FIRST DO NO HARM

Paper for Seminar at Scottish Parliament

David Bell

Consultant Psychiatrist

Former President British Psychoanalytic Society

I am very honoured to be asked to address this meeting. My brief is to consider the effects upon children of the medical interventions for childhood Gender Dysphoria. As many will know I am the author a report on the Tavistock Gender services , but in what I say I am only expressing my *own* views – I should not be misunderstood as **representing the Tavistock and Portman NHS Foundation Trust nor in any of my comments should I be understood to be referring to that Trust or any of its services.**

This is a subject I have been deeply involved in for the last three years or so and have a considerable amount of contact with colleagues in the UK, Scandinavian countries , Australia, Canada, USA. Like many I have been very concerned by the whirlwind of change that seems to have come about in a very reactive non-reflective way- it is an international phenomenon (and of course we need to be wary of being drawn into thinking there is any necessary relation between the popularity of a system and its rightness) .

James Kirkup a journalist 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."

The proposed legislation to facilitate /remove obstacles to Gender Recognition needs to be considered in the context of these massive social transformations but today we are focusing on the consequences for children and young people, for whom we have such a deep responsibility. It is clear I believe that the proposed changes are both symptomatic of and consequential for these momentous transformations - consequential in that they would be highly likely to form a major contribution to what might be best characterised as a resetting of the thermostat , increasing the numbers of children and adolescents embarking on medical and surgical treatments- treatment whose effects are irreversible and whose consequences we have very little knowledge (though we do know about infertility, cardiovascular disease, changes in bone density, possible higher incidence of malignancies) all these apart from the potentially devastating direct physical effects of the surgery and the lifelong care of the operative sites. Patients are advised to have total hysterectomies after 5 years on testosterone because of the vaginal atrophy which can have dangerous consequences.

In 2011-2012 there were about 50 referrals to the our UK national service – in 2019 2,700

Referrals for Scottish children to the Sandyford Young People's Gender Service have risen by an unprecedented 705% since 2013, in comparison to a rise of 438% for the Tavistock in London over the same time period.
As of 2018 there are also an additional 470 children (aged 16.5 years or younger) on a waiting list for a first appointment.
The age group with the largest number of referrals is that of 15-16 year olds, for whom referrals have increased by 35% in the year from 2017 to 2018. Worryingly the number of much younger children referred has rocketed with a rise of 62% for 11-12 year olds, and a startling rise of 83% for 4-10 year olds between 2017 and 2018.

There has also been a sudden reversal of the gender ratio of those children seeking gender reassignment rapid increase - the numbers of girls wanting to

change to male identity is now between 70 and 80 per cent and a new description ‘Rapid Onset Gender Dysphoria’ (ROGD)has emerged.

This explosion in numbers , the sudden increase in natal girls, the appearance of ROGD all indicate a cultural phenomenon of enormous importance that we do not understand although if we have time later I will make some tentative suggestions (see appendix) .

The implications for us all of these changes are massive yet the professions of Psychology, Psychiatry and Psychotherapy have shown a marked reluctance to maintain an enquiring stance in relation to gender re-assignment, even a reluctance to get involved. General practice has been a notable exception.

So let’s consider the situation of the child who presents at a clinic complaining of discomfort with their natal gender (and of course this discomfort may be extreme, very often manifested as hatred of their sexual bodies) . It is vital to distinguish between Gender Dysphoria and Transgender as these are easily conflated , itself a cause of serious damage. Gender Dysphoria might arise from many sources and in mild forms is certainly not uncommon in adolescents (the relation between milder forms and severe forms of gender dysphoria is very under researched). Transgender refers to the situation when a decision has been made that the way to manage the gender dysphoria is through the child being set on a course to change her gender identity . This may be achieved through changes in behaviour, forms of dress (the more benign and more imaginative outcome) or though medical and surgical intervention. In many situations there is support for the belief that the child is actually in the wrong body (there is absolutely no scientific evidence to support this).

In clinical services there is usually a tremendous pressure to close down any discussion that might involve understanding how this has situation has come about and rapid unquestioning acceptance of the child’s view , a demand (often supported by the family) for ‘closure’. As it is so often heavily resisted , it takes considerable sensitivity and skill to manage children and families in such a manner that areas of discussion and thoughtfulness can be opened up. However, many service idealise the lack of space for such work through creation of what has been termed ‘an affirmative agenda’, itself a cause of serious damage.

This refers to the situation where the doctor or health professional, when confronted with a child who states they must change gender should act is such as way as *only* to support that view, not question it-- as if that is a human right.

The Memorandum of Agreement does NOT in fact demand an affirmative stance but it is very often misinterpreted as if it did .

If one thinks of the situation in anorexia- the child/adolescent will very often maintain that their dangerously low body weight is normal but we would regard it as very strange if the only option available to a physician was to affirm the child's view.

We need to bear in mind that a substantial percentage of these children, if left without intervention will desist and emerge as gay and lesbian (there is evidence to support this) .Thus rapid decisions as regards the provision of medical and surgical intervention is *itself* a form of conversion therapy-for it brings about transformations in the body converting it in order to satisfy unexamined individual, family and social agendas some of which are manifestations of homophobia.

It is thus vital to distinguish between conversion therapy and a wish to think. The job/ role of the physician is absolutely NOT to champion one solution or another but to maintain a position of interest , curiosity, doubt - but of course it is entirely reasonably -minded to need to be *very* persuaded before embarking on a course that will irreversible damage to the body of a child. We do generally accept that the capacity of an adult to be able to remain thoughtful when the child is overwhelmed with a sea of emotions is absolutely vital to development Reneging on this position is necessarily damaging - it further undermines the child's sense of reality.. and also the family's. I am reminded of the psychoanalyst Tom Main who once wisely remarked that the job of the psychiatrist is often to 'Not just do something but stand there' .

A large number of these children have multiple serious problems (experienced clinicians have described them as the most disturbed and complex group of children they have ever worked with) and where thought and enquiry are drowned out by the highly politicised agendas ,these problems may *never* be addressed, a very damaging outcome

In many centres parents, who may have important knowledge of the child, of their history , of troubles in the family in this generation and previous ones, if they are not automatically affirmative , are in danger of being marginalised or even treated as the enemy. In other situations the parents themselves are very determined on this course for their children and exert pressure ,again, for immediate closure, and very often this is not appropriately resisted (I will have something to say later if we have time as to how we might understand this phenomenon in the parents - guilt, fear, anxiety, terror of going against the child….)

One clinician who was able to follow up a child who transitioned who was able to, much later on, reflect on what had occurred. The patient could now see that there was a dynamic in the family which was pressuring towards transition. He said to the therapist 'How could the service have allowed this to happen, how could you have allowed my mother to do this to me?'. The fact that most services do not follow up these children (there is hardly any follow up data) protects them from having to face these outcomes.

In many services, because of the huge numbers of referrals (often far above what the services where designed for) clinicians have massive case loads (often well over 100) . These huge caseloads combined with the clinician hearing the same rehearsed story over and over again combine to makes it impossible for them to have the necessary real thoughtful engagement, over time, with these children. A number of clinicians have said something like this:

> 'In previous jobs I would have seen very many families but years later you just mention one thing- such as the one where the father was a taxi driver who wrote off his cab- and everything comes tumbling back….but with these families they all become a blur, there were just so many and so many of them said more or less the same thing'

This is worsened by the fact that many services , because of resource problems, are often staffed by very junior and inexperienced staff who can be employed at lower salary bands .

Children arriving at clinics, then , very often been carefully trained on line, by peers and even by parents, to produce a plausible narrative (and these are recognisable for their stereotypy), a narrative that evades exploration, ticking the right boxes so that they can be referred for medical treatment. It requires a lot of time and space to resist these pressures and get past these scripts,

and so open up the possibilities of thought in these highly toxic situations. (where centres are essentially gatekeepers to intervention , and this is so for most, this is inevitably even more difficult).

So let's look at some of the typical pathways to Gender Dysphoria - there are many and my account does not aim to be exhaustive but only to provide some sense of the kind of things we are dealing with.

Problems with sexuality Many children and adolescents of course have difficulties in coming to terms with the transformations of their sexual bodies , and here a particularly heavy burden falls upon girls . A feeling of disgust, even hatred of the sexual body as it develops is not uncommon and needs careful management . However in a socio-cultural context where that disturbance is misread by the young person and also by the clinicians as indicating 'transgenderism' , that whole area of thinking and potential development is shut down.
Many girls express their conflicts with their sexual bodies through anorexia-

> Jane had undergone medical and surgical intervention as an adolescent. She had been anorexic but it was only, tragically , as an adult that she came to understand that her gender dysphoria and anorexia were *both* expression of conflicts with he female sexual body. Noone in the gender service she attended had tried to help her see that

Homosexuality. It is not uncommon for a girl ,to think that because she is attracted to the same sex, that she must 'really' be a boy (or similarly boys who are attracted to boys thinking then they must be a girl) . Some children who show characteristics of being gay/lesbian find this is not tolerated by their family, often very overtly, but equally often in a more subtle even unconscious ways- this requires considerable expertise to uncover and so bring into a place where it can be thought about; these children/young people internalise this intolerance of their sexual orientation and combined with their own disgust , it becomes manifest as hatred of their own sexual bodies.

There is, as I said above, considerable evidence that many of these children if helped in a proper (that is non-invasive manner) end up being gay or lesbian without having undergone any medical intervention at all. It is noteworthy that in many centres there has been a very damaging absence of discussion of sexuality, this being eclipsed by gender- of course the two are inseparable.

There are then two groups: Gp A who benefit and Gp B who do not. But we have no way of determining which group any particular child belongs to- but we do have evidence that Gp A is highly likely to be very small indeed.

How is it conceivable that we can go ahead and risk doing irreparable damage to children's bodies on this basis?

Gender non-conformity

Many young people find themselves unwilling/unable to conform to gender stereotypes (for example a boy may want to be feminine, a girl may want to be more masculine)- but again this is easily misread as wanting to be change gender . There is this a regressive non thinking about gender- that is the medical interventions support not fluidity but rigid binary construction of gender that has a caricaturistic quality.

Other pathways include:

The presence of serious psychological disorders including depression, anorexia, autistic spectrum disorder (over 35% of children referred are on the autism spectrum) .

Serious family disturbance is common often with intergenerational transmission of major trauma such as child abuse in the mother/ maternal line (sometimes a source of the mother's not wanting a girl child which the mother may not even be properly aware of, but her daughter may pick up)).

Some families have suffered other major traumas, for example families where the death of, say, a female child (this is a real example) brings her brother to seek transition to support the identification with the dead sibling (experienced as helping the parents inability to mourn, and also expressing survivor guilt and so on -a familiar scenario for any family therapist .

Then there are children who for multiple and complex reasons live a lonely and isolated life, feeling that they just have no place in the world, psychically lost and homeless. They go on line and then, because one aspect of their difficulties expresses itself through difficulties in their relationship with their gender, become convinced they are 'Trans' - this provides them with a sense of belonging to a community; there is a positive feedback loop as the feeling of belonging increases the sense of being 'trans' . Many of these children are

thus easy targets for highly politicised cults who provide them with a place in the world, but one that is highly contingent on supporting the politicised agenda of the group - this has many of the qualities of online radicalisation.

We have come to understand the importance of social contagion (see the work of Littman[1]) . This is particularly evident in Sudden Onset Gender Dysphoria- that is children who had given no indication of major gender dissatisfaction suddenly come to the decision that they are really of the opposite sex

Incidentally these massive demographic changes in numbers of children referred, in the appearance of this new phenomenon of SOGD and the inversion of sex ratio (70- 80 per cent now girls) are significant in that what guidelines there are for a *completely different* demographic. In any case the guidelines (WPATH) were created on the thinnest of evidence and are not of worthy serious consideration (I can supply further information on request).

Overburdened child mental health services who cannot cope with the combination of increasing demand and cutting of resources are stretched to breaking point (see Association of Child Psychotherapy report 'A Silent Catastrophe'[2]). Faced with children suffering complex serious disorders and the lack of resource it is understandable that any mention of gender problems can prompt immediate referral to specialist gender services (in the belief that these other problems will be then be addressed in that specialist context). But in reality these complex disorders (now filtered through the prism of gender), are most often left completely unaddressed as such centres very often do not see it as their role to investigate and provide help for other mental health disorders. Some may even function as if profound problems with gender identification can be managed completely separated from the rest of the psychological functioning of the child/adolescent.

In many services children are seen for only a few meetings before commencing what are termed 'puberty blockers'. But this is the wrong nomenclature as it implies that this is their main function. These drugs that have various actions and were not designed for this purpose (they are

[1] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0202330

[2] See: https://childpsychotherapy.org.uk/acp-report-silent-catastrophe

prescribe 'off label'[3]. It is also the case that the body cannot be treated like a video recorder where one can just press a pause button. At a certain point in development the brain and the rest of the body, the psychology, the family and social context are all prepared and ready for puberty . Chemically interrupting and the falsely producing puberty at some later stage is a complete different biological, psychological and social scenario.

In any case, although until recently it was said that these drugs were given to create an interregnum we know this is not the case as 100 per cent/nearly 100 per cent of pubertal children in puberty blocking drugs go on to opposite sex hormones in complete contrast to the situation 5-10 years ago when the majority desisted It ay well be that the provision of services in such an ill thought out way has in fact been a major causal factor in this change from the majority desisting to nearly one hundred per cent persisting. It has *now* been accepted by Gender services, that the function of 'puberty blocking drugs' has in fact changed – such prescription is now accepted as the first stage of transition - this of course adds considerable concern to the issue of consent at this first stage it is consent NOT for an interregnum but to the entering onto the pathway to opposite sex horns and surgery.

In this peculiar atmosphere , thoughtful engagement is treated as a kind of enemy and this is certainly the experience of many clinicians working in gender services. The wish to think over time and understand why a particular child has developed gender dysphoria comes to be seen as an expression of 'transphobia', so creating a world where you are 'either with me or against me', where there is no room for a mind that just wants to think about things- a paranoid universe. The intolerance of doubt and thought that characterises certain kinds of very difficult and disturbing mental states, here leaks out and becomes a force in the social realm.

John was aged 10 in 1988 . He had three older sisters and idolised them. He started wanting to wear feminine clothes and his parents accepted this (being helpfully liberal minded). When he wanted to wear pink clothes to school it cause some difficulty but after some discussion the school accepted this. When John was a teenager, some years later he wanted to wear boy's clothes . He is now grown up a man of 40. He sees himself as male and is rather feminine

[3] An off label medicine is a medicine with a product licence but where the product licence does not cover the indication for which the medicine is being prescribed. ..

in identity . He may well be bisexual - he accepts and lives reasonably comfortably in his body.

Brian was 11 year old in 2015. He had an older sister and became increasingly interested in being feminine, wearing girls clothes, playing girls games etc. He was referred to a gender clinic and within a few moths had started on puberty blockers progressing to opposite sex hormones.

It may be that the only important difference between them is that Brian had the good fortune to express his difficulties in a world which could accept his gender non conformity , allow him to be who he wanted to be without any possibility of a closing things off prematurely [4]

There is a profound interference with the capacity for play and imagination - as Charlie a de-transitioner put it put it 'I speak for a generation who have been robbed of their capacity for imagination'

So the harm done children we can be divided into two broad categories direct and indirect

The *latter* harm comes when the children's multiple and complex problems are so easily rebadged as gender and once everything is seen through this prism their often serious disorders receive no attention at all (some gender services clearly state they cannot deal with child mental health problems but only 'gender' problems- as if these can be split off from the rest of the functioning of the child, and also the family of which she is part (a further damaging effect of the affirmative model)

The *former* refers to the direct effects of the intervention

Closing off thought and setting the child onto a pathway where other outcomes are sealed off.

When the child is set on this course we know they will be infertile, suffer irreversible changes in the sexual body, be anorgasmic, have a lifetime of being a patient taking hormones, suffer vaginal atrophy, suffer the daily

[4] The Psychotherapist Stella O'Malley gave an excellent account of this premature foreclosure including her own experience of gender dysphoria , in her Channel 4 documentary 'Trans Kids: It's Time to Talk' 21st November 2018

routines of tending for the parts of the body that have been surgically modified.

Then there is the damage rising from being encouraged to have the false belief that medical and surgical interventions change biological sex.

Many detransitoners have describe he intense feeling of being trapped- that is in many cases severe psychological disturbance projected onto the body which is then felt as a prison from which one can only want escape, that is escape into another place, imagined as opposite gender, where the individual will feel completely free of disturbance. They often describe a complete euphoria after surgery and then the subsequent collapse when many of the problems they had ,reappear, but now with the massive added problem of a mutilated body

Taking puberty blocking medications whose effects we do not know though there are indications of brain bone and cognitive damage is an extraordinary[5] .

These off label drugs have never been formally studied for this purpose – they have been used for prostate cancer and precocious puberty, known serious condition – this is *not the same* as giving the drug to a normal body

Then there is a long list of iatrogenic conditions caused by the opposite hormones which we only beginning to understand

Lastly, we have to be mindful of the whole issue of consent. The so-called liberal agenda which uses a rights rhetoric to situate even young children as being able to consent and understand the implications of lifelong treatments causing irreversible damage to their bodies, as being able to weigh this up against their wish to be a different gender. This is I believe entirely mistaken and is a terrible betrayal.

[5]'The current evidence base does not support informed decision making and safe practice in children' Carl Heneghan (Editor in Chief BMJ EBM, Professor of EBM, University of Oxford) and Tom Jefferson Senior Associate Tutor University of Oxford, Visiting Professor Institute of Health & Society, Faculty of Medicine, Newcastle University https://blogs.bmj.com/bmjebmspotlight/2019/02/25/gender-affirming-hormone-in-children-and-adolescents-evidence-review/.

I think, as an aside, that as we emerge from the unchallengeable very peculiar mode of non-thought that has dominated this area, as de transitioners start to become a force, health services have to face the consequences of this damage I n the courts (judicial review under way)

Last year ago a young woman was referred to me by a plastic surgeon. She believed there was something wrong with her nose. But the surgeon thought there was nothing sufficiently wrong with her nose to warrant surgery, the problem he thought was in her *relation* to her nose. After one year psychotherapy with a colleague she recognised her deep hatred of her father and also that she understood that she saw her nose as like his. She became more reconciled with her nose. On that same day, as I saw her for the original consultation, in clinics throughout the world , young children and adolescents presented with a deep feeling of loathing of their sexual bodies and, within a few appointments, were set on course for puberty suppression, opposite sex hormones and surgery.

If we take it as a fact that gender identity is socially constructed, then there is a paradox at the heart of the trans phenomenon. The apparent freedom/liberation it expresses is totally undermined by locating all possibility of change only concretely, in material alteration of the body, rather than in the mind.

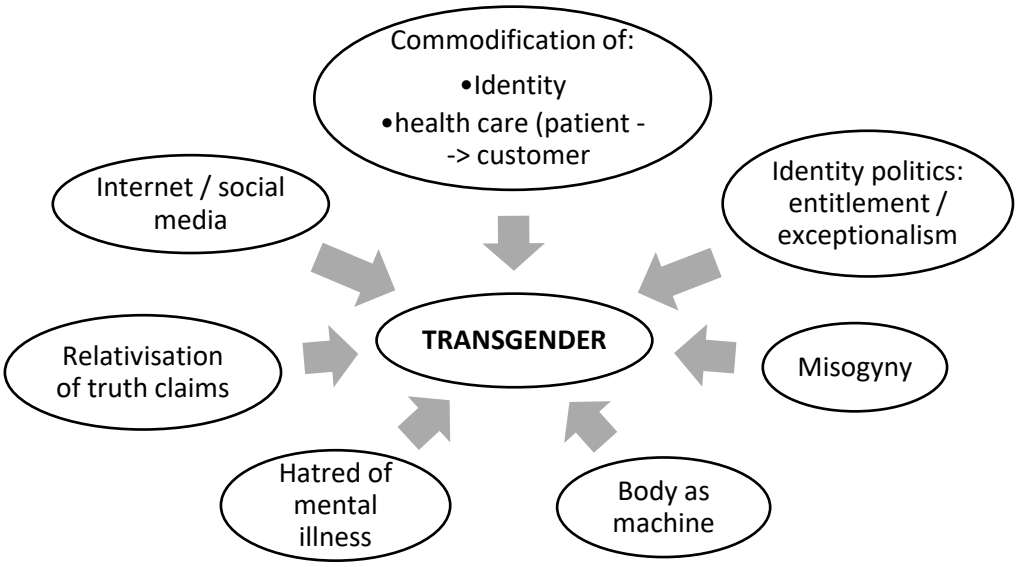
I recently read a paper by one of the director of a gender service. She is very straight forward in listing what we do not know- no follow up studies of any worth, no real knowledge of which children would benefit from medical intervention, no real knowledge of the effects of medication.. and so on. I am impressed with the modesty but if this is the case, and it clearly is, should we not first assure ourselves that we do no harm

……..

Appendix

Extract from another paper- mainly considering socio-cultural issues in Gender Dysphoria

I offer here is only a preliminary sketch of some of the factors that may be relevant to this sudden transformation.



1. The ever increasing penetration of the market form into all aspects of life reaches deep into the psychology of the person, reformulating identity so that identity comes to manifest features of the commodity form; it moves from being something that one lives with, struggles with over time, to a more transient structure which, somewhat like a commodity, is exchangeable. Commodity exchange, because of its extraordinary rapidity, supports the illusion of instantaneous transformation (note: I do *not* mean that a Trans person just chooses a new identity, without any painful struggle, just that this underlying socio-cultural transformation acts as a tendential force influencing the way we all think).

This transformation is increasingly expressed in the relation between doctors and patients, which degenerates into its perverse form, the celebration of customer-hood (misunderstood as democratisation). The distinction between need and wish here evaporate. We have been used to a world where a patient requests X treatment, but the professional can disagree, introducing a triangulation that may be welcomed or resisted. However powerful social forces misrepresent this triangulation as only representing a kind of patriarchal power play, and where this is successful, externality collapses.

2. Overburdened child mental health services who cannot cope with the combination of increasing demand and cutting of resources are stretched to breaking point (see ACP report ‘A silent

Catastrophe'[2]). Faced with children suffering complex serious disorders it is understandable that any mention of gender problems can result in referral to specialist gender services, and in the process, complex disorders (now filtered through the prism of gender), can be left completely unaddressed. This also leads to a damaging foreclosure of the ordinary turbulence and confusion of adolescence.

3. Another major change is to be found in transformation of political life so that Identity Politics (race, gender) moves into a dominant position. This movement started off life as liberal and progressive but then (and this has been brilliantly discussed by feminist and black theorists[3]) it twists and turns, coming to manifest the very characteristics it sought to challenge; it becomes fixed, narrow and all

[2] See: https://childpsychotherapy.org.uk/acp-report-silent-catastrophe

[3] see for example Haier Assad (2018) Mistaken Identity, Race and Class in the Age of Trump, Verso London

[5] I have written on this in a paper written at the time of the entry of the market form into the NHS which marked the beginning of the destruction of the welfare consensus, see Bell D (1997) Primitive Mind of State Psychoanalytic Psychotherapy vole 10, 1 45-57

[6] see Littman L https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0202330
The most explosive of Littman's findings may be that among the young people reported on—83% of whom were designated female at birth—more than one-third had friendship groups in which 50% or more of the youths began to identify as transgender in a similar time frame.

determining; critical engagement is recast as the enemy to be silenced.

4. The increasing recourse to medical and surgical intervention enacts a breakdown in the boundary between the bodily self and technology.

5. Lastly I think that in our current conjuncture we are witnessing a growing misogyny. What I have in mind here is this: since the second world war up until the late 70s a strong femininity, expressed by the increasing theorisation and respect for maternal caring, and in our society the creation of the Welfare State maintained a certain social dominance. However, that version of strong caring has been re-presented in its perverse form, 'nanny state', a contemptuous attack on femininity[5]. This is both expressed and reinforced by ideological forms that promote the delusion of the autonomous man, seeking to service only his own needs, enacting a hatred of all forms of dependence. This growing misogyny may be having profound effects on girls and, in conjunction with more individual factors, supports the internalisation of this hatred of femininity, transformed into a hatred of their female bodies.

6. The internet/ social media are a major determining force and occupy a position that is *both* causal and a vehicle for other causes. Through a kind of viral social contagion[6],

children who feel lost in the world become radicalised on line, join trans groups that provide them at last with an identity and social belonging and also an explanation for all their suffering. Further, because of its overwhelming ubiquity and power, it is the medium through which the other factors listed above are transmitted at speed and with no obstruction.

This factor is of considerable importance in the very marked increase in the occurrence of so-called Rapid Onset Gender Dysphoria, where onset is sudden sometimes literally from one day to the next. There is considerable evidence of social contagion in schools.

A Peculiar Mode of Thinking

I will here elaborate on some aspects of the peculiar form of thinking that has come to dominate the discourse in this area.

As I think we have made clear, thoughtful engagement is treated as a kind of enemy and this is certainly the experience of many clinicians working in gender services. The wish to think over time and understand why a particular child has developed gender dysphoria comes to be seen as an expression of 'transphobia', creating a paranoid universe. You are either with me or against me, that is no room for a mind that just wants to think about things. The intolerance of doubt and thought that characterises certain kinds of mental state, here leaks out and becomes a force in the social realm.

The term 'transphobia' has, for our psychoanalytic community a particular unfortunate resonance, the homophobia that is a part of our history. I have in mind that dark history of conversion therapies for homosexuals (particularly, though not only, in the USA); I believe the fear of repeating this has interfered with our capacity to think through these issues and led us to turning a blind eye. But it is vital to distinguish between conversion therapy and a wish to think. As I see it the rapid decisions as regards the provision of medical and surgical intervention is *itself* a form of conversion therapy- it brings about transformations in the body converting it in order to satisfy unexamined individual, family and social agendas.

Lastly, the possession of a particular identity is taken as supplying one with a peculiar kind of higher authority. If for example a person says 'as a gay man, or Jewish man, or disabled man, or black woman or whatever…….' It would be reasonable to accept that such a person, because of their specific experiences, will enrich any discussion of that world. But this does *not* bring entitlement to an unquestioned higher authority. That is a by belonging to X or Y group, my views as to what is true of the world, particularly about the group to which I belong, remain as open to question as the views of any other person. This assumed 'higher authority' exhibits a kind of entitlement (that can in part derive from the link between a particular identity and victimhood), an entitlement not to be questioned, that is a demand to be exempt from the ordinary canons as to what counts as good judgement (there can be no personal or group sovereignty as to what counts as true). There is here I believe a link to the attack on truth value that is also a characteristic of our age.

One wonders if the peculiar intransigence of these beliefs, is at times a result of the awareness of doubt, doubt that is disowned and projected into the other, who then must be silenced.

If we take it as a fact that gender identity is socially constructed, then there is a paradox at the heart of the trans phenomenon. The apparent freedom/liberation it expresses is totally undermined by locating all possibility of change only concretely, in material alteration of the body, rather than in the mind.

This has been described by a colleague as a peculiar regression in thinking. In our contemporary world we are generally tolerant, even celebrate, a certain fluidity in expression of gender and sexuality. We are less interested in who a person goes to bed with, less bothered by a man being somewhat camp or a woman being unfeminine. However this exists alongside a toleration of certain limitations arising from the body. In the ideology of the militant trans lobbies- there is a peculiar rigidity of gender identity coupled with a belief in the total fluidity of the body, a most peculiar reversal.

Bea Campbell:

> *The sexual revolution wrought by feminist and gay activism has, of course, changed the political landscape in which trans lives can be lived. It co-exists with the commodification of gender archetypes and the reinstatement of seemingly polarised and parotic masculinities and femininities.*

I will end with a story.

As medical student I attended a lecture by Essence on his electric shock treatment to decondition gay men. In the discussion a young gay philosopher asked if there were not ethical matters that needed consideration. Essence responded that these men were suffering as a result of being homosexual and sought help. We have, he said, the technology to relieve them - there is no further ethical consideration. The questioner suggested a thought experiment. Let us imagine, he said to Prof Essence, that you are an orthopaedic surgeon and that one day a man approaches you complaining 'I cannot bear my arm, it is ugly, I never know what to do with it, my wife also hates it, look its covered in bruises as I always knock it, could you please remove it'. Well, said the questioner, I think you might send him to a psychiatrist to find out what is wrong in the relation between the man and his arm, you would not say – we have the technology to relieve him of his suffering and so proceed to amputation. There was a deafening silence in the room. The point here is, of course, that the homosexual man who seeks treatment of this type is *not* sovereign over decisions as to what afflicts him- for there are individual, family, social determinations (including living in a world where hatred of homosexuality would be a daily experience) that affect him that are beyond his awareness.

However the last time I told that story I was disturbed to learn that in the USA there *are* surgeons who *will* amputate under these conditions; here patient-hood has collapsed completely into customer-ship and so wish transcends any conception of need, externality is annihilated.

It is indeed strange to be living in a world where I receive a referral from a plastic surgeon to my service at the Tavistock, of a man who had asked for surgery on his nose, said surgeon informing the patient that there is nothing wrong with his nose, but with his relationship to it. After a year's psychotherapy the man gave up his wish for surgery having understood the complex identifications that underlay his belief. Meanwhile a person with acute gender dysphoria within only a few consultations may well find agreement to change her name, commence medication, and thus be heading for surgical removal of her breasts and genitals, any questioning foreclosed.

Many years ago if your television seemed not be functioning you would use various controls to reset it. But sometimes a message from the broadcaster appeared 'Do not adjust your set there is a problem with the signal'. A version of this made its way into a popular political slogan of the time 'Do not adjust your set, reality is disturbed'.

However it is much darker than this as I believe that children are being damaged in ways that are irreparable, by treatments for which there is no evidence of safety, and where critical thought is silenced. It is not easy for us analysts to be confronted with this, but I am hoping that today's discussion can mark the start of a critical engagement. There is now much broader debate in the media than would have been possible only a few years ago, so the pendulum may be starting to swing the other way, but there are many beleaguered colleagues who are struggling to maintain thought and ethical responsibility and they would value greatly our support.