Filippini strongly condemned the decision and argued that GID should be seen as a form of mental illness and not treated with surgery and hormones (Kelly, 2004, p. 3; Gough, 2004, p. 1). Two child abuse experts suggested that Alex's problems stemmed from child abuse and thus the proposed treatment was not appropriate (Goddard & Tucci, 2004). The main area of concern voiced by critics was over whether the child was competent at 13 to make up her mind (Child gender change takes the law too far, 2004). Feminist voices, however, were absent from the public debate. My opinion piece in *The Australian* newspaper was exceptional in condemning this decision from a feminist perspective which questioned the diagnosis itself, as well as the traditional male-dominant, female-subordinate notions of correct gender behaviour which underpinned it (Jeffreys, 2004, p. 9).

Subsequent discussion in law journals has concentrated on various issues to do with the case which do

not touch on feminist concerns, particularly that of competency (Tilbury, 2004; Donaldson, 2004). Various writers discuss previous decisions in which children were not considered competent by the courts and the child, the parent or another adult must seek the Family Court's permission to make the decision. Parlett and Weston-Scheuber in the *Deakin Law Review* show an implicit criticism of the Re Alex decision by saying that a child may not have "sufficient experience of life or awareness of the various ways of living a transgender or intersex life, to consent to irreversible treatment" (Parlett & Weston-Scheuber, 2005, p. 397). These responses, however, do not consider the sexual politics of the decision. Even legal theorist Jenni Millbank from the University of Sydney, who might have been expected to provide a feminist critique since she specializes in 'issues of gender', does not do so (Radio interview with Millbank, see Carrick, 2004). She makes it clear that she considers the decision to have been correct because the child knew her own mind, "all the evidence in this case... was that he (sic) did know from a very early age that this is what he (sic) wanted... to deny that desire would be to put that child through years and years of desperate unhappiness" (Carrick, 2004). Neither Jenni Millbank's response nor that of any other commentator asks where the notion of GID comes from politically, and what implications it has for the construction of gender and for homosexuality. The construction of the notion of GID is treated as a fait accompli, and discussion merely traverses the appropriateness of certain kinds of treatment and the proper age at which a girl might be expected to know her own mind on the issue.

The politics of the diagnosis: biology or social construction

A consideration of where the idea of GID comes from should be central to discussion of the appropriateness of the Family Court Decision. If GID is a socially constructed diagnosis and condition rather than a biological one, then social change might be a more efficacious solution than irreversible hormonal and surgical treatments. As the background to the 'Alex' case suggests, there are a number of social factors which could be seen to have influenced the desire of 'Alex' to be a boy. Proponents of GID argue, however, that the disorder has some kind of essential cause. Most rely on biological explanations though there is little evidence to suggest that biology is relevant. Aspirants to sex reassignment surgery are not intersexuals, i.e. those in whom there is some ambiguity as to which sex to assign to a child on account of either genes or physical anomalies. Those identified as suffering from GID such as 'Alex' are unambiguously of a particular biological sex as identified from physical appearance, genes and hormones. Indeed this is stressed in the Family Court case about 'Alex'.

In the 'Alex" case the work of Professor Louis Gooren of the University Hospital of the Vrije Universiteit of Amsterdam was cited as evidence by expert witness Dr C, for the role of biology in transgenderism, but he is careful to point out that Gooren's study is unreplicated. Gooren's is the only work usually put forward by transgender activists to support their belief in biology. Gooren claims that, on examining the brains of a handful of male-to-female (MTF) transsexuals, he found a particular brain area to be smaller than normal for males and similar in size to that found in females (Gooren, 1999). This has similarities to research by Simon LeVay that took place in the 1990s to find a biological basis for male homosexual behaviour (LeVay, 1993), which has been much criticised by lesbian and gay scholars who consider homosexuality to be a form of behaviour rather than a biological condition (Rogers, 1999, p. 68–69).

Another expert in the court case, Professor W, says that he believes GID is a "biological disorder because it can be detected so early in life". However, as he admits, "there is no direct evidence" (Family Court of Australia, 2004, p. 53). The belief in biology amongst the experts is, I suggest, a matter of ideology. It is clear from the medical evidence heard in the 'Alex' court case that the expert witnesses concurred in thinking that the diagnosis of GID was an appropriate one and disagreed only on matters such as when was the best time for treatment to begin. The proceedings of the case took place in an 'inquisitorial' rather than an 'adversarial' manner. This means that Nicholson chose and took evidence from witnesses he saw as experts in the field of GID. Although significant critics of the notion of GID do exist within the medical profession, they are not numerous and were not called. One such is Dr Meyer from the Johns Hopkins University Gender Identity Clinic, for instance, which abandoned sex reassignment surgery in 1979. He states, "My personal feeling is that surgery is not a proper treatment for a psychiatric disorder and it's clear to me that these patients have severe psychological problems that don't go away following surgery" (quoted in Fleming, Steinman & Bocknek, 1998, p. 451).

Feminist theorists who have written critiques of transgenderism take a social constructionist perspective. Janice G. Raymond argues, for instance, that gender identity disorder is an expression of dissatisfaction with the two hierarchical gender categories, mas-

culine and feminine, in male-dominant western societies. Diagnoses of GID serve to prevent challenges to what she calls 'sex-roles', "Transsexualism at this point constitutes a 'socio-political program' that is undercutting the movement to eradicate sex-role stereotyping and oppression in this culture" (Raymond, 1994, p. 5). Raymond, a philosopher of science, points out that it was the medical empire that created the idea of transsexualism, controlled the definition according to conservative 1950s notions of what constituted correct masculine and feminine behaviour, and doled out the surgery. The notion of GID, then, creates a safety valve which serves to protect the political system of western male dominance from the upheavals begun through the feminist and gay liberation movements of the late twentieth century.

It is important to retain a historical perspective when considering GID. Bernice Hausmann explains that the concept originated in the 1950s as a result of changes in medical technology (Hausman, 1995). The phenomenon of people considering themselves 'really' and essentially members of the opposite sex arose in response to advances in the science of endocrinology in the first half of the twentieth century. The possibility of using hormones to change the body offered the possibility, combined with improved surgical techniques, for men to 'really' become women. The phenomenon of transsexualism was overwhelmingly one of male-to-constructed-females until the last decade when there has been a rise in demand from lesbian women (see Jeffreys, 2003, pp. 122–143). Women who dressed in men's clothes in the nineteenth century, and the men in Ellis' case studies in the 1880s, did not have surgery or hormones available to enable them to 'transition' to the opposite sex. But in the twentieth century, sexologists with similar biologistic understandings about gender and sexuality to Havelock Ellis developed both the notions of transsexualism and physical treatments. As Hausman explains, "Public knowledge about medical advances and technological capabilities produces a situation in which individuals can name themselves as the appropriate subjects of particular medical interventions, and thereby participate in the construction of themselves as patients" (Hausman, 1995, p. 23). She compares the construction of transsexualism with the construction of other forms of cosmetic surgery "where the demand for medical attention is made possible by public knowledge of its existence and probable success" (Hausman, 1995, p. 23). The most famous figure in the history of the construction of transsexualism was the sexologist Dr Harry Benjamin, educated in Germany in the early twentieth century, who advocated sex change surgery for those who requested it. The organisation named after him and his practices, The Harry Benjamin Gender Dysphoria Association, publishes the specialist journal of the field, *The International Journal of Transgenderism*.

Setting limits: GID and body integrity identity disorder

The problematic nature of the practice of sex reassignment surgery is thrown into relief by the emergence in the 1990s of a new diagnostic category, AID or amputee identity disorder. AID represents the desire to have limbs amputated and follows in many particulars the development of the notion of GID (Furth & Smith, 2002). The US medical ethicist Carl Elliott argues that both GID and AID should be understood as "transitory mental illnesses" which will not make much sense in 50 years' time (Elliott, 2000). In AID, aspirants, who are usually men, go to medical practitioners demanding that they amputate one or more limbs because they have more than they are comfortable with. In this disorder, some demand the amputation of all four limbs to become 'quads'. The proponents of AID make similar arguments to those proffered by aspirants for sex reassignment surgery. They say they have always felt that they had one or more limbs too many, or at least since an early time in childhood. Promoters of AID have now changed the name of the disorder to BIID or Body Integrity Identity Disorder and are seeking to have it added to the DSM (Body Integrity Identity Disorder, n.d.). This inclusion would mean BIID had achieved respectability in a similar way to GID and sufferers could then be subjected to amputations by regular surgeons. Presently, only one surgeon has carried out the amputation of healthy legs in a regular hospital. This is Dr Robert Smith, of Falkirk General Hospital in Scotland, who was stopped after taking healthy legs off two men (British Broadcasting Corporation, 2000). Sufferers have to go, as those seeking sex reassignment surgery once did, to poor countries with less effective regulation.

The criteria for diagnosis of a patient with BIID, as discussed at the 2003 conference of medical professionals on the disorder, closely follow the model already established for diagnosing suitable candidates for sex reassignment surgery. They are as follows, "age at onset in childhood or adolescence, reason for amputation is to restore true identity, absence of other psychiatric conditions that could explain desire for amputation, especially psychosis" (Body Integrity Identity Disorder, n.d.). The medical professionals who speak at the BIID conferences are luminaries in the

diagnosis and treatment of GID such as the psychiatrist Ray Blanchard, and the MTF psychologist Anne Lawrence. Speakers at the 2003 conference all compared BIID with GID and stressed the similarities. One similarity that the speakers did not mention is the way in which people experiencing severe psychological distress are likely to grasp at diagnoses such as GID and BIID, once they have the imprimatur of the medical profession and, as is increasingly the case, of law, with the hope of relieving their mental pain.

Normalisation of GID leads to rising rates

As the idea of GID has been normalised by medical professionals and the media, there have been rising rates of those seeking sex reassignment. Writing about changes in transsexualism and sex-reassignment over 30 years, Richard Green, President of the Harry Benjamin Gender Dysphoria Association supports the idea that rates are rising, "Transsexualism, then esoteric, is now familiar to school children. Previously solid medical opposition to endocrine and surgical treatment has melted. Origin(s) of transsexualism remain enigmatic but more evidence is in place for a substantial biological contribution" (Green, 2000). In the 1960s, when the UK clinic at the Charing Cross Hospital was set up, it had 50 referrals per year. By the mid-1980s, this had risen to 100–200 and is now around 1300. Only 450 out of 5000 to date are female (Batty, 2004, p. 12).

Those who cleave to an essentialist explanation see the phenomenon of rising rates of identification of GID and a rising demand for surgery as arising from a previously untapped reservoir of 'real' transsexuals; that is, they posit that there is a steady percentage of the population who are biologically transsexual and the demand will rise only from increasing awareness of the possibility of surgery. However, the media, who increasingly cover transsexualism and offer little or no critique of the phenomenon, appear to play a part in its construction. Peter Ringo's research on the role of media in transgender identity formation explains that "Respondents' detailed answers to my questions indicated that media played a significant and often pivotal role in the development of a wide range of trans identities" (Ringo, 2002). The Australian sociologist Frank Lewins interviewed 50 MTF transsexuals and found that 50% realised they were transsexual "at the same time or after they first had access to information on transexualism", which suggests that media coverage plays an important role (Lewins, 1995, p. 75). Innumerable Internet resources on transgenderism are now offering troubled youth a "psychological and physical support system", which explains their distress and which suggests a remedy (Pazos, 1999, p. 71).

One example of the normalisation of the phenomenon of GID is the fact that there are now programmes and publications directed at workers in services directed at children encouraging them to identify those suffering from the 'disorder'. One volume from the US, for instance, is entitled *Social Services with Transgendered Youth* (Mallon, 1999) and encourages social workers to identify teenagers who they see as having GID and advises them to engage in "acceptance and positive affirmation" (Burgess, 1999, p. 45). This essentialises the condition by accepting that there is such a phenomenon as a 'transgendered youth' and creates the serious problem that those with the responsibility to support and protect young people may increasingly be expected to prepare them for, or suggest to them, a dubious treatment by drugs and surgery which will entail castration or sterilisation.

There are powerful pressures upon the professionals involved in identifying and treating GID in children. In the newsletter of the state-funded Gender Centre in Sydney, Australia, Katherine Cummings argues that the medical profession's reluctance to treat children with hormones and surgery before they reach 18 is a form of "organisational and Institutional violence" and "perhaps the greatest violence committed" against the transgendered (Cummings, 2005). Cummings says that early medical intervention is necessary so that children do not begin to develop the body shapes and characteristics they will then have to have reversed with surgery, and welcomes the decision in the 'Alex' case as a step along this road. In the Netherlands, early medical intervention with those identified as 'transgender' adolescents is well advanced. An article in the American Academy of Child and Adolescent Psychiatry journal examines the postoperative functioning of the first 22 adolescent transsexual patients of a gender clinic who underwent sex reassignment surgery (Cohen-Kettenis and van Goozen, 1997). They argue for an early start for hormones and surgery on the same grounds as Cummings, to prevent the development of physical characteristics that would have to be removed later, and because delaying treatment causes distress to the adolescents concerned.

Homosexuality and GID

One serious problem with this approach to youth is the fact that most of those identified as suffering from GID would, and despite treatment, still will grow up to be homosexual. The expert, Dr C, makes this point in

the transcript of the 'Alex' case, "A good proportion of children with Gender Identity Disorder who do not become transsexual adults may develop a homosexual or a bisexual orientation" (Family Court of Australia, 2004, p. 28). The identification of homosexual youth as suffering from GID seems to show a cultural bias. Parents from cultural backgrounds that are particularly unsympathetic to homosexuality, for instance, may be more likely to favour a diagnosis of GID in their offspring. It is more acceptable to some parents and communities that a child should be seen to be a transsexual rather than gay. In the case of 'Alex', there are hints that she may have come from a religious if not cultural background that would have been particularly intolerant of homosexuality.

A crucial component of the present promotion and expansion of transsexualism is the idea that there is such a thing as a 'real' transgender person; that is, not homosexual or just a 'masculine' lesbian or a 'feminine' gay man. The practitioners who recommend women and men for surgery, and the surgeons themselves, like to think that they are dealing with a discrete phenomenon, but this is not so. In the case of 15-year-old 'Faheed', described in the volume on social services for 'Transgendered Youth' mentioned above, the family was East Asian and Muslim, and "The patient was well aware that homosexuality was absolutely forbidden by his religion, and his parents had told him the penalty for being caught could be death" (Swann & Herbert, 1999, p. 26). There are situations where it is safer for the child, and more comfortable for the family, to receive a diagnosis of GID rather than consider homosexuality. A study of children and adolescents referred to a gender identity clinic in London found a percentage of Asian children higher than would be expected in accord with their percentage in the population. The writers note that children from the Indian sub-continent are over-represented (Di Ceglie, Freedman, McPherson, & Richardson, 2002). Children from Indian backgrounds formed 6%, from Pakistani backgrounds a further 6%, and from Bangladeshi backgrounds 1%. Interestingly, children classified as 'Black Caribbean' formed only 1% of the referrals.

The connection of GID with homosexuality was clear in the 'Alex' case. The court considered the possibility that 'Alex' might be 'really' a lesbian rather than suffering from GID. Indeed the social worker who cared for 'Alex' said in her evidence that she thought that this was at least partly the reason behind 'Alex's' desire to be a male. She explains, "early on I actually raised with him (sic) that he (sic) may simply have a same sex attraction and that this is where his (sic) gender issues arise from. He (sic) quite vehemently denied that it was anything to do with that. I'm still not totally convinced in every single way possible that that isn't part of the issue for him (sic)" (Family Court of Australia, 2004, p. 29). Nicholson commented that Ms R, though, "deeply involved in Alex's well being. . .of course is not an expert witness on the question of the distinction between gender identity and sexual identity in respect of Alex" (Family Court of Australia, 2004, p. 30). The basis for the rejection of the possibility that 'Alex' might be a lesbian was the fact that she denied it. It is not surprising, however, that she would deny it, considering that social disapproval of lesbianism may have been exacerbated in her case by her cultural background. Dr N reported that 'Alex', "has feelings of sexual attraction towards girls but is adamant that this is (sic) a male and not as a lesbian (sic). [He] (sic) does not want girls to think of [him] (sic) as a girl and sees [him]self (sic) as in long-term relationships with women as a heterosexual man" (Family Court of Australia, 2004, p. 25, square brackets in original). Professor P. also reported that 'Alex' wanted to have a relationship with a girl (Family Court of Australia, 2004, p. 24). But his belief that 'Alex' is therefore really a male and not a lesbian stems from the fact that 'Alex' "is adamant that [he] (sic) is not 'gay or lesbian'. [He] (sic) sees this as the worst insult that anyone could make to [him] (sic)" (Family Court of Australia, 2004, p. 25, square brackets in original). Rejection, and even adamant rejection, by a young teenager of the idea that she is a lesbian is quite to be expected in a homophobic culture.

Nicholson says in his judgement that he does not rule out that Alex may "come to view himself (sic) as a lesbian" but does not want to "delay treatment" because of the "theoretical risk that Alex is constructing his (sic) self image as 'really' male when in fact he (sic) is 'really' a female lesbian and will come to see himself (sic) that way over time" (Family Court of Australia, 2004, p. 30). The notion of GID, I would argue, may be just as 'theoretical' as lesbianism in this case. Fear of lesbianism is one of the factors identified in Holly Devor's extensive research into female-to-male transsexualism.

Social causes of transsexualism

The interviews that Holly (now Aaron) Devor carried out in her research on FTMs suggest powerful social reasons for seeking sex reassignment amongst which discomfort with lesbianism is prominent. She comments on the role of "rampant homophobia" in the lives of her

participants. It was responsible for "temporarily derailing" their interests in "pursuing sexual relations with females" (Devor, 1999, p. 302). The oppression of lesbians under a male dominance that is based in heterorelations seems to lie behind the determination of many FTMs to transition. They fear lesbianism and seek men's bodies so that they can be 'normal' (Rees, 1996; Thompson, 1995). The vast majority of FTMs are involved in relationships with women before the sex reassignment. This distinguishes them from MTFs many of whom are involved in heterorelations and conventional marriages before transitioning.

There are other powerful social forces that pressure women towards sex reassignment, as Devor's interviewees make plain. They stem from the oppression of women, from child abuse (Devor, 1999, p. 141), and the hatred of the female body that derives from the cultural denigration of women and fear of being socially despised as a woman, and particularly an ageing woman (Devor, 1999, p. 341). Other FTMs have written of the allure of male power that they believe can be attained by imitating a male body (Cameron, 1996, p. 85). Some of the advantages of male power are achieved, such as feeling safer in the street, the delights of being able to feel powerful over and dominate women in relationships, and feelings of superiority over other women.

Child abuse seems to be a significant thread in the histories of both FTMs and MTFs, though there has been little research on this link. In the case of Alan Finch, an Australian MTF who changed back to living as a man and now opposes the surgery, his father was "aggressive" and the family was "petrified of him" (Australian Story, 2003). His father "would hit him and say things like, 'My son doesn't play piano. You're some sort of poofter'". His sister described how "my brother would often get hit through trying to protect my mum". Alan thought he was gay in his teens but then read a book by a transsexual and decided he was a woman. In the operating theatre prior to the surgery, he cried, and tried to stop the procedure, but the surgeon said he was just suffering from preoperative nerves and went ahead anyway. Finch says he felt "conned" immediately he woke up and "What this all boiled down to was that I didn't like my father and I look a lot like him physically. My fear was changing into him. It was killing him off, really" (Australian Story, 2003).

Interestingly, Finch rejects the argument that suicidality is a reason for surgery. He asks why people who want a sex change are treated differently from other psychiatric patients who hate their bodies, "The fact that someone's suicidal and wanting something isn't a reason to provide it. The analogy I use about giving surgery to someone desperate to change sex is it's a bit like offering liposuction to an anorexic" (Batty, 2004, p. 12). Terri Webb, a British man who associates his GID with having been sexually abused as a child, underwent sex reassignment but now identifies as a gay man. He puts the problem in a similar way. He calls his transsexualism a 'fantasy' which he tried to get others to legitimise and says, "I have heard a psychiatrist give the opinion that if a man comes to him and claims to be Napoleon he does not attempt to cure him by amputation of one of his arms" (Webb, 1996, p. 160).

Negative effects of GID diagnosis in the 'Alex' case

I describe the decision in the 'Alex' case as judicial child abuse because of the adverse consequences it is likely to have on many aspects of her life, particularly social and sexual relationships and her physical and mental health. The issue of health is specifically picked out in the Convention on the Rights of the Child which requires states parties to "recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illnesses and rehabilitation of health" (United Nations, 1990, Article 24i). Considering the likely impact of GID treatment on 'Alex's' health, the decision should be seen as in breach of the requirements of this Convention. Another reason the decision should be seen as abusive it that it will greatly reduce her opportunity to change her mind, as a significant minority of those seeking sex reassignment do both before and after surgery.

There is a dearth of long-term follow-up studies of the consequences of sex reassignment treatment for individuals. The Aggressive Research Intelligence Facility (ARIF) of Birmingham University, which advises the National Health Service in the West Midlands of the UK about the evidence base of healthcare treatments, reviewed 100 international medical studies of post-operative transsexuals. They found that it was hard to make a judgement about the clinical effectiveness of transsexual procedures because there was such uncertainty about the effects of gender reassignment (ARIF, 2004). Most research did not use control groups and there were high levels of loss to follow-up in many studies, 50% in some cases. Those who disappeared and could not be followed-up could be dissatisfied, they point out, or they could have committed suicide. Follow-up research was only able to examine the best outcomes.

This lack of long-term follow-up studies means that there is little information on the effects of hormone

treatment of transsexuals (Schlatterer et al., 1998). One short-term follow-up study warns, however, that "cross-sex hormonal treatment may have substantial medical side effects" (Futterweit, 1998, p. 209). It found that the main side effects of androgen therapy in FTMs were: water and sodium retention and occasional "cerebrovascular accidents"; increased erythropoiesis i.e. overdevelopment of red blood cells which may require bloodletting; decreased carbohydrate tolerance; decreased serum high-density lipoprotein cholesterol which is an indicator of diseased arteries; liver enzyme abnormalities which can indicate cancer risk; obesity; emotional or psychiatric problems including "very frequent early increased aggressiveness, fluctuating moods, as well as hypersexuality. Affective and/or psychotic symptoms, as well as depression may occur" (Futterweit, 1998, p. 215). The study warns against prolonged hormone treatment in FTMs prior to surgery because of the risk of endometrial cancer. One study of two cases of long-term exposure to androgens leading to ovarian epithelian cancer concludes that androgen use is a risk factor for this form of cancer and recommends removal of ovaries in FTM surgery (Hage, Dekker, Karim, Verheijen, & Bloemena, 2000).

Surgery provides a different set of problems. Mastectomy can lead to severe scarring and Holly Devor explains that such amputation surgery can lead to serious losses, such as permanent loss of feeling in nipples (Devor, 1999, p. 480). The majority of FTMs in Devor's study chose not to go on to phalloplasty, though such a decision can lead to them feeling incomplete in their sexual lives. For those who do there are two methods by which this is accomplished. Metoidioplasty involves "release of the suspensory ligament of the hypertrophied clitoris and placement of testicular prostheses in the centrally approximated labia majora" (Lawrence, n.d.). This procedure has fewer complications than the other version but provides a "micro penis without the capacity for standing urination". The other procedure can be more hazardous. A phallus is created using an "abdominal flap, radial forearm flap, or fibular flap" and is a "lengthy, multi-stage procedure with significant morbidity, including over a 50% rate of urinary stenosis, and unavoidable donor site scarring" (Lawrence, n.d.). Neither procedure creates a phallus which is functional in the way that a penis might be. Sex reassignment surgery requires the amputation of healthy body parts with the dangers of having to undergo anaesthetics and the problems of healing from serious and invasive surgery. Most importantly, the surgery leads to sterilisation and loss of the capacity for pregnancy. Since the sterilisation of girls for eugenic purposes causes concern amongst those interested in human rights, I argue that the sterilisation of young persons who do not fit into socially and politically approved gender categories, i.e. those diagnosed as suffering from GID, should be seen as a contemporary form of eugenic intervention.

The psychological consequences can also be problematic. A German follow-up study after 5 years found that 30–40% of the patients who had been very carefully selected for sex reassignment surgery did not "seem to benefit fully from SRS" in areas such as social, psychological, and psychiatric functioning (Bodlund & Kullgren, 1996, p. 311). The Gender Centre Inc. in Sydney, Australia, has a 'Health Report' on depression in transgenders on its website, but does not connect this with transgenderism itself but rather with "seemingly unresolvable social and circumstantial pressures" (Israel, 2005, p. 2). The article is clear on the negative consequences that sex reassignment can have on the personal lives of transgenders explaining that "interpersonal difficulties and social hostilities which transgender persons experience can play a large role in causing or aggravating depression". The author further states that these can include "disclosure concerns, balancing transition costs, social isolation, family rejection, and being single or unable to find acceptance from a significant other" as well as "gender identity conflicts in pre and post-operative persons, pre and post-surgical emotional adjustment, poor body image and low self-esteem" (Israel, 2005, p. 2).

There can be problems for FTMs in finding partners and having satisfactory relationships and this seems common considering that in one study only 34% of the FTMs were satisfied with their sexual lives (Lawrence, n.d.). The choice of future partners for 'Alex' is likely to be limited. She will probably seek girls and women who see themselves as heterosexual and these potential partners may not be happy with a surgically constructed male partner as they might expect a male partner to have a working penis, or be fertile so that they could have children. There is little recognition of the difficulty 'Alex' might have finding friends and lovers though social isolation is a recognised negative consequence of sex reassignment surgery.

A most important negative effect of embarking on treatment that will change 'Alex's' body is the fact that she will find it harder to change her mind and revert to considering herself female, and perhaps, a lesbian. The problem of transgenders changing their minds is becoming increasingly significant. A survivors' movement is beginning to develop in Australia and the UK of men who consider that they were 'misdiagnosed' and

had healthy body parts unnecessarily removed. Some of these men have accused the gender identity clinics in Melbourne and in London of misdiagnosis. Alan Finch, the Australian MTF who changed his mind and returned to living as a male, has set up the Gender Identity Awareness Organisation to campaign against the surgery and offer support to those who "have, or have had, gender identity issues" and their families and friends (Gendermenders, n.d.). The organisation's website lists harmful health consequences of surgery and hormone treatment, the statistics on suicide after surgery and the numbers of those who change their minds. Gendermenders seeks to promote non-surgical treatments for those with "gender identity issues… with an emphasis on reconciling gender identity with biological sex" and warns "these individuals of the pitfalls and often tragic consequences of sex modification surgical procedures and hormone therapy". It wants "reconstructive reversal surgery" to be available to those who are dissatisfied. Gendermenders makes an argument that might have been useful for the Family Court to consider, i.e. "Those who promote 'medicated' transsexuality as the answer to the agony of gender identity and role confusion, only serve to prolong the suffering, offering a 'band-aid' solution to the problem" and argues for social change instead.

Alan Finch says that transsexualism was invented by psychiatrists and he campaigns against what he calls "the sex change industry". Of his own case, he says, "The surgery doesn't alter you genetically. It's genital mutilation. My 'vagina' was just the bag of my scrotum. It's like a pouch, like a kangaroo. What's scary is you still feel like you have a penis when you're sexually aroused. It's like phantom limb syndrome. …I've never been a woman, just Alan" (Australian Story, 2003). A 2001 Report on the only public hospital clinic offering surgery in Australia, the Monash Medical Centre Gender Dysphoria Clinic, led to a number of former patients coming forward with complaints about procedures and inappropriate treatment. A review was ordered to take place in 2004 but the findings have not been released.

A survivors' movement of sorts seems to have arisen in the UK too with a number of transsexuals suing the GID clinic at Charing Cross Hospital for misdiagnosis. A *Guardian* article on the problem of transsexuals who change their minds describes the case of one man, Mark Dainton, who has changed sex for the third time in 11 years. He, now living as a woman, has "smooth skin where her (male) genitals once were" (Batty, 2004, p. 12). The article suggests that a "growing number" of post-operative transsexuals are critical of their treatment and estimates from international research that 3–18% come to regret their sex change. In January 2004, the General Medical Council began an inquiry into the UK's best known expert on transsexualism, psychiatrist Russell Reid (Batty, 2004, p. 12).

Research from the US and Holland suggests that up to a fifth of patients regret changing sex. A 1998 review by the Research and Development Directorate of the NHS Executive found attempted suicide rates of up to 18% noted in some medical studies of sex reassignment (Batty, 2004, p. 12). Considering that adults given treatment for GID have changed their minds, and suffered irreparable harms, it does seen unwise to authorise treatment for a 13-year-old even if that treatment does not involve surgery before age 18. The imprimatur of the court and medical profession and her change to a male name and identity in school, as authorised even before the court case started, is likely to make a reconsideration before 18, when surgery may be embarked upon, rather difficult. However, she may change her mind at any time.

The diagnosis of GID is socially and politically constructed at a particular time in the history of male dominance. It should perhaps be seen as a way of relieving the tensions caused by questioning of the 'sexual difference' which lies at the very foundations of this political system without the need for social change. Gender dissidents are swapped from one political category in the hierarchy of gender to another. Homosexuals are made straight. The Family Court has become the handmaiden of male dominance in its decision in the 'Alex' case. The decision reaffirms traditional understandings of gender and sexuality. A child who has questioned the strict parameters of female gender and sexuality has been classified as a 'boy'. But most importantly, I posit, it is judicial child abuse because of the effects it will have on the life and health of this child. 'Alex' has been started on powerful drug treatments that will cause irreversible changes to her body and have potentially severely damaging side effects. The treatment will make it more difficult for her to change her mind. It begins a regime of treatment that is likely to end in surgery that will harm her health through sterilization, scarring, serious potential complications and is likely, on the balance of the evidence, to lead to social isolation, depression, and difficulty forming loving relationships and achieving sexual satisfaction. It seems clear that 'Alex' suffered from abuse, neglect and loss that caused her to identify with her father and with masculinity. Her problems of aggression and self-harm are considerable, but changing her body with hormones and surgery will not necessarily solve

them. Indeed the male hormones, as noted in the case transcript, may make an already aggressive child more aggressive. Changing her body irreversibly in order to solve problems that originate in her mind is not the answer. It constitutes the imposition of an ideological solution, historically specific and medically created.

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