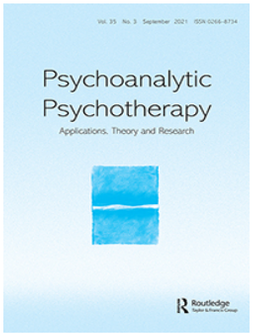

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Shapes of gender identity: three stories with impact

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The paper describes three stories of children and adolescents with atypical gender identity development followed in psychotherapy. These cases have already been published, but are revisited here to show how these experiences contributed to the creation of the therapeutic intervention model of the Gender Identity Development Service originally established in 1989 at St George's Hospital, London. The service transferred to the Tavistock Centre in 1996. The first case shows the gradual recognition of dealing with the development of an atypical gender identity rather than a psychiatric condition. Reflection on this case led to the definition of possible therapeutic goals. The second case illustrates the difference between solid and fluid identities, an important distinction in the decision to consider the possibility of physical intervention. The third case shows the network management model and addresses issues concerning autonomy.

Keywords: autonomy; developmental age; gender dysphoria; therapeutic aims

Introduction

This presentation, which was given at the Tavistock Centre via Zoom on the 16th of February 2021, describes the early history and origins of the Gender Identity Development Service (GIDS) and of its model of care and philosophy.

Within the Centenary Events of the Tavistock, it seems particularly appropriate to reflect on the foundations of a service which has a focus on the complex dynamics of identity development and, in particular, of gender identity.

I will do this by briefly describing three cases which made a significant contribution to the construction of the original model through the use of 'observation and imagination' in the words of Donald Meltzer as well as of clinical experience and available empirical research.

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Figure 1. *Young women in the garden* by Pierre Bonnard.

> *Young Women in the Garden* [Figure 1] is one of the most extreme examples of a painting made over a long period of time. Having started work in 1921–3, Bonnard put the canvas aside for many years before revisiting and revising it in 1945–6. Resuming his work was part of an attempt to rediscover the original experience, bringing it into the present without losing its place in the past. (Matthew Gale, curator of the exhibition 23 Jan-6 May 2019, Tate Modern)

In this presentation, I will use a similar approach to that of Bonnard to three cases that I saw in the past and published. I will look at these cases from a new perspective applied to the case material: their impact in the creation of a model of care for children and adolescents with atypical gender identity development or gender diversity, in today's language.

Case 1

Jennifer was 16 when she was referred in the eighties to the Adolescent Department of Tavistock Clinic following three suicide attempts. She had been assigned female at birth, but perceived herself as a male. She presented very distressed with depressive episodes and a number of features which at the time were considered borderline. Today we would have looked more closely for the presence of autistic spectrum features as she had difficulties in communication and avoided eye contact. Recent studies have shown the presence of autistic spectrum features in some transgender people (Di Ceglie et al., 2014; Jones et al., 2012; Skagerberg et al., 2015). A large part of the session was spent in

silence. At the time of the referral, Jennifer was still living in a female role, maintained her female name and wished to be addressed using a female pronoun. She was uncertain about physical interventions. Her mother, who had died just before Jennifer came to the clinic, had suffered depression after Jennifer's birth, and her father had been physically violent towards his wife during Jennifer's childhood, until they separated. During her psychotherapy sessions she remembered episodes when her father, in fits of temper, had kicked her mother in the stomach. In one session she admitted, not without a sense of embarrassment and shame, that she had identified with him, an experience that she could not explain. She loved her mother, and her main aim in life was to do something extraordinary that would have made her mother happy. There was no recollection that Jennifer herself had been physically abused by her father, but witnessing violence between her parents had been a traumatic childhood experience.

It is possible to hypothesize that the way Jennifer coped with the fear of damage to her mother, and possibly to herself, was to identify with a male, possessing the strength of a masculine body. Once established, this gave her a sense of survival and also a sense of protecting in her mind the 'damaged' mother. A female representation of herself had to be strongly avoided, as it was equated in her mind with being weak and damaged.

Another important factor also seemed to play a part. After the birth of two older sisters, her mother had miscarried a baby boy. One year later, Jennifer was born. Jennifer seemed to feel that her mother had expected her to be a boy, and in one session she alluded to her mother having 'psychic qualities', as if she had been part of a magical experience in which she and her mother could read each other's mind. She had probably received, and made her own, her mother's wish that she had been a boy. Her mother probably never consciously expressed this wish, but possibly it remained unconsciously active in the relationship between them.

Two years of psychotherapeutic exploration with this young person allowed the therapist, together with Jennifer, to make this partial reconstruction of her childhood relating to her atypical gender identity development. However, any attempts to explore this understanding further with Jennifer led to continuous interruptions of the therapeutic work, which may have indicated her extreme resistance and fears of having the foundation of her gender identity revisited.

Even if Jennifer retained some of this understanding, it certainly did not alter her gender identity development, that is to say, the sense of who he was. His male gender identity seemed well established and fixed. It formed very early in life, and it is likely that traumatic events had played some part in it.

Towards the end of therapy, Jennifer was able to live in a male role with a male name and his well-being improved. He did not attempt suicide again. He settled in a job and he was more able to establish relationships with other people. One might say that therapy had helped him to cope with his well-established

gender identity in a better way, to make the transition to a male role and to give him a sense of hope (an important therapeutic aim). He was eventually referred to an adult gender identity service to explore further his perceived identity and the distress generated by the incongruence between his perceived gender and his sexual body. Physical interventions, aimed at harmonizing his gender identity and his body, could also be considered in the adult service.

I became aware in working with Jennifer that I was fundamentally dealing with a developing identity and not a psychiatric condition, long before there was a legal recognition of these new identities in many countries. A question remains: what conferred continuity to his atypical gender identity development?

This case shows that the combination of an exploratory and accepting attitude, could be a good approach in terms of promoting well-being. In this case the main focus of the work was the amelioration of the associated psychosocial difficulties. I later realized that these are present in a number of cases. Reflection on this case led to the original formulation of the therapeutic aims in work with children with gender diversity and their families (Di Ceglie, 1998).

The therapeutic aims were summarized as follows:

(1) *To foster recognition and non-judgemental acceptance of gender identity issues.*
(2) *To ameliorate associated behavioural, emotional and relationship difficulties.*
(3) *To break the cycle of secrecy.*
(4) *To activate interest and curiosity by exploring the impediments to them.*
(5) *To encourage exploration of the mind-body relationship by promoting close collaboration among professionals in different specialities, including paediatric endocrinology.*
(6) *To allow mourning processes to occur.*
(7) *To enable symbol formation and symbolic thinking.*
(8) *To promote separation and differentiation.*
(9) *To enable the child or adolescent and the family to tolerate uncertainty in gender identity development.*
(10) *To sustain hope.*

It is important to add to this list the need to combat stigma which is often associated with the experience of atypical gender identity and which is, at times, internalized by the individual experiencing GD.

It is also valuable to alleviate the feeling of shame that some children/adolescents and their family experience and enable people to develop skills in handling social interaction and dealing with possible hostility.

This therapeutic approach is developmentally based, is not prescriptive, addresses the young person's distress and aims at promoting well-being. It is not part of reparative/conversion therapy and has elements of affirmative therapy.

In one of the last sessions after two years of exploratory therapy, Jennifer said that perhaps this form of help had come too late and that her parents should have been aware of how she was feeling by the way she behaved as a child. She wondered why they had not sought help at that time. Jennifer's thoughts made me wonder why there was no service for children with these rare, unusual and distressing experiences. This planted in me the seed for the creation of such a service. About three years after, GIDS was established in the department of child psychiatry in 1989 at St Georges Hospital in South London. In 1996, the service transferred to the Tavistock and Portman Trust (Di Ceglie, 2021).

Case 2

Britton (1998), in his book *Belief and Imagination*, distinguishes between beliefs and fantasies. He states: 'Beliefs have consequences: they arouse feelings, influence perception and promote actions … Fantasies, conscious or unconscious, which are not the object of belief, do not have consequences: disavowal therefore can be used to evade these consequences' (Britton, 1998, p. 11).

Therapeutic exploration will help to clarify these two different states of mind. The following interaction illustrates the level of conviction of belief of a 13-year-old, assigned female at birth whose self-perception was of being a boy. This interaction occurred in a family session involving the mother, the step-father, the young person called Max, a child psychotherapist colleague and myself. The session was recorded for a documentary in 1994.

The metaphor, which I use in the following clip, came to my mind after reading an article by Jan Morris 'On the sadness of living abroad'. Here Morris describes the psychological experience of some English people who had migrated to France. Today we could call this experience 'the migrant dysphoria'. She says:

> It is not just that I am sorry for the French, who are going to have to suffer the proximity of these cuckoos in the nest of the world; in a way I am sorrier for the English, who are going to turn themselves into expatriates. All over the world one sees them, the islanders, evading their heritage, looking for the London newspapers in the Spanish newsagent, talking about duchesses at the New England Tennis Clubs, and, above all, almost anywhere beautiful in France, visiting each other's houses, remembering old times, comparing Major with Thatcher, Gooch with Botham. How happy they always say they are! How sad they generally seem to me. (Morris, 1991)

The following section is the transcript of a clip from the documentary.

Female Therapist (FT): What would you like to be called?
Max: Now? It's certainly not Sarah.
FT: What would you like us to call you?
Max: I don't know.
Mother (M): We just call Max, Max. But when I hear somebody else calling her, Sarah, or something, I just …
Max: Why do you say 'her'?
M: Sorry, sorry.
Father: That's the hardest bit …
M: It's the 'he' and the 'she' because it's really difficult and I feel weird calling Max 'her' or 'she'. Yeah. (To Max) I feel weird calling you it.
FT: Is that the bit that hurts the most?
Max: Yes. (M) says it all the time.
M: I do. I do. Yeah.
FT: But do you feel (hurt) with your mother or with everyone?
Max: No, [Male Therapist] calls me it too.
FT: Does it hurt the same?
Max: Yes.
FT: It hurts the same.
Max: Yes.
M: I know you'd rather be called 'he' but I do try, promise, we both do.
Male Therapist (MT): But I think it is a difficult issue to tackle because it's a bit similar to an English boy, born in England, brought up in England, about 15, 16, who emigrates to France and then goes around and says to everybody that I'm French. That I want to be considered French. While his accent will show that he is not French. So this is …
Max: No, that's not it though, because he wants to be, he isn't, but I am.
MT: But that is one of the problems because, of course, what your body says is different from what you feel inside you are. Like in this person, what he would like to be is French and this is different from what his accent, at least, you know, no other features …
Max: I don't want to be, I don't like to be … a boy.
FT: You are a boy?
Max: Yes.

An extract from another session shows further the strength of the conviction of this teenager and the difficulties in tolerating uncertainty or that the mother could have another point of view.

M: Max has asked us specifically on several occasions not to call him Sarah because we have called him Max since he was incy, and to say 'he' and not 'she'. And he's explained that it really, really hurts when someone says 'she'. And also it's ever so complicated if I introduce him as 'she' because people think I've gone mad so …

Max: You sound as if you're just doing it …

M: Because you've asked me to …

Max: Yeah, one of the reasons. Why aren't you doing it for you?

M: Also for me, because eventually if you do go ahead and have all the treatment I'm gonna have …

Max: Why do you say 'if'?

M: Well, all right then, 'when'. I'm gonna look pretty stupid if I'm the only person on the planet calling you 'she'.

Max: You sound as if you're just worried about what you do.

M: No, it's for you and for everybody. What you need to understand is that it takes some time for somebody like me to readjust and I do try, really, really, hard because the last thing I want is to upset you …

MT: The important point that you are making is that you feel that there should be no doubt about who you are …

Max: Yeah.

MT: … in this case you feel that you are a boy and there should be no doubt that you are a boy. And when you pick up any doubt about it, or that people are uncertain about it, that's very upsetting for you …

Max's perception of his male gender identity persisted until he was in contact with the service. At 18 he pursued further treatment in an adult service.

This case shows the value of a psychotherapeutic exploration in helping to distinguish between gender identity presentations which are more solid and presentations which are more fluid and changeable. The material from this case in particular, enabled the formulation of the so-called 'atypical gender identity organization' (AGIO) (Di Ceglie, 1998).

The characteristics of the organization are as follows:

(a) *Rigidity–flexibility or solidity–fluidity of the AGIO. This refers to the capacity of the atypical gender identity organisation of the individual to remain unchangeable or, alternatively, along a continuum, to be amenable to evolution in the course of development. Organisations which are more rigid or solid will contribute to the persistence/continuity of the atypical gender identity development, while organisations which are more flexible or fluid will lead to shifts in gender identity development. In about 10–30% of pre-pubertal children the gender dysphoria persists into adolescence. After puberty, the persistence/continuity into adulthood is much higher.*

(b) *Timing of the AGIO formation. Atypical Gender Identity Organisations that develop very early in the child's life may be more likely to become solidly structured than organisations that develop later. The early onset of gender dysphoria is in fact one of the criteria for considering early pubertal suppression.*

(c) *Traumatic events in childhood. It can be hypothesized that in some cases an AGIO may be formed as a psychological coping strategy in relation to a traumatic event in childhood. The earlier the trauma occurs, the more likely it is that the organisation will acquire unchangeable qualities.*

(d) *Position on the paranoid-schizoid-depressive continuum. The Klein-Bion model of psychological development posits a continuum from the paranoid–schizoid to the depressive positions. An individual oscillates between these two positions or mental states. Precisely where the child's mental state resides along this continuum when an AGIO is formed is of significance. The hypothesis here is that if the AGIO is formed during a period of development within the mental functioning of the paranoid – schizoid position, it is more likely to become very structured, have the quality of a solid identity and therefore be less amenable to change. Alternatively, if it is formed within a mental functioning of the depressive position it is likely that the organisation will have more fluid qualities (fluid identity) and be amenable to evolution.*

Therapeutic exploration may be able to elucidate the characteristics of the organization or the shape of gender identity of that particular individual and therefore guide management.

Case 3

Martin was referred in the early 1990s to the Gender Identity Development Service (GIDS) at the age of eight when he was attending a primary school. The educational psychologist reported that his mother said that he had told her when he was seven that he wanted to be a woman when he grew up. He enjoyed dressing in women's clothing and, ever since he could walk, he liked to wear high heels and use tea towels to mimic long hair. He was very fond of Barbie dolls and his mannerisms and style of walking were feminine. At school he played only with girls. He lacked confidence and was teased by other children, who called him offensive names. He suffered from symptoms of anxiety including stomach upsets, dizziness and headaches. His mother did not encourage his feminine behaviour but was supportive.

During his assessment at GIDS, we confirmed that Martin presented the features of a well-established gender identity disorder (now gender dysphoria in DSM-5). His anxiety about attending school resulted in poor attendance, and he also experienced teasing on the estate where he lived. He also had difficulties separating from his mother. At our service, we started working closely with the family, which consisted of Martin, his mother and his stepfather and had meetings with the school staff to facilitate his attendance at school.

Two years later Martin moved with his family to another town in England. Here, his wish to live in a female role became very intense and the parents agreed to let him live as a girl, expressed by dressing in female clothes and changing his name to Martina.

In her new town, Martina became involved in individual therapeutic work with a community nurse in the local child and adolescent mental health service (CAMHS). A colleague and I continued to see the parents every two months to help them to reflect on the gender identity and other developmental issues involved and to be able to make more informed decisions with their child (parental counselling). The parents attended a group for parents of GD children for six months (Di Ceglie & Coates Thümmel, 2006). We continued to hold regular professional network meetings, including the school staff, two or three times a year. Martina attended a small special educational unit in a female role, following careful preparation and discussions of the issues involved between the professional network (including us) and the family.

When Martina was 13, the Social Services Department called a child protection conference as the school had become concerned that parental attitudes could have contributed to the development of Martina's gender dysphoria. After an investigation and a child protection conference, no child protection issues were found. As a result of this conference, the mother was offered further supportive individual counselling by local services.

When Martina was 14, while waiting to be seen by our paediatric endocrinologist, as she was entering puberty, she unexpectedly announced to her mother that she no longer wished to be a girl, and she now felt happier about being a boy. From then on, Martina reverted to living as Martin. The next time I saw him he had physically developed a lot and had the clear appearance of a boy. At the last professional/family network meeting I asked Martin if he thought that his parents had made a wrong decision in allowing him to attend school in a female role and he replied without hesitation that it had been right because that was how he had felt at the time (DiCeglie, 2018b).

From this case, which I saw in the 1990s, I drew the following conclusion:

(1) *Pubertal development can sometimes, even in well-established cases of gender dysphoria, change the course of gender identity development.*
(2) *A parental response, which goes along with the intense wishes of the child to live in the perceived gender identity and role, does not necessarily influence the course of gender identity development. However, maintaining an open mind facilitates the process of change if this occurs.*
(3) *My professional role was to maintain a reflective approach in working with the family and the professional network, evaluating pros and cons,*

and to facilitate decision- making within the family regarding what was in the best interests of the child in that particular social context.

There is very limited research evidence to suggest which approach to children living in their preferred gender role (social transition) during childhood is best. Long-term follow-up studies have shown that only in a small proportion (up to 30%) of pre-pubertal children presenting with the features of gender dysphoria, did the gender dysphoria continue through adolescence and adulthood with or without any therapeutic intervention (Cohen-Kettenis, 2001; Green et al., 1987; Zucker & Bradley, 1995; Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008). Steensma et al. (2011, p. 1) suggest that among young people who changed: 'the period between 10 and 13 years of age was considered to be crucial … Both persisters and desisters stated that the changes in their social environment, the anticipated and actual feminization or masculinization of their bodies, and their first experiences of falling in love and sexual attraction, had influenced their gender related interest, behaviour, feelings of gender discomfort, and gender identification'.

My initial thinking about the management of gender role and social transition in childhood were based on a long-term observation of the case described from the 1990s. Since then, I have seen a number of pre-pubertal children and found that the exercise of autonomy in decision-making on the part of the parents and the child has been a helpful policy. The provision of a therapeutic exploration, jointly with the family and a neutral professional, is helpful. The exploration would aim at enhancing the capacity for autonomy in the family and, in this way, lead to better informed consent to what is in the best interests for the development of the child and in particular of their gender identity. The value of therapeutic explorations and counselling with young people and their families could be seen from a new vertex: 'their role in the service of the ethical principle of autonomy and better-informed decision-making'. Long-term follow-ups and further research in this area can contribute to the continuous development of appropriate guidelines.

Conclusion

In this paper I have tried to show how reflecting over a period of time on case material, as Bonnard did with painting, can allow a process of 'learning from experience' in the words of Bion and contribute to the development of models of care for different shapes of atypical gender identity. As clinical experiences and research evidence evolve, so will models of care.

The management of gender dysphoria in a number of young people may require for the young person and the family decision making regarding hormonal intervention. There is a risk, in our digital age and current cultural climate, that the process of evaluation and assessment becomes rather mechanical and simplistic. The role of

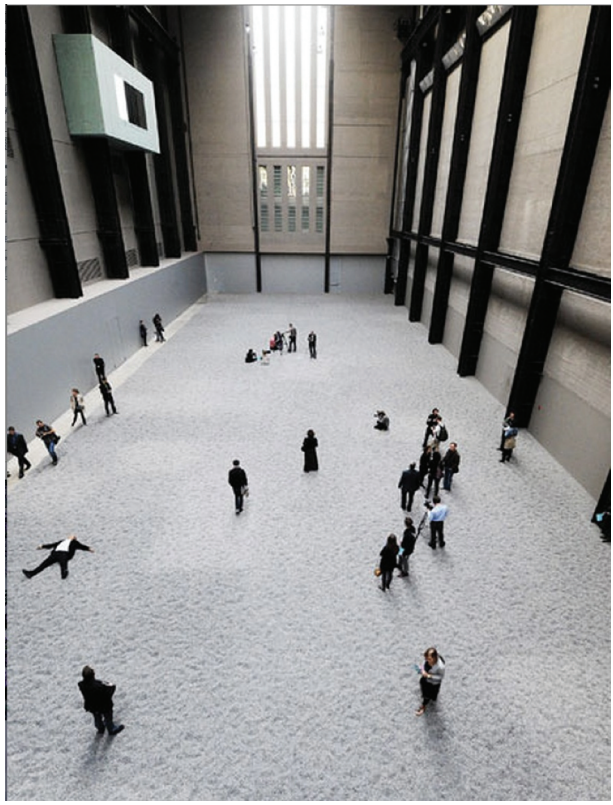

Figure 2. At a distance: an apparent undifferentiated mass of sunflower seeds.

Figure 3. Close up: the uniqueness of each individual seed.

therapeutic exploration may be to promote the development of autonomy and better-informed decision making in young people and their families.

I would like to end with a metaphor which stimulates a reflection on the nature of gender diversity in children. Recently, the Chinese artist Ai Weiwei created an installation at the Tate Modern in London which he called *Sunflower Seeds*.

This extensive mass of seeds (120 million) seen at a distance looks uniform and undifferentiated (see Figure 2), but as one looks a bit more closely, the individuality of each seed becomes more and more evident (see Figure 3).

There are no two seeds which are the same.

Ai Weiwei explained that each porcelain seed was individually painted by workers, who collaborated in the project, and not by a machine. Each seed required between three and six strokes according to the ability or the style of each collaborator. Therefore, the diversity of the seeds was the result of the creative process (DiCeglie, 2018a).

In a way similar to this work of art, children who present with atypical gender identity development, ('gender dysphoria', in DSM-5) all present differently within this category and not as part of a stereotype. It is therefore important to offer different types of help according to a range of diverse needs. 'One size fits all' cannot be applied to this group, instead, as professionals and society, we should respond empathically and flexibly to the particular experiences and story of each young person.

Disclosure statement

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