# The care and treatment of children and adolescents in relation to their gender identity: ethical issues

## Call for evidence

## Section 1: The nature of gender dysphoria

In carrying out our exploratory work, we found that disagreement about what gender dysphoria is underlies many of the disagreements about what the approach to care and treatment of young people should be. Some people think that gender dysphoria is a medical condition, and explain it as a genetic, hormonal, neurodevelopmental or psychiatric condition. Other people reject the idea that gender dysphoria is a medical condition and understand it as either a social construct or a normal variant of gender expression. In the absence of clear evidence as to what causes gender dysphoria, it is unlikely that a single agreed view will be reached. That being the case, we want to understand views on whether and how a lack of consensus on what gender dysphoria is, and what causes it, should affect the approach to care and treatment.

1. **How should gender dysphoria be characterised?**

Discomfort, confusion or distress experienced by persons whose sense of gender is incongruent with their biological sex.

2. **In your view, how should young people with gender dysphoria be treated, cared for, or supported?**

Treatment should be evidence-based not ideologically driven. There is no robust evidence to support the 'affirmation' approach that encourages early social transitioning. Care should err towards watchful waiting, as neurological changes in the brain continue well into a person's 20s. Existing evidence suggests that identity may be 'fluid' during childhood and adolescence, and most (80%)[1] [2] gender-incongruent children and adolescents will settle with a gender identity that is congruent with their biological sex by the end of puberty. Support should reflect this by being non-directive, neither affirming nor rejecting, during those years.

There is also good evidence that many gender-incongruent children and young people also experience mental health disorders, especially mood disorders, anxiety and depression. Some have grown up in dysfunctional family settings and others have been subject to abuse. Autistic spectrum disorders are also more prevalent in this cohort of children. Time, and professional help to disentangle these concerns from each other and from gender dysphoria are needed.

Many of these young people imagine that the problems in their lives would be solved if they were the other sex. They need opportunities to reflect on what it means to be male or female, sensitive

[1] DSM-5. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 5th edn. Washington DC:American Psychiatric Publishing, 2013, 302.85:455

[2] Zucker, Kenneth J. 2018. The myth of persistence. International Journal of Transgenderism, 19(2): 231–45

help to work through their personal and family problems, and time for the brain to adjust to the changes of puberty.

3. **Do you think that treatment and care of gender diverse young people should take into account the deep disagreement about the nature and causes of gender dysphoria? If so, how?**

Opinions multiply in the absence of facts. Gender incongruent children and gender diverse young people must not be used as guinea pigs in (potentially harmful) experiments. An axiom of medical care is 'first, do no harm.' Responsible clinicians will construct trials and publish results in peer-reviewed articles. Treatment pathways cannot attempt to represent a compromise position between conflicting ideologies – robust evidence must be the determining factor. Humility and openness are needed on all sides as evidence is accumulated.

## Section 2: The social context

The number of young people being referred to gender identity services has increased significantly over the past ten years, both in the UK and internationally. There has been an increase in the number of referrals from girls (sometimes referred to as natal girls, biological females, or those assigned female at birth). There are divergent views as to the reasons for this. Some think that gender dysphoria has always been prevalent among young people but was often unrecognised or repressed. Others think it is a new phenomenon, specific to today's social context. Various social factors and societal changes have been suggested as playing a role in the number of those seeking treatment or contributing to how gender dysphoria is perceived and understood, including:

• shifting social attitudes towards sex and gender;

• intense sexualisation and objectification of women associated with female puberty and womanhood;

• increased visibility of transgender individuals in public life and coverage of trans issues in the media;

• social pressures to conform, or not conform, to gender norms;

• experience of homophobic or other types of abuse and bullying;

• the significant role that social media and the internet play in young people's lives – which, alternatively, upholds and enforces traditional gender norms; offers opportunities for self-expression and the chance to find supportive communities; or contributes to what some have called a 'social contagion' of gender dysphoria.

4. **In your view, what social factors are most relevant to the discussion about gender identity in children and adolescents? How might these contribute to:**

   **(a) the onset or expression of gender dysphoria in children and adolescents; and**

   **(b) the way gender dysphoria is understood and perceived in society?**

A 2018 study[3] into the dramatic rise in the number of adolescents and young adults (AYA), most of them natal females, self-identifying as transgender and seeking help to transition, concluded:

*Rapid-onset gender dysphoria (ROGD) describes a phenomenon where the development of gender dysphoria is observed to begin suddenly during or after puberty in an adolescent or young adult who would not have met criteria for gender dysphoria in childhood. ROGD appears to represent an entity that is distinct from the gender dysphoria observed in individuals who have previously been described as transgender. The worsening of mental well-being and parent-child relationships and behaviours that isolate AYAs from their parents, families, non-transgender friends and mainstream sources of information are particularly concerning. More research is needed to better understand this phenomenon, its implications and its scope.*

The phenomenon that provoked the research by Lisa Littman, a behaviour and social sciences professor, is described as follows:

*Parents have described clusters of gender dysphoria outbreaks occurring in pre-existing friend groups with multiple or even all members of a friend group becoming gender dysphoric and transgender-identified in a pattern that seems statistically unlikely based on previous research. Parents describe a process of immersion in social media, such as 'binge-watching' Youtube transition videos and excessive use of Tumblr, immediately preceding their child becoming gender dysphoric. These descriptions are atypical for the presentation of gender dysphoria described in the research literature…*

The study appears to reinforce what many parents and doctors have suggested – that ROGD may be a social contagion linked with having friends (often on social media sites) who identify as LGBT, an identity politics culture, and an increase in internet use.

Anecdotally, it seems that a significant proportion of the natal girls requesting help do so because they reject the 'intense sexualisation and objectification of women associated with female puberty and womanhood' that is a feature of Western culture. We also note the correlation between ROGD and parent-child relational stresses, family breakdown and isolation from other influences and sources of information.

ROGD might, over time, come to be seen as a separate clinical entity from gender incongruency and dysphoria more generally in children and adolescent young adults (AYA). The causes of childhood gender dysphoria are unknown. Anecdotal accounts[4] suggest that early sexual abuse may drive some children to want to change their gender as a means of escape, but correlation does not prove causation. Much more research is needed to uncover causative factors. However, the 'lenses' through which gender dysphoria (GD) is viewed have changed. Until comparatively recently, GD was viewed as a 'disorder' (and classified as a mental health disorder – 'gender identity disorder') that could be investigated with a view to understanding causes and treatment options. The prevailing view today, however, is that gender identity is not dependent on biology, but self-declared and potentially 'fluid.' The lens of 'disorder' has been superseded by the lens of 'diversity'. If GD is no longer a disorder, then it cannot be investigated as if it is – research funds and ethical permission are likely to be withheld.

[3] Littman L (2018) Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports. PLoS ONE 13(8): e0202330. https://doi.org/10.1371/journal.pone.0202330

[4] Such as https://www.thepublicdiscourse.com/2018/03/21178/

5. **How might the social factors you have identified affect whether, what, and how care and treatment is provided to children and adolescents?**

It is important that initial assessment should take a holistic view of the social setting of the child or young person. Co-morbidities are common. A recent Australian study[5] makes clear that gender dysphoria in young people is often accompanied by mental health disorders such as anxiety and depression, including attempted suicide. A psychiatric assessment should therefore be mandatory, and any relevant treatment given for a sufficiently long period to make clear the contribution such mental health conditions are making to the overall picture. Without such screening, there is a real risk that individuals who require psychological support and specialised psychiatric treatment will not receive it.

According to trans activists these mental health symptoms are due simply to 'minority stress' resulting from society's negative attitudes towards trans people. The results of another recent study[6] suggest otherwise. It offers no proof that radical therapies such as puberty blocking drugs, double mastectomies and cross-sex hormone treatment will prevent adolescents from attempting suicide. If anything, the findings of the survey underline the need for serious scientific research into the potential environmental causes of gender dysphoria and the risks – both physical and psychological – of medical transition.

Paediatrician Michelle Cretella observes: *'[The Toomey study] shows that the much higher rate of attempted suicide among female-to-male, non-binary, and questioning transgender youth has more to do with factors relating to their biological sex than it does with anything related to gender identity. If confirmed, this may help explain the causes, since it is possible that common underlying psychological and environmental factors may be at play triggering both gender dysphoria and suicidal tendencies in a subset of these adolescents.'*[7]

Autistic spectrum disorder (ASD) is ten times more prevalent in young people identifying as trans,[8] so this too must be professionally assessed. Support and therapy for the family should also be considered.

Erecting sensible 'barriers' to overly-easy transition, by ensuring such careful assessments are routinely in place, will prevent more young people embarking on early medical transition with insufficient thought, more people living to regret irreversible changes to their bodies, and an overall increase in co-morbid mental health issues including suicidality.

## Section 3: Research evidence

There are differences of opinion as to what the existing evidence base on the use of puberty blockers (gonadotropin-releasing hormone agonists (GnRHas)) and cross-sex hormones means for clinical practice. Some believe that existing evidence and clinical experience provides an ethical justification for the use of puberty blockers and cross-sex hormones in care, pointing to literature

[5] Strauss P et al (2017). Trans Pathways: the mental health experiences and care pathways of trans young people. Summary of results. Telethon Kids Institute, Perth, Australia

[6] Toomey RB et al. Pediatrics October 2018, Volume 142 / Issue 4

[7] https://www.dailysignal.com/2018/09/18/new-study-on-transgender-teen-suicide-doesnt-prove-kids-need-gender-transition-therapy/

[8] Annelou L. C. de Vries et al. Autism Spectrum Disorders in Gender Dysphoric Children and Adolescents. Journal of Autism and Developmental Disorders, Vol 40, Issue 8, 2010: 930–936.

which claims to show the potential risks of not providing that treatment (increased psychiatric morbidity, self-harming behaviour and suicide). They reject the claim that the use of these treatments is 'experimental,' or they argue that it is similar to other areas of paediatric practice where there are no licensed treatment options.

Others believe that the current state of research evidence provides an insufficient basis for treatment, and that puberty blockers should be considered experimental treatment and prescribed only in the context of a research study. This was the conclusion reached by the High Court in the recent Bell v Tavistock and Portman NHS Foundation Trust case, on the basis of the uncertainty over the short- and long-term clinical and life-course outcomes and ambiguity over their purpose.

**6. In your view, does the available evidence support medical interventions in gender diverse children and adolescents? Please expand on your comments.**

In our view, there is insufficient evidence to justify the current affirmative approach that includes early social transitioning, followed by puberty blockade and trans-sex hormone treatment. We agree with the conclusion reached by the High Court in the recent case *of Bell v Tavistock and Portman NHS Foundation Trust.*[9]

A preliminary study[10] by the National Institute of Health and Care Excellence (NICE) has found that the science supporting the use of puberty blockers is of low quality. *'The results of the studies that reported impact on the critical outcomes of gender dysphoria and mental health (depression, anger and anxiety), and the important outcomes of body image and psychosocial impact (global and psychosocial functioning) in children and adolescents with gender dysphoria are of very low certainty using modified GRADE. They suggest little change with GnRH analogues from baseline to follow-up.'*

*'Studies that found differences in outcomes could represent changes that are either of questionable clinical value, or the studies themselves are not reliable and changes could be due to confounding, bias or chance.'*

A linked NICE study[11] looked at the clinical effectiveness of gender-affirming hormones compared with one or a combination of psychological support, social transitioning to the desired gender or no intervention. The study found that certainty of the impact of the hormone therapy on gender dysphoria, on depression, on anxiety, on quality of life, and on suicidality and self-injury was all 'very low'. All the studies in the review of the literature were flawed. They were all uncontrolled observational studies, which are subject to bias and confounding; they had relatively short follow-up; most of them did not report comorbidities (physical or mental health); most of the studies were poorly reported and used a confusing variety of scoring tools and methods.

The study concluded that *'Any potential benefits of gender-affirming hormones must be weighed against the largely unknown long-term safety profile of these treatments in children and adolescents with gender dysphoria.'*

Another reason to resist the current affirmative policy stems from a growing understanding of neurodevelopment. Development psychologists consider identity development to be a process that continues long after adolescence. Modern neuro-imaging techniques have shown that brains

[9] [2020] EWHC 3274 (Admin). Case No: CO/60/2020

[10]file:///C:/Users/LocalAdmin/Downloads/20210323_Evidence+review_GnRH+analogues_For+upload_Final%20(1).pdf

[11]file:///C:/Users/LocalAdmin/Downloads/20210323_Evidence+review_Genderaffirming+hormones_For+upload_Final%20(1).pdf

continue to develop into our mid-twenties. It has even been suggested that a term such as 'emerging adults' should be adopted to designate 18- to 25-year-olds, for whom it is normal to continue a significant exploration of their own identity.[12]

The Australian expert on adolescent health Prof Susan Sawyer puts it this way:

*'An expanded and more inclusive definition of adolescence is essential for developmentally appropriate framing of laws, social policies, and service systems. Rather than age 10–19 years, a definition of 10–24 years corresponds more closely to adolescent growth and popular understandings of this life phase and would facilitate extended investments across a broader range of settings.'*[13]

It is unrealistic to expect a child or young person whose sense of personal identity, including gender identity, is still forming, to be able to confirm that they have a settled intention to live for the rest of their lives in their preferred gender. The increasing number of people requesting help to de-transition can only strengthen the conclusion that early intervention with puberty blockers and hormone therapy is as irresponsible as it is lacking in evidence base.

Studies show adolescents and young adults to be less risk-averse, more open to novel experiences and more motivated by potential rewards than more mature adults.[14] As a result, teenagers are more inclined to risky behaviours and traditionally the law has put legal barriers in their way to save them from making decisions they might later regret.

For consent to be valid it must be fully informed. Recent discoveries in developmental psychology suggest that the capacity to make fully informed decisions about one's own gender identity is not reliably mature before one's mid-twenties, let alone one's mid-teens. The long-term effects of puberty blockers in this clinical situation are largely unknown, and so consent cannot be fully informed. What is known is that puberty blockers lead to stunted growth and subfertility, and impair normal neurodevelopment that affects, among other things, the developing sense of identity. The overwhelming majority of children who receive puberty blockers choose to graduate to cross sex hormones. These hormones may produce permanent infertility, bone changes, clotting disorders, raised blood pressure and more.

**In our view it is essential that the Government call a moratorium on the current rush towards early social transitioning, puberty blockade and cross-sex hormone treatment of children. Failure to do so now could mean that in five- or ten-years' time the health service is faced with many thousands of sterile young adults whose mental health was not improved by gender transitioning and who wish to de-transition and have fertility treatment to enable them to become parents.** Not to mention a slew of expensive court cases brought by those who claim they were catapulted along the road to transition and reassignment, without careful assessment of their mental health and without the maturity necessary to provide fully informed consent.

7. **Does the use of puberty blockers in this context warrant a different standard of evidence to support decisions about treatment compared to other paediatric interventions? Please expand on your comments.**

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[12] Arnett JJ., Emerging adulthood. A theory of development from the late teens through the twenties. Am Psychol. 2000. 55(5): 469-80.

[13] Susan Sawyer S. et al. The age of adolescence. The Lancet – Child and Adolescent Health, 2018, 2(3), p223–228.

[14] Gardner M and Steinberg L. 2005. Peer Influence on Risk Taking, Risk Preference, and Risky Decision Making in Adolescence and Adulthood: An Experimental Study. *Developmental Psychology*, Vol. 41, No. 4, 625–635.

For reasons already stated, the use of puberty blockers in this clinical situation cannot be regarded as safe. There are known downsides in terms of stunted physical growth and impaired neurodevelopment. Given the overwhelming likelihood (98%) that, having received puberty blockers, an adolescent will elect to receive continuing treatment with cross-sex hormones, the known dangers associated with this treatment must also be taken into account, not least that of infertility.

Suicidal ideation among gender confused and dysphoric young people, desperate to avoid the bodily changes of puberty, has been argued as justification for the use of puberty blockers, but robust data in support of this hypothesis is lacking.

Prof Michael Biggs, using data from the NHS Gender Identity Development Service's (GIDS) own records, has shown that *'suicides of trans-identified children are rare tragedies [four cases in the years 2008-18] and not—as transgendering organizations like Mermaids imply—a common occurrence.'*[15]

Even reports that supposedly support the hypothesis, on digging deeper suggest the exact opposite. For example, a 2020 report by Turban et al[16] was widely heralded as proof that puberty blockers reduce suicidal ideation among transgender teens. The report compares mental health outcomes in two groups of transgender adults, one of which received puberty blockers as children and the other which did not. Over a lifetime, 90% of those who did not get puberty blockers had thought about suicide whereas 'only' 75% with puberty blockers had. However, while 58% of those who had not received puberty blockers had planned suicide in the last year, so had 55% of those who had received blockers as a child, a statistically insignificant difference between the two groups. The report went on to admit that the number actually attempting suicide in the last year was higher in the group who had taken puberty blockers as a child, with twice as many of them being hospitalised after an attempt when compared with those who had not received blockers in childhood.

The intrusion of ideological and/or commercial interests into this area is unhelpful. **Until there is robust evidence as the result of credible studies undertaken by unbiased experts to show that puberty blockers save lives, the current practice of affirmative management that includes the widespread use of puberty blockers followed seamlessly by cross-sex hormones should be halted.**

## Section 4: Approaches to care and treatment

The current approach to care and treatment in the UK is based on the World Professional Association for Transgender Health (WPATH) guidelines. It focuses on providing psychological and psychosocial support to patients and families and, if there are persistent signs of gender dysphoria upon reaching puberty, making a referral to a paediatric endocrine clinic for puberty suppression with the option of receiving cross-sex hormones to masculinise or feminise the body from the age of 16.

### The purpose of puberty blockers

One of the current dilemmas in treatment decisions relates to the purpose of puberty blockers: whether it is to give young people time for reflection and exploration before proceeding with

[15] https://www.transgendertrend.com/suicide-by-trans-identified-children-in-england-and-wales/
[16] Jack L. Turban, Dana King, Jeremi M. Carswell and Alex S. Keuroghlian. *Pediatrics* February 2020, 145 (2) e20191725; DOI: https://doi.org/10.1542/peds.2019-1725.

further, irreversible treatment, or whether it is intended as the first step towards other treatment and designed to facilitate more straightforward transition with cross-sex hormones and later surgical interventions.

There is also a broader question about whether the provision of puberty blockers at a young age opens up or closes down future choices, for example, whether it leaves room for gender identity to fluctuate or evolve over time, or whether it determines or fixes a particular identity which excludes exploration of other options. Evidence on the number of children and adolescents with profound and longstanding gender dysphoria who persist in their gender identities, and on those who desist and do not become transgender adults, illustrates the complexity of the situation.

**8. What should be the purpose of puberty blockers? Does this match up with how they are used in practice?**

Please see our answer to Q7. The current use of puberty blockers is as one stage of a seamless affirmative approach that begins with social transitioning for gender-incongruent children as young as five or six years of age and continues after puberty with cross-sex hormone therapy and discussions about future surgical options. The whole approach seems to be driven more by ideology than science. Co-morbid depression, anxiety and mood disorders are dismissed as merely the result of 'minority stress'. The risk of suicide among gender dysphoric children and adolescents is exaggerated. Parental hesitancy is swept aside in a zealous campaign of affirmative action that has no evidence base.

From the beginning of the 'experiment' with puberty blockers, results were negative. Initial results from GIDS[17] showed that after a year on blockers children reported greater self-harm; girls experienced more behavioural and emotional problems and expressed greater dissatisfaction with their body – in other words, the drugs exacerbated gender dysphoria. The fact that these results have never been published is an indictment of those who proposed the research.

Virtually all children who are put on blockers will proceed to trans-sex hormone treatment at around 16 years of age. They are already on a conveyor belt and do not choose to get off it. Those who continue taking these hormones for a year or more will become irreversibly infertile. In effect, they will have closed the door to parenthood at around the age of ten. More accurately, others will have closed that door on their behalf. If there was good evidence of the effectiveness and safety of this approach, and that gender dysphoric children and adolescents were finding consistent relief from their distress, then there might be some reason to persist with it. But such evidence is lacking.

**In our opinion there is no place for the use of puberty blockers in this clinical situation**. There is evidence that around 80% of gender incongruent children will self-identify with their natal gender by the end of puberty if offered only supportive care, about half identifying as gay, lesbian, or bisexual adults.[18]

**The gender affirmative approach**

One current approach to care and treatment of children and young people is often referred to as the 'gender affirmative' approach. It seeks to affirm the gender identity expressed by young people

[17] Gender Identity Development Service. 2015. Preliminary results from the early intervention research. Tavistock and Portman Foundation NHS Trust, Board of Directors Part One: Agenda and Papers … 23rd June 2015, pp. 50–55.

[18] Zucker, Kenneth J. 2018. The myth of persistence. International Journal of Transgenderism, 19(2): 231–45

without questioning it. This approach complements the idea that gender is innate, sometimes expressed as the view that gender diverse and gender incongruent young people are 'born this way'. According to the gender affirmative approach, refusing to acknowledge and affirm gender identity, or attempting to 'cure' gender dysphoria, would be an attack on the identity and dignity of children and young people.

Others note evidence that a number of young people will desist from questioning their gender identity and will not become transgender adults. They also note evidence that suggests the majority of gender-questioning young people later identify as homosexual or bisexual adults and worry that it is not always easy for children or clinicians to distinguish early questions and feelings about gender identity from early questions and feelings about sexuality. On this basis, they question whether the presence of gender non-conforming feelings and behaviour provides sufficient basis to endorse, unquestioningly, a child's view of their gender. Those who view gender dysphoria as a symptom of broader mental health or social problems may advocate psychological and therapeutic approaches which adopt a more enquiring approach to a young person's expressed gender identity. Finally, the high rates of autism spectrum disorders (ASD) and mental health conditions in gender diverse and gender incongruent children and adolescents, and whether they are interrelated or simply co-existing, may also influence views on the most appropriate approach.

**9. What is the best way to respond to a child or adolescent who expresses unhappiness or discomfort with their gender identity?**

For the great majority of adults, gender identity conforms to natal sex. Statistically at least, this is 'normal.' In our view, the best way to understand and address gender incongruence is through the framework of 'disorder,' a disruption of the normal developmental process by which a person's sense of identity is arrived at. Causative factors are unknown but may include genetic, neurodevelopmental and/or environmental factors.[19]

The trajectory of response to a gender-unhappy child or adolescent would, in this view, be to adopt a watchful waiting approach, neither affirming nor rejecting their claims about their gender. In a supportive environment, the gender-unhappy child or adolescent is enabled to explore why they feel their bodies and the 'real them' do not match. To question their assumptions about male and female roles and, where necessary, to help them find the courage to resist social media group pressure. Engaging with the child's family; observing and helping with family dynamics; encouraging the child and parents to work through relational difficulties, isolation etc, all contribute towards that supportive environment. It is known that about 80% of such children and young people will eventually settle with a gender identity that is congruent with their natal sex.

The 'affirmation' approach would encourage many of these young people to pursue a transgender identity through early social transformation and the use of puberty blockers and trans sex hormones, such that some of them, who would have chosen naturally to identify with their birth gender, will instead be on a very different trajectory.

## Social transition

Another approach to gender dysphoria is to support young people to live in accordance with their chosen gender identity, through choice of dress, changing names or pronouns - known as social

[19] Yarhouse, Mark A. 2015. *Understanding Gender Dysphoria.* IVP:Illinois, p78.

transition. Some encourage early social transition as a way of exploring and expressing gender without the need for medical intervention and note that it can help to reduce signs of distress and dysphoria. Recent trends in referrals indicate that a growing number of young people presenting to specialist gender clinics do so having already made a social transition. Others have argued that social transition makes it difficult for young people to change their minds, and in fact increases the likelihood of later medical transition. Some raise concerns about external pressure to socially transition, perhaps from parents, mentors, or peers. They question whether social transition opens up or closes down future options. Some note that young people who later desist from identifying as trans may find this difficult it they have socially transitioned.

**10. Should children and adolescents with gender dysphoria be encouraged or supported to transition socially? When should this occur?**

It is our opinion that early social transitioning is not appropriate. An affirmative approach will inevitably make it more likely that a child will be steered towards puberty blockers and later trans-sex hormones. Neurodevelopmental imaging studies show that a person's sense of identity is still developing into their twenties.[20] In our view, social transitioning should not be encouraged in childhood. A young person who emerges from puberty with a strong trans identity should be supported in social transitioning but not encouraged to proceed to forms of treatment, hormonal or surgical, with irreversible effects.

## Section 5: Understanding benefit and harm

As with other medical interventions, decisions about treatment can be seen through the lens of benefit and harm: what is most likely, given the available information, to prevent the greatest harm and yield the greatest overall benefit for a child? There are differences in opinion as to what those benefits and harms are, and the extent to which the available evidence can be used to draw conclusions. Some believe that the existing evidence base provides a definitive answer as to whether medical interventions are beneficial or harmful, while others believe that the long-term risks and benefits have not yet been fully established.

Some of the suggested benefits associated with medical interventions in relation to gender identity include:

• in the case of puberty blockers, the prevention of irreversible development of secondary sex characteristics, making any further surgical intervention easier or unnecessary;

• in the case of cross-sex hormones, the development of physical features which complement one's gender identity;

• the alleviation of distress associated with gender dysphoria;

• greater social acceptance and improved relationships;

• improved psychological functioning; and

• reduction of risks of suicidality and self-harming behaviours.

These need to be weighed against a number of suggested harms, which include:

[20] Arnett JJ., Emerging adulthood. A theory of development from the late teens through the twenties. Am Psychol. 2000. 55(5): 469-80.

• unknown or uncertain long-term adverse effects of puberty blockers;

• in the case of puberty blockers, the risk of decreased bone density and increased risk of osteoporosis;

• adverse effects on brain function by blocking puberty's normal role in cognitive development;

• loss of fertility;

• the negative consequences of disrupting physiological puberty, given the role it might play in the formation and development of a consistent gender identity;

• adverse impacts on social and emotional function - for example, the feeling of being 'left behind' or 'out of sync' with peers who will be going through puberty;

• inhibition of age-appropriate sexual and romantic development and exploration;

• later regret and distress at an earlier decision; and

• for some individuals, a decision to desist or detransition if gender identity subsequently changes - with no reliable way of distinguishing between those individuals who will persist in their gender identities and benefit from treatment and those who will not.

**11. How should the possible benefits and harms of treatment and nontreatment be weighed?**

The harm/benefit calculus is a part of everyday medical practice. Healthcare professionals are well acquainted with the need to balance potential benefit against the risks of harm. They make judgments based on good quality evidence – the result of data gathering, robust and repeatable clinical trials by competent scientists, free both of bias and of commercial interest in the outcome. This remains the right way to go.

But in this case, the normal scientific process has been overtaken by ideology. Research departments fear a Twitter storm of outrage by activists if they permit research into areas that might undermine the ideology. In 2019, research into possible reasons for the growing number of requests to de-transition was refused by Bath Spa University.[21] A paper,[22] originally published by Brown University, and written by one of their own associate professors, suggesting that so-called Rapid Onset Gender Dysphoria could be due to peer pressure or online influences, was hurriedly withdrawn in the face of opposition.[23]

In such a climate, responsible research is under threat. Universities must be brave and researchers too. Bullying by a small number of ideological activists must not be allowed to prevail over scientific method.

**12. How should we balance the needs of young people who will become trans adults ('persisters') with those who will not ('desisters') if we cannot reliably distinguish between the two?**

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[21] https://www.thetimes.co.uk/article/dispute-over-detransition-study-heads-for-high-court-2zjtzxn30. The Times, Thursday February 07 2019.

[22] Littman L (2018) Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. PLoS ONE 13(8): e0202330. https://doi.org/10.1371/journal.pone.0202330

[23] https://www.mindingthecampus.org/2018/09/06/a-professor-at-brown-uncovers-a-transgender-inconvenient-truth/

If early social transition is resisted and treatment with puberty blockers avoided, data already shows that a large majority (at least 80%) of gender-unhappy children will emerge from puberty identifying with their biological sex. As a result, the number of adolescent young people that persist as trans into adulthood will be a fraction of those who would otherwise have done so.

**13. How should the evidence on desistence and detransitioning be factored into decisions on whether and when children and adolescents should be permitted to embark on different stages of treatment?**

In our opinion, children should be helped to grow in acceptance of their natal gender, and not be given puberty blockers. Those who persist as trans should, from 16, be permitted to socially transition if all co-morbid mental health conditions have been assessed by qualified professionals and appropriate treatment given. Ongoing talking therapies and support for patients and their families are assumed. We cannot support the use of treatments, hormonal or surgical, that will have permanent and irreversible effects.

**14. What are the ethical implications of providing treatment that children and adolescents might later regret or reconsider?**

1. It would transgress legal precedent. In the recent case of *Bell v Tavistock and Portman NHS Trust,*[24] Dame Victoria Sharp, sitting with Lord Justice Lewis and Mrs Justice Lieven, said: *'It is highly unlikely that a child aged 13 or under would be competent to give consent to the administration of puberty blockers.'*

*'It is doubtful that a child aged 14 or 15 could understand and weigh the long-term risks and consequences of the administration of puberty blockers.'* It cannot be ethical to commence life-changing treatment in children who are considered incapable of providing fully informed consent. How can a child of 14 or 15 know how they will feel about their gender identity or expression 10 years later?

The High Court judges added: *In respect of young persons aged 16 and over, the legal position is that there is a presumption that they have the ability to consent to medical treatment.'*

*'Given the long-term consequences of the clinical interventions at issue in this case, and given that the treatment is as yet innovative and experimental, we recognise that clinicians may well regard these as cases where the authorisation of the court should be sought prior to commencing the clinical treatment.'*

It is likely that, if this ruling (which is under appeal) is upheld, there will be a slew of legal challenges from desisting adults who as children were affirmed as transgender, and given puberty blockers followed by trans sex hormones, only for them to conclude as adults that the transitioning process has not 'fixed' their underlying distress.

2. There is increasing evidence that the neurodevelopmental processes involved in shaping a person's sense of identity continue into their early 20s. Instituting treatment in childhood that is not lifesaving and that brings about irreversible changes, including infertility, that may be regretted later in life, is ethically indefensible.

3. In the same way, the changing hormonal environment of the brain during normal puberty is thought to be essential to the process by which an individual's sense of personal identity (including

[24] [2020] EWHC 3274 (Admin)

their gender identity) is forged. Absent puberty, that process is hindered or prevented and can only serve to aggravate the person's sense of identity confusion.

It is accepted that gender dysphoria is a distressing condition and that transitioning enables some people to live more comfortably. Our contention is that the decision to identify as trans and start transitioning should not be possible for children and adolescents, and should only be made by adults who first have been thoroughly assessed and treated for co-existent mental health disorders.

## Section 6: Consent and capacity

There are differences of opinion as to the capacity of children and adolescents to consent to medical interventions in relation to gender identity. Some believe that decisions about capacity should be made on an individual basis, and that with appropriate consultation, discussion, and the provision of detailed and age-appropriate information, many young people reach the standard of competence to make such decisions. They may hold that there is no reason for treating this decision differently from other types of medical treatment to which - if found to have capacity - young people can consent themselves.

Others express doubts about whether children and adolescents have reached an appropriate state of cognitive development and emotional maturity to be able to make this sort of decision. They emphasise the uncertainties surrounding the long-term effects of medical treatment for gender identity; the (in)ability of young people to properly understand how treatment will affect future decisions and desires; and the uniqueness of treatment for gender identity as lifelong and life-changing in a way that few other treatments are.

There are differences of opinion too as to whether the consent of a young person alone should be sufficient, or whether there is a role for those with parental responsibility in addition to, or instead of, that young person's consent. In the UK, a young person is deemed to have capacity if they are able to weigh the information required and arrive at a decision; understand the nature and purpose of the proposed intervention; understand the risks of any proposed intervention as well as any alternatives; and are free from undue pressure or influence. This is often referred to as the standard of 'Gillick competence'. If the young person is not deemed to have capacity, the normal position would be that someone with parental responsibility must consent to medical treatment on their behalf. In the context of medical interventions in relation to gender identity the policy of the Gender Identity

Development Service (GIDS) in England and Wales has always been that it would be inappropriate to administer puberty blockers to any patient without their consent and on the basis of parental consent alone.

A recent High Court judgement in the UK held that there will be 'enormous difficulties' in a child under 16 understanding and weighing the necessary information and being able to give consent to puberty blockers or cross-sex hormones. The Court concluded that it was 'highly unlikely' that anyone aged 13 or under could be deemed competent to give consent and 'doubtful' that anyone aged 14 or 15 could do so. Furthermore, in respect of young people aged 16 and over, clinicians 'may well regard these' as cases requiring consideration by the court. This decision is currently on appeal.

15. **Do you think that children and adolescents under the age of 16 have the capacity to consent to puberty blockers and cross-sex hormones? Please expand on your answer.**

We do not consider children and adolescents under 16 have the capacity to consent to these forms of treatment. Reasons include:

- The recent ruling in the *Bell v Tavistock and Portman NHS Trust,*[25] referred to in your introduction to Section 6.
- Neurodevelopmental processes involved in shaping an individual's sense of identity are ongoing into their 20s. A settled sense of gender identity certainly cannot be assumed under the age of 16.
- There is also some evidence that without the normal burst of sex hormones associated with puberty, the natural process of identity formation is hindered or prevented.
- It is against UK law for a person under 18 to order an alcoholic drink. Not until a person is 16 is he or she considered legally able to give consent to have sex with another person of 16 or over. The idea that a child under 16 years is mature enough to make a decision with such far-reaching and irreversible implications is plainly inconsistent with other age barriers that are in place for their own safety. Ideological imperatives have robbed a generation of gender-incongruent children of basic protections under the law that they should have been able to rely on.

16. **Who should have the authority to consent to and make decisions about medical intervention in relation to gender identity? (eg, a competent young person alone; a competent young person and those with parental responsibility; those with parental responsibility should be able to consent on behalf a young person who lacks capacity; a court)?**

The ruling in *Bell v Tavistock and Portman NHS Trust* suggested that in respect of young people aged 16 and over, clinicians 'may well regard these' as cases requiring consideration by the court. We would agree with that judgment.

Where younger children are concerned, parents (or those with parental authority) should have the authority to consent or withhold consent. In considering such a decision they should have access to information and non-directive counsel from unbiased sources to be able to make a fully informed decision. It is our opinion that the use of puberty blockers should be discontinued with immediate effect, until definitive data about their effectiveness and possible side-effects in this clinical situation are available.

17. **Is there anything distinctive about the use of puberty suppressants and cross-sex hormones such that they warrant a different standard of consent compared to other paediatric medical decisions?**

Yes. As confirmed by the recent NICE studies,[26] [27] there is no valid evidence-base for their use in this clinical context. In effect, this is experimental treatment given to vulnerable persons who are unable to give valid consent. That they have been permitted in use thus far is scandalous.

Not only is there no robust evidence to support such treatment protocols, but there are known and serious long-term implications including stunted growth, thinning of bone density, infertility,

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[25] Ibid.

[26] file:///C:/Users/LocalAdmin/Downloads/20210323_Evidence+review_GnRH+analogues_For+upload_Final%20(1).pdf

[27] file:///C:/Users/LocalAdmin/Downloads/20210323_Evidence+review_Genderaffirming+hormones_For+upload_Final%20(1).pdf

problems with blood clots, stroke and myocardial infarcts,[28] acne, weight gain, gallstones, dyslipidaemia, polycythaemia, raised liver enzymes and androgenic alopecia.[29]

That hope of improvement with treatment is not based on robust evidence, and that long-term implications are numerous and, in some cases, life-threatening, must be reflected in the standard of consent required.

## Section 7: Other

Please use this section to share any other thoughts and comments which you have not been able to make in response to earlier questions.

Finally, we are also interested in understanding people's views and experiences of how this topic is debated and discussed more broadly. Many people have highlighted how polarised and hostile the debate around issues of gender identity and trans rights has become, and noted that this may inhibit open discussion about some of the clinical, legal and ethical complexities of this issue.

**18. Are there any other ethical issues which arise in the context of the care and treatment of children and young people in relation to their gender identity that you would like to draw to our attention?**

1. The current, strongly affirmative approach appears to draw its strength from ideology, not evidence. Those who dare to question it are immediately labelled as transphobic and can expect a vitriolic backlash on social media. University research departments are intimidated by the threat of 'bad press' and will not support academic research into possible causes of the sudden rise in ROGD, or the reasons for the growing number of trans people seeking to de-transition.

2. The influence of the ideology has extended to the classroom, with early social transitioning adopted as normative, sometimes even in the face of parental objection. Teachers who take a different view can find themselves under pressure to conform to the prevailing view or risk their careers.

**19. More generally, have you felt able to engage in talking about these issues openly in your personal or professional life?**

Yes, in both settings.

[28] https://www.acpjournals.org/doi/10.7326/M17-2785
[29] https://www.nhs.uk/mental-health/conditions/gender-dysphoria/treatment/