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Abstract

The medical “transition” of children with “gender dysphoria” is increasingly normalized in North America, Western Europe, Australia, New Zealand, and the United Kingdom. Although each country has specific national gender identity development services, the rationale for prescribing hormone treatment is broadly similar. A minority rights paradigm underpinned by postmodern theory has gained traction in the past 10 years and has been successful in influencing public policy, the education of pediatricians, endocrinologists, and mental health professionals. In this view, any response other than an affirmation of the child’s claim to be the opposite sex or “born in the wrong body” is understood as a denial of their human rights to have their “outer” body match their authentic “inner” self. The postmodern paradigm has brought about a concomitant shift in the classification of the patient from a child who *suffers* “gender dysphoria” to a child who *is* “transgender”. Yet the practice of putting children on a medical pathway brings severe, life-long consequences including bone/skeletal impairment, cardiovascular and surgical complications, reduced sexual functioning, and infertility. Examination of postmodern “transgender” health care reveals it is rarely expert, evidenced-based or objective but on the contrary, is highly politicized and controversial. Although the High Court in the United Kingdom has ruled those children 16 years and under cannot consent to hormone treatment, several lobby groups, as well as the NHS Tavistock and Portman Hospital Trust Gender Identity Development Service (GIDS), have been granted legal permission to challenge the ruling. With the example of the United Kingdom, I demonstrate that if the appeal is successful, children’s rights to protection from bodily and psychological harm will continue to be abused by the postmodern social justice paradigm which, in the very name of upholding children’s rights, violates them.

Keywords

UK, puberty blockers, postmodernism, the Tavistock, Gender Identity Development Service, GIDS, social justice, sex and gender

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THE VIOLENCE OF POSTMODERN "GENDER IDENTITY" MEDICINE

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ABSTRACT

The medical "transition" of children with "gender dysphoria" is increasingly normalized in North America, Western Europe, Australia, New Zealand, and the United Kingdom. Although each country has specific national gender identity development services, the rationale for prescribing hormone treatment is broadly similar. A minority rights paradigm underpinned by postmodern theory has gained traction in the past 10 years and has been successful in influencing public policy, the education of pediatricians, endocrinologists, and mental health professionals. In this view, any response other than an affirmation of the child's claim to be the opposite sex or "born in the wrong body" is understood as a denial of their human rights to have their "outer" body match their authentic "inner" self. The postmodern paradigm has brought about a concomitant shift in the classification of the patient from a child who suffers "gender dysphoria" to a child who is "transgender". Yet the practice of putting children on a medical pathway brings severe, life-long consequences including bone/skeletal impairment, cardiovascular and surgical complications, reduced sexual functioning, and infertility. Examination of postmodern "transgender" health care reveals it is rarely expert, evidenced-based or objective but on the contrary, is highly politicized and controversial. Although the High Court in the United Kingdom has ruled those children 16 years and under cannot consent to hormone treatment, several lobby groups, as well as the NHS Tavistock and Portman Hospital Trust Gender Identity Development Service (GIDS), have been granted legal permission to challenge the ruling. With the example of the United Kingdom, I demonstrate that if the appeal is successful, children's rights to protection from bodily and psychological harm will continue to be abused by the postmodern social justice paradigm which, in the very name of upholding children's rights, violates them.

KEYWORDS

UK, puberty blockers, postmodernism, the Tavistock, Gender Identity Development Service, GIDS, social justice, sex and gender

IN THE UNITED KINGDOM, SPECIALIZED GENDER IDENTITY DEVELOPMENT SERVICES for children and adolescents are provided by the Gender Identity Development Service (GIDS) which is managed by the Tavistock and Portman NHS Foundation Trust and commissioned by the National Health Service (NHS) England.

When it opened in 1989 the GIDS was one of the first gender identity development services for children internationally. Working therapeutically with only a handful of young patients at that time, the GIDS was seen by many as progressive, even revolutionary, and certainly in line with newly emergent cultural tolerance for gender and sexual diversity. In contrast to the psychoanalytic approach of the Tavistock at that time, which attempted to help adult patients with gender dysphoria reconcile with their biological sex, the GIDS innovated an approach that locates children's wish to

change sex as belonging to the area of gender identity development rather than psychopathology. This heralded the beginning of what is now known as the "affirmative model" because its first principle was that a child's gender identity must be affirmed and not pathologised (Di Ceglie, 2018). The affirmative model has subsequently been informed by the gender identity theory of postmodern philosophy.

The GIDS has evolved from a therapeutic service to a service which assesses whether a child can be deemed eligible to be referred to an endocrine specialist. Although medical intervention (puberty blockers and cross-sex hormones) is often prescribed, the child is not referred to an endocrinologist for a medical issue but for a social justice issue, namely the perceived need of the child to have the "outer" body match the authentic "inner" self.

Over the last 30 years, the affirmative model has become hegemonic in gender identity development services not only in the UK, but across Western Europe, North America, and Australia. The child is no longer classified as gender dysphoric but as "transgender," an allegedly wholly natural condition for which psychotherapy is unnecessary.

It is of great importance that as a society we pay collective attention to the shift in the definition of the child who is uncomfortable with its own sexed body. Is the child suffering from a psychological condition caused by emotional, familial, and sociological factors for whom psychotherapy and reconciliation with the sexed body would be beneficial? Or is the child inherently "transgender"? The answer is not a matter of semantics but ethics.

My research into transgender health care in the UK reveals that policy and practice are often not evidence-based but, on the contrary, are ideological and highly politicised.

In this paper, I explore the postmodern paradigm of health care within which the GIDS operates and the consequences of applying a philosophical theory to children which does not originate in medicine or psychology, and which is inextricably involved in political activism. I demonstrate this point with the example of the UK GIDS but suggest that similar conclusions can be drawn about other clinics internationally.

BACKGROUND

I became interested in "trans children" in 2016 after I had been initially contacted by parents in the UK who told me that their teenage children, the majority of whom are girls, had suddenly begun to identify as "transgender." These parents were fearful of disagreeing with their children who claimed that "they had been born in the wrong body" and were truly sons or daughters. The parents' fear occurred not merely because their children were adamant that they needed hormone therapy but because, in attempting to seek support to help their children, with very few exceptions, their children were almost inevitably directed to specialist gender identity services where their "transgender" identity would be automatically affirmed. I learned that parental refusal to accept their child's new identity as the other sex can be deemed a child-protection issue within school settings and by social services.

I am a philosopher and social theorist who specialises in analysing the historical relationship between medicine, culture, and society. In 2017 I wanted to explore the reasons for the almost sudden cultural emergence of the "trans child" in the UK, and why the increase in referrals had disproportionally involved girls. Since 2011 the girl-boy split at the Tavistock GIDS was roughly 50/50 but by 2019 the sex ratio had

changed so that 76% of referrals were girls (De Graaf *et al*, 2018). I also wanted to examine the affirmative model and postmodern gender identity theory not only for its implications for safe and effective services for children at the GIDS but also more generally

In 2018, I co-edited a volume critically appraising the affirmative model, postmodern gender identity theory, and the impact of medicalisation on children (Brunskell-Evans & Moore, 2018). The contributors were a mix of international scholars, psychologists, parents, and "detransitioners." I began to realize that I had inadvertently entered a public health issue that was more politicized than I had originally anticipated. In 2019, I embarked on a second edited collection that reflected on the impact of the first book, and which amplified the critical voices of further contributors (Moore and Brunskell-Evans, 2019).

At this time two events deepened my understanding of the politicization of gender identity medicine. First, several GIDS clinicians contacted me and my co-editor privately to discuss professional concerns and we were shocked to discover the deep disquiet *within* the GIDS at the affirmative model. Second, the Tavistock attempted to intercept our second book from publication by threatening us with possible legal action. We felt intimidated but pressed ahead, nonetheless.

In 2019, several GIDS clinicians whistle-blew to the UK national media, in particular the *Times* and *BBC Newsnight*, warning of the severe internal disagreements about the most appropriate way to assess, diagnose, and care for young people. Media exposure raised the public profile of the GIDS and brought clinical concern issues into the public domain. The public was also made aware of the exponential rise in children seeking puberty blockers, the majority of whom are girls, with a backlog of nearly 4,500 children and young people waiting for an appointment.

It is in this context that the GIDS has come under intense scrutiny in the UK and has been reviewed, or is currently being reviewed, by (1) The UK High Court which carried out a Judicial Review in 2020 (Bell v. Tavistock, 2020); (2) The Care Quality Commission which regulates health and social care services in England and which inspected the GIDS in 2020 (Care Quality Commission, 2021); and (3) An independent review called The Cass Review commissioned by NHS England and NHS Improvement in Autumn 2020 and which is still ongoing (The Cass Review, 2020).

CAN CHILDREN CONSENT TO PUBERTY BLOCKERS?

The Tavistock GIDS is a gender identity development service for children and young people 17 and under. Children can be referred for hormone blockers in the early stages of puberty, in some instances aged nine or 10. A Judicial Review of the GIDS was held at London's High Court in the autumn of 2020 regarding whether children have the capacity to consent to this medical intervention (Bell v. Tavistock, 2020). The language of postmodernism was never used by the three presiding judges—children were said to have "gender dysphoria" and were not referred to as transgender. Gender dysphoria was described as:

> a condition where persons experience distress because of a mismatch between their perceived identity and their natal sex, that is, their sex at birth. Such persons have a strong desire to live according to their perceived identity rather than their natal sex (Bell v. Tavistock, 2020a).

The case against the GIDS was brought by Keira Bell, a 23-year-old woman who is an ex-GIDS patient, and Mrs. A, a parent of an autistic girl on the waiting list for assessment. They claimed that the GIDS's referral of children for puberty blockers is unlawful since children cannot, by reference to Gillick competence criteria[1], validly give consent to a treatment that is both life-changing and probably irreversible.

Mrs. A's child remained anonymous, and Bell became the focus of media attention. She describes herself as having been extremely vulnerable when she was referred to the GIDS aged 16, deeply distressed about her sexed body, and suffering a range of underlying familial, emotional, and psychological problems (Holt, 2020). She had begun to think her problems would be resolved by becoming male, and her identification as male gradually built up as she found out more about transitioning online. As she proceeded down the medical route, "one step led to another," and although she now says she wouldn't have wanted to listen to voices of caution, no one challenged her. She alleges that the GIDS allowed her to pursue the unrealizable fantasy that she could change sex, left her psychological issues unaddressed, and referred her for puberty blockers after only three one-hour-long appointments. One year later Bell was prescribed testosterone; three years after, aged twenty, she had a double mastectomy; subsequently, she has decided to stop taking testosterone and now accepts that she is female (Holt, 2020).

I sat through the hearing. Concerning the issue of consent to puberty blockers, counsel for the Tavistock argued that a 10-year-old child with the same mental capacity can consent to life-changing medical procedures. She portrayed this as an identity and social justice issue stating that to refuse a mentally competent 10-year-old puberty blockers was to deny her voice, agency, and bodily autonomy.

The following evidence against the use of puberty blockers was given by expert witnesses (Bell v Tavistock, 2020):

- Most children who have gender dysphoria grow out of it. Possibly only 10% to 15% have dysphoria which continues beyond puberty;
- Puberty blockers are "off-label" (i.e., drugs which are legally ratified only for other medical conditions);
- Hormone blockers harm the body, for example, decrease in bone density, restrictions on growth, etc;
- Nearly 100% of children taking puberty blockers go on to take cross-sex hormones which leads to infertility, reduced sexual function, and eventually to surgery such as the removal of breasts, ovaries, wombs, and testes, surgical removal, and revision of sex organs; and
- There are no longitudinal studies to demonstrate the psychological efficacy of hormone treatment or surgery and the long-term consequences are virtually unknown.

The evidence provided by the Tavistock in support of puberty blockers was inadequate on several grounds. Firstly, it provided no results from its research study undertaken since 2011 which had been specifically commissioned to finally establish

[1] The current legal position which the judges had to consider is a presumption that children 16 and under, if 'Gillick competent', can consent to medical treatment. This term originated from a legal precedent in English case law and means the child is considered sufficiently mature and cognitively developed to give informed consent to the procedure in question.

whether or not puberty blockers are effective in improving the psychological health of 12-15-year-olds. The judges were concerned that, although the research was complete, the results had not been given to the court. An interim paper written by Dr. Polly Carmichael, the current GIDS Director, had been provided but lacked any substantive evidence in the following areas:

- Data about the ages of the children had not been collated for each year;
- Data showing the number of young people who had autism, or any other mental health diagnosis, had not been collated, nor had there been any investigation or analysis;
- The effect of puberty blockers on children with precocious puberty was the source of almost all the data on the medical effects of puberty blockers. The study did not distinguish between the effects of blockers on this latter group and their use for children with gender dysphoria going through puberty at a normal age;
- There was no data on the proportion of children who progressed from puberty blockers to cross-sex hormones; and
- Children and young people who completed their treatment at the GIDS were not tracked into adult services.

Interestingly, the results of the GIDS's research study were released the following day after the court case ended. The most important outcomes were the following: Using standardized psychological measures, "children had no overall improvement in mood or psychological wellbeing" after puberty blockers; of the 44 children who participated in the study, 43 continued to cross-sex hormones (Carmichael *et al*, 2021). Sociologist Dr. Michael Biggs points out that this corroborates data that had already been known by the GIDS since 2006 (if not before) i.e., in almost all cases puberty blockers lead to cross-sex hormones and eventually surgery (Biggs, 2019).

Secondly, counsel for the Tavistock was unclear and inconsistent about the aim of puberty blockers and how success could be assessed. She referred to a "pause," or a time in which a child could think or reflect. This mirrors the GIDS's advertised claim that:

> The blocker allows the young person time to consider their options and to continue to explore their developing gender identity before making decisions about irreversible forms of treatment (Gender Identity Development Service, n.d.).

Thirdly, counsel said it would be easier for a child or young person to "pass" in adulthood if puberty had not occurred. This revealed the ideological presumption that a child who identifies as trans will become a trans-identifying adult. Lastly, no explanation was given for the exponential rise of children wanting to access the GIDS or for the significant change over a relatively short time in the patient group from boys to girls.

In December 2020 the Judicial Review concluded that, due to their experimental nature and the evidence that they are a crucial steppingstone to cross-sex hormones and eventually surgical interventions, children 16 and under have reduced capacity to consent to puberty blockers since they cannot weigh up the consequences of their life-long effects in adulthood (Bell v Tavistock, 2020). It ruled that the GIDS cannot

administer puberty blockers (in most cases) to young people without application to the court.

The GIDS' conviction that children do have the capacity to consent and that advancing a medical pathway promotes an ethical and accountable stance towards "the transgender child" has not been dimmed by the High Court's ruling. The GIDS, as well as the hospitals which facilitate the hormone treatment, have been granted permission to appeal the decision at the Court of Appeal in June 2021. Other organizations have been given leave to intervene, including Gendered Intelligence.

THE POSTMODERN MAKING OF "THE TRANS CHILD"

Gendered Intelligence, established in 2008, is "a registered charity that exists to increase understandings of gender diversity and improve trans people's quality of life" (Gendered Intelligence, 2021). It is also a lobby group. Jay Stewart, the CEO of Gendered Intelligence, has had a meteoric rise as an "expert" on "trans children" and has been invested with authority to advise psychologists at the GIDS on best practices (Stewart, 2018). Stewart's alleged expert status has been granted on the following grounds: Firstly, Stewart was "assigned female at birth," transitioned as a young lesbian in her twenties, and now "lives as a man" (Stewart, 2015); Secondly, Steward is in possession of a humanities Ph.D., awarded in 2013, which used postmodern gender identity theory to analyze the relationship between power, language, and popular culture. Stewart decries orthodox psychology as a modern discourse complicit with "the heteronormative power that reinforces gender norms" (Stewart, 2015).

Stewart insists that the psychology practiced at the GIDS, if it is to be truly enabling for children, should be informed by postmodern gender identity theory, in particular the work of postmodern philosopher Judith Butler. Butler, building on a theory of language developed by the French philosopher Jacques Derrida, argues that the binaries sex/gender and male/female are oppressive language constructs (Butler, 2019). She argues that dividing people by binary sex as either female or male is from the start normative, "assigned" at birth by powerful cultural authorities such as medics, families, and the law. Instead of teaching children that there is a link between biological sex and gender, teaching children that gender identity is disconnected from biological sex "opens up the possibility for young people to find their way in a world that often confronts them with narrow and cruel social norms." Accepting a person's internal sense of gender identity "affirms human complexity and creates a space for people to find their way within this complexity." Building on an "existentialist" account of human agency and freedom, she stipulates "one may be born a female but become a man" (Butler, 2019).

Stewart applies Butler's philosophy to children and young people. Sexing a child at birth is based solely on visual, physical signs—that is, on genitalia—and thus adults can mistake the true "gender identity" of the child; many children and young people experience gender identities that don't correspond with "assigned sex" (Stewart, 2015). Until the success of trans campaigning, most psychologists were resistant to "hearing" the voices of children. But when children and young people are given a platform "they are very intelligent when it comes to gender and it is their insight and experience that should steer services, not vice versa" (Steward, 2015). Postmodern concepts of sex and gender, Stewart claims, have brought society to "the cusp of a gender revolution." Gender identity theory constitutes a paradigm shift in thought, and, like other paradigm shifts, it is "a revolution, rather than a gentle evolution." In developing our intelligence about gender, Stewart asserts: "It looks like that revolution has

started" (Steward, 2015). Stewart asks: "Why does the gender binary continue"? It is "absurd, oppressive and dangerous" (Steward, 2015).

Stewart tells us: "The old idea of two distinct genders "is (or will be) no longer tenable" (Stewart, 2017). "Trans people expose the norms and power attached to notions of the *Real*" (2018, p.49). To instil "a bodily reality" (whether one is a girl or boy) into self-hood is to "insist 'this is who we are' with no room for agency" (Stewart 2018, p.50). Teaching children and young people what is or is not possible for them according to biological sex is "disciplinary" and "normative" (Stewart 2018, p.50). Freedom for children and young people lies in "dismantling the culturally ascribed power of the biological" (Stewart 2018, p.51). Since puberty blockers pause puberty, it is "useful for young people to have access to them" (Stewart 2018, p.51). Young people can decide for themselves whether they want to take the medical pathway so the "inside" and the "outside" match, or they can accept the body as it is (Stewart 2018, p.51). "It is important that children and young people … can experiment, change their mind, try out new styles, express themselves" (Stewart 2018, p.52). "Many people change their bodies in irreversible ways," for example, "tattoos and "pregnancy." Stewart insists the reason why some adults are exercised about the "irreversible decisions" children and adolescents make about their bodies is because "there is an undercurrent in our societal thinking that trans is *wrong*" (Stewart 2018, p.52).

In a Gendered Intelligence sexual health booklet for adolescents, two drawings illustrate the bodily consequences of hormones and surgery. The first is a drawing of a "transman" with a vulva, double mastectomy, beard, and body hair; the second is a drawing of a "transwoman" with a penis, breasts, and no body hair (Gendered Intelligence, 2012). Gendered Intelligence is proud that in contrast to traditional sex education which focuses on biologically sexed bodies, "within the trans community we realize that it is identity that's more important":

> The fundamental thing … is that your identity is paramount. A woman is still a woman, even if she enjoys getting blowjobs. A man is still a man, even if he likes getting penetrated vaginally" (Gendered Intelligence, 2012).

Stewart is proud that Gendered Intelligence provides children and adolescents with a virtual social space where postmodern philosophical ideas are translated into a format that children can allegedly understand (Gendered Intelligence (a) (n.d.). Young people can find information that "offers meaning" and which enables them "to be empowered" (Gendered Intelligence (a) (n.d.)). This includes resources to help children transition, for example, information on where to buy clothing/equipment such as breast binders for girls (Gendered Intelligence (b) (n.d.)) and advice on how to navigate alternatives nouns, adjectives, and pronouns that cover the whole range of gender as a spectrum (e.g., genderqueer, gender-fluid, agender, etc.) (Gendered Intelligence (c), (n.d.)).

Regarding psychology at the GIDS, Stewart argues (2018) that:

- Psychologists specializing in gender identity development should abandon the term "gender dysphoria" when working with "children who have trans, fluid or uncertain gender identities". Gender dysphoria is a "clinical term" that names "a mental health condition." Stewart prefers the terms "*being* trans" or "identifying as trans" (2018, p.47);

- Psychologists should "think about working with trans people … in relation to equalities and inclusion issues, not in terms of 'gender dysphoria'" (2018, p 49);
- The NHS service provision can be very variable and often psychologists convey, even unconsciously, their own "personal values and attitudes, including prejudicial ones" (2018, p.47);
- Although "many trans people experience distress" this is not due to being trans but largely due to "discrimination" (2018, p.47);
- Mental health services should have "a good understanding of trans experiences and implement … trans-inclusive practices" (2018, p.48);
- Psychologists should reflect upon political philosophy: "At what point can a person have agency over their own life?" Do other people know best about who we are? Do doctors know best about who we are? Does the state know best about who we are?" (2018, p 49); and
- Psychologists should not view the child "who is trans" as "'delusional' about who they are … this is *normativising*" (2018, p. 50).

THE GIDS: "SOCIAL JUSTICE" FOR "GENDER DIVERSE CHILDREN"

The NHS specifications for the GIDS prescribes between four to six assessment meetings before a young person can be referred (or be refused referral) to an endocrinologist. The GIDS is proud to inform that a set of principles were initially laid down by which it still abides: "the unconditional acceptance and respect for young people's gender identity" (NHS Tavistock and Portman, 2018). Dr. Bernadette Wren, until recently the Lead Consultant Clinical Psychologist at the GIDS, provides a clear explanation for the GIDS' affirmative approach in the assessment meetings. Using postmodern terms, she describes herself as a "cis-gendered clinician" who has "come to value the postmodern turn in psychotherapy … in particular the work of Judith Butler" (Wren 2014, p 272).

Wren's postmodernist view of orthodox psychology is that it is restrictive and reactionary, exercising heteronormative "regulatory power" over children (Wren 2014, p. 273). It constructs "male/female and hetero/homosexual binaries" as "foundational meta-narratives" (Wren 2014, p. 273). The relationship between orthodox psychologist and client "gives the power of definition and judgment too readily into the hands of the medical establishment keen to define and regulate gender" (Wren 2014, p. 280). Orthodox psychology aspires to be classified as a science, and in proclaiming it is objective it is deployed to "… bolster the usual binaries in mental health: normal/abnormal, straight/perverse, healthy/sick" (Wren 2014, p. 282).

In contrast, postmodern psychology deconstructs the "fundamentalist modernist notions that underpin psychology" and in doing so, exposes "important social, political and ethical issues in psychotherapy" (Wren 2014, p. 272). The purpose of postmodern psychotherapy is not to explore any experiences of conflict with or distress regarding the young person's "trans" identity. To insist to a young person, for example, a female teenager who identifies as male, that her "trans" identification has underlying causes would, in Wren's view, pathologize her or suggest that in some sense she is misguided or delusional. The masculine gender identity of an "assigned female"—the biological girl—might be "a good enough compromise" of "her needs,

historical conditions, and life circumstances." Wren says that the postmodern psychotherapist aims to "restore dignity to those whose transgender identification feels to them viable, respectable, and worthy of value" (Wren 2014, p. 282).

Wren asks: "How do we justify supporting trans youngsters to move towards treatment involving irreversible physical change when we subscribe to a highly tentative and provisional account of how we come to identify and live as gendered?" (Wren 2020, p. 40). Although she fully acknowledges there is "a relative dearth of empirical research" to positively support puberty blockers, there are "other issues centrally at stake … issues around power and rights, autonomy and authority, and responses to suffering—grappled within our particular contemporary social context" (Wren 2020, p. 41).

Wren asserts that the GIDS' practice of prescribing puberty blockers doesn't arise from "narrow 'clinical' judgment" but rather from "broader social acceptance of the challenges brought by new medical technologies, new ideologies of self-determination and new models of parental responsiveness and love" (Wren 2020, p. 41). We now live in a "permissive culture" where we believe that children and adolescents can achieve "a measure of authentic self-knowledge" and that "young people—including those who are gender diverse—may be allowed considerable freedom to make their own mistakes" (Wren 2020, p. 41). Wren refers to the views of a mother who had supported her 16-year-old "son" (a biological girl) in this "grave step." The "boy" is now happy because the "pain and confusion" of "gender feelings" at variance with "the sex assigned … at birth" have been alleviated. Wren paints parents who affirm their children's non-normative gender identities as facilitating for their offspring "the conditions for flourishing and rewarding lives" (Wren 2020, p. 41).

Wren insists the predominant issue for the GIDS is "social justice" for the "gender diverse" (Wren 2020, p. 42). She acknowledges that different orders of social justice are pre-figured by those who object to puberty blockers, and those who support them. Some objectors are gender-critical feminists who view adolescent girls' desire to "'fix' gender" (through hormonal and surgical techniques) as "a perpetuation of sexist norms" (Wren 2014, p. 281). In this form of feminism, Wren argues, gender is understood as the societal roles, behaviors, and expectations that are placed on biologically sexed girls and boys. She endorses the transactivist charge that when feminists critique the postmodern theory of gender they are "biological essentialists"—they believe in "'inborn' masculinity or femininity" (Wren 2014, p. 273). From this perspective, medical intervention *could* be seen as "socially just"—*or* they could be understood, as the GIDS does, as "a backlash against the expansion of gender norms and possibilities and the re-pathologization of young people's feelings and desires" (Wren 2020, p. 42).

In conclusion, the GIDS's postmodern reversal of the established meanings of sex and gender is not a human-rights claim such as that of gender-critical feminists that all children should that is, an adolescent girl is not a female teenager who, for complex reasons that need addressing, identifies as a boy, rather, when she asserts that she is a boy, "he" is one. By reifying young people *as* "trans" the GIDS concretizes the "trans child" as objectively existing. It is on the basis of this constructed "truth" that the GIDS' social justice ethics are founded.

GIRLS AND RAPID ONSET GENDER DYSPHORIA

Hannah Barnes, a senior journalist for *BBC Newsnight,* reports that in 2015 the GIDS had been through a period of enormous change. Six years earlier in 2009, it had

become a national service responsible to the central NHS and from that time onwards demand rocketed, increasing 50% per year (Barnes, 2021). The number of children and young people referred to the service grew from 97 in 2009-10 to 697 in 2014-15. Referrals came from GPs, schools, social workers, and even some charities and youth groups and exploded in 2015-16 at their fastest rate yet, more than doubling from the previous year to 1,419. Accompanying the increase in numbers was a shift in the type of patients being referred: In 2011, girls equaled boys in number, and by 2015 girls outnumbered boys two to one; young people did not only experience themselves as having been born in the wrong sexed body but often appeared to have complex mental health problems. Many were self-harming or were struggling with depression, anxiety, bullying, or eating disorders, and some suffered traumatic or abusive childhoods. There are now over 4,600 young people on that GIDS waiting list, the majority of whom are female, with some waiting over two years for their first appointment (Barnes, 2021).

Dr. Lisa Littman, a Brown University School of Public Health assistant professor in the US described the rapid onset of trans identification in girls who had no previous history of childhood body dysmorphia before puberty as a condition—Rapid Onset Gender Dysphoria (ROGD) (Littman 2018). Despite overwhelming evidence, the Tavistock repudiates that ROGD exists. Without irony, it calls upon the very science postmodern thought castigates as modernist. It describes "rapid-onset gender dysphoria" "as a descriptive term and not a recognized diagnosis" (The Tavistock and Portman NHS Foundation Trust 2021). It claims that it is "both premature and inappropriate to employ official-sounding labels that lead clinicians … to form absolute conclusions about adolescent gender identity development": "Alarmist descriptions of social 'contagion' can contribute to the stigma and isolation around gender-diverse young people" (The Tavistock and Portman NHS Foundation Trust 2021).

In 2017, two GIDS psychologists wrote anonymously to *The Guardian,* allegedly the UK's most liberal broadsheet newspaper, trying to flag up the reality of ROGD at the GIDS but the letter was never published (Anonymous Clinicians, 2019). They relayed their deep concern about the exponential rise in children presenting at the GIDS, and the automatic affirmation of the "transgender" identity of these children, largely girls, who suffer profound, complex confusion and turmoil. They warned that the affirmative approach is letting down the young people by collapsing them into "a one size fits all concrete explanation" that they are "transgender." These psychologists confessed what they were thinking in the consulting room, but couldn't say to parents:

> The children are caught in a terrible moment of social contagion, ensnared in a toxic storm of psychological and emotional distress meeting homophobia, sexism, misogyny against the backdrop of the most appalling 'bad science'. There is no such thing as a male or female brain, and you cannot be 'born into the wrong body' (Anonymous Clinicians, 2019).

The psychologists had been left with little option but to affirm a child who tells them that they are the opposite sex, thereby foreclosing exploration of feelings and meanings, or of underlying issues or mental health problems that may have led to a cross-sex identity. They say:

> We have truly wandered through the looking glass with our eyes closed and opened them only to see the emperor's new clothes (Anonymous Clinicians, 2019).

Drs Anna Hutchinson and Melissa Midgen, gender-critical psychologists at the GIDS with many years' experience, argue that the teenage girls at the GIDS suffer a constellation of psychological, familial, and social problems such as child sexual abuse, bullying, low self-esteem, rigid stereotypes of femininity, shame about being same-sex attracted. Many have comorbid mental health issues and neurodevelopmental conditions such as autism (Hutchinson & Midgen, 2020). Their mental health issues are far less the result of the stigma and unique prejudice at their gender nonconformity, as Jay Stewart suggests, but rather the somatization of their multiple problems. They also point out that these girls are heavily influenced by social media which is awash with the narrative that girls can become male. Social media "influencers" promote being a "transboy" as a truly authentic identity and solution to the discomfort girls feel about their developing bodies. Indeed, adopting a "trans" identity is glamorized and now has a certain cultural cachet. These clinicians conclude that the GIDS' lack of interest in the *causes* of the exponential rise of girls wishing to be boys—the gendered roles placed on biologically sexed girls—is negligent and tantamount to further abuse on top of that which the girls have already suffered (Hutchinson & Midgen, 2020).

Stephanie Davies-Arai is Director of Transgender Trend, an organization of parents, professionals, and academics concerned about the growing number of children identifying as transgender and who are critical of postmodern gender identity theory. She was given leave to intervene in the Judicial Review on the issue of "the recent unprecedented rise in the referral rate of teenage girls and the specific cultural context within which the most vulnerable young people are now suddenly adopting a transgender identity" (Transgender Trend, 2020). Davies-Arai stresses that the High Court's ruling endorsed many of the concerns of Transgender Trend. She argues that the GIDS operates "within a core illogicality":

> … a belief that biological sex is irrelevant to being a boy or being a girl while providing a service that is predicated on the existence of, and ability to define, a 'boy body' and a 'girl body' that children might move between through medication and subsequent surgery (Transgender Trend, 2020).

Davies-Arai points out that in allegedly affording young people freedom from the restrictions of gender norms, the terrible irony is that the GIDS exposes girls (and boys) to the same sexist stereotypes that have caused them to seek help in the first place. Concerning the specific example of Keira Bell, she points out that Bell was "unable to fit into the feminine stereotype expected of her and feeling this is her fault, there's something wrong with her" (Transgender Trend, 2020). The affirmation model confirmed her feeling that the fault lay with her:

> Affirmation of her wrongness, affirmation that her failure to live up to those stereotypes means she is not a girl, affirmation that her insecurities are well-founded (Transgender Trend, 2020).

Davies-Arai argues:

> the GIDS is not competent to safeguard the bodily autonomy and integrity of adolescents who arrive at the clinic fully conditioned in gender theory and eager for the medical interventions they have been told they need" (Transgender Trend).

She concludes that the most damning evidence of the GIDS' complacency about bodies and biological sex is the fact it offers "troubled adolescents no alternative therapeutic treatment pathway." Far from being a last resort (as the GIDS constantly claims) in fact "blockers and hormones are the ***only*** treatment for children with complex histories and mental health conditions." She continues: "This is the result of a service that operates on the basis of ideology in place of clinical standards" (Transgender Trend, 2020).

THE POLITICISATION OF 'GENDER IDENTITY' MEDICINE

In autumn 2020, the GIDS was inspected by the Care Quality Commission (CQC), an executive non-departmental public body that regulates health and social care services in England, due to concerns about safeguarding procedures, and the correct assessments of children reported to it by healthcare professionals (Care Quality Commission, 2021). In January 2021 the CQC rated the GIDS "inadequate" highlighting "overwhelming caseloads, deficient record-keeping and poor leadership" (Care Quality Commission, 2021).

Paul Jenkins, the Tavistock's Chief Executive put out a public statement about the CQC report (The Tavistock and Portman NHS Foundation Trust, 2021). Without mentioning the problem of leadership, he nevertheless fulsomely apologized for the long waiting lists and inadequate record-keeping saying that the GIDS is "falling short" of its long and honorable history supporting young people and families. He suggested this was the result of the GIDS being under enormous pressure, "particularly in the current climate," when it has "found itself in the middle of a political and cultural battleground … which has been hugely challenging" (The Tavistock and Portman NHS Foundation Trust, 2021).

Jenkins is right that there *are* opposed groups with different epistemologies and ontologies. On the one hand, many clinicians, and researchers are deeply worried about the administration of puberty blockers for children with "gender dysphoria" and see the practices at the GIDS as "an uncontrolled experiment on youth" (Society for Evidence-based Gender Medicine, 2020). On the other hand, lobby groups like Gendered Intelligence and Mermaids, "a charity supporting transgender, non-binary and gender diverse children" (Mermaids, 2021) insist "transgender children" should be affirmed in their "gender identity" and state categorically that they have a "right to make decisions around their own bodies." Mermaids constantly raises the spectre of suicide if children are not given hormone therapy, even though its claims children will commit suicide if not affirmed are not based on evidence (Biggs, 2018). Dr. Michael Biggs, an associate professor of sociology, analyzed suicide statistics. He says that "suicides of trans-identified children are rare tragedies, […] and not a common occurrence" (Biggs, 2018).

Newsnight reporters Hannah Barnes and Deborah Cohen point out that the GIDS's internal dissent has been known to management ever since clinicians reported worries that some patients suffering from unaddressed psychological issues including familial abuse were referred onto a medical pathway too quickly (Barnes & Cohen, 2020). Staff allege they were discouraged by the GIDS's Director Dr. Polly Carmichael from consulting the Trust's safeguarding lead Sonia Appleby or from referring cases to social services. Ironically, Appleby herself is now attempting to bring a legal case against the Tavistock for its treatment of *her* when she raised the GIDS' staff concerns that "the health or safety of children were being, had been or was likely to be endangered" (Appleby, 2021). The internal unrest has been so grave that clinicians have attempted to whistle-blow by using print and broadcast media to alert the general

public that children with complex histories were being referred for puberty blockers after a few sessions and without proper investigation of their cases (Barnes & Cohen, 2020).

Barnes has investigated an external 2015 report which described the service as "facing a crisis of capacity" to deal with ever-increasing demand and strikingly it recommended the GIDS "take the courageous and realistic action of capping the numbers of referrals immediately" (Barnes, 2021). Although the CQC 2020 inspection confirms that many of the risks highlighted in 2015 remain, there is now concern over why neither it nor NHS England, which has ultimate responsibility, did not do more to safeguard children and young people (Barnes, 2021). Dr. David Bell is a recently retired Consultant Psychiatrist and whistle-blower (Bannerman, 2020). He says: "It is, to put it mildly, surprising that given the degree of mismanagement and serious neglect they [NHS England] have not intervened" (Barnes, 2021).

Questions about the CQC also need to be asked since a year after the external report a CQC 2016 inspection rated the GIDS as "Good" (NHS The Tavistock & Portman, 2016). One pressing question that needs to be raised is that of the possible ideological capture of the CQC. Although tasked with overseeing and regulating the GIDS, it is also ideologically positioned. Stonewall is the UK's leading LGBT charity and it is also an extremely lucrative business enterprise funded by more than 850 UK employers who are signed up to its LGBT "Diversity Training." Through its Diversity Championship Scheme, to which the CQC belongs, it provides training to workplaces up and down the country (Stonewall (a) (n.d.)). The CQC has been working with Stonewall since 2012 (Care Quality Commission, 2012). In 2014 it ran an in-house LGBT role models course on how to manage a diverse workforce with the help of Stonewall. The CQC tells us it is proud to be on Stonewall's Workplace Equality Index. The Chief Executive of the CQC said in 2015 (Care Quality Commission, 2015).

> We are pleased to have progressed and been named in Stonewall's top 100. This outcome reflects a sustained program of work and continued activity around the LGBT agenda by our network and senior leadership within the Commission.

The CQC sees no contradiction in claiming neutrality in its role as a regulator of the GIDS, and at the same time paying Stonewall money from the public purse to allow this charity to heavily influence the content of its diversity and inclusion policies which not only affects the employment of staff but determines its definition of "trans" (Care Quality Commission, 2020). Here is Stonewall's definition of trans, a catch-all term encompassing a range of self-declared identities which the organization refuses to debate (Stonewall (b),(n.d.)) "Trans" is:

> An umbrella term to describe people whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth. Trans people may describe themselves using … a wide variety of terms, including … transsexual, genderqueer, gender-fluid, non-binary, gender-variant, crossdresser, genderless, agender, nongender, third gender, bi-gender, trans man, trans woman (Stonewall (b), (n.d.)

Stonewall was previously an LGB lobby group but added the "T" in 2016 after its London office received a grant of £100,000 from the Arcus Foundation for integrating "trans" into all aspects of its work (Arcus Foundation n.d.). The LGBT acronym has helped construct "transgenderism" as identical with sexual orientation, existent in "nature" outside of social and political context. Stonewall teaches that gender identity is "a person's innate sense of their own gender, whether male, female or something

else which may or may not correspond to the sex assigned at birth" (Stonewall (b)(n.d.)). Stonewall says that "trans people" have existed forever, like lesbian, gay, and bisexual people, and that their interests are homogenous (Brunskell-Evans, 2020). The CQC, in its guidance to "Relationships and sexuality in adult social care services Guidance" for CQC inspection staff and registered adult social care providers, defines "gender identity" as the sense that we are male or female or not aligned with either gender" (Care Quality Commission, 2019).

Questions about the NHS ideological capture by Stonewall also need to be raised. The NHS is also a Diversity Champion. It says: "As a Stonewall Diversity Champion, we are committed to taking steps to advance sexual orientation and gender identity equality in the workplace" (NHS Health Education England, (n.d.)) The Department of Health has produced a specific guide for "young trans people" in which it defines being male and female as "to do with your chromosomes, genitalia, hormones, etc." In contrast, it defines being "a man, woman, boy, girl … [as] to do with your internal sense of self and how you choose to express yourself" (Department of Health, 2012, p.4). For those young people who want "to take their gender identity further"

> the guide gives information about hormone blockers, and surgeries such as the construction of vaginal cavities, orchidectomy (the removal of the testes), metoidioplasty (the release of the clitoris to form a small penis), mastectomy, hysterectomy and phalloplasty (Department of Health, 2012, p.15).

Those who think trans activism is a grass-roots movement are mistaken. In the UK trans activism is highly orchestrated by Stonewall which has almost single-handedly shaped the publicly accepted "truth" of inherent "gender identity" and tied it to progressivism. Researcher Jennifer Bilek says that medicalized identities are driven on a global scale by a multi-trillion-dollar industry

> Puberty blockers, wrong sex hormones, and invasive surgeries on young people's sex organs are not a human rights movement but driven by the medical-industrial complex for-profit" (Bilek, 2020a).

During the same period that the GIDS has witnessed the exponential rise in demand for the service, the relationship has intensified between alleged "social justice for transgender children" and medical technologies which don't just facilitate children's identity projects they *incite* them (Bilek, 2020b). Bilek says:

> In less than a decade, the 'transgender' 'human rights' 'movement' has morphed [for children and young people] from 'born in the wrong body' to 'gender identity disorder' to 'gender dysphoria' to 'gender incongruence' to 'gender identity' to 'gender expression' complete with its own line of make-up, fashion and body scars (Bilek, 2020c).

She says:

> The LGB civil rights movement has been subsumed by elites [such as the Arcus Foundation] who have added the T to normalize the overriding of our sexed reality as humans, staging a political coup of mammoth proportion (Bilek, 2020c).

The medical-industrial complex "interfaces with LGBT NGOs and are driving the normalization of a biology-denying ideology" (Bilek, 2020d).

THE SOCIAL INJUSTICE OF 'GENDER IDENTITY' MEDICINE

The GIDS, as well as the hospitals which facilitate the hormone treatment (University College London Hospital NHS Foundation Trust and Leeds Teaching Hospital NHS Trust), were granted permission to appeal the High Court ruling that children 16 and under have reduced capacity to consent to puberty blockers since they cannot weigh up the consequences of their life-long effects in adulthood and that the GIDS cannot administer puberty blockers (in most cases) to young people without application to the court. The appeal took place in June 202 at the Court of Appeal. Other organizations were given leave to intervene, including The Endocrine Society and Gendered Intelligence.

Endocrinologists are central to the superstructure of public and private gender identity medicine. The Endocrine Society insists endocrinologists do not exploit children for financial gain but merely provide "needed medical care for their patients" (Endocrine Society, 2021). The Society makes the unevidenced claim that "considerable scientific evidence" demonstrates that "gender identity" is "not malleable and subject to external influences" but rather has "a durable biological element" and that there are no "external forces that genuinely cause individuals to change gender identity" (Endocrine Society, 2020). It asserts that "pubertal suppression" is "reversible" and says this is "the conservative treatment approach available to transgender and gender diverse youth to avoid physical development that might require surgery to reverse later" (Endocrine Society, 2021).

The intervention of The Endocrine Society and Gendered Intelligence has been funded by The Good Law Project (The Good Law Project, 2021). The Good Law Project is a not-for-profit campaign organization that "uses the law to protect the interests of the public, challenging abuses of power, exploitation, inequality, and injustice" (The Good Law Project, n.d.). The Project says that these "NGOs" "speak for the voices that were not directly heard in the original Court judgment, in particular the voice of the child and the voice of prescribing doctors with expertise in the medical evidence and standard of care for transgender health" (The Good Law Project, 2021).

I argue that the ethical issue of whether a child and young person can give consent to puberty blockers goes beyond the legal criteria of whether a person 16 years and under has mental capacity, theoretically understands to what s/he is consenting, and can express independent wishes (Brunskell-Evans, 2019). Although the lived experience of young people is of utmost importance, the young person's "authentic voice" is refracted through the ideology of postmodern philosophy, Gendered Intelligence, quasi-science, the inordinate reach of Stonewall, and the medical-industrial complex. Whether children and young people can consent should be considered within the context that they have no knowledge of the complex web of knowledge/power/ethics within which their identities are both constrained and incited.

The GIDS and the endocrinologists who administer the hormone treatment flout a fundamental medical ethic—first do no harm—since they help sterilize physically healthy and phenotypically normal young people by moving them along a path from puberty blockers to cross-sex hormones and then to major surgeries based on subjective feelings which, for the overwhelming majority of children, would have resolved after puberty.

If the appeal is successful, children's rights to protection from physical and psychological harm will be eroded in the very name of upholding them.

CONCLUSION

The ongoing independent Cass Review of the GIDS was commissioned by NHS England and NHS Improvement and will eventually make recommendations about some of the following issues: Pathways of care into the GIDS, including referral criteria; clinical models and clinical management approaches at each point of the specialized pathway; best clinical approach for individuals with complex presentations; the use of puberty blockers, supported by the review evidence of the National Institute of Health and Care Excellence (NICE) (which concluded that the quality of evidence for positive outcomes of puberty blockers was of "very low certainty" (NICE, 2021)); and exploration of the reasons for the increase in referrals and why the increase has disproportionately been of natal females (The Cass Review, 2020).

I suggest that although these issues are important the Cass Review will not fully grasp the implication of these matters if it does not incorporate into its investigation the politicisations of the GIDS. The GIDS is not innocently operating in a middle ground, caught between opposing and clashing epistemologies, ontologies, or political ideologies. Affirmation of "gender identity" is an activist agenda, not a clinical approach, and the GIDS management has been wholly committed to the affirmative model of care and the postmodern theory and activism which underpins it.

The GIDS dogged commitment to "thinking postmodern" but claiming to practice evidence-based medicine is a contradiction in terms. Firstly, sex is not "assigned" but is a biological fact. Secondly, science cannot be applied to a phenomenon for which there is no objective test, and where the diagnosis is not provided by the clinician but by listening to the voice of the child. The dismissal of gender as a social phenomenon prevents the GIDS from recognizing evidence of the specific experiences and pressures faced by girls in a highly sexualized culture. Far from rejecting biological essentialism, affirmation endorses it, mirroring almost exactly traditional heteronormative definitions of "masculinity" and "femininity" which gender identity theory allegedly subverts. When the affirmation of inherent gender identity is seen as a matter of social justice, the future sexual function and fertility of children and young people are deemed subsidiary.

In conclusion, the GIDS operates from within the same lobby group culture that has influenced the young people referred to it. To make the changes it promises, the Cass Review needs to incorporate into its analysis an understanding that the meaning of "trans" rests on no demonstrable foundational truths. The alleged ahistorical transgender child is not a naturally occurring figure but is a newly emergent, discursively produced figure, given flesh by the GIDS, and shaped, and reshaped before our very eyes by postmodern theory, transactivist politics, social justice movements, and capitalist enterprise.

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