GENDER DYSPHORIA

A Therapeutic Model for Working with Children, Adolescents and Young Adults

Susan Evans and Marcus Evans

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For Laurie, Oliver
and our families,
with love

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Preface

I am writing this preface just a few weeks after the result of a judicial review which addressed the legality of the prescribing of so-called "puberty blocking" drugs for children and adolescents. The judgement found in favour of the complainants against the Tavistock and Portman NHS Foundation Trust and University College Hospital, that children are highly unlikely to be able to give informed consent to puberty blocking drugs for the treatment of gender dysphoria. The judgement was, necessarily, narrow in its remit but its broader consequences are very considerable. Reading the judgement, even as someone who has been deeply involved in this issue for some years, still has the effects of leaving me shocked as to how a "treatment" that has no evidence, for which no reasonable consent can be given by children (because of their age, and because of the lack of any evidence on which such consent might reasonably be given), and which has such damaging consequences, could possibly have been continued for so long and could have had such success in terms of professional and institutional capture.

James Kirkup, in an article titled "Is Britain FINALLY coming to its senses over transgender madness", in the *Mail on Sunday*, March 3, 2019, wrote:

> During a Westminster career which began as a junior Commons researcher 25 years ago, I have never encountered a movement that has spread so swiftly and successfully, and has so fiercely rejected any challenge to its orthodoxy … The transgender movement has advanced through Britain's institutions with extraordinary speed. The only thing more extraordinary than the rapid spread of this new orthodoxy is how little scrutiny it has faced and the aggressive intolerance directed towards those who question it.

How this near hegemony was achieved is an extraordinary story and one that will occupy us for a long time.

This book, written before the result of the judicial review was known, is by two professionals who have stood firm against the attempt to silence all debate that has so characterised this area. Susan Evans as long ago as 2005 raised very serious concerns as regards treatment carried out by the Tavistock's Gender Identity Development Service (GIDS). In 2018, a large number of staff working on GIDS sought me out, in my role as staff representative on the council of governors of the Trust. They did so to raise very serious ethical and clinical concerns about the service. On this basis I prepared a report in order to bring these concerns to the urgent attention of the Trust. These concerns included lack of appropriate consent of patients and families, intimidation of staff, inappropriate involvement in the service of highly politicised lobbying organisations, ignoring the concerns of parents, and lack of support for young people who were unable for various reasons (most particularly internalised homophobia) to accept that they were attracted to the same sex (this being misunderstood as being "trans"). All of these problems with the service were bound up with one central issue—the lack of an appropriate clinical stance (the GID service had adopted affirmation instead of neutrality). The Trust dealt with this report by attempting to deny its significance and undermine those who had raised the concerns. This led to the resignation of Marcus Evans from the council of governors, a principled move.

These events need to be set in context. Over the last ten years or so we have witnessed the exponential increase in the number of children and adolescents who present to services with gender dysphoria, but we have very little understanding of the factors that underlie this. Even so, I believe we can say with a considerable degree of confidence that this must result from a peculiar conjunction of an internal propensity and a cultural transformation. We saw something similar many years ago with the sudden rapid increase in individuals suffering from "false memory syndrome".

In the 1980s a girl who expressed a deep loathing of being female, who wore male clothes and cut her hair like a boy, might have been thought a bit odd. If her parents and local community were reasonably liberal, she might have been thought of as a tomboy. Many such girls would later come to recognise themselves as lesbian, some continuing to look more masculine, others not. Yet others would emerge from this phase in their development and become more conventional heterosexual women. But no one would have thought of such a girl as "*really* a boy". Yet, if that same girl were born thirty years later and exhibited similar behaviour in today's world, she would be in danger of being immediately "affirmed" as a man, going on to take opposite-sex hormones and subject herself to major surgery such as mastectomy, removal of sexual organs, and fashioning of an artificial penis.

This book makes a very substantial contribution to our understanding of gender dysphoria. Although over the last few years there have been a number of excellent academic papers, articles, and some books on this subject, this book is unique in bringing a wide and deep understanding to the phenomenon of gender dysphoria married to a psychoanalytic clinical model of work. As well as providing a general account of the phenomenon of gender dysphoria, the authors take us right into the intimacy of the clinical situation. Here they show how an appropriate clinical attitude (one informed by psychoanalytic understanding) can provide a context for accessing and understanding the complex inner worlds of these young people. This attitude is neither affirmation nor opposition but a kind of deeply engaged neutrality that provides the basis for real thoughtful engagement. I am reminded of a patient of mine whose friend asked what it was like being in analysis. "Well," he responded, "it is like having someone on your side. . . . But *not* siding with

you … that is an entirely different matter." It is this distinction, crucial to the relationship between a mental health worker (be they therapist, nurse, or doctor) that has been so catastrophically dispensed with in most clinical services that deal with young people with these problems. It is of course a great sadness to me that the Tavistock, renowned for the depth of its psychoanalytic engagement both at the level of clinical work and in thinking about broader cultural considerations, has fallen hostage to this "unthinking", causing damage to children and to the reputation of the Trust.

Trying to think through these events at the same time as being caught up in them is no easy task, and this book, fruit of this long labour, is exemplary in its thoroughness. It will provide a rich resource for those working with individuals who express their human suffering through a disturbance in the relation between their mind and their sexual bodies. And, because the authors manage to discuss this complex matter in ways that will be understandable to the non-expert, without compromising or simplifying, it will be of considerable interest to those who, whilst not directly involved in working with people suffering gender dysphoria, seek to understand it in depth.

David Bell, consultant psychiatrist and past president of the British Psychoanalytical Society

Foreword

A new socio-psychological category of gender identity has been firmly established over the last forty years in most cultures. Trans identity, previously an entirely hidden phenomenon, began to evolve in 1948 when Harry Benjamin published a book about his hormonal feminisation of male adults. Five years later, Christine Jorgensen made headlines all over the world when it became known that this American soldier had his genitals removed in Denmark and returned to the United States as a woman. For the next three decades, men and women who wanted to change "sex" were referred to as transsexuals.

Today, transgender communities are far more diverse in their age at presentation, natal sexes, and their aspirations. Cross-gender-identified young people, who used to be known as tomboys and sissies, are being understood in a new way. There has been an explosive increase in the number of never previously recognised as gender-atypical adolescents who identify as trans. An estimated 1–2% of adolescents and adults have modified their bodies with hormones and surgery or are considering it. Some aspire only to use hormones, others want to define their gender differently by combining masculine and feminine attributes in unique ways, still others reject gender categories entirely, and finally there are

those who are uncertain about their current and future gender identities. Professionals now separate those who aspire to live in the opposite gender—the gender binary population—from the increasingly prevalent group who want something else—the gender non-binary population. Not only has society shifted, the forms of expression of gender incongruence have as well.

Mental health organisations' views of trans phenomena have evolved from the 1983 *DSM* conception of transsexualism as a psychopathology to current assertions by psychiatric and psychological organisations that no form of gender identity represents an inherent psychological abnormality. Despite this, the American Psychiatric Association's *DSM-5* provides a psychiatric diagnosis of gender dysphoria for those who are distressed by the incongruence of body and gender identity. This within-house contradiction results from the fact that specific organisational policies arise from small psychiatric committees; the same phenomena occur within psychological, paediatric, and endocrine societies. These institutional policies have alarmed family members who consider their offspring's, spouse's, or parent's self-definition as trans to be an indication for psychiatric care rather than for affirmation and transition. They and their clinicians look to science. Many clinicians, informed by institutional policies, assume that science has already established the best approach. They may be surprised to learn that while affirmation, transition, hormones, and surgery have been widely accepted, a definition's scientific basis is uncertain. Hundreds of cross-sectional studies have affirmed the problematic mental health and social patterns at all stages of transition, yet affirmation clinics continue to increase in number. While recent publications acknowledge the uncertain long-term outcomes for young people, adolescents, and adults who have been affirmed, these authors consistently find positive outcomes despite many acknowledged methodological limitations (Branstrom & Pachankis, 2019; Costa et al., 2015). Ironically, the day after writing this last sentence, the *American Journal of Psychiatry* published a reanalysis of the data in Branstrom and Pachankis (2019) after receiving numerous letters to the editor. The authors' major conclusion that gender-confirming surgery improves mental health was retracted (Kalin, 2020).

Clinicians might wonder why after more than a half a century of trans care, the internationally organised field has never agreed upon how to

comprehensively assess psychological, social, and medical outcomes. Three specific questions have remained unanswered:

1. How long after an intervention should such an assessment be done?
2. What outcome measures should be used?
3. What constitutes an appropriate control group?

The lack of scientific certainty has enabled other factors to shape the direction of trans care and cultural responses to it.

Positions in the culture war

Modern societies are embroiled in a culture war about this topic. While this battle ebbs and flows with competing news in the media, the dominance of the change-the-body approach is apparent. Transgender phenomena readily elicit intense feelings. Such passion, which is antithetical to objective scientific appraisal, derives from eight overlapping humanistic, clinical, and scientific sources. Their confluence makes it difficult to judge their relative contributions to how individuals or institutions regard trans health care.

1. Fascination with sex change. The intriguing question, "Can 'sex' be changed?" has long been explored in the arts, where men and women have for centuries been presented as the opposite sex in humour, drama, dance, opera, and popular music. Today, it is better understood that in a basic biological sense, sex cannot be changed, but gender presentation can, with or without medical assistance.
2. Political sensibilities. The Right may consider transgenderism morally wrong and dangerous to societal health, and approach studies and clinical services with scepticism. The Left may consider transgenderism the courageous pursuit of self-expression, a civil right, and another praiseworthy social movement to eliminate discrimination, and approach studies and clinical services through a positive lens.
3. Religious sensibilities. They derive from theological assumptions and may resemble either political position. In the United States, vocal religious institutions tend to lean to the political Right.

4. Orientation sensibilities. Membership in the heteronormative or sexual minority communities may influence unease with, or endorsement of, transgender phenomena.
5. Intuitive sensibilities. When people are neither religious nor political, they may have a "gut instinct" that one should be supportive or wary of trans phenomena. Such sensibilities are best reflected through age; younger and older people have different life experiences with which to be intuitive.
6. Personal clinical experience. The writing group of the 7th edition of the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, by the World Professional Association for Transgender Health (WPATH), downgraded the importance of a comprehensive assessment of psychiatric comorbidities in determining the next step (Coleman et al., 2011). Adult and older adolescents were assumed to know best what should be done, despite their frequent psychiatric comorbidities. This policy diminished the frequency of unpleasant clinical experiences between patients who immediately wanted a transitional service and clinicians, mindful of the ethical guideline of Above All, Do No Harm, who thought it prudent to thoroughly investigate the situation. Depending on patients' attitudes towards these clinicians and the clinicians' knowledge of their patients' outcomes, clinicians may develop a positive or negative attitude.
7. Clinical reports from innovators. Outcome studies of transgender treatments typically consist of retrospective case series without control groups. Encouraged by these pioneering clinicians, others began providing care and formed national and international specialty groups to report on their experiences. Over time, groups that initially existed to share knowledge about how to help these individuals evolved into advocates for their specialty-specific therapy, teaching newer professionals how to care for patients. Once clinicians facilitate transition, they tend to believe they are facilitating happy, successful, productive lives.
8. Scientific studies. Groups of studies demonstrate particular patterns that individual studies do not. The priority of scientific data is assumed to be dominant but at times is ignored. For example, high desistance rates in trans young people have been demonstrated in all

eleven of eleven studies, but a committee of paediatricians created a policy of supporting transition of grade school [UK years 9 to 12] young people (Cantor, 2020). The forces that shape the interpretation of studies and that create policies need to be better understood.

Scientific foundation of medical interventions for transgendered individuals

The principles of evidence-based medicine classify uncontrolled case series and expert opinion as the least trustworthy on its hierarchy of validity. There are many questions in every field that have not been answered by respected scientific processes. The new commitment to quickly providing social affirmation and hormones derives from recipients' observed happiness and hopefulness about the future. A nagging ethical question remains. Is short-term patient happiness a sufficient justification for affirmation given data-based concerns for long-term outcomes? Specifically, do transitional services enable patients to have better social, psychological, economic, vocational, and physical health outcomes? The intensity of ethical concern is greater the younger the patient. Even though to date, the data are not impressively positive, transitional therapies are increasing. There are no international coordinated plans to create a better means of answering the questions.

Science versus advocacy

There are fundamental differences between clinical science and advocacy. Science represents a commitment to ask questions that will be answered with predetermined parameters of measurements to generate objective data. Methods can and should vary in order to establish a fact. Its processes benefit from doubt, scepticism, and the critical appraisal both prior to and after publication. Findings require replication, refinement of next questions, and improvements in methods of measurement. Despite the fact that certainty is rarely achieved in clinical science, such studies ideally precede advocacy.

In contrast, advocacy begins with a social goal in mind. Mental health professionals are ethically called upon to advocate. For instance,

we try to destigmatise alcohol-use disorder by emphasising it is a chronic brain-based disease of addiction, or advocate for more funding to help those with serious mental illness. All forms of advocacy marshal facts to advance a goal. Advocacy ignores evidence to the contrary. It does not welcome scepticism; it tends to be certain that the goal is for a greater good. Neither advocacy nor science is free of political influences. While all of medical and behavioural science is philosophically seeking the truth, its various stakeholders weigh evidence differently.

Evidence of continuing maladjustment

Numerous cross-sectional studies have demonstrated that the mental health, physical health, and educational, vocational, social, and economic well-being of trans populations are problematic compared to general populations (Dhejne et al., 2016). The transgendered are commonly described as a vulnerable marginalised group with dramatic health disparities who contend with significant barriers to accessing health care (Ard & Keuroghlian, 2018). Studies in various countries have found elevated prevalence of suicidal ideation, depression, anxiety, substance abuse, eating disorders, domestic violence, and suicide. There have been no consistent distinctions established between trans men, trans women, and the gender non-binary groups. A 2011 national registry study of every Swedish person who had surgery over a thirty-year period documented increased death rates, cancer and cardiovascular disease incidence, criminality, suicide attempts, and completed suicide compared with age-matched controls of both sexes (Dhejne et al., 2011). The shortened life expectancy and high incidence of suicide was demonstrated in Denmark in a thirty-year study (Simonsen et al., 2016) and in a subsequent review of Sweden's experience (Swedish National Board, 2020). Worldwide, the incidence of AIDS among economically poor trans women is dramatically higher than in the general population.

Affirmative treatments have been implemented by assuming that these indications of vulnerability are largely explained by societal prejudice, minority stress, and trans communities' distrust of health professionals. Affirming clinicians hope that as the world is becoming friendlier to trans individuals, the suffering of this cohort will abate.

They prefer to view a trans identity at any age as the unfolding of the true, never-changing self. Two hypotheses are rarely mentioned:

1. A trans identity represents a symptom of an underlying developmental problematic process
2. A trans identity, however established, creates a new worrisome symptomatic relationship to the self, to others, and to the tasks of development.

These hypotheses converge to suggest that the genesis of a trans identity lies within the person but that the actual external obstacles to successful adaptation derive from consequences of the decision to transition. The closest that advocates come to this idea is their notion that trans phenomena are caused by biological embryonic processes, which is an idea still in search of convincing evidence.

Gender dysphoria: a therapeutic model for working with children and young people

This book is a most welcome addition to the professional culture debate about the treatment of trans youth. It provides a powerful argument, particularly for multinational policy debate on treatment for this problem. It suggests scepticism about the clinical and social wisdom of swift hormonal and interpersonal support for young people and adolescents who want to inhabit the gender of the opposite sex. The authors provide guidance for therapists who think it is prudent and ethical to investigate the conscious, socially hidden, and unconscious reasons for patients who repudiate their natal sex. They see a trans identity as a solution and are asking others to consider what problem is being solved by this radical redefinition of the self. They are incisively aware of difficulties that mental health professionals face to suggest a prolonged exploratory process to investigate this significant question. In today's environment, clinicians (or patient, parent, sibling) who respond with alarm about a trans identity are considered to be transphobic. This sounds like a bad thing to be. But a close reading of these chapters will illustrate that such alarm, rather than being deplorable, is reasonable.

Clinicians are permitted to be concerned with the long-term outcomes of these individuals and their families. Trans gender identities have been divorced from the characteristics of the numerous other aspects of identity that are well known to evolve (Levine, 2020). These identities are portrayed as a special case requiring clinical expertise not found among well-trained, experienced, traditional mental health professionals such as the authors. They require professionals with certain ideological beliefs, about which scepticism is not appreciated. Psychological development and its intrapsychic consequences have not changed in the last twenty years, but how these are conceptualised and dealt with has. Today, interfering with the multiple facets of biological, social, psychological, and sexual development with puberty-blocking hormones, cross-sex hormones, and surgery of adolescents is justified by the principle of respect for patient autonomy. These interventions are occurring even when by age, maturation, psychiatric symptomatology, and past egregious disadvantages, patients and their families may be unable to seriously consider the risks being undertaken.

Trans community advocates have a compelling argument. Prior to 1973, society and its agent, the mental health profession, viewed male and female homosexual persons as mentally ill, much to their detriment. It took science to end this view. Advocates argue that sceptical people are merely repeating what society used to promulgate about homosexual persons. The advocates' goal is to similarly make the world safe for trans individuals whether they are binary or non-binary individuals. They see delaying physical interventions for psychotherapy as withholding treatment that has already been proven to be highly effective in relieving the pain of gender dysphoria. In my experience, most clinicians are in favour of civil rights and full opportunities for trans persons despite their alarm over early hormonal interventions.

I suggest keeping ten questions in mind when reading about this psychotherapeutic approach

1. Can one be born into the wrong sex? This is a question of aetiology, which at this point in the history of psychiatry is a bit academic as it is well known that most mental and behavioural phenomena are created by biology, individual psychology, interpersonal relationships, and culture.

2. Is gender identity immutable? A related question is: Is the private understanding and labelling of the self along the masculine–feminine continuum subject to lifelong private evolution? What are we to think when we listen to a professional who asserts that a preschool young person who prefers to play as a member of the opposite sex knows his or her future identity?
3. Are gender identity and orientation separate phenomena that do not influence one another? While trans ideology proclaims that they are, it is readily apparent that there are frequent cross-gender manifestations within sexual minority communities.
4. Where does paraphilia come into the trans clinical picture? Both orientation and gender identity play a role in the shaping of the third component of sexual identity, intention, about which most researchers and clinicians are silent. Intention is how the person imagines or behaves with a sexual partner; the conventional pattern is peaceable mutuality; the stylised and sometimes obligate pattern in order to be aroused is a paraphilic pattern. Paraphilic phantasies and behaviours, particularly sadomasochistic ones, are integral to the adolescent developmental processes of many individuals of any orientation or gender identity. Paraphilic sexuality is relevant because it is a challenge to long-term viability of coupledom, which is one of the adult challenges of the transgendered (Levine, 2016).
5. Is every gender identity a normal variation of gender identity, as trans ideology asserts? If one is not permitted to think of these identities as maladaptive, that is, predisposing to adverse outcomes, another explanation must be found for the presence of more anxiety and mood disorders, substance abuse, suicidal ideation, suicide attempts and completed suicide, eating disorders, other forms of self-abuse, and premature death among trans populations. Trans communities are referred to as vulnerable and marginalised.
6. Does affirmation prevent suicide? The completed suicide rate and the presence of suicidal ideation are higher among trans populations than other sexual minority groups and conventional people. How much so varies from study to study (McNeil, Ellis, & Eccles, 2017). The vast majority of trans people do not kill themselves, although the majority may at times consider it. When a clinician asks parents, "Would you rather have a living daughter than a dead son?" they are not speaking from a knowledge base. In applying the medical ethical

principle of honesty, scientific knowledge—not social or political ideology—is the correct basis of what clinicians share with patients and their families.

7. What have randomised, prospective, controlled studies shown about the efficacy of puberty-blocking hormones for preteens and cross-sex hormones for teenagers or adults? The usual explanation for their absence is that it would be unethical to withhold effective treatment from these suffering individuals who believe interventions will help them. Sophisticated studies are expensive, take years to accomplish, involve a team of professionals, and require a widely perceived relevance and necessity.
8. What is known about the outcome of psychotherapies for trans-identified young people and adolescents? This book's erudite chapters about highly defensive intrapsychic development provide evidence that some psychotherapies can enable some patients to decide to desist from a trans identity. Those of us who have faith in the benefit of such work regardless of the patients' ultimate decisions about their gender expressions do not have compelling data to support our faith. We occupy the same posture of faith as those who support rapid hormonal intervention as to what the appropriate first step should be.
9. Does the psychiatric ideology of the therapist matter in terms of short-term outcome? One must not confuse formal psychoanalysis with what is described here. The authors treat us to descriptions of how they conceptualised the defensive mind and how they have spoken to patients to free them up to be more honest and articulate about what they have thought, felt, and desired. Studies have indicated that therapist ideology is less important in creating a positive short-term outcome than the quality of connection to the patient. Warmth, caring, absence of hostility, and grasp of what the patient is feeling and saying seem to predispose to better outcomes. Insight is vital (Hogland, 2018). The authors' ideology is helpful. It will enable some therapists to refocus their work and deal with their counter-transference more productively. It will help parents to grasp what may be going on in their young person's sessions. The case histories may awaken some patients' memories and give them hope that they can be more equipped to take on their future.

10. Is there a defined standard that must be met before transition, hormones, or surgery is recommended? The value of controlled research is the careful definition of inclusion and exclusion criteria. Clinical work is more subjective and requires trust in the clinicians' judgements about mental health. Given what the authors and others have noted about internet guidance for how to handle the evaluation, we should remain somewhat uncertain about our judgements.

Welcome to the professional aspects of the larger societal culture wars.

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at Case Western Reserve University School of Medicine