‘Trans’ – the emerging current clinical picture in an age of identity politics

by James Caspian UKCP.

I am a psychotherapist registered with the United Kingdom Council for Psychotherapy; a former Trustee of UKCP; a Trustee of the Beaumont Trust, a charity which supports and educates about transsexual, transgendered people and cross dressers; and I have worked for ten years in the UK’s only private gender identity clinic where I have counselled and assessed hundreds of people undergoing, or considering undergoing, medical gender transition. I provide transgender awareness training to the public and private sector, and have also undertaken extensive preliminary research into people who reverse their gender transition.

‘Gender dysphoria’ – unhappiness with one’s gender, is the only condition for which a doctor prescribes or performs surgery for which there is no test, it is diagnosed by a self report from the patient. There is no agreed body of work or theory about the aetiology of transgenderism [1] – it encompasses such a wide variety of presentations that it cannot be explained by any one factor, and it seems that an ever wider variety of people now identify in this way. ABC News reports that there are 58 different gender identities on social media [2]. In the past we worked clinically with a small number of people sufficiently distressed with their gender to seek treatment, by 2015 it was reported that 3,779 people had acquired gender recognition certificates [3]. However in the past few years the gender field has changed with the advent of many new and different gender identities to which it seems young people in particular are drawn. Some of these may be transsexual – that is they feel that while born in the body of one sex they belong to the other and seek medical treatment, hormones and surgery, some are not. There is currently research being done in the US into three different types of gender dysphoria (unhappiness in one’s gender), the newest type being Rapid Onset Gender Dysphoria which is being seen in more teenagers and which it is thought has a connection to internet use and social contagion [4]. In my clinical work the age and profile of the patients changed markedly in the last few years, many more much younger people (around three times as many 17 to 25 year olds between 2010 and 2015) and more natal females were presenting with a wider variety of gender identities. Studies show that patients at gender identity clinics are six times more likely to be on the autistic spectrum than the general population.

I know of cases where patients have regretted their surgery and have then reported the doctor who referred them to the General Medical Council where an investigation then takes place, over many years. I have witnessed first hand the extreme stress undergone by all parties concerned in such cases. I began my own research (currently suspended as the university refused permission for it to continue) into people who reversed their gender re-assignment, after a surgeon colleague told me he had done seven reverse operations [5], although it is not actually possible to reverse the surgery, rather to try to create a cosmetic approximation of the removed genitalia. When I began my preliminary research I was shocked by what I discovered was happening. As in my own practice, there appeared to be greater numbers than previously of teenage girls transitioning to be male, having hormone treatment and some having their breasts removed, and then regretting and reversing their transitions. Many had complex

mental health problems and felt that transition would alleviate them, which for the regretters it did not. Some said they saw their gender dysphoria as a reaction to their own histories of sexual abuse and that they hated their bodies, and also that part of that was because of their experience of attitudes to women within the society in which they live. They may have been gender non-conforming, but they were not transsexual. I am seeing more reports of this nature on a regular basis [6].

In the US, where the affirmation model of treatment is widespread - that is, where a clinic affirms the patient's declared gender identity and there is minimal assessment and exploration of underlying issues carried out – I have heard of cases involving teenagers where hormones are prescribed after one or two half hour appointments, and breast removal within a few months [7] – the feeling is that gender identity is sacrosanct and to question it is discrimination, which is enshrined in policy. The World Professional Association of Transgender Health removed the requirement for counselling prior to treatment from the most recent Standards of Care [8]. Two weeks ago in the UK the Memorandum of Understanding to ban conversion therapy with trans people came in, and whilst no one could dispute the fundamental aim of the Memorandum, it contains within it the guidance that no one gender identity should be favoured over any other, and whilst it says that a practitioner may work with a person uncertain about their gender identity to explore underlying issues, the implication is that if a person is saying that they are certain then one may not question or explore, and that is a move towards the affirmation model of treatment I have described and which is contributing to the greater numbers of people regretting and reversing their gender transition in the United States [9] and [10]. I have been contacted by several therapists who work with young people on the autistic spectrum and who are worried about the implications of the Memorandum for their work.

My research into people who reverse gender re-assignment was vetoed by Bath Spa University [11], and that is redolent of the current climate in which there is an atmosphere of fear and inhibition around discussion of the topic of transgender, so politicised has it become; to the point that a colleague, on discussing the possible influence of the internet on the rising numbers of trans identities, said 'I feel like a heretic' and another said 'I didn't think we were supposed to talk about that'. I have heard other people who work in the gender field express similar fears about speaking publicly about what they were seeing and have observed a growing reluctance amongst clinicians to speak openly about the changes happening in the transgender field, which include the proliferation of many different gender identities, the politicisation of gender, the different types of people who present at gender clinics with a variety of possible motivations. It was in this atmosphere that the Memorandum of Understanding was formed and my advice that it acknowledge recent developments in the field, such as the rising de-transition rate, in order to make it safe and do no harm, was repeatedly ignored. It is very unhealthy if policy is being made in this kind of atmosphere and without proper recourse to an evidence base and a full consideration of the potential unintended consequences. This policy should be re-assessed in light of current developments.

What is going on when experienced clinicians use language like that? They instinctively know that if they say what they observe and what they think that they will be attacked. Perhaps they fear for their jobs. I feel that as the transgender field has become highly politicised and identity

politics – where the politics of oppression and the idea that a person who identifies as a member of an oppressed group cannot be criticised – has become part of the current zeitgeist. In this climate critical thinking has become conflated and confused with criticism; and critical thinking, where we examine something critically, is thus seen as a threat to the political agenda that underlies some (certainly not all) of transgender activist politics. The result is that people are afraid to voice concerns about contemporary developments, such as the rising number of very young people identifying as 'trans' and the growing numbers of de-transitioners.

The transgender field is a highly complex, fast changing, controversial and under-researched field that has become central in the arena of social justice and identity politics. It is the only category within those areas that can involve medical and surgical procedures and where membership of the group is simply by a person's declaration. Please before passing life changing policy and law would honourable members make themselves as informed as possible about the realities and potential unintended consequences of such changes and with a full awareness of the complicated and politicised nature of this field. It has been of grave concern to me for some time that consideration and discussion of the very serious nature of the issues I have described has been effectively minimised and silenced.

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