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A discussion

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Why are so many schoolchildren coming out as trans?

By Toby Young

Last November, a school in Brighton called Dorothy Stringer made the news when it was revealed that 76 of its pupils are either transgender or gender-non-conforming (TGNC).[1] This isn't as unusual as you might think. At another school, which also hit the headlines last year, 17 pupils are in the process of changing gender, and many schools now have policies in place to support pupils who identify as TGNC, including more than 80 with 'gender neutral' uniforms.[2] Referrals to the Tavistock, Britain's only NHS clinic specializing in children and young people who are TGNC, jumped from 697 in 2014-15 to 2,016 in 2016-17, an increase of 289 per cent.[3]

In some cases, these patients will be prescribed 'puberty blockers', drugs that delay the onset of puberty, or, if they're over 16, be offered hormone therapy so they develop the secondary sexual characteristics associated with the gender they identify with – breasts for those transitioning to female and facial hair for those

transitioning to male. Older patients may even be given the option of gender reassignment surgery provided their psychotherapist is satisfied they are genuinely suffering from 'Gender Dysphoria' (see below).

Should we be alarmed by this trend? And make no mistake, it is a growing phenomenon. The *Sunday Times* reported in January that a record number of children are applying to change their gender by deed poll – seven to 10 a week.[4] Before answering that question, some definitions might be useful, although it's hard to be precise because the 'correct' words to use when discussing this subject are constantly changing. Until 2013, Gender Dysphoria was referred to in the *Diagnostic and Statistical Manual of Mental Disorders (DSM*), the psychiatrist's Bible, as 'Gender Identity Disorder'.[5] But it was renamed because of the stigma attached to the word *disorder* and it is now taboo for mental health professionals to think of it as a mental illness. (Last year, the World Health Organisation stopped classifying transgender people as mentally ill.)[6] Nonetheless, the condition, if that's not too inflammatory a word, is still classified as a form of mental illness in the *DSM*, albeit one that is defined a bit more carefully. A person who is gender dysphoric is someone whose gender identity – that is, the gender they intrinsically *feel* themselves to be – is at odds with their biological sex, usually referred to as 'natal sex' or 'sex assigned at birth' because the word *biological* is also controversial. This is sometimes expressed as the feeling that they were born in the wrong body. People

who identify as 'transgender' generally fall into one of two categories – trans male (chromosomal female, but identify as male) or trans female (vice versa). Those who present as 'gender-non-conforming', by contrast, can fall into one or more of over a dozen categories, including 'non-binary', 'gender fluid', 'bigender', 'genderqueer', 'demi-boy', 'demi-girl', and so on. At Dorothy Stringer School, a comprehensive for 11-16 year-olds, 40 of the children identify as transgender and 36 as gender-non-conforming.

So should we be concerned about the growing number of young people presenting as TGNC, particularly as some of them are opting for medical treatment? For lobby groups like Mermaids, a transgender charity that was recently awarded £500,000 by the Big Lottery Fund, the answer is emphatically 'no'.[7] According to trans activists, the rise in the number of young people identifying as TGNC and seeking help at places like the Tavistock is entirely attributable to the decrease in the social stigma attached to the condition and, as such, should be celebrated. They are adamant that the underlying rate of TGNC people in the general population hasn't changed. Rather, as the taboo attached to expressing feelings of Gender Dysphoria has faded, those who would otherwise have suffered in silence have found the courage to 'come out' – and the parallels between trans youth and teenagers who identify as lesbian, gay or bisexual don't end there.

A common mistake made by those who are new to this discussion is to assume that trans people are also

homosexual, but that isn't true – at least, not exactly. While only a minority of adolescents diagnosed with Gender Dysphoria identify as 'straight', it isn't always clear what they mean by that. For instance, if a teenager who was born with two X chromosomes but now identifies as male says they are attracted to men, does that make them gay? If they're attracted to women, by contrast, does that make them straight? Most trans adolescents would say 'yes' to both questions, but for some it can be difficult to disentangle gender identity from sexual orientation and they might opt for the catch-all term 'queer' to cover all bases. One psychological theory about Gender Dysphoria is that it is a way for teens who don't want to think of themselves as gay to rationalise their attraction to people of the same sex. Whether consciously or not, the theory goes, it is easier to think they are born in the wrong body than to admit to themselves or others that they are homosexual. That hypothesis has now fallen out of fashion[8] – although some experts still stand by it and it might help explain why more sex change operations are carried out in Iran, where homosexuality is punishable by death, than any other country apart from Thailand.[9]

Mermaids is a cheerleader for what is known as 'affirmative care', whereby any claim by a child or adolescent to be gender dysphoric should be taken at face value, and if they express a desire to transition they should be unquestioningly supported. Mental health professionals who recommend a more cautious approach, exploring whether a young person might

be feeling this way because of other, extraneous factors before committing to a diagnosis of Gender Dysphoria, are looked on with intense suspicion by activists. They're often compared to religious bigots who think homosexuality can be 'cured' by conversion therapy. Indeed, anything less than an enthusiastic rubber-stamping of a child's self-diagnosis is generally frowned upon and can lead to accusations of 'transphobia' or attempting to 'erase' the identity of the young person in question.

This same approach – affirming the way a child feels about their gender rather than questioning it – is recommended in the school 'Toolkit' co-authored by the Allsorts Youth Project, another charity in receipt of lottery funding, and adopted as official policy by Brighton and Hove City Council.[10] It is clear from the public statements made by the headteacher of Dorothy Stringer, which repeat this advice verbatim, that he and his staff have been following the guidance.[11]

The Toolkit encourages teachers to be open-minded and non-judgmental when faced with a child who claims to be TGNC. But not 'open-minded' in the sense of entertaining the possibility that the child could be mistaken. On that score, the advice is pretty dogmatic: 'The important thing is to validate the young person's identity as it is now, and support any changes that may arise as they come to explore their gender identity further.'

As part of this overall strategy, the guidance urges schools to embed 'trans inclusive practice' in their

teaching materials: 'The curriculum should be used to explore and raise awareness of issues of assigned sex, gender identity, sexual orientation and transphobia and to make visible and celebrate lesbian, gay, bisexual and trans people. Work to challenge sexism and champion gender equality will benefit all pupils and students, including those who are trans.'

On the vexed question of whether someone who identifies as trans should be allowed into male- or female-only spaces, such as girls' changing rooms, the guidance is also pretty unequivocal: 'In most cases, trans pupils or students should have access to the changing room that corresponds to their gender identity.' If a teenage girl or her parents objects to an adolescent natal male who identifies as female using the girls' changing rooms, the 'appropriate response', according to the guidance, is to offer 'alternative changing arrangements for the child who feels uncomfortable around the trans person'. Ditto if a girl or her parents complain that it's unfair that she should have to compete against a natal male on sports day. The child in question should be 'supported to do a different activity'.

Charities like Mermaids and the Allsorts Youth Project are not shy about invoking the 2010 Equality Act to underscore this approach. The Act identifies 'gender reassignment' as a *protected* characteristic, meaning it's unlawful to discriminate against someone because they have that characteristic. According to Brighton and Hove's official guidance, a trans person doesn't

need to have done anything other than announce that they want to start transitioning to qualify for this protection. Gender reassignment, it says, is defined in the Act as applying to anyone who is undergoing, has undergone, or *is proposing to undergo*, a process of reassigning their sex by changing physiological or other attributes. 'This definition means that in order to be protected under the Act, a pupil will not necessarily have to be undertaking a medical procedure to change their sex,' it says. 'Pupils who are undergoing a social transition, for example, going by a preferred name or pronoun are protected by the Equality Act.'

The police and courts seem to share this interpretation of the law. Last year, a teacher accused of 'misgendering' a trans child, i.e. refusing to use their preferred gender pronoun, was told by the police that she had committed a hate crime, a verdict confirmed by the Crown Prosecution Service.[12] In another case, a teacher was dismissed for saying 'well done, girls' to a group of natal females that included a trans student who identified as male. However, it's worth noting that the Equality and Human Rights Commission's (EHRC) interpretation of the Equality Act on some of the above points isn't as hard line as Brighton and Hove's. For instance, it says that schools are only required to provide 'appropriate changing facilities' to trans pupils, not to let them use the changing rooms of their preferred gender. So letting them use the staff changing room would be fine. Similarly, the EHRC says it is not always unlawful to restrict

participation in sporting competitions to children of a particular natal sex: 'Section 195 of the EA 2010 makes it lawful to restrict participation of transsexual people in competitions where physical strength, stamina or physique are major factors in determining success or failure, if this is necessary to uphold fair competition.'

The other big lever used by trans activists to encourage schools and parents to 'validate' and 'affirm' children presenting as transgender or gender-non-conforming, rather than question their self-diagnosis, is to flag up their high risk of suicide. Sceptical parents reluctant to approve risky and potentially irreversible medical procedures are often told 'Better a live son than a dead daughter' (or vice versa) and the Brighton and Hove Toolkit claims 25% of transgender students have attempted suicide and a further 25% have considered it.

Is that true? While surveys do suggest the suicide rate for trans adolescents is well above average, exact figures are hard to pin down because nearly all the research evidence is contested. Susie Green, the CEO of Mermaids and herself the mother of a trans child, claims that attendees at the Tavistock have a '48% suicide attempt risk'.[13] According to the clinic, the true rate is less than 1%. When an NHS psychiatrist accused her on Twitter of 'making stuff up', Green wrote: 'You need to f*** off. You know nothing.''

So that's the case for the defence. The growing number of young people presenting as TGNC should be welcomed because it reflects our society's more

enlightened, better informed attitude towards gender identity. There's still some way to go, but as the stigma has lifted, so it has become easier for children suffering from Gender Dysphoria and related conditions to get the help they need. Nearly all the websites of the trans lobby groups include video testimonials from confident, attractive teenagers who've successfully transitioned and are now leading happy, fulfilling lives, often with their own YouTube channels where they proselytise about the benefits of 'T juice' (testosterone injections) and 'top surgery' (a double mastectomy).[14] The favoured metaphor is of a chrysalis becoming a butterfly – indeed, *Butterfly* was the name of a recent three-part ITV drama about an 11-year-old natal male transitioning to female that received Mermaids' seal of approval. And it's not just the ITV drama department that echoes the views of the trans lobby. It has been so successful that its militantly affirmative approach – *if you say you're trans, then you're trans, period* – is rapidly becoming the official view, endorsed by the NHS, local authorities, the Department for Education and MPs from across the political spectrum, including Conservatives.[15] Indeed, this seems to be the thinking behind reforming the 2004 Gender Recognition Act, which will almost certainly result in it becoming easier for people to legally change their gender.[16] That's an initiative of the present Conservative Government and few Tory MPs are willing to publicly dissent, partly because they've bought in to the idea that being trans is like being gay – some even think it's the same thing.

They are haunted by the ghost of Section 28 and don't want to appear bigoted or behind the times.

What about the alternative position – that the number of children identifying as TGNC is something we *should* be alarmed about? Those who take this view aren't necessarily opposed to transgender rights. Some are, obviously, but it would be a mistake to dismiss all the critics of the current direction of policy as Bufton Tufton types who think men are men and women are women and there's an end to it. Many believe that children with genuine cases of Gender Dysphoria should be supported and, in some cases, given the help they need to start transitioning. But they worry that it's become fashionable for teens to identify as TGNC, particularly in trendy, metropolitan areas, and a policy of 'affirmative care' – unquestioningly accepting a trans child's self-diagnosis – is prompting some adolescents to seek life-changing medical treatment that they will later come to regret.

The starting point for these critics is usually a large dose of scepticism about whether teenagers identifying as TGNC really are as dysphoric or uncertain of their gender as they claim to be. There is no consensus among psychiatrists as to what the true underlying rate of Gender Dysphoria is in the general population, but few would put it as high as it appears to be at Dorothy Stringer School. In the US, the Williams Institute estimated in 2016 that 1.4 million Americans were transgender, double the number a decade earlier, but still only 0.6 per cent of the population.[17] (That rises to

0.66 per cent for 18-24 year-olds.) Even if we discount the 36 pupils at Dorothy Stringer who identify as gender non-conforming, that still leaves 40 out of 1,653 children claiming to be transgender, which is 2.5 per cent. According to the sceptics, that's abnormally high.

So what could be prompting these young people to come forward? One of the chief witnesses for the prosecution, albeit a reluctant one, is Lisa Littman, an American physician and researcher at the School of Public Health at Brown University. Last August, she published a paper in a peer-reviewed academic journal in which she discussed 'Rapid-Onset Gender Dysphoria' (ROGD), a proposed form of dysphoria that is less *authentic* than typical Gender Dysphoria.[18] For one thing, ROGD only manifests itself during adolescence or early adulthood and not during pre-pubescence, suggesting it's less hard-wired than the standard condition. For another, it comes on very quickly – in some cases overnight – and the young person in question is often a member of a peer group in which one or more people have 'come out' as TGNC.

Littman, who surveyed the parents of 256 gender dysphoric young people, suggested several reasons why their children's claims should be taken with a pinch of salt. For instance, 62.5% of them had one or more diagnoses of a psychiatric disorder or neurodevelopmental disability prior to the onset of Gender Dysphoria and many had experienced a traumatic or stressful event just beforehand. In addition, 21.5% belonged to a friendship group in which one or

more person had identified as transgender at the same time as them, 19.9% had exhibited a recent increase in their social media/internet use and nearly half ticked both those boxes. This suggests that 'social contagion' could be a factor in the spread of ROGD, in much the same way it is in the spread of eating disorders like anorexia. Littman noted that 82.8% of the children of the parents in her survey were natal females and the Tavistock reports a similar skew among its patients in the last few years.

What are we to make of that imbalance? Littman cites it as a reason to doubt that the surging diagnoses are entirely due to the lifting of the taboo. 'Although a decrease in stigma for transgender individuals might explain some of the rise in the numbers of adolescents presenting for care, it would not directly explain the inversion of the sex ratio,' she wrote.

Other sceptics have made similar points. Jane Galloway, a parent and women's rights campaigner, questions whether the growing number of children identifying as TGNC can be explained by more enlightened attitudes alone. 'If that's the case, where are the adults, the middle-aged people seeking transition?' she told the *Sunday Times*.[19]

An alternative explanation suggested by the parents in Littman's survey – apart from 'social contagion' – is that claiming to be transgender is a way for otherwise fortunate teens to claim the mantle of victimhood. Nearly all the parents in Littman's sample were white and college-educated and most were well-off. Among

their children, straight white people – particularly those who are 'cisgender', which means someone who's gender identity matches their natal sex – have become demonised as complicit in 'systematic oppression'. Being trans, by contrast, is cool and *au courant* and enables them to enhance their status by mocking 'privileged' classmates.

'They passionately decry 'Straight Privilege' and 'White Male Privilege'—while emphasizing their own 'Victimhood',' said one parent.

'To be heterosexual, comfortable with the gender you were assigned at birth, and non-minority places you in the 'most evil' of categories with this group of friends,' said another. 'Statement of opinions by the evil cisgendered population are consider phobic and discriminatory and are generally discounted as unenlightened.'

Bradley Campbell, a sociologist at California State University and the co-author with Jason Manning of *The Rise of Victimhood Culture* (2018) says that claiming to be oppressed in order to boost your moral status is commonplace among American college students.

'In doing so, activists and others can create a kind of reverse hierarchy where those perceived as victimizers are denigrated and stigmatized while those perceived as victims receive aid and admiration,' he says. 'This happens in a 'victimhood culture', and it's very different from what you see in the 'honour cultures' of the past, where strength and the ability to use violence were sources of moral status. It's clear victimhood culture has

spread beyond universities, and even large corporations have adopted much of the oppression framework in employee training. It seems likely, then, that it's begun to alter the moral life of adolescents as well.'

Theories such as these are vigorously disputed by trans activists, who succeeded in persuading Brown University to stop publicising Littman's research.[20] They question whether ROGD is a real thing, rather than a diagnosis invented by parents trying to persuade their children that they're not really suffering from gender dysphoria, and point out that the costs of being transgender far outweigh any superficial gains, such as an increase in status among one's peers. Why would anyone *volunteer* to become a member of such an oppressed group? It makes no sense to them. On the contrary, it's grossly insensitive since it ignores the discrimination trans people suffer at the hands of the straight, white, cisgendered population.

Critics of Littman's research point out that two thirds (67.2%) of the parents in her survey had been told by their children that they wanted to take cross-sex hormones, while more than half said they wanted surgery. Surely, it's implausible to think that any adolescent would embark on the process of medically transitioning, up to and including painful operations on their genitals, just because they're swept up in a teenage fad?

For sceptics, however, the seriousness of these medical procedures is all the more reason to proceed with caution. Puberty blockers can affect bone density and, according to the NHS guidance, some of the

side effects of hormone therapy are blood clots, gallstones, weight gain, acne, hair loss, sleep apnoea and, eventually, infertility. Beyond this, the long-term effects of taking massive doses of testosterone during adolescence – a standard treatment for natal females who identify as male – are unknown.

A natal female who has a double mastectomy cannot reverse the procedure, while a natal male who takes estrogen in order to grow breasts will have them for the rest of their life. Both a 'phalloplasty' – the creation of a penis for a natal female – and a 'vaginoplasty' – the opposite procedure for a natal male – are hard to reverse for obvious reasons.

None of that would matter so much if the patients never had second thoughts about their gender identity, but some do. They are known as 'de-transitioners' and are becoming an increasingly vocal lobby in the U.S. The American journalist Jesse Singal interviewed several of them for a cover story in *The Atlantic* last year and was promptly rounded on by trans activists who accused him of exaggerating the scale of the problem.[21]

What is harder to dispute is that the vast majority of minors who identify as trans do, eventually, change their minds. (The technical term for these children is 'desisters'.) According to the latest edition of the *DSM*, 70 to 98% of gender dysphoric boys and 50 to 88% of gender dysphoric girls come to accept their chromosomal sex over time. Partly for this reason, the American Psychological Association cautions against immediately embracing a trans child's self-diagnosis,

even early on, when no medical interventions are on the table, since doing so 'runs the risk of neglecting individual problems the child might be experiencing and may involve an early gender role transition that might be challenging to reverse if cross-gender feelings do not persist'.

I've tried to be even-handed in this article, but as you can probably tell I lean towards the sceptics. There are some thoughtful clinicians who, while endorsing the 'affirmative care' approach in principle, believe it's possible to be supportive of adolescents who present as trans without rubber-stamping their self-diagnosis. Jesse Singal encountered some of these in the course of reporting his piece for *The Atlantic*. 'I would say 'affirming' isn't always doing exactly what the kid says they want in the moment,' one told him. Another said: 'Our role as clinicians isn't to confirm or disconfirm someone's gender identity – it's to help them explore it with a little bit more nuance.'

After surveying all the evidence, it's hard not to agree with Jane Galloway, the parent activist who told the *Sunday Times* that the militantly affirmative approach borders on recklessness.

'People are embarking on medical transitions they may not need or want in the end,' she said. 'I fear greatly that in 10 to 15 years' time, we will find ourselves with a slew of young adults with mutilated bodies, no sexual function, who will turn round to the NHS and ask, "Why did you let us do this?"'

* * * *

I have little doubt that some children identifying as TGNC have a genuine case of Gender Dysphoria and will lead happier, more fulfilling lives if they transition. The tricky thing is that word 'genuine'. How can you tell? The DSM sets out various diagnostic criteria, but what if an adolescent failing that test insists they are dysphoric nevertheless? It's one thing to dispute a child's self-diagnosis of a physiological condition, but telling them they're dysphoric feelings are 'all in the head' doesn't really cut the mustard. After all, isn't *the head* where gender identity is supposed to sit?

One way out of this conundrum may be provided by neuroscience. Various teams of brain researchers have done MRI scans of trans people and found that, when it comes to specific areas of the brain, they have more in common with cisgender people of the opposite sex than with people of the same sex.[22] That suggests there may be a neurobiological basis for our gender identity and it could be at odds with our natal sex.

It's important to stress that the evidence for this is fairly limited to date, partly because there just aren't that many transgender people around to study – not until recently, anyway – and partly because MRI scans are expensive to do and research funding is scarce.

Dr Qazi Rahman of King's College London thinks it's a plausible hypothesis. His area of expertise is the neurobiology of sexual orientation and he says it might be that gender identity is 'innate' in the same way that being straight or gay is, something for which there's a good deal of research evidence.

'Could people be born with gendered brains that are at odds with their natal sex?' he says. 'Yes, they could. The brain systems involved in gender identity might be the same as those involved in self-recognition and recognizing others and it's possible that those systems could get swapped around in transgender people.'

However, he says it's too soon to draw any conclusions. Some MRI scans show that transgender people have more in common with the brains of cisgender people of the opposite sex than the same sex, but some don't. The picture is complicated if you factor in sexual orientation – and that's assuming you can sort out how to classify transgender people as 'gay' or 'straight'. Finally, gender identity may be less fixed in children than it is in adults and that could influence the findings of brain imaging studies. 'There isn't really a compelling signal in the noise at the moment,' he says.

I quite like this hypothesis because it contradicts the post-modern shibboleth that gender is a 'social construct'. Indeed, this is one of the main reasons for the schism between trans activists and 'gender critical' feminists. If gender is rooted in biology, as some in the trans community maintain, that suggests the broad differences between males and females – differences that persist across societies, across time and even across some species – are less easily eradicated than most feminists would like. That's not an argument for eroding women's rights, obviously, but it means the emphasis on achieving gender parity at every level in every profession could be wrong-headed. Perhaps,

at a population level, men and women have different interests and should be allowed to pursue them without being chastised by 'social justice' advocates. The idea that these gender differences might float free of chromosomal sex, at least for a fraction of the population, is a novel one and I'm still not sure what to make of it. But if the evidence for this hypothesis becomes overwhelming, we will have to accept it. (One reason to think it might be true is that some children identify as transgender from a very young age, almost as soon as they start talking.) It could also provide us with a useful diagnostic tool for deciding whether a person really is gender dysphoric. Not with a view to denying adults with 'normal' brains the right to transition, but to accurately diagnosing minors presenting as transgender before discussing treatment options.

In the meantime, schools should avoid parroting every word of the pro-trans lobby. I think it's sensible for them to have a transgender policy, but it shouldn't be bundled together with their policy on lesbian, gay and bisexual children – we need to separate the 'T' from 'LGBT'. Affirming and validating the self-diagnoses of children who identify as one of the first three makes sense, not least because there's no attendant risk of them going on to make irreversible, life-changing decisions. A teenager can decide she's bisexual one minute, a lesbian the next, and straight a year later. If she changes her mind, there's no harm done. But if a natal female decides they're transgender and then injects massive doses of testosterone and has

'top surgery', only to then have a change of heart, that would be tragic.

A majority of teens presenting as TGNC don't go on to have these procedures and schools probably shouldn't fret about the growing number of children who want to experiment with different gender labels. The risk of treating them all with the same furrowed-browed intensity, nodding along gravely when they say they're 'non-binary' or 'tri-gender' and handing them leaflets about transitioning, is that they'll take what may be a temporary phase more seriously than they should. We owe it to adolescents at risk of making medical mistakes to urge caution and not just unthinkingly applaud their 'honesty' and pack them off to private clinics. Schools need to find the courage to stand up to the trans activists and not let them dictate best practice in this area. Teachers would be better off trusting to their common sense.

This essay was published first in the February 2019 edition of Standpoint.

Is 'affirmation' an appropriate approach to childhood gender dysphoria?

By Stephanie Davies-Arai

The 'gender affirmative' model, or 'affirmation,' is an experimental approach towards children and young people with gender dysphoria. It is not a model which has been informed and developed through clinical research and evidence but one which has been promoted by transgender lobby groups and activists. 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 current evidence base shows that around 80% of children will outgrow their gender dysphoria during adolescence and that the most likely outcome in adulthood is gay or lesbian sexual orientation. 'Watchful waiting' does not necessarily mean 'do nothing' but recognises the variables in the incidence of cross-sex identification in childhood, which could be anything from a common developmental variant to,

at the other extreme, a response to past sexual abuse or trauma. Every child's circumstances are different and the approach reflects this.

Nevertheless, charities such as Mermaids advocate 'affirmation' as the only compassionate response to every child who believes themselves to be the opposite sex, framing this as 'acceptance of who a child really is.' As the child knows best who they are, to refuse to accept them surely would be cruel?

The reality is not so simple: it is not a child's 'identity' we affirm when we agree with a young boy that he is really a girl, but his (mis)perception of his sex. Proponents of 'affirmation' are not being intentionally dishonest to the child, but true to their belief that a 'girl' is not a young human female but a personality type, a person of either sex who 'identifies' as female.

A child cannot distinguish between personally-held beliefs and facts, nor does the child know that this is a minority belief which involves the denial of biological reality. To the child, the adult knows everything; the child's developing understanding of reality and interpretation of the world depends on the information imparted to them by adults.

A child under the age of about nine will believe that putting a dress on a boy doll changes the doll into a girl. In early childhood, before the understanding of biological sex has developed, children are informed by gender stereotypes – girls love pink and ballet, boys love football and fighting – and these stereotypes are fed to children in direct and indirect ways from the moment

they are born. To the boy who loves wearing princess costumes 'I am a girl' is the explanation which makes the most sense at this developmental stage of childhood. 'Affirmation' reinforces these stereotypes as true.

It is beyond children's cognitive abilities to understand the biological impossibility of a male child growing up to become an adult woman or a female child growing up to become an adult man, that a 'girl' is not *who* you are, but *what* you are and that no amount of medical innovation can change the biological reality.

As the child does not yet understand that 'boy' and 'girl' are stable categories which do not change depending on clothes and hairstyles, a child is vulnerable to misinformation. Put simply, you can tell a child anything and they will believe it.

When children are very young, before puberty, they are still on a developmental pathway of learning to distinguish between fact and fantasy. The Tavistock Gender Identity Development Service (GIDS) states this on their website:

> 'Children go through various stages of 'magical thinking,' during which they can get confused between reality versus fantasy, until at least middle childhood, and sometimes this makes it hard to know how much a younger child fully grasps about what they are saying or understands about their own gender.'

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

> 'Another reason we recommend against early transitions is that some children who have done so (sometimes as pre-schoolers) 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.'[1]

Tavistock GIDS consultant clinical psychologist Bernadette Wren echoes this concern in a paper for the Journal of Clinical Child Psychology and Psychiatry, stating that 'The younger the child, the more likely they are to hold inflexible and innate conceptualisations of gender' and 'Before the age of around 10 years, they predictably hold to rigid gender stereotypes and are less aware of the possibility for further change in gender-related behaviour.'

> 'This is why at GIDS, we would prefer that young children (below 10 years of age, say), while receiving plenty of genuine support and affirmation for their gender preferences (in play, clothing, etc.), not make a full, legally confirmed social transition to the 'other' sex at a young age, since this runs the risk of making entry into their biologically-programmed puberty even more unexpected and agonising and reducing their scope for a greater range of identificatory options later.'

This raises questions about what we are setting children up for when we affirm their gender identity

in early childhood. As the affirmation of a child's gender identity necessitates denial of their biological sex, the child is unprepared for the significance of the changes of puberty, the point at which reality hits. We cannot know the extent to which 'affirmation' may be a contributing factor to the suicidal feelings experienced by some children as they are brought face to face with the biological reality they had been led to believe was immaterial.

De Vries explicitly warns of the difficulty a child would face in changing their mind after social transition:

> 'we recommend that young children not yet make a complete social transition (different clothing, a different given name, referring to a boy as 'her' instead of 'him') before the very early stages of puberty. In making this recommendation, we aim to prevent youths with non-persisting gender dysphoria from having to make a complex change back to the role of their natal gender'.

Dr Thomas Steensma from the Netherlands is another expert who, at the Hot Topics in Child Health conference in London in 2017, warned of this difficulty, citing the case of a girl who waited two years to move to a new school before she felt able to 'transition back'.[2]

If social transition is difficult to come back from, there must be a question about how possible it is, realistically, for some children to change their minds at all, when their mind has been influenced, through affirmation by parents, teachers, other trusted adults

and their peer group, during critical developmental years.

Unquestioning affirmation of a child's belief is not a neutral act of kindness, but an active intervention that shapes and changes a child's understanding and development. Affirmation by trusted adults forms or reinforces a child's perception of reality. Living, and being affirmed daily as the opposite sex will affect and change the child's developing sense of self, which risks creating a self-fulfilled prophesy of outcome.

The claim by activists that as 'affirmation' is not a medical treatment it is benign, shows a lack of understanding of the power of psychological intervention, especially in a very young child. The finding of a 2013 research study by Dr Steensma that social transition is the most powerful predictor of persistence of childhood gender dysphoria should come as no surprise to anyone with a knowledge of child development.[3]

It is also a disingenuous claim. 'Affirmation' is only the first step on the path to full social transition followed by puberty blockers and cross-sex hormones, and the lobby groups such as Mermaids and the Gender Identity Research and Education Society (GIRES) who promote 'affirmation' are the same organisations who campaign for earlier and earlier medical intervention for children.

The 'solution' to the created crisis at puberty for children who have been affirmed as the opposite sex is medical intervention to block their puberty and

stop those changes from happening. A child's body and brain are not designed to be 'paused' at puberty, but to experience a critically important physical, psychological and neurological growth surge. In a 2019 letter to the journal Archives of Disease in Childhood a group of paediatricians describe this intervention as 'a momentous step in the dark.'[4]

Studies on children undergoing this treatment pathway are notoriously weak – the Endocrine Society recommends puberty blockers despite classing the evidence for their use as 'low quality' – but there is one result which has been replicated again and again. There is now emerging evidence that puberty blockers may act to prevent the natural resolution of gender dysphoria in adolescence: once on puberty blockers, children rarely come off the medical pathway.

A 2011 study in the Netherlands found that: 'No adolescent withdrew from puberty suppression, and all started cross-sex hormone treatment, the first step of actual gender reassignment.'[5] In 2012 a small study in Australia also found 'no young people ceasing hormone treatment' after being treated with blockers, and in 2016 Dr Norman Spack reported the same result in the US: no children change their minds.[6] Also in 2016, early results of the Tavistock GIDS puberty blockers trial echoed the same result:

> '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.'[7]

At the Hot Topics in Child Health conference in London in 2017 Bernadette Wren expressed the concerns of clinicians working in the field:

> 'There is increasing concern about puberty suppression and the risks and uncertain outcomes. They may affect gender identity development by increasing the likelihood of persistence. We don't know the long-term effects on cognitive development, sex organ development and so on.'[8]

This is critical information; if affirmation, social transition and blockers all increase rates of persistence, the outcome is not negligible. The progression from blockers in early puberty to cross-sex hormones at age sixteen results in irreversible sterilisation and impaired sexual function.

Evidence of the psychological effects of blockers is mixed and inconclusive as virtually no studies include a control group, but one result is consistent: blockers have not been found to alleviate gender dysphoria. Emerging evidence calls into question the idea that blockers are safe and fully reversible as is claimed by lobby groups. 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.'[9]

Commissioned to review the evidence base for hormonal interventions in 2019, Professor Carl Heneghan, director of the Oxford University Centre for Evidence Based Medicine, concluded that hormone treatments are 'an unregulated live experiment on children' and that 'The current evidence base does not support informed decision making and safe practice in children'.[10]

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

> '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.'[11]

If very young children are not developmentally equipped to understand the reality of the transition pathway, what of adolescents? Respect for autonomy and agency are key principles as children grow up but just as young children form their understanding of the world through their primary care-givers, teenagers

look outwards to the peer group and society. This is a critical stage of development as young people make the transition from childhood to adulthood and the key task is the search for a sense of self and personal identity, through an intense exploration of personal values, beliefs, and goals.

Teenagers are sensitised to their social world which becomes their overriding focus of attention and motivation. The fundamental task of adolescence—to achieve adult levels of social competence—necessitates a great deal of learning about the complexities of human social interactions. Teenagers' intense emotions are due to the surge of hormones coupled with a loosely connected frontal lobe: feelings are experienced more intensely but 'executive control' over those feelings is less accessible to a teenager than to an adult.

Teenagers' poor decisions are not a matter of poor reasoning abilities, but because neural reward systems are more intensely activated – teenagers get more of a thrill out of rewarding stimuli than adults do – and because a teenager's frontal lobes are still only loosely connected to other parts of the brain, so there is less 'connectivity' to assess risks, rewards and consequences.

Teenagers are uniquely vulnerable to indoctrination, social contagion and peer pressure. This is also the age when mental health issues may emerge. The recent exponential rise in the number of adolescents and young people, predominantly girls, who 'come out' as transgender with no previous indication of dysphoria

in childhood is unexplained and not yet understood. There is a high correlation with pre-existing mental health problems, neurobiological disorders such as autism, previous trauma and sexual abuse and troubled and chaotic family backgrounds.

However, teenagers who suddenly self-diagnose as transgender are offered undifferentiated diagnosis and treatment which was originally intended to be available only for a small minority of adolescents with profound and persisting gender dysphoria since early childhood. The first step of that treatment is 'affirmation.'

In schools and youth organisations, transgender guidance mandates the affirmation of young people who self-identify as transgender and the NHS joins in with validation of everything an adolescent has learned on Tumblr. A clinician who worked at the Tavistock satellite clinic in Leeds described the treatment pathway for adolescents aged 16 and over like this:

> 'It isn't a psychosocial assessment, it is a tick-box exercise to ensure that the young person has correctly learnt from the Internet about how to self-diagnose as meeting the criteria for gender dysphoria.'[12]

We recognise the social contagion factor with other teenage problems such as anorexia, bulimia and self-harm but adolescents today are growing up with technology which can spread contagion much faster and more widely than anything we have known before. The internet is awash with transgender propaganda,

teaching teenagers a very modern way to conceptualise their body-hatred, alienation and non-conformity to the extremes of femininity and masculinity they are exposed to as 'normal' today. Psychiatrist Stephen B. Levine writes:

> 'It is exceedingly rare to encounter a trans teenager who has not developed 'friends' through the Internet, where they are often counselled that they are trans and directed to numerous websites that help them to stabilize their identities.'[13]

In a first exploratory study of parental reports by Dr Lisa Littman of Brown University, 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.'[14]

In less than a decade there has been a 1,460% increase in referrals of boys to the Tavistock GIDS, a figure which in any other area would be viewed as an epidemic. It is easy to forget the boys when this increase is totally overshadowed by the staggering 5,337% increase in the number of girls, but we should be concerned about all of these young people. Ex-GIDS clinicians testify that 'experimental treatment' is 'being done not only on children, but on very vulnerable children.'[15]

Over the last two years a number of clinicians have resigned from the Tavistock Gender Identity Development Service on grounds of conscience.

Testimony from five of these clinicians 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. They expressed fears that many of those treated will detransition and feel anger and regret at their disfigured bodies. Their testimony corroborates evidence communicated earlier by whistle-blowers at Tavistock GIDS to senior Tavistock clinician Dr David Bell.[16]

The results of a detransition survey of 203 females (2016) indicate 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.[17]

The exponential rise in the number of referrals of children and young people to the Tavistock has coincided with the rise of transgender rights activism and the ideological capture of government, schools, youth organisations and the NHS. For the 'gender dysphoric child' psychotherapeutic support structures may be developed with the aim of alleviating the dysphoria; however, for the 'transgender child', as the emblem of a social justice movement, the only acceptable treatment is validation, reinforcement and consolidation of a transgender identity.

'Affirmation' is the political treatment of a clinical condition, its very aim is to facilitate persistence. Until we are honest about that, the most vulnerable children and young people will continue to be subject to experimental and unnecessary medical interventions with lifetime consequences which can never achieve the goal of changing a child's sex.

Notes

Toby Young

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Stephanie Davies-Arai

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Children registering as 'transgender' – that the gender they feel themselves to be is at odds with their biological sex – is a growing phenomenon. Applications by children wanting to change their gender by deed poll have leapt in recent years, as have referrals to the Tavistock, the only NHS clinic specialising in this subject.

This publication features two short essays – one by Toby Young, the other by Stephanie Davies-Arai – considering whether this trend should be a cause for alarm, and whether current approaches to children experiencing gender dysphoria are appropriate.

Trans activists argue that the rise in young people identifying as transgender or 'gender non-conforming' is due to the decline of the stigma attached to doing so and, as such, it should be celebrated. Others are concerned that it has become fashionable to identify as transgender and that it is unlikely that the true underlying rate of gender dysphoria is as high as it has recently seemed to be, especially in certain areas.

This in turn raises questions about the policy of 'affirmation', whereby children's feelings about their gender are taken at face value and that, if they wish to transition, they are supported in doing so. This despite the fact that the majority of those with gender dysphoria outgrow it during adolescence – and that there remain significant gaps in medical understanding about the treatments that are provided to those who choose to transition at such an early age.

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