Freedom to think: the need for thorough assessment in gender dysphoria (presentation to House of Lords 15 May) by Marcus Evans, Psychoanalyst IPA

Dr Bell, a senior consultant in the Tavistock Trust and a Member of the Council of Governors was approached by 10 staff from the GIDs service who all had grave ethical concerns – inadequate assessment, patients pushed through for early medical interventions and an inability to stand up to pressure from lobbies. A letter to the trust board from a concerned group of parents, whose children had been treated by the service, raised similar concerns, claiming that children were being 'fast tracked' to medical interventions. In response to these, complaints the trust asked the medical director to conduct a review. However, this was not the first internal review of the service as twelve years ago GIDs staff had raised serious concerns. In the six months after Dr. Bells report, I witnessed a sometimes subtle, at others not so subtle attempt by Trust management to dismiss or undermine the serious concerns raised in it and the letter from the concerned parents. This included accusations that he had fictionalizing the cases studies, questioning his credentials to undertake a report, withholding his report from governors involved in the new review and preventing him from attending a meeting organized to discuss the Medical director's response to his report.

People in the field often report that patients who undertake medical intervention for Gender Dysphoria have high levels of satisfaction and make a good transition. However, this claim does not tally with emerging or research or suppression of with my own or others experience. I used to assess adult parasuicides admitted to A&E during the late 1980s. A number of patients were admitted having taken an overdose, post Gender Reassignment Surgery. Amongst many things, they were often angry at the loss of their biological sexual functioning. They were aggrieved with psychiatric services, whom they felt had failed to examine their motivations for requesting reassignment surgery or to adequately investigate their psychological difficulties. Also as a psychotherapist, I have consulted to various Adult Mental Health Services over the management of patients with challenging behaviours. There have been examples of patients who had a history of either serious and enduring mental illness or personality disorder, developing a late-onset Gender Identity Dysphoria. A common theme in their presentations was a belief that physical treatments would remove or resolve aspects of themselves that caused them psychic pain. When the medical intervention failed to remove their psychological problems, the disappointment led to an escalation of self-harm and suicidal ideation, as resentment and hatred towards themselves was acted out in relation to their bodies.

As we know, adolescence is a developmental process and all individuals experiment with different identifications, including both male and female ones, as part of this. This can stir up all sorts of confusions, doubts and conflicts. When these forces become overwhelming, they may push the individual to focus on a fixed solution in an attempt to reduce feelings of confusion - one of which might be "I'm that gender, not the one I was born with." The experience of being dislocated from one's changing body is not uncommon in adolescence and touches on anxieties associated with the transition from child to adulthood. It is essential to tolerate these confusions and try to prevent early foreclosure. However, the Gender Dysphoric person and their family often put huge pressure on the clinical service to provide medical interventions that they believe will cure the Dysphoria. In this way a psychological pain is treated as if it were a concrete problem located in the body. Indeed, the Chief Executive of the Tavistock Paul Jenkins made this point in response to a complaint written by a parent by stating that Gender Dysphoria was 'not a psychiatric condition'.

The parent replied by pointing out that Dysphoria is actually a psychiatric term. This idea, that gender dysphoria is nothing to do with a mental disorder is often promoted by pro trans lobbies. This is an important issue because it attempts to deny any psychological disturbance underlying the patients thinking.

The clinician needs considerable experience and clinical maturity to be able to empathise deeply with the individual's confusion, distress and mental pain, yet resist the pressure to join them in their view that active medical (rather than psychological) intervention is the only solution. Whatever decisions are made in the long term regarding physical treatments, again, a thorough psychotherapeutic and psychiatric assessment is an essential part of helping both the vulnerable young people and their clinical teams make informed decisions about treatment and care. This involves a process of opening up a dialogue with the individual about who they really are, and what issues they may be struggling with - crucially, trying to understand what role they believe gender plays in their life and emotions. It is also important to register that although they may eventually decide to transition, they cannot entirely eradicate the biological realities of their natal birth and have to find some way of living with the losses involved. In this way assessment can help the individual think through the social, psychological and biological implications of medical interventions.

The intense pressure from pro trans lobby groups that Dr. Bell mentioned in his report, interferes with the freedom of thought necessary to understand the individual. When this happens, the patient undergoing assessment becomes a symbol for a political group that see themselves as battling against prejudice. In this environment thorough investigation and freedom to think is prohibited by politically driven accusations of transphobia and conversion therapy. This deprives the individual of the space they need, in order to think things through with an experienced and impartial clinician. I have learned that dismissing serious concerns about a service or clinical approach is often driven by a defensive wish to prevent painful examination of an ‘overvalued system’. In contrast to this dismissive attitude, communication between different perspectives is an essential ingredient of a healthy psychological system (as underlined in the Francis report on Staffs). Closing down debate and discussion creates silos that resist thoughtful examination of important issues. This is a particularly worrying approach in the GID unit because it is treating vulnerable individuals and families who are making decisions which may have permanent, far reaching and as yet not fully known consequences for their lives. We do not completely understand what is going on in this complex area and it is essential to examine it from different points of view. This is difficult in the current environment as the debate and discussion required is continually being muted, often described as ‘offensive’, ‘hate speech’ or ‘transphobic’! This accusation serves a purpose of shutting down thoughtful enquiry and examination, something that absolutely needs to be secured, so that we can protect children from being harmed.