



# Current Evidence in the Treatment of Gender Dysphoric Children and Young People

Since 2011 there has been an exponential rise in the numbers of children and young people with gender problems.<sup>1</sup> At the Tavistock Gender Identity Development Service (GIDS), the only NHS clinic for gender non-conforming children and young people in the UK, referrals have risen from 72 in 2009-10 to 2,590 in 2018-19.<sup>2</sup>

Whilst some professionals attribute this rise to increasingly liberal social attitudes, clinics are seeing young people who are intensely distressed and who demand medical intervention. At the same time, there is little research and no consensus on the causes of this phenomenon. A recent paper by GIDS staff says that the 'reasons are not fully explicable' and speculates that the marked rise in young women who want to be men may reflect the view that 'male status' is 'still regarded as preferable'.<sup>3</sup>

We are concerned that a changed social climate may encourage vulnerable adolescents to ascribe mental health problems to a transgender identity. We know that around 35% of referrals for gender dysphoria are of young people with 'moderate to severe autistic traits'.<sup>4</sup> Over 70% are adolescent girls. Emerging evidence suggests that girls may be particularly vulnerable to mental health problems associated with heavy social media use.<sup>5</sup>

We are grateful that clinicians and scientists are now joining us in speaking out about the danger of premature medical intervention for young people with gender dysphoria. A 2019 letter to the Archives of Disease in Childhood describes these treatments as 'a momentous step in the dark':

*'Butler provides evidence that intervention with a gonadotrophin-releasing hormone analogue (GnRHa) promotes a continued desire to identify with the non-birth sex — over 90% of young people attending endocrinology clinics for puberty-blocking intervention proceed to cross sex hormone therapy. In contrast, 73%–88% of*

*prepubertal GD clinic attenders, who receive no intervention, eventually lose their desire to identify with the non-birth sex. Our concern is that the use of puberty blockers may prevent some young people with GD from finally becoming comfortable with the birth sex'.<sup>6</sup>*

Commissioned to review the evidence base for these interventions in 2019, Professor Carl Heneghan, director of the Oxford University Centre for Evidence Based Medicine, concluded that they are 'an unregulated live experiment on children':

*'The development of these interventions should, therefore, occur in the context of research, and treatments for under 18 gender dysphoric children and adolescents remain largely experimental. There are a large number of unanswered questions that include the age at start, reversibility; adverse events, long term effects on mental health, quality of life, bone mineral density, osteoporosis in later life and cognition. We wonder whether off label use is appropriate and justified for drugs such as spironolactone which can cause substantial harms and even death. We are also ignorant of the long-term safety profiles of the different GAH regimens. The current evidence base does not support informed decision making and safe practice in children'.<sup>7</sup>*

Over the last two years a number of clinicians have resigned from the Tavistock Gender Identity Development Service on grounds of conscience. Five shared their concerns with the Sunday Times.<sup>8</sup> Their testimony suggests that pre-existing mental health problems in young people with gender problems may be overlooked and left untreated. They revealed that GIDS did not sufficiently explore whether children with gender dysphoria might grow up to be gay. Worryingly, a number of children adopted a transgender identity after homophobic bullying.

All five clinicians believed that too little information was provided about the effects of hormone treatments on fertility and sexual function in adulthood. They expressed fears that many of those treated will de-transition and feel anger and regret at their mutilated bodies. They talk of 'experimental treatment being done not only on children, but on very vulnerable children.' Their testimony corroborates evidence communicated earlier by whistle-blowers at Tavistock GIDS to senior Tavistock clinician Dr David Bell.<sup>9</sup> The report commissioned by the Tavistock medical director Dr Sinha in response to the Bell report confirmed many of the issues reported by whistle-blowers and made twenty-six recommendations.<sup>10</sup> Despite these recommendations, Tavistock governor Marcus Evans resigned at what he saw as a failure to address 'serious concerns'.<sup>11</sup>

This sequence of events should alarm anyone concerned for the health and well-being of a vulnerable population. We believe that the debate is disproportionately dominated by political campaigning groups which promote transition as a cure for all forms of gender non-conformity. Most worryingly one of the former clinicians claims that the charity Mermaids is able to ‘call up executive members (of GIDS) and influence them’.

The experimental ‘affirmation’ approach advocated by these groups fails to take into account the fluid and changing nature of immature and developing identities, together with the susceptibility of children and young people to suggestion and influence from online sources as well as the peer group and trusted adults in positions of authority. The established global model of care for children with gender dysphoria is a ‘watch and wait’ approach which does not steer a child towards any pre-determined outcome, but recognises developmental change as an intrinsic part of childhood and adolescence.

The Position Statement from the Royal College of General Practitioners (June 2019) acknowledges the lack of research into different approaches in the clinical management of gender dysphoria in youth:

*‘The promotion and funding of independent research into the effects of various forms of interventions (including ‘wait and see’ policies) for gender dysphoria is urgently needed, to ensure there is a robust evidence base which GPs and other healthcare professionals can rely upon when advising patients and their families. There are currently significant gaps in evidence for nearly all aspects of clinical management of gender dysphoria in youth. Urgent investment in research on the impacts of treatments for children and young people is needed’.*<sup>12</sup>

In their written submission to the government’s Health and Social Care for the LGBT Community consultation, a group of GPs, paediatricians and psychiatrists highlighted the need to differentiate between the ‘T’ and the ‘LGB’ in the treatment of children and young people, given that in the case of transgender identities ‘the issues are complex, the stakes high and the evidence very weak’:

*‘It is important to acknowledge that gender questioning and feeling trans are influenced by a complex mix of cultural norms and personal predispositions (related e.g. to trauma and autism traits). This means parents, teachers, social workers etc must be careful to be both kind and neutral – ‘affirming a child as a child’ is not the same as ‘affirming’ another gender or actively discouraging children to believe they are not trans. ‘Wondering’ about identity and experimenting with roles is a normal*

*part of growing up and most children desist from seeing themselves as trans with the passage of time and development'.<sup>13</sup>*

The model of affirmation and social transition, which reinforces a child's sense of themselves and their perception of reality, runs the risk of creating a self-fulfilling prophecy of persistence of gender dysphoria. A child's brain is impacted by life experience and environmental factors: living, and being affirmed daily as the opposite sex will affect and change neural pathways. Historically, around 80% of children with early-onset gender dysphoria desisted naturally from these feelings during adolescence<sup>14</sup> but there is increasing evidence that social transition followed by puberty blockers may prevent this natural resolution of gender dysphoria in the adolescent years.

In a letter to the British Medical Journal, a group of doctors and professors warned:

*'It is long-accepted that conversion therapy for homosexuality is ineffective, damaging and unethical. The Royal College of Psychiatrists has explicitly supported a ban. As working with people with gender dysphoria requires a different model of understanding, it remains legitimate to listen, assess, explore, wait, watch development, offer skilled support, deal with co-morbidities and prior traumas, and consider use of a variety of models of care. While respecting individuals' right to a different viewpoint, it is neither mandatory to affirm their beliefs nor automatic that transition is the goal, particularly when dealing with children, adolescents and young adults. These risk closing the 'open future', as well as life-long physical problems including lack of sexual function, infertility and medical dependency. With 85% desistance amongst referred transgender children and increasing awareness of detransitioning unquestioning 'affirmation' as a pathway that leads gender dysphoric patients to irreversible interventions cannot be considered sole or best practice'.<sup>15</sup>*

The findings of a 2013 research study by Dr Thomas Steensma from the Netherlands indicated that social transition is the most powerful predictor of persistence of childhood gender dysphoria.<sup>16</sup> There is now strong evidence that puberty blockers also increase persistence, as reported at the 2016 WPATH conference presentation by Tavistock GIDS staff:

*'Persistence was strongly correlated with the commencement of physical interventions such as the hypothalamic blocker ( $t=.395$ ,  $p=.007$ ) and no patient within the sample desisted after having started on the hypothalamic blocker. 90.3% of young people who did not commence the blocker desisted'.<sup>17</sup>*

A paper by De Vries (2012) warns of the danger that a young child who is unduly affirmed may not really understand the concept of natal sex:

*'Another reason we recommend against early transitions is that some children who have done so (sometimes as preschoolers) barely realize that they are of the other natal sex. They develop a sense of reality so different from their physical reality that acceptance of the multiple and protracted treatments they will later need is made unnecessarily difficult. Parents, too, who go along with this, often do not realize that they contribute to their child's lack of awareness of these consequences'.<sup>18</sup>*

Tavistock GIDS Consultant clinical psychologist Bernadette Wren also expressed the need for caution in her paper for the Journal of Clinical Child Psychology and Psychiatry (2019):

*'It is my belief that we need to make creative opportunities for the open, accepting exploration of the gender experience and gender expression of these younger children; my fear is that to proceed to a full emphatic social transition may hamper their development'.<sup>19</sup>*

The idea that blockers are safe and fully reversible has been called into question. Recent evidence shows continuing effects on brain function after puberty blockade is stopped. Early results from ongoing studies on sheep indicate that long-term spatial memory performance remains impaired after blockers are discontinued:

*'This result suggests that the time at which puberty normally occurs may represent a critical period of hippocampal plasticity. Perturbing normal hippocampal formation in this peripubertal period may also have long lasting effects on other brain areas and aspects of cognitive function'.<sup>20</sup>*

The exponential rise in the number of adolescents, predominantly girls, who adopt a transgender identity after puberty is not yet understood. In a first exploratory study of parental reports by Dr Lisa Littman of Brown University, natal females made up 82% of cases.

Parents reported that 41% had expressed a non-heterosexual sexual orientation before identifying as transgender and 62.5% had been diagnosed with at least one mental health disorder or neurodevelopmental disability prior to the onset of their gender dysphoria. 47.2% of parents reported subjective declines in their son's or daughter's mental health and in parent-child relationships (57.3%) after 'coming out' as transgender. 86.7% of the parents reported that, along with the

sudden onset of gender dysphoria, ‘their child either had an increase in their social media/internet use, belonged to a friend group in which one or multiple friends became transgender-identified during a similar timeframe, or both.’<sup>21</sup>

The results of a detransition and reidentification survey of 203 females (2016) suggest that medical transition is not a cure for underlying trauma or mental health issues. 65% of respondents received no counselling at all before transitioning and only 6% felt they had received adequate counselling.<sup>22</sup> In Sweden, the Medical Ethics Council (SMER) is calling for caution in the medical treatment of gender dysphoria in young people.<sup>23</sup> The Swedish Paediatric Society writes that:

*‘Giving children the right to independently make life-changing decisions at an age when they cannot be expected to understand the consequences of those decisions, lacks scientific evidence and is contrary to established medical practice’.*<sup>24</sup>

We believe that the care of gender dysphoric children must be based on robust medical evidence which can withstand scientific scrutiny. As yet this quality of evidence is lacking in the treatment of children and young people. There is no evidence to support the use of the affirmation and social transition approach in schools; conversely, emerging evidence suggests that we may be encouraging children towards irreversible medical interventions they may later regret.

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