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Can we think psychoanalytically about transgenderism? An expanded live Zoom debate with David Bell and Avgi Saketopoulou, moderated by Rachel Blass

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Introduction by Rachel B. Blass

In Issue 5 of last year's IJP we published a controversial discussion titled: "Can we think psychoanalytically about transgenderism?" The participants were Avgi Saketopoulou, a New York psychoanalyst who has worked extensively with trans adults, trans children, and otherwise gender variant patients in various private and institutional contexts and stages of transitioning and London analyst, David Bell**,** who in his role as a Staff Governor of the Tavistock and Portman NHS Foundation Trust was approached by a large number of clinicians who were working in the Tavistock Gender Identity Development Service (GIDS). They raised very serious ethical and clinical concerns which formed the basis of his subsequent report which was part of the chain of events leading to the Judicial Review which found that children and young people lacked the capacity to consent to this treatment. Since then he has researched the area of gender dysphoria in children. The controversy included a paper from each of these analysts. We reserved for a later time the discussion of each other's papers, normally included within the same issue. We are now publishing this discussion, which was held in a new and very different format, one which we thought would be helpful to the elucidation of this complex issue. Rather than inviting written responses we invited the two authors to an exchange within the context of a live Zoom meeting, with me (R. B.) as moderator. We had originally planned to publish the transcription of the live meeting with minor editorial modifications in order to avoid redundancy, for purposes of confidentiality, and to allow for focusing of the issues. To facilitate the last aim we also added headings. But in the process of the approving the edited transcription it was greatly expanded. Additions by one discussant in the effort to present fuller and more accurate positions required response by the other and ultimately a further series of written exchanges was blended into the original live one. As will be seen agreement was not at all reached, and thus it seemed that the back and forth could go on endlessly. Avgi had begun the cycle of additions and so she kindly offered David the opportunity to conclude it (with his final comments appearing in an addendum).

Obviously, this hybrid live/written format takes away some of the spontaneity of the original live one that we intended to present. However, this format does offer a more

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comprehensive picture of the arguments and counter arguments contained in this controversy and removes any doubt that further reflection would have resolved or even only moderated the profound differences that emerged in the live exchange.

As we know from the history of psychoanalysis, to think analytically one must be able to think freely, and more specifically to be able to freely wonder about the involvements of inner unconscious forces even on matters of great sensitivity, even where this entails questioning socially accepted ideas. We hope that that the publication of this exchange will contribute to analytic freedom and thought on the complex and highly charged issue of transgenderism.

Expanded Zoom Debate

The question of rushing to judgement: does the public vs private context of treatment matter?

DB: I think the first thing I would say, Avgi, is that the papers aren't really connected. I don't really think that your paper is a comment on my paper. I think you've written about patients in analysis, which to me are a very important subgroup of individuals because they've come to analysis. And I think I have some experience of this through supervision, and so on, of individuals who go to analysis or psychotherapy, and have an open mind – because they're prepared to explore. The population that I'm talking about are a very different population. Most of these children or adolescents wouldn't go near an analyst. And they need a lot of help to even go near a psychotherapist. They require an experienced psychotherapist to be able to sensitively help them start to think about themselves. *Now* the children who come to the clinics come with an agenda: they see the clinic as a route to starting medical treatment, and they come with highly developed narratives, which they have often practised and been coached in. And it takes a lot of time to be able to help them get into a position in which they can be a bit more curious. So the patients that you're writing about are not the patients who I'm talking about.

And secondly, I think allied to that, I do think there's a quite an important conceptual confusion in your paper. Some of your paper I agree with, but I'll go for what I don't. And that is I think you confuse transgenderism with gender dysphoria; you don't distinguish them properly. Now the kids I'm talking about suffer from gender dysphoria, that's a clinical condition. And there's a high comorbidity with autism spectrum disorder, depression, severe family disturbance, various other things. So the gender dysphoria is a complex problem. And one possible route, I think for the very small minority, is that they would come into a category that we might call transgenderism, or transgender. But that would have to come after a lot of thought, and thinking with them about the complexity of the clinical problems they have, and being very cautious about confusing gender dysphoria with transgender. So those are the first few things about the different population. And I think there's an important conceptual confusion there which is unhelpful.

AS: That's great. I'm so glad you're starting there. I couldn't agree more that we need to talk. I would say, though, that we're talking from different institutional positions, because

you're starting from the premise of working in a clinic with a certain kind of patient "traffic", and a certain press for time that doesn't have the luxury of analytic time and of waiting … But I would also say the following: I would not agree with you, David, that these (the patients you've seen as part of a gender clinic, and the patients I've treated in institutional and analytic settings) are different kinds of patients. And I'll tell you why: Because some of the patients that I work with have come to me starting out not requesting an analysis or even requesting therapy, but they have come asking for letters – like, would you give me the piece of paper I need to get hormones? Would you do whatever needs to be done with my insurance for me to qualify to have my surgery? To me that is not unlike other clinical situations where, for example, people come in for mandated treatments, or when people come in having a very specific notion in mind of what you can do for them as the analyst. But then, what I think of, is that it's the clinical work and the analyst's stance that also has the charge, in a way, to proliferate the space for analysis to become something that interests the patient. In other words, it may not be a matter of these patients being different but that you and I may think about them differently: this may make the difference between a trans patient who will stay in analysis and one who won't. This is not to say that there aren't patients, trans or otherwise, who are overly pressured in their presentation and can't use the space we offer. But it is to also ask if the difficulty engaging trans patients may be the analyst's, not only, or even primarily, the patient's.

As for the issue of distinguishing between gender dysphoria and transgenderism, you speak of those distinctions with a lot of confidence and conviction, as if there is general agreement about these terms. And I don't think that's the case.

D.B. It is not the case that I'm overconfident about my position in insisting on the distinction between Transgenderism and Gender Dysphoria, or that I believe there is general agreement on this matter. Of course, I am aware that many people disagree with me. But it is not a matter of the popularity of my view, or even how confident I personally am about it, but a question of whether what I say is right or not. Not making this distinction, which you seem to be supporting, I believe causes very considerable harm, as many children, as I have explained, will eventually, if managed and contained, desist from pursuing a medical pathway. But also I think what you are talking about is really different to the kind of people that I'm talking about. The reason is, I'm talking about clinics. In the clinics that I know of – the Tavistock, colleagues in Scandinavia, Australia – –, in my paper I showed that the number has gone up in eight years from 50 to nearly 3000/ 2700. Clinicians are working with case-loads of about 100. And they're seeing kids for often up to six meetings. And during those six meetings, the decision is made. And the last figure I heard, and this may not be accurate, but over 50% of them went on to medical treatment. So that's very different from an individual setting in which you have all the time in the world to see them and so on. Well, in those six sessions, it's not possible to disentangle the complexity of the case, the roads to gender dysphoria, the pressure coming sometimes obviously from the child, sometimes from the family who want closure; they want it all done quickly. Peer groups and the huge influence of the web, you know, the online sort of support, and often learned scripts, so it (that is a proper assessment) can't be done in that short time. So I called my paper 'First do no harm'.

And I think it is my view that because of this motoring through with a tendency to trans-affirmation, rather than understanding gender dysphoria, it is doing considerable harm to children and adolescents. That's a very different population to the ones who are not under that kind of pressure.

AS: Let me first say that I am confused about your explanation: you are saying you are not overconfident but that people who disagree with you as to the distinction between trans and gender dysphoria are wrong and will cause harm. To me, that's the definition of over-confidence.

Also, when I question this distinction (as you draw it) I am not speaking about whether you represent a popular view or not. I am speaking, rather, about how such a distinction is not an established metric, nor has it been shown to be a useful one. In some ways such thinking is allied with Harry Benjamin's efforts in the 1960s to form a taxonomy that determined who is a "true transsexual" (those people would need, and should be permitted by the medical establishment, to transition) and others (for whom psychiatric factors were at play, making medical transition not indicated or justifiable). Thinking on this matter has progressed considerably since that time, and permits us to see that the "genuine" vs. "pseudo" distinction was too crude of a measure for a matter as layered and complex as gender.

As for the issue of pressure, I'm actually saying two things about this. The one is that some patients come to me with that kind of pressure–

DB: Yes, but how long do you see them for?

AS: Years.

DB: That's what I mean. That's not the pressure. And I'm talking about people for whom there's a pressure that things are decided in four- six meetings. And there are no further meetings.

AS: I understand that that has been your experience, but it hasn't been mine. What I'm saying is that not all such patients came to me for analysis per se, or to understand themselves deeply. Some came under pressure, imagining they'd stay for only as much time as was necessary for them to obtain the documents they were asking for. That feeling of pressure is multi-factorial, not because trans people as a population are uninterested in insight, or cannot use treatment. The hesitation to engage with mental health services has to be considered in the context of a long and documented history in trans peoples' contact with professions of care (i.e. the medical and mental health establishment, including psychoanalysis) that have treated them as subhuman, with condescension, and which have caused harm (in the name of "do no harm"). So it's reasonable that some come to a consulting room only reluctantly, wanting to get what they need and get out as soon as possible. To me it seems that it is incumbent on us as analysts to create clinical spaces where trans patients can be relieved of the anxiety that they will continue to be treated as definitionally pathological, prone to action rather than

insight, or seen as incapable of benefitting from treatment. It is our job to help the patient be able to imagine that a different kind of space can be afforded in a psychoanalytic treatment than has been the case in our profession's past.

DB: That's the difference, and often the clinicians involved are not that experienced

How we think analytically about actually changing one's gender

RB: I'd like to intervene here if I may. I think you're dealing with different groups in different situations … I think there is agreement within the psychoanalytic world – that it's better not to rush. I don't think some psychoanalysts think, "No, it's better to decide on these matters in six meetings." The fight then is outside of the psychoanalytic world. This is being imposed on us, something that is clearly not analytic. But I think on that point, whether the groups correspond or not, there was agreement that it shouldn't be the situation that David has been describing.

So then the question is: what are the differences? Despite this kind of broad feeling that there should be time to think, where is the disagreement despite this kind of agreement?

… David mentions gender dysphoria, as opposed to transgenderism … but I would think that also there's something more fundamental at stake here. And this has to do with what it means to think about these situations in an analytic way. … you have, let's say, a boy who says I want to be a girl, or I am a girl, and I want to become one physically; where you have an adult who says I'm a man and I want to be a woman, or I'm a woman, I want to be a man. I think you have different conceptions of what it is to think about this analytically. And this has to do, I think, with different horizons to some extent. What I mean is that analysts regularly hear patients say things about what they'd like to do and who they are, and we think about the inner fantasies and the dynamics that's associated with this. And here there's an action waiting to take place. And there is a question in general about what we think about this kind of action, what we think about changing one's gender, right? Our patients may say they want to get a pet. And we tried to understand that, and we understand it differently if they want to get a pet tiger.

So we have a horizon about what people do and how they think of their body, and how we should be - and I think you differ on that. And I think that transgenderism, in a way, forces analysts to examine what they take as their background assumptions about human beings. And I think, perhaps, whether changing one's body is the kind of thing one does, or is it regarded as more along the lines of wanting to get a pet tiger. So I think we have different basic assumptions within the analytic world over what it is for a girl to not only want to become or feel that she's a boy, but to actually go ahead and do that.

AS: Rachel, I want to question for a moment something that I think is an assumption built into your question: when you say that we all agree that there should be time to think, that we may all theoretically agree on that. But whether the patient has the space to think or not, has to do with reality constraints as well: the reality of puberty and its effects on the body, the social realities of how gender is read in the social milieu and treated by others. Those realities may be arrived at through the socially constructed nature of gender but they have real, material effects. So the idea that "we shouldn't be in this situation as

analysts" divorces us from the social world in which our patients live. And it's worth thinking about this as an example: if a patient comes in for treatment and tells us in the first session that they're planning to get married in two months, we would not be assuming that they should wait and think about it with us before they proceed, postponing the wedding to give the analysis time to explore it. And yet, some analysts think this way with some categories of experience, transitioning being one of them, because they are starting from a very different premise—

RB: We have different premises about getting married and changing one's genitals, right? That's what I'm saying.

DB: I think about gender and biological sex. And it's very striking how these get confused … that they're different things. And I think probably one place that we disagree is, yeah, I think gender is largely socially constructed. Not completely, because biology makes a contribution, and it's complex the to and fro dialectical relationship between one's body and one's gender identity, but it's a construction. Social construction is very, very important, whereas I think biological sex is not socially constructed; I think it's a material fact.

Now, I think one of the things that I would say is that the chromosomes, if you like the materiality of the body, is your biological sex. But a lot of the language in these debates is a confusion of three things. There's the material reality of what your biological sex is; the social and psychological construction of gender identity; and thirdly, sexual object choice.

So, and I think you [Avgi] don't agree with me, I don't think you believe that there is a material basis to biological sex. Let me again state my position clearly. Bodily sex is a material reality, gender identity is largely (but not totally) socially constructed. There is no innate gender identity.

AS: No, I don't disagree with you on that, I agree that there's no innate gender identity. And I do think that, of course, there is a material basis to biological sex (there are hormones, chromosomes, gonads etc.). But you seem to believe that that material basis is where normative gender comes from: ie. someone is a man because he has male genitals or xy chromosomes. I say that yes that material basis exists (i.e. one may have male genitals or xy chromosomes) but that does not tell us their gender (i.e. if they are a man). And in fact, in regard to biological sex in and of itself, there is no pre-discursive notion of sex that is pure biology, scientific and objective, without cultural considerations that are always already baked into our understanding of biology. If anything, the work that has been done on intersex children has taught us that we come into the notion of biology being always already contaminated by cultural ideas. There is no prior-to-culture to which biology is an objective fact. So to the question of whether we have material bodies, I'd say-

DB: Intersex is a very rare condition.

AS: Yes, intersex is an unusual and statistically rare condition-though how rare is hard to tell given how systematically medicine works to shoehorn intersex children into the gender binary. But the exception – Freud taught us to look to the margin to understand more about the center. And what the statistical exception of intersex helps us discern here is that culturally, but also some brands of psychoanalytic theorizing assumed that

morphology equates to biology and to gender. So is there a bodily materiality? Yes. But materiality is one thing, and the psyche-soma is another; the latter requires psychic meanings that develop, and which are not always in full accordance with what cultural prescriptions say about biology. For example the notion that someone with a penis would have a male gender identity is not a biological fact: it's a social fact that we have been treating as a biological one. Biology is not telling us what gender is or how gender is done; that's culture– and that is an observation that starts with Freud.

DB: Freud distinguishes between the materiality of bodily sex and gender (though he doesn't call it gender). The fact of the rare condition of intersex (of which there are many types- some having clear chromosomal definition others not) does not in itself throw any light on the sexual dimorphism of the human being. It is true that in some of these cases sex is assigned as it is thought there is no alternative (though some now believe they should not be assigned and should grow up as 'intersex' which is certainly worth considering). But I fail to see how this is relevant to the identification of natal sex in the normal case … .

And you see, some of the children who I come across and know about, one of the big problems they have – and I've also talked to a lot of de-transitioners, people who have changed their minds, a growing group – and one of the problems there's been talk of, and this is actually now corrected in the schools guidelines in England, is that it points to an important mistake; we might all agree that fluidity of gender identification is a fact of our culture, probably has been for much longer than many of us realize, and it is to some extent I would say to be celebrated: that people shouldn't be pigeonholed or shoehorned into caricatured versions of gender identity. So, if a man is very female in his gender identity, that doesn't change the fact of his biological sex, if that's the way he feels and he wishes to express himself, and vice versa.

Where I was referring to the schools' advice, it was saying that many girls in particular are not happy with being girly girls, and it gets misunderstood as being an expression that they are a boy. And what this schools advice has pointed out is that this is to indulge in a caricaturing version of gender identity. And I think the trans movement, the ideologues, have been very involved in this. They haven't helped encourage children to be fluid in their gender identity, for instance, to stay a girl but to express themselves fluidly: to have short hair, to be very masculine in the way they think and talk without changing their bodies, and that's what I'm saying. I think that's a very important distinction: a fluidity of gender identity. But what's happened is sudden - over a few years - a rush to configure that as needing to change the body.

AS: Intersex does not throw any light on the sexual dimorphism of the human being; it sheds light, as many biologists have shown, on how the notion of sexual dimorphism is a fantastical construction *made by human beings,* not an ontological fact. It was made, for example, by operating on children that had ambiguously sexed genitals so that their appearance might conform to a neat male/female divide.

As to your point about gender fluidity, I think that a multiplicity of gender possibilities is indeed important. But I don't see transitioning, as you seem to, to reduce this multiplicity but to extend it. I wonder if we might be able to think about your premise that there's a certain degree of gender transgression -and I use that word in its statistical

sense- which should be acceptable if the degree of transgression stays in the range of what we understand as fluidity. But when it accrues enough momentum to cross into the different category, that it is a problem. I would say that premise is itself ideological.

RB: When it accrues what?

AS: When it accrues enough density to cross into a different category, for example when one's gendered experience and sense of self are too transgressive of social expectations, such that one is not an effeminate man but a woman. Just because someone may look to us to be an effeminate man, when that person identifies as a trans woman or as a woman, does not mean she is not accepting of her femininity *as a man;* it may, rather, mean that it is we who are having trouble sensing how her self-perception violates our normative beliefs. To say that we are the experts who know ahead of time that her transness is a perversion of gender– to say that it is a pathology because it overrides what we have imagined to be the limits of an expansive psychic bisexuality that, nevertheless, remains within the range of assigned gender at birth is itself an ideological position. Erasing trans in favor of a psychic bisexuality that orbits around two genders only (men; masculine, effeminate, etc.; and women; butch, feminine, etc.) is itself an erasure of difference.

RB: Avgi, I'd like to press you on your point about the ideological position. Isn't it to not say that it's a perversion also an ideological position?

AS: Of course it is.

RB: What you have at stake here are ideologies …

AS: No, I wouldn't agree with you on that.

RB: Someone might have the view that however much someone feels he's a girl, the fact is that he's a boy. And you could say, well, no, at a certain level, the boy becomes or should become a girl. But that option of changing your body, one might say, has to do with ideological assumptions; that this in itself is a concrete solution to someone's complex sense of identity, which can be further analyzed and understood.

AS: First of all, we don't have a lot of clinical examples of that, where someone comes in with a sense of being gender non-normative, and which gets "resolved" through therapeutic intervention.

And when you say "there is the fact that he is a boy", that is the thing on which, I think, David and I disagree: the notion that anatomical difference factually determines gender– or should do so. If you start with this assumption, what David says makes sense, but for me it's a problematic assumption.

RB: To recap, the point you have been bringing up with David was that, yes, there is this fluidity. And, you know, a boy can be a girly boy. And a girl can be a boyish girl. And there's the fluidity, and biology doesn't determine gender, per se. There's a certain point in that fluidity where you say this girl is a boy … her claim, that she's a boy has a different status. In trying to focus where the differences lie, I've raised the question of ideologies. One that suggests that this transition is a perversion in some way, or a concretization, or a prevention of fluidity, and another that says no, there's this point in which

transitioning just becomes the next thing to do; the person then is the boy. And that those are two different ideologies in a way.

AS: To clarify, I'm not suggesting that there's a point at which we, as clinicians, say okay, this is too much gender of this sort, now it's crossed into the other category. That is a self understanding comes from the patient. But I am saying that on the level of metapsychology, we have trouble grappling with the idea that fluidity will not capture some peoples' gender sufficiently. That for some people, the experience of "gender", whatever that means, and the category of experience is complicated; we don't necessarily always and only take it at face value: it has a depth to it.

DB: You talk about a certain fluidity in gender expression reaching a point where it becomes socially transgressive – and thus becomes intolerable to the culture. I don't know if you are implying that that those who take my position are manifesting this intolerance. These concerns do not reflect an intolerance of trangressiveness, but centre upon the damage wrought through early foreclosure of a complex problem. In my view, the transgender movement far from supporting gender fluidity imposes a binary construction of gender which is very damaging to children and young people.

AS: We cannot outright rule out intolerance. As for the conversations around these concerns, what's striking to me is the lack of curiosity about trans experience, and the dearth of intellectual rigor with which some clinicians pronounce on trans. For example, let's take a child who expresses, both verbally and through their symptom picture, tremendous distress over their upcoming puberty. You seem to think that the problem is in the rush to give puberty blockers which forecloses thought. But what is more foreclosing than allowing a puberty with irreversible effects to proceed when the child is so distressed about it? Here is the paradox: the position that has been formulated as "watchful waiting" involves letting kids experience the development of secondary sexual characteristics, which is not at all about waiting. Another example of lack of curiosity is not seeing that colleagues of ours who treat trans patients might be seen as a resource; we could be asking them, "what, in your opinion, made it possible for patients who came just for a hormone letter to enter a long analytic treatment?"

Disphoria vs transgenderism and the consequences of transitioning

AS: I'm not saying that we can be outside of ideology, but that the notion that observed sexual difference (which is how gender is assigned at birth) is determinative of gender is an ideological position that does not understand itself as ideology but thinks of itself as truth or fact; like earlier, when David said to me, that I am confused about the difference between trans and gender dysphoria, almost as if there is a clear distinction between the two. I would actually love to hear more about how you differentiate the two, David.

DB: I think that in what you've said you've conflated biological sex with gender. And I think there's a distinction. So I think if someone feels that they're of the opposite gender, and maybe they should be helped, if that's the end result, to live like that. But I think there's a distinction between that and rather rapid moves in children and adolescents to embark on irreversible changes in their body, which we do not know what the outcomes are.

We know that there's risk in terms of opposite sex hormones. We don't really know so much about what the risks are of hormone blockers, but the NHS has just changed their website to say that we do not know what the effects of hormone blockers are; the implication is that there may be effects on bone, brain and psychological development that we don't know.

So I'm saying that before we embark on irreversible changes in children and adolescents, we need to be very careful and have due caution. I've certainly come across cases who've been helped psycho-therapeutically, in which they've changed their mind, but only after two or three years. Some have come out as being gay or lesbian, and wanting to live in a non-stereotypical gender identity. So all I'm saying is it takes us time. I don't deny that there may be some people for whom embarking on a medical transition may be the right thing.

RB: Who would that be David? What would make you think that that's the case?

DB: Well, I suppose that what I'm saying is if, after a number of years in the treatment, the child seems to not be able to be helped in any other way, then I think *perhaps* medical transition should be considered; at least it should be a possibility.

RB: How do you understand this as an analyst?

DB: Maybe I could just say one of the things you mentioned in your paper Avgi, the idea of life saving. There's no evidence for that at all. There have been two studies. One is called the PACE study. And the other one was done by Stonewall. And those studies are not in peer reviewed journals. And they're based on asking individuals to complete questionnaires and they are not random samples. And they're completely discredited. There's absolutely no evidence that suicidality, or completed suicide, is higher in children with gender dysphoria …

Secondly, children with gender dysphoria have very high comorbidities of depression, autism, and other difficulties. So even in these samples, which are not random samples, it's people choosing to fill in a questionnaire, often a retrospective questionnaire asking them how they felt x years ago. So they just don't stand. There are two things wrong with it. One is this. The inappropriate samples taken in order to heighten the belief in the risk, and that's been used: I've come across many parents who have been told, would you prefer a dead boy or a trans girl? And it becomes a kind of terror, so I think that shouldn't be in your paper, because there isn't any evidence for it.

But when you ask me: How do I distinguish between transgender and gender dysphoria, it's quite simple. They are conceptually different things. So gender dysphoria is the feeling of being at odds with your biological sex. There are many routes to that, as I've indicated in my paper, and we do not understand why there's been this huge surge. And my own belief is that it's a cultural phenomenon that we've yet to understand.

Transgender is, if you like, one of the causes of gender dysphoria. It is one route out of gender dysphoria. Another common cause of gender dysphoria is in women, particularly in girls, a feeling of hatred of their bodies, particularly their sexual body. Another important route is girls who have a same sex object choice.

So what we know, for example, is two things. One is if you say we have Group A and Group B. Group A that gender dysphoria is transgender. For children and adolescents, it is an expression of, if you like, true transgenderism. And Group B, where gender dysphoria isn't transgender. We have no way in any child of distinguishing who belongs to group A

and who belongs to Group B. In other words, who might in a few years change their minds. So I think a lot of damage is done by not taking up a neutral position and instead taking up an affirmative position. And to some extent, your paper seems to agree with that. But I think other times it wavers. That's my distinction between gender dysphoria and transgenderism. And I think it's really important that they're conceptually distinct, because there are so many different routes to gender dysphoria.

The other thing is … I know I come across a number of adult women who, when they were girls, hated being a girl, but now they're 40. So this is like 30 years ago. And they joined boys' clubs that had nothing to do with girly things. Now they're grown women. And they're more or less at home in their female sexual body; they're mothers and have children, but they recognize that if they had said these things nowadays, because of the huge cultural change, because of pressures coming from ideological groups, they would have misunderstood themselves very easily as being of the wrong gender. That wasn't a category available to them 20 years ago, but it is very available now because of cultural change, because of the internet, because all sorts of things that have changed. And therefore some of those girls who would later become reasonably adapted mothers, reasonably okay with the biological sex that they are, would have, I think, been referred to clinics, and they might well have had medical treatment, and possible surgical treatment.

RB: David, I'd like to question you about your position on two things. One is: when you come to explain dysphoria, you give a range of psychological and social reasons. But what explains transgenderism? What's your view of what makes someone truly transgender? What is that point at which one goes from the state of being unhappy with one's gender to one is another gender? What is that really?

And the other point has to do with the notion of "girly things", "Girly things" is a cultural notion, which in a way limits fluidity, does it not? One could ask whether playing football as a girl is a manly thing or a girly thing? So, what makes something girly?

DB: In regard to your first question, I think you're quite right to push me on that. And I don't have an answer. I really don't have an answer about how I would have an understanding of what it would be; that is, what kind of understanding would lead me to accept that a child really is transgender. I don't have the equipment available to do that. And I think when I say "really is transgender" … I suppose a better way of putting it would be, I might accept that the only way of being able to help this person is to pursue that avenue in terms of medical and surgical treatment. But it's quite possible I think that the individual who has made that decision in another culture would not have made that decision.

So the second thing you asked me: that's exactly my point. That gender identity, say the "girly girl" and the "boy-y boy" and so on, are completely cultural constructions. I think we tend to think that maybe because we live in urban environments in which things are more liberal and emancipated, at least we like to think so. But many children live in environments, at least in the UK, in which there's still quite a high expectation of girls conforming to a kind of gender stereotype (for instance a Barbie doll) which we feel is a stereotype. And boys are expected to be macho and so on. And so that when a child rebels against that, for whatever reason, they're sometimes rebelling against the stereotype of gender identity. And I think they could be helped to become more able to express

a less stereotyped version of gender identity, or maybe alongside that to accept their homosexuality without undergoing medical and surgical treatments. I think the very easy availability of medical and surgical treatments for children has had the effect of making it happen much more, that there's much less obstruction, I believe, than there should be, because there needs to be time to think before you embark on possibly doing irreversible harm. Given that we have no evidence, there are no follow ups on GIDS.

AS: You've touched on many points David that I'd like to comment on. First off, I think that we need to think a little bit about methodology because you are talking about studies and research. And the only clinical methodology that we have available to us as analysts who think analytically is not when we can call on resources from other fields, our methodology is the single case study. So when you say, David, that we don't have evidence, that is simply not true. We have anecdotal evidence. And that's the only evidence that we rely on as analysts. We have clinical evidence, we have clinical data. And while someone may contest the methodologies of aggregate data about suicidality, as you are doing, clinical data from psychoanalytic treatments tell a compelling story. Many analysts, myself included, who have worked with trans analysands find that suicidality is high in many such patients.

Further, when Rachel pushed you about clarifying the distinction between gender dysphoria and transgenderism, to me what it sounds like you are saying is that trans is something we have to concede to when other measures (to fix gender) have failed. So there's a kind of resignation and a kind of hopelessness that come with this person who has gone through treatment: "there's nothing else we have to offer them. So maybe they need to transition". But if a record of failed gender-adjustment has to be established before transitioning can be deemed viable *to the analyst* (or the doctor, or the law, etc), well that is not allied with a commitment to allow our patients to choose their own life paths rather than having to conform to our visions of what's right.

And I think, actually, that this kind of attitude is part of the reason why we don't have more trans people in analysis, and why so many analysts struggle to keep trans patients in treatment, to engage patients who are struggling with their gender in long term analytic treatments. Because we start with these assumptions and they are problematic, not on the level of ideology, but on the clinical level-and on the level of our patients' humanity. It is also why trans candidates are few and far between and why not all trans analysts are out about being trans.

I know what you're talking about when you speak of the pressure of patients who come to my office and say "I don't care what you think, I don't care about what this means. I just want the paper, I know who I am." But that is not an unusual clinical conundrum, a patient who comes in and thinks that they know what they need-in part, because they can't imagine what more analysis can make possible. And it's our job to engage them, and to interest them in questions they might have not otherwise asked about themselves. But if we're starting with the premise that transition is only an option if all else fails, then we're also closing up space to explore things, including things that the analyst too may not be able to forecast ahead of time.

RB: What's your ultimate premise here?

AS: My ultimate premise is that we can't start with an assumption of knowing what is the likely outcome, or even the possible outcomes, and that we follow the patient, not in the

sense of just going along to agree with whatever the patient says, but that we do things in the patient's time. So, a patient may come in who says, "You know what, in six days, or in six weeks, or in six months, I am going through surgery." We do not have it within our means as analysts to intervene in that necessarily and stop it, neither in my opinion should we. It's much like if a patient was coming in and saying I'm going in for high-risk back surgery; we would not be looking at the research to decide, to help them with whether that's a good decision. We would actually be trying to understand what this means to them, what are their worries, and what are they concerned about, and what is enabled and foreclosed. But we would not become preoccupied, as we do with gender, about whether this is a good decision.

RB: Yes, but this is really the crux of the issue – because with back surgery we wouldn't be wondering in this way. In David's paper, he mentioned the person who wants to have his arm cut off. So we wouldn't in that instance say we know what's going on here, my patient's going to have their arm cut off, right? So when you say that option should be in the range of normal, there's always some sort of premise of what that normal horizon is. It seems that you're saying changing one sex to one's gender is within your realm, but that's an assumption too.

AS: Of course, it's an assumption–

RB: Not a better assumption, necessarily.

AS: No, it's not a better assumption. It's an assumption that is supported by what's happening around us in many ways. It's an assumption that is based on the fact that we see people who have transitioned and are living happily – happily not in the sense of an ideality, ordinary unhappiness applies to trans people too, but as people who live lives that are much more fulfilled than if they had not transitioned.

David was talking earlier about suicide. I have sat with patients who have been intractably suicidal until they've started transitioning. I am not saying that all patients who have come to me and who have struggled with that and transition are then not suicidal anymore, or that all of that completely wanes. But your earlier emphasis on completed suicidality baffles me, as if we do not know as analysts how tragic it is for somebody to feel suicidal … I mean, why is a completed suicide the metric? I hear you on parents being terrified and being asked to consider "transition or a dead son?" I mean, that's, that's an awful predicament. It's an awful way to phrase it, and the wrong way to phrase it. I don't know any analyst who works this way. And I wouldn't defend any clinician who speaks that way to a parent. But I don't think that's the analytic question here.

And one of the things that I was struck with in your paper, David, is that, on the one hand you urge analytic thinking, and on the other hand there's no engagement with literature on trans, even as psychoanalysts have now spent decades thinking about it; I mean, if someone had only read your paper, they wouldn't know that analysts have been talking about trans in very complex ways, ways with which you may disagree, or with which anybody might disagree, but there's a discourse around it that doesn't even appear on the horizon of your paper. And I think that is confusing and something for us to think about. We're trying to have a conversation with each other about this very difficult issue, but the resources you are turning to are very selective.

DB: I'd like to go back to the issue of the single case study. You emphasise the value and importance of the single case study, in this regard, to our theoretical and clinical knowledge, and this is of course important and core to our work as psychoanalysts. But this knowledge is in the 'ideographic' domain – that is what we learn from the unique qualities of a single case. This is distinct from the situation where we seek to make more general claims about groups or categories.

A case study where the analyst believes that an individual patient may have committed suicide if they did not transition may be very helpful in bringing a deeper understanding of that situation, but it cannot be used to make pronouncements about the frequency of suicidality/suicide in transgender children, or even whether such suicidality is directly a result of suffering from Gender Dysphoria or of other factors I have referred to. In our discipline, there is a further complication of such generalisation. Beliefs about a patient firmly held at one point may later be understood as being part of a complex countertransference (for example a patient may put pressure on analyst to believe they will kill themselves unless they transition and this pressure may have complex origins).

These different kinds of knowledge can of course creatively interact with each other but the absence of the distinction between them constitutes, as I see it, a major epistemological and methodological error in your approach.

AS: I see we are back to the question of a completed suicide. I do not claim to know who might or might not have suicided if they had not transitioned-and have not said anything to that effect. And I continue to be confused as to why the loss of life is your focus, when a life of suffering is also catastrophic. What I have seen clinically are patients who are suicidal on account of their feeling that they are not allowed to be themselves gender-wise. And the work of psychoanalysis can, for some of these patients, free them to live their lives not according to what others want of them but by overcoming the considerable internal obstacles to be able to say: *this* is who I understand myself to be. Contrary to popular belief, such conclusions are not reached simply because of the internet, peer pressure, etc. Oftentimes, I see in my practice, a lot of internal resistance to accepting one's gender experience-and addressing that resistance-can be at the heart of the work.

And, David, you seem to worry about clinicians being "forced" by "ideologues" to accede to definitive identity claims. What I have found is that underneath the surface of patients' declarative definitiveness, can be a struggle with accepting themselves for who they are, with accepting their transness. On the outside it can look like some such individuals are clear about it and pressuring others to conform; but psychoanalysis has never been satisfied with looking at the outside alone, and what we discover on the couch is always different. This is why I am so insistent on psychoanalytic data.

The question of evidence and decision making in analysis

RB: Avgi, you're saying that your evidence supports this basic assumption that it's a normal and good thing to transition and the patients that have transitioned are happy.

AS: "No," I'm not saying that it's a normal and a good thing to transition as a matter of course. I'm saying that for some people it is the right approach, the right solution. I think

of gender, not just trans gender, but normative gender as well, as a solution. And I think normative gender is a solution that works for some people and not for others. But non-normative gender is not a solution if we (analysts) are expecting -or requiring- our patients to go through years and years of analysis before we permit that transitioning might be a good solution for them-and then only because we (analysts) are kind of at our wits' end, as David was implying earlier, and we just don't know what else to do with them.

RB: Well, I should say most analysts aren't involved in directing their patients to do this or that. I mean a basic analytic attitude is to understand the dynamics of the patient and help them integrate who they are. It's not about "Yeah, you know, given your situation … I think you should do this or that." That's not the basic stance.

AS: That's such a great comment because I think that's actually one of the linchpins of our difference, which is that, yes, we would theoretically all agree on that. But then I'm thinking even of your Introduction, Rachel, where you say it's not our job to make decisions. Now, of course, if somebody tells us they want to have twenty children we would not treat this statement the same way we would if somebody said that they want to have one child, we might wonder about why twenty. My point: why we wouldn't also query the more normative wish. I would actually urge us to think about why we wouldn't grant the same level of curiosity to a wish that we understand as normative in gender as well.

For example, we don't ask in our minds gender questions of cis patients. We're only preoccupied with gender when it comes to trans patients, and some of the momentum right now is in thinking about trans and what psychoanalytic discourse on trans is contributing as a way of rethinking our assumptions about cis genders - and about the ways in which the body's materiality does end up lining up with psychic experience.

So yes, theoretically, we never tell our patients what to do. But that is an asymptotic ideality that we never quite reach. We always have our own countertransference intrusions and objections, and the regulatory anxiety which we always have to tend to-and mind. So when, for example, I hear David say, look some people eventually have to transition because – and these are not your words, David, but I think I'm saying the same thing, as you said – because … there's nothing else to do about their gender, so maybe then they have to transition, that's a problematic stance. Not only is it disparaging but, it presumes a gender that is a core identity that is either discovered to be right, and then you're on the right track-or not. I think that the question of "is somebody trans" is the wrong question, to me. Somebody *is* not trans in the same way that somebody *is* not a woman or a man. These are all gendered adaptations and solutions that we come up with, that feel real to us on the level of the ego, but they are all psychic constructions, ways of crafting a life independently of whether they align with one's body or not.

DB: About what you were saying about suicidality: the claim has been made by trans ideological organizations such as Mermaids, and Gendered Intelligence, that not only completed suicide, but suicidality, thinking of suicide, is commoner; it is commoner in individuals who are not put on the pathway to medical treatment. And there is no evidence for that. So that's it. I'm not talking about what a patient tells you or doesn't tell you. I'm talking about what is stated about this group. And that gets into the culture. And people start to think it's true. And it's really important. And you, I guess you'd

agree with me that if there's no evidence to support that in the population it shouldn't be said. That's not the same thing as being very concerned. I agree about an individual patient who's saying they feel suicidal and they feel the only route is to go on medical treatment. But these are different things. It sounds as if you'd agree with me, that it's unfortunate that this false information has got into the culture, and it's affecting the way services act.

To come back to what you're saying, I suppose my position is that I don't think a child of ten has the capacity to consent. We've had cases, I think it's fairly recently but I'm not sure, of a young woman of 21 who wanted to be sterilized. And the doctors refused because they said, having talked to her, that they didn't think she really understood what it would mean. And they had tried to encourage her to use contraception and talked to her about contraception. And this was supported in the courts – that the doctors had taken the right route.

Now, 90% of children who are around puberty who go on hormone blocking drugs go on drugs for which there's been no trials for this problem, none at all; they were originally used for prostate cancer, and they were used for precocious puberty, so they're called 'off-label[1]', so we don't know what the consequences are of these drugs. Does a child have the capacity to understand what they might become, for example, infertile, or possibly anorgasmic, or have to endure– probably having to have a hysterectomy for vaginal atrophy, and to be on medication for the rest of their life? So I am saying that to affirm a choice, in that situation, is not helpful.

I think one should be neutral as far as a patient is concerned. For example, if a patient said to me: "You know, I'm born a girl but my name is John," I would call her John. What's the point in arguing if that's what she wants me to call her? But I wouldn't *affirm* her necessarily as biologically different, nor would I disaffirm, I would try and maintain a kind of third, neutral position. But as Rachel says, we all operate within culture. And as you say, we're all affected by presuppositions, perhaps we don't interrogate them enough. But nevertheless, if a child came to me, or my colleagues, with a great pressure to proceed immediately to medical treatment, I would think it'd be helpful to do what one can to delay things. Now, that doesn't mean to say, in some insensitive way, you say: No, no, no, no, no, that's the wrong decision, that doesn't exist what you've got. Of course not. It means listening. As a patient put it to me: someone had asked him what it's like to be in analysis and he said: "well, it's like having someone on your side, but not siding with you, that's a completely different matter'. I think the pressure is that we need to be on the patient's side in terms of exploring things, but not side with them too quickly in terms of quick action.

… I think that the sense of first doing no harm doesn't mean telling people, "No, you can't do it". But I would still think it was a good thing if a child, as a result of help – maybe for them and for their family – decided I'm going to put this off, I'm going to wait until I'm 17 or so. And if I still feel the same, well, maybe they're an adult and they can pursue it. But I think we have a responsibility to children … I think my position is that we need restraint and waiting, that the child can be sensitively helped into that position, as I know some children have with a lot of help, with some of them turning out to be gay and lesbian. That's my position.

[1]This refers to medications which have been approved, but approved for a different purpose.

The meaning of undergoing sex change

RB: David, you emphasized a special issue that comes up in regard to children, but it seems that you're impacted by your understanding of the meaning of changing one's life in this fundamental way. It touches on those basic presumptions about changing one's sex in general, which as you say are culturally influenced. Is it a good thing? Would you hope, would you feel - yes, I look forward to my grandchild becoming transgender?

DB: Well, you see, I don't think you can change sex. You can change gender identity. But I don't think you can change biological sex. Because that's a material fact of life. And phalloplasties are not penises. So I think we misinform patients. You know, the individuals who I've been talking to, some girls, now young women, say I'm not a boy I'm just a girl with a mutilated body and that's what I have to live with now. So, um, and there's a growing number … the clinics do not know how many people regret it because they don't follow them up.

AS: Can I say something about that? First of all, I think that you are forgetting, or rather, are assuming that trans people who transition medically would identify in a straight way after transitioning, that transitioning saves them from the homosexual orientation, when in fact, there are a lot of people who transition who are attracted homoerotically after transition. So that throws a little bit of a wrench in the ideological thinking that transition saves somebody from homosexuality and the perils of homosexuality. But I also want to push back a little bit, Rachel, on your question to David when you say, could you say that you look forward to your child being transgender? And I think that this is the sort of question that 20 years ago would have been asked about homosexuality – would you want your child to be gay? Well, no, the assumption is, because they would have a bad life, or because the world will not accept them, or because that's the wrong decision for them. I think that such statements are inching closer to attitudes that might actually be quite damaging for not only for trans people, but also for psychoanalysis as a field. And I'm actually quite worried about whether we make room in our practices for trans patients, or in the field for trans clinicians, for example, and I said this in my paper as well, here we are having a conversation about trans and there's no trans identified person in the conversation.

On exclusion

AS: Now I know, David, that you have some concerns about what it means for somebody to speak from an identity position. But if we're also trying to think about something that is extremely complex but the subjects of whom we are speaking are excluded – or they're not included, they're not excluded, but they're certainly not included. I think that we need to give this some thought and to also think about what is baked into our thinking that may have to do with transphobia. Not because psychoanalysis is always or exclusively transphobic, but because we have all been raised, socialized, and analytically trained in cultures and metapsychologies that treat normative gender as the expectable, unquestionable endpoint.

RB: I think there are two factors that come into play here. And perhaps we can reflect on this. One is the fact that someone has presumptions or assumptions about what's normal, what's pathological, or about what it is to be a human being, what it is to be a man or a woman, doesn't mean that they are unexamined assumptions – one could have examined assumptions. One could say – yes, I think this is what it is to be a man. And this is what it is to be a woman. And this excludes certain people from that realm of normal, right? Just as you too somewhere, Avgi, have things that you exclude from the realm of normal, everyone does. And you say, well, now it's more culturally accepted to include this group or that group. But the fact that it's culturally accepted doesn't mean that there isn't still a debate on the level of assumptions of what is right and what is good. And assumptions may not only distort but actually also open us to see reality.

Secondly, there's a question of what psychoanalysis can contain. I mean, psychoanalysis deals with the limitations of one's bodies and accepting the limitations: that not everything is changeable. …

So what I'm saying is on two levels. One is that these assumptions don't mean that they're unexamined – they can be examined. And the other is: what is the role of psychoanalysis thinking about these assumptions? What about analytic assumptions having do with accepting limitations, rather than overcoming them through concrete solutions? People who object to transitioning often say – well that's a concrete solution to an inner dynamic.

AS: But so is marriage. Marriage too is a concrete solution to an inner dynamic. But, disciplinarily, psychoanalysis does not go after the institution of marriage.

Back to the issue of irreversible consequences

DB: You can get divorced, but you can't undo the surgery.

AS: Oh, but you're talking as if getting divorce is of no consequences as if it's just reversible, as if people who get divorced don't leave sometimes with huge psychic scars, including how that affects children. There is a kind of privileging of the body in treating trans as a special category. That I think is where we might differ. And, to be clear, I'm not saying that everybody *should* transition, only that those who want to should have access to it.

DB: But would you agree with me that if a child of 10 has acute onset gender dysphoria – and one knows already that they come from a troubled childhood, and one suspects that there may be ambivalence about sexual object choice, and there may be other complexities that the child may be on the autism spectrum, which somewhere between 25 and 50 percent of girls are – would you agree with me that it would be a good outcome for the time being if the child and the family said: "Look, we've thought about this, and we've decided not to put that pressure to have irreversible treatments, but to wait and see, and let's have a year or two of analysis or psychotherapy." I can't deny I think that would be a good outcome, because a child isn't embarking on irreversible treatment. Would you agree with me?

AS: I'm not sure and I'll tell you why. I think it's a very complicated situation. There are times when a child comes in who has a very consistent gender history. And from very early on-

DB: No, I said – acute gender dysphoria.

AS: I'm getting there … And they've been very consistent, and there's no seeming ambivalence. And then there are children who come–and for me, the most difficult thing is when a child like that walks into my office and they're like a year before puberty, or six months before puberty – not that puberty can be accurately predicted – but let's say that they are like 11. That's a difficult age because puberty is about to hit. And there's an urgency to it, an urgency that has to do with biology as well-puberty won't wait. And let's say for example, and this is an example from my practice, a child of that age whose parents divorced six months ago, and all of a sudden the child is now wearing dresses and is presenting themselves as a girl, and is on the cusp of making identity statements but not quite there yet. It's very complicated but I am not prepared to say this child *should* wait. I am hoping that there will be space for this child to wait. But I think it's very, very complex.

DB: Could you distinguish this? Like me, you say you want to be able to create the time and space to think and wait. But you say you're not hoping they will do that.

AS: No, I didn't say I'm not hoping. When you say to me, "okay but would you agree with me that that's the better choice?" My answer to that is I don't know. I don't know if it's a better choice, because there are also children – I don't know what the percentage is, I don't think anybody knows yet the answers to these questions – there are also children for whom a divorce or a crisis in the family has permitted them to express something they couldn't express before. I do not know and we cannot always tell in real time. Some of these things happen are only possible to discern *après-coup*. I cannot forecast where the child's gender would go-

DB: I wasn't just saying waiting.

AS: Yes, but let me finish. So would I say it's always better to wait? I wouldn't. The reason why I wouldn't is because there is a cost to waiting which is that to "wait" means to allow puberty to go on. Like, if puberty starts there are a certain number of irreversible changes that the child will have to live with. Now, I'm not saying because of that, we don't consider complex questions. I'm not taking an either/or position. What I'm saying is that I do not feel as confident as you do that waiting is the best choice, because waiting is not without consequence either. Because there's a third factor, which is puberty, and we have no say over puberty, puberty will proceed if we don't intervene. So my position in cases like this, and the position that I take with parents, is that my role is not to advise them for or against transitioning, but to make sure that they're keeping all the information in mind, and that nothing gets dissociated. So when I sit with parents, I never advise for or against transitioning

The place of transgenderism in analytic treatment in general

RB: There's a more fundamental difference here, because you're waiting to see where it's going to fall: if he's really a boy or girl … which way is it going? For David, I don't think it is on that same status; it's more like let's see if he can maintain his biological sex and live happily with that.

And if so, in a way, Avgi, I think you'd be suggesting almost all non-transgenders should explore whether they're transgender, and that would be a positive thing. One should explore whether they want to change and maybe they're not aware of the possibility, and why not? This would be consistent with your view, wouldn't it?

AS: No, it wouldn't be because that's extreme. And it's at the far end of what I'm suggesting. I'm talking more about gender conflicts and gender, the ways in some cis people coagulate their gender into very restrictive forms because any degree of deviation from that restrictive male or female form feels dangerous to them. That's a cis kind of identity that would benefit from some questioning, but not specifically from the question – would you like to transition? Have you ever thought about that? I'm not talking about that. I would never advise that that is done that way but keeping normative gender open to inquiry is important as well, and that gets easily overshadowed by the hypertrophied emphasis on trans.

What I'm saying about David's question, is that there are instances where I struggle when kids with seemingly new gender evolutions come to my practice. … Of course, I will ask questions like: how long have you been thinking about this? How did this develop? What are your thoughts? Of course, I would be asking these questions, the difference between what you're saying, David, and what I'm saying is that I would not be asking them with an eye towards slowing them down. But that the very act of asking them has the hope to create time. But whether it can create time, or not, is not something that I have control over.

RB: Avgi, why is transitioning a good option … You're saying, you're not trying or hoping to slow them down … that we should be more inclusive and allow for this as an option. But why?

AS: I think that you're mis-hearing me, Rachel. I'm not saying that I would hope that they transition–

RB: No, I'm just saying: why is that a good option?

AS: And I'm not saying that it's a good option on the level of – these are my beliefs, this is what *should* happen. I'm saying that for some people that's the option. That for some people that has worked. I'm thinking of a trans woman I have in analysis who came to see me after a long 12-year analysis with a colleague, during which the patient had a psychotic break. The analysis was very successful, the patient felt they stabilized during it. The treatment ended and a few years after that, she felt, "I have never addressed my gender issues and I want to see somebody to talk about gender." And I've been seeing her now for eight years. And for the first three years we never talked about gender. We talked about her psychotic break, and what her break meant and evoked for her, and how she was coming to live with and reflect on her lingering delusions, and she eventually was able to go on medication. And she further stabilized in several ways. And it was only after that that she brought in the question of gender again, that's when she was ready to address it. And we started talking about it and she began transitioning. And the difference in her life that transitioning has made has been tremendous. She has felt that it permitted her to get into a relationship with somebody with whom she's very

connected. She has been able to work through some of the issues in her family and her relationship with her mother; not because of transitioning, I'm not saying that transitioning was this magical solution. But because less energy was taken up in her trying constantly to prove to others that she is who she is. So that it opened up space for her. Now, I'm not saying that everybody should do that, or that, you know, this is a good solution for everybody who's struggling with X or Y issue. I'm just saying that for her, and for many trans people, it's proving to be the right path.

Happiness as a criterion for success of transitioning?

RB: Yes, so you're taking as your measure subjective happiness – that whatever makes people happy. And I should say that when you refer to non-transgenders as "cis", which I understand is part of the jargon, there is a position that there are two kinds of stances: there are those who are transgender and those who are cis. And these are just two kinds of positions, which can make one happy.

AS: Yes, I don't know if I used the word happy, but it's not a word that that I find useful. I'm not saying that people who transition are happy or that that's the criterion or hope. In fact, a couple of years ago the New York Times published an article by a trans woman, Andrea Long Chu, and she made a very interesting claim which I have found to be very true for many of my trans patients. The title of the article was 'My vagina will not make me happy. But that should not stop me from having it.' In it, she talked about how she was about to go into genital surgery. And that she did not expect that her surgery would magically and completely cleanse all of her life difficulties, or that it would make her happy. She said something like: I fully expect on the other side of the surgery to be struggling with various dynamic issues that I'm still struggling with. But the fact that it will not bring me complete happiness should not be a reason for me to not be allowed to have it.

And that was actually very clarifying for many of my patients-as well as my colleagues and supervisees, and, I think, also in the public discourse on trans here in New York in general. Because in a way what she was saying was, I'm being asked to have it both ways: on the one hand, I should be allowed (legally and medically) to transition because if I transition, I'm going to be happy, but on the other hand, that leaves me with very limited ways for me to be petitioning for my surgery, arguably overly simplistic, rightly, people will say surgery is not a magical solution. So I think that the notion that happiness is what lies on the other side of transitioning is an incredibly impoverished notion of how we understand transitioning. I think that we're talking about somebody's experience, we're not talking about magical solutions that leech the difficulty of living out of anyone's life; trans people remain human beings with complexity, with anguish, with pain. Transition does not solve something, it can improve some aspects of one's life, but it doesn't completely do away with all unhappiness. This is my concern with the "happiness" discourse on trans.

Cause vs choice in the context of transgenderism and homosexuality

DB: Can I just come back to something else? Um, two things really. One is, some people think that if say a child presents with gender dysphoria, and as a clinician you want to

think about how this has come about. So I would call causal with a small c, obviously we don't know a cause, but causal pathways that have contributed. Like in one case I came across there was a bereavement in the family and the child suddenly wants to be the identity of the child who died and says I am now a girl. Or other pathways we might think of, like to do with homosexuality, which I think is a very, very big one. But some people believe that to think in terms of that way is wrong, that it's a form of discrimination; it's a form of patriarchy to say, you know, I'm going to think of causal pathways. Because they would say it's purely a matter of choice and nothing else. Now, I wonder whether you agree with that, or whether you think it is helpful to think in terms of developmental pathways that have led to this. And that one would think in a different way if someone said I suddenly got interested in sports cars. That is, one might be interested in why – but it has a different kind of cultural weight, and a different meaning to a psychoanalyst.

AS: So I have a third opinion, which is not in your list. I don't believe that it's a choice any more than anything else is a choice. I think that there are unconscious determinants for all gender positions. My understanding of the position advocated by people who say we shouldn't be asking 'why' is that that "why" question comes from a very particular way in which that "why" has been asked, which is that, swirled into it, is the premise that if we can understand why then we also know how to treat it and how to make it go away. And I think that's the anxiety, at least as far as I can tell, that accompanies some of the pushback against the search for etiological factors. But if we were able in some way to leave out that preoccupation about "why", and replace it with "how" to make people comfortable in the bodies that they have or want to have, and just observe how patients manage their own solutions, instead of the solutions that we feel they should have, ideally, I think that there are ways to ask after developmental pathways to think about how has something come to be? And what does it mean to the patient? And what work does it do? And how does that work for the patient or not work for the patient? It's a different kind of sensibility …

RB: If I may comment, it seems that there's a different approach to conscious versus unconscious determinants here; that what you're saying is I think that you'd be more concerned with the patient's conscious; that you'd give it a different weight from the weight David gives, when someone says, for example, I'm a boy or girl …

AS: No, what I mean is that when we ask questions to patients, like "what do you think of that?" we don't take their answers at face value. We will listen to their answers for content, but we also listen for associational trails, we'll listen for slips, we listen for all kinds of things. So, I am not implying that whatever the patient says is what goes, though that should not be overlooked completely either. I am saying that the "why" question has historically been wielded with a certain kind of force-this is what I think some analysts, myself included, are pushing back against when we say we don't want to be thinking about etiological factors. That's why I very much appreciate the psychoanalysts Ken Corbett and Griffin Hansbury who, in relation to homosexuality and trans respectively, ask us to move to push past the "why" to think about "how". "How" does not have the value judgment in the same way, and, like it or not, we are in a culture where there's not a lot of room for non-normative kinds of experiences. Despite this proliferation of activism and

activity around trans, there is still, popular misconception notwitstanding, not a lot of room for thinking about these kinds of gendered experiences. So, the "why" comes across as assaultive or aggressive even when it's not intended to be.

DB: I had someone referred to my service a while ago. And she had been to a plastic surgeon because she said that there was something very wrong with her ear. And she wanted plastic surgery. And he saw her number of times. She was a young woman and he couldn't understand what it was that she thought was wrong with her ears. They weren't very unusual. They talked to her for a while, and then he referred her to my service. And he said, I don't think there's something wrong with your ears. I think there's something wrong with your relationship with your ears or what it means to you. And that person had psychotherapy for a couple of years. And at the end of that decided–and I don't think she was pressured– that she hadn't recognized that her ears were like her father's. And for reasons that I can't go into, really, but there were very disturbing dynamics between her and the father. And she regarded it a good outcome that she'd waited and not had surgery, because she needed to understand and now she felt she could stay with her ears and not just feel it was a part of her father that had been intruded into her.

So the reason I give that example is that we regarded that as a good outcome. And I think most analysts would. So I think there's something of the same kind of thinking going into what does the sexual body represent to the person? What are the identifications? What are the pressures known and unknown, some are cultural, some are conscious or unconscious, some are family. And it takes a long time to disentangle these. That is my central point. You know, when you mentioned homosexuality, one of the most distressing things I've come across is that it has been particularly young women not having recognized that they were gay, they were lesbian, and really being so disappointed that they hadn't been helped to see that, and that they would not have what – given where they are now, seven, eight years later – they wouldn't have had medical and surgical treatment.

And just before I stop, I do think there's a difference between the problem about homosexuality and this problem, and again I think they easily get elided. And I think many therapists and analysts are actually sort of worried that if I have concerns or worries, am I being transphobic likened to homophobia? And I think it's entirely different, as I tried to illustrate in my paper with the example from Eysenck**,** and his extreme form of conversion therapy. And what the gay philosopher saying to Eysenck, is that the man who comes wanting to change from being gay, he may say he wants to change, but he doesn't know what the determinants are that are pushing him; that some of them are social, some of them cultural, some of them individual. And being helped to understand those determinants, which may take time, goes against making any quick decision for this kind of terrible conversion therapy. Now, I think the pressure to have medical treatment quickly is a form of conversion therapy. That is, it closes things down. And it sides with a move to change the body quickly into the person's mental view of how the body should be. And I think doing that quickly, I would call that conversion therapy, because I think the forces that are bringing that quick solution are coming from so many unknown quarters and need to be interrogated. So I think it needs very much to be distinguished. I don't think I'm transphobic in hoping that children might

be able to wait. And I'm certainly fiercely against any discrimination against trans people because of their trans identity. But I think it's too easy to elide these things, and I think they're different.

AS: So here's where I disagree with you about your example. I don't think actually that your example completely transfers to thinking about trans and I'll tell you why. The woman with an ear problem: this woman was told I think you should see a therapist, and this woman came to see a therapist, and she benefited from that. And I agree with you that was likely a good outcome. But this woman wanted to come and see a therapist and she had some interest in participating in this process. Now imagine, especially a woman with a history that you've described, if she were told, "You know what, you think you know about your ears, I know better about your ears. This is not what you think, and I will not give you the surgery. No, absolutely not, you're illusioned here." In that scenario, that imaginary scenario, the doctor would be doing to her exactly what her father has done to her: something very disturbing. So the doctor, in trying to protect her, and with the best intentions, would be harming her. This is my issue actually with the title of your paper.

DB: I'm sorry, the doctor wasn't harming. The doctor said to her: "I don't think there is something wrong with your ears. I think you need to think about it." So, you think that was harm?

AS: No, you didn't hear me. I'm saying that if the doctor had said to her. "I am not going to give you the surgery because you don't know what you're talking about. This is not about your ears, this is about something else, go figure it out", and the patient had no buy-in, if the patient had no curiosity, or was not in some way interested in exploring that; if it was an injunction rather than something that the patient was herself interested in exploring. To bring it back to gender, it's as if we were to say to our patients, "What? You want to transition? No, I'm not signing on to that, because I don't think it's the right thing for you." Who are *we* to think we know? What I'm trying to say here is that we don't know and that if that doctor had said to her, "this is the wrong decision for you," even though she wanted the surgery, for him to say "no" to her would have been psychically harmful because there is in fact no equivalence between the ear and gender. That's what I'm saying.

DB: Would it be the same if someone said, "I want to have an appendectomy, it's my body and I want to have an appendectomy. And the doctor were to say, "there's nothing wrong with your appendix. I don't operate on normal bodies."

AS: That's the crux of the question, David, that we're starting with different premises about what harm is. You seem to know ahead of time what harm is. That's why you say something like, "if somebody wants to transition I think they should wait; maybe they can find a way to connect with their body". That's why when you said to me, what about this 11-year-old? Wouldn't you think that it's incontestably a good decision for them to wait? And I'm saying to you, no. I don't think it's incontestable.

RB: The example of the appendix, what would your position be?

AS: I don't think it's a parallel. Because our relationships with our gender and with our sexual beings are not equivalent to our relationship to an appendix, or to our relationship to severing the arm, like in your example in your paper-and if the arm has that kind of meaning for someone that needs to be explored. But when we are starting with the premise that it is harmful for somebody to transition, or that it is harmful for somebody to not transition, we're acting as if we can know ahead of time something that can only be known in the *après-coup*. As analysts, we just do not have that kind of foresight.

DB: I'm saying because we don't have it it's better to wait.

AS: But the waiting is also a doing, it's not neutral. It is also a decision with material effects, and also psychic impacts especially if the waiting comes from the analyst and not from the patient.

DB: It is a form of doing … but I think there's a quantum difference between having some form of psychological help and having irreversible changes made to your body medically and surgically.

The judgement of the Judicial Review in England and Wales took the position that children and young people do not have the capacity to consent to Puberty Blockers (I recommend the careful reasoning in this judgement which is available on the line). They found, and I agree, that the child is often in too disturbed a state to be able to weigh up calmly the pros and cons in a balanced thoughtful way and even if they could, there is no available evidence to base consent on (e.g. no proper follow up studies, etc.).

Although clearly waiting is, as you point out, an action, an action with consequences, it is clear that with the appropriate help children can be supported. This is doing far less harm than rapidly putting them on the road to potentially irreversible damage to their bodies.

AS: Indeed, the High Court found recently that children cannot consent to puberty blockers. This is such a big issue to open here because it involves legal concepts, Gillick competence, and other dimensions that space constraints prevent us from addressing in full detail. But since you raised it, I have the following to say.

First of all, this decision has been appealed, and new arguments will be heard in June of 2021.

Secondly, the decision of the High Court is (on the global stage) in stark opposition to the medical recommendations made by a number of professional bodies, such as (to name a few), the American Medical Association, the Pediatric Endocrine Society, the American Academy of Pediatrics, the American Psychiatric Association, the American Psychoanalytic Association, the Endocrine Society, and the American Academy of Child and Adolescent Psychiatry, all of whom have issued clear and studied guidelines that clash with the court's decision that children should have no say over their gendered development.

Third, part of the way that case was brought to court was to conflate cross-sex hormones (CSHs), which are prescribed in mid-to-late adolescence, and which have irreversible bodily effects, with the administration of hormone blockers (PB), which are prescribed

before puberty's onset to delay the development of secondary sex characteristics. The impact of PB is fully reversible once discontinued; CSHs are not. The plaintiff's legal team claimed, and the court's finding agreed, that since PBs are often followed by a prescription of CSHs, PBs effectively have irreversible effects. This conclusion has been heavily critiqued. That PBs are often followed by CSHs mistakes correlation for causation: PBs *do not cause* the need for CSH, the correlation testifies to how carefully kids are screened for blockers to begin with. Many commentators have made such observations.

Fourth, however much popular culture is treating trans as a new phenomenon and medical transition as a new medical horizon, neither are new. Medications in children *are often used off-label,* and there are a lot of data on puberty blockers being used for other conditions, as you mentioned (like precocious puberty). We have a sense of what biological and medical effects PBs can have, so the claim that we are in completely uncharted territory is exaggerated. As for the risk of CSHs, let us remember that what is administered is not a newly concocted chemical compound but a synthetic form of a naturally occurring hormone that human bodies already manufacture-and which medicine already uses (e.g. in treating menopausal women, etc.) Gill-Peterson's research supports a lot of these points very compellingly.

RB: Suppose the person with the appendix managed to find a doctor somewhere that removed it. And he felt better about having his appendix out. So what then? It's still not right … So the question, is it really some sort of finding that determines the difference that you're pointing to, Avgi? Or is it again, an assumption, and then it's an assertion open to debate about how we see what it is to be a person.

On transitioning regret

AS: But since when did psychoanalysis make it its province to prevent patients' regrets about their decisions?

… So David is saying, I would rather they wait because I've seen too many people regret it. And I'm saying, since when has it been our job to help people not regret something, like patients go marry people, they go and have kids, patients who shouldn't have kids, patients with whom we have all kinds of concerns, and yet we don't step in. But when it comes to trans, many analysts feel that it's our duty to step in. I have serious ethical concerns about that. With patients who have kids, we may raise questions, but we don't advise that they wait to have children, even when we feel we see the problems coming. And if they don't wait, and they have kids, and things go badly, we don't tend to feel responsible that the children suffered because of the parents' pathology though, of course, we often feel concerned and sad about it.

DB: I do not see the relevance of the fact that we do not advise patients in analysis not to get married or not to have children. Clearly individuals who come for analysis may lack a deep wish to understand themselves and may want to get on with some plan of action which may be damaging- and of course we do not stand in their way. And I of course agree that an analyst should take a neutral attitude with her 'trans' patient (not rejecting *or* affirming). But this necessary neutrality is currently under attack from trans ideologists who

claim the only appropriate attitude is 'affirmation' and they are seeking in the UK to persuade government that this is the case, claiming that neutrality is 'conversion therapy'. ..

So it's not a matter of advice. But take for example anorexia. You may not want to say you must eat, but you still regard it as a good outcome if they became able to eat and have a normal weight. I say that because some people think that some of the patients presenting with gender dysphoria are the same people are used to present with anorexia.

AS: I am not sure about that parallel-that there is an analogy, that is, between normal weight (which is a matter of health, though that too is ideologically vexed), and … what would be the analogy here– "normal" gender?

As for neutrality, as I've been saying "doing nothing" has effects-and thus, is "doing something": if anything, it is an implicit siding with or sanctioning of normativity. I notice, for instance, the scare quotes you put around the word trans here (about the analyst's neutral attitude with her 'trans' patient), and wonder what implicit work those scare quotes do. Do they imply that trans is invalid? That we have to concede to "trans" though, as analysts, we should understand it as a problematic experience that should be avoided if at all possible, and delayed for as long as possible?

To me, the notion that trans is an ideology sounds chillingly similar to the old notion of the "gay agenda." It is not ideological to think complexly; quite the opposite. On the level of public discourse, I wonder if some of the debate about refraining from using PBs is a way of wishing trans children out of existence in the name of saving them.

I also want to stay a little bit with your question of regret. Whatever the numbers you cited earlier mean, and I am not familiar with those numbers you reference, it's too early to don't know what they mean … but, what we do know is that rates of post-operative regret in trans patients are lower than rates of post-operative regret in patients with medical surgeries. They're actually lower than in patients with that because-

DB: You don't know that because they've not been followed up. There's not a single years on follow up study.

AS: Actually, there are two. There are two studies that compare medical regret in trans patients who transitioned medically comparing them to surgeries of a medical nature.

DB: What percentage of patients were followed up?

AS: I don't have that information in front of me.

DB: Well that's crucial, because some of these are just self-reports. They're not properly designed as cohort follow ups.

AS: But if you say to me, there's no research. And then when I say to you, there's research. You say to me, it's the wrong research. But the research that does exist is pretty consistent on these findings.

DB: I asked you … if you wrote a paper, you must be able to give me something of the figures.

AS: I don't have it in front of me but I can send it to you[2]. But I'll give you what I do have immediately available, which is anecdotal data from my experience of working with patients analytically, which is that in the amount of time that I've worked with patients, and these are patients who have gone through long processes, I have had patients who have gone off hormones but felt that was a part of their gender exploration. They do not necessarily think of what they did as detransitioning, but as their gender further evolving. And I have not yet seen a patient that I have worked with regret their genital surgery, except for one case, very early on in my career, where somebody came to me right after surgery they had and was very regretful of it. But research shows that that is statistically very rare.

DB: I would be happy to discuss the paper you feel that I've neglected. But I should say that the studies, that I know of, are methodologically flawed and have been subject to rigorous critique. For example, in regard to suicidality, one major methodological issue is to rely on surveys where the participants are self-selected and so the data is unreliable in the extreme; then there is the problem of assuming that any suicidality in a child/young person with Gender Dysphoria, results *only* from problems of gender identity and not from other comorbid problems that I have referred to such as autism, depression, internalised homophobia etc.). There is no basis for such a claim- recent studies show the high incidence of adverse early experiences in this group.

Coming back to your point about regret, The Tavistock has given a number of 1 to 2 percent regretters. But when that was interrogated, this referred to patients who came back to see them saying they now regretted the medical/surgical intervention. . But this is a completely unreliable figure as it relies, not on follow up (there is none) but on individuals coming back to say this and the large majority of the patients who regret *don't* come back. You would need to follow up for over 10 years to get some sense of the percentage of regretters.

AS: First, I am not sure where your ten-year follow-up mark comes from-why not 4 or 17, it's not a standard I have seen in the literature. Secondly, and more importantly, it is true that, for varied reasons, transphobia being one of them and lack of genuine curiosity and rigor being others, there has not been as much medical research in the area of trans medicine as in other areas of medicine. But this is not to say that there are no studies at all, or that what I say is simply conjenctural. We do have research coming out; for example, a recently published study,[3] which appeared in the respected journal *JAMA Surgery*, looked at an N of 27,000 patients in the US who had undergone gender-affirming surgeries and found (at a statistically significant level) that surgical interventions improve mental health, reduce substance abuse, and depress levels of suicidality.

And yeah, we don't know much about regret; you're right about that. We don't have a lot of longitudinal data. And what we also don't know is what regret means to the people who regret it – to go back to the case that you were talking about – how many people regret it because it was the wrong choice, as opposed to bad surgical outcome. Because I can see a patient who has a bad–

[2]Dr. Saketopoulou provided Dr. Bell and Dr. Blass with a list of several such studies in a follow-up email. To preserve the conversational tone of the exchange, this discussion does not include references. Interested readers who want access to the studies referenced here may contact Dr. Saketopoulou directly at avgisaketopoulou@gmail.com

[3]Again, please contact Dr. Saketopoulou privately for the reference to this study.

DB: No, the ones I'm talking about, the clinical examples, I know about 20 of them (it wasn't the wrong surgical outcome, that one case I mentioned was a different thing: that was a catastrophe), they've got the right surgical outcome, but they regret it.

AS: I agree with you that we don't know the numbers.

DB: So shouldn't we first do no harm?

AS: We don't know what the harm is ahead of time.

Working analytically with trans

RB: Well, there's not only the outcome; there's the dynamic of the person wanting this kind of concrete change. So there are differences in how one sees the role of the unconscious dynamic, even before they regret it. Is there a place to see what's going on? And why someone wants that? And there's room for understanding that as well.

AS: You say that goes back to the "why" question.

RB: Which is actually why it's not aggressive. "Why" isn't shouting at someone in some mean way – "Why?!"

AS: I didn't say that it is. What I was going to say is that I see a lot of patients in my practice who have transitioned, who are living their lives, and who are talking about their mother or who are talking about areas of great psychic pain that have nothing to do with gender. We're talking about trans patients as if they're only about gender. And there's a whole host of other dynamics.

DB: I think that's absolutely right … One of the problems in the settings I know of – which are not patients in analysis – is that because of the huge cultural changes which affected schools and therefore affected clinics, a number of clinicians have made it clear to me that child psychiatry services are completely overburdened.

Now that you've heard there's a gender specialist service, one of the things that we've realized that happens, and I don't know if we can stop it, is a child has many complex issues, but they mention amongst these issues gender, and then, because of the cultural changes and also the lack of resources, everything quickly gets filtered into gender. In referring them to the gender clinic, it concretizes all the problems they have into being something about gender, which can be a relief, because it's one thing now, it's not many things, and then the clinic is a funnel for passing patients on for medical treatment. So I think that's a fact. And that's very unfortunate.

AS: This is important. I couldn't agree with you more that things can get boiled down to gender too easily by us as well, such that when we hear about a complex case, and gender comes up everybody's suddenly preoccupied with "is this about trans? Is this not about trans?" And I find, for the most part, and you may be surprised to hear this given our conversation, that with most of my patients who are gender non-conforming, or trans, our conversations about gender, or what comes up around gender, is not always the main issue. Like, I have patients who've come to treatment to talk about gender and for

three years we didn't even touch gender, we're talking about other things that are way more important, and gender becomes the lightning rod for other things as well.

DB: Because I think as well as being analysts, we're citizens. And as citizens, we have responsibilities. So would you agree with me that children being seen 3, 4, 5, 6 times, and then the decision being made, that that's a bad thing?

AS: I would not –"bad" is a word that doesn't resonate with me. I would wish that there were mechanisms for these children to have access to more time and to have access to the resources for such work; I say nothing new in noting that trans kids who are White, financially resourced, and grow up in educated, two-parent households have access to resources that other kids do not.

DB: But there isn't.

AS: Okay, but I can't do anything about that as an analyst. We, as analysts, have to admit that we are not in control of all the factors in this conversation; that there are larger frameworks (the law, discourse, medicine) that we are also embedded in.

DB: So wouldn't it be better to give them more time?

Addendum (DB)

I would like to thank the editors for allowing this discussion to continue and providing me the opportunity to respond to Avgi's final extensive additions. In doing so I will highlight the areas of disagreement, which are profound.

At a kind of meta-level we occupy very different epistemological positions. Avgi, as I see it speaks from a postmodern, relativist position. She thinks of me as lacking sufficient doubt whereas I think I am merely stating as clearly as I can what I think is the case (of course, like anyone else I could be wrong). I have discussed the epistemological problems of relativism in a paper published in the IJPA.

I would like to re-emphasise is the distinction between our contexts. The clinical setting from which my contribution stems is UK national gender service for children and young people, GIDS, based at the Tavistock, which functions as a gateway to medical intervention. As with other public health settings for GD there is no availability of psychoanalysis and hardly any possibility of psychoanalytic psychotherapy. Avgi is mainly referring to patients in private analysis; a very different situation.

Avgi and I also disagree completely on the importance of the distinction between transgender and gender dysphoria. There is good evidence that a majority of children if helped and supported in the right way, desist, many going on to be gender non-conforming gay and lesbian adults. Avgi characterises this as my saying x is a 'true' transgender and y is not. This is not how I wish to be understood. What I am saying is that that there is no way of knowing in any group of children which ones will be likely to desist and which will persist - but we have a first duty to do no harm and I am clear that less harm is done by delaying irreversible medical interventions until adulthood, whilst providing appropriate help and support for the children. I am convinced that eliding the distinction between GD and being transgender has resulted in large number of children progressing to inappropriate irreversible treatment that has caused harm. The growing number of detransitioners is testament to this.

I have nowhere said that biology is destiny as far as gender is concerned - I agree that having a penis does not confer male gender identity per se, as gender identity is, largely (though not wholly), social constructed. So, I agree that gender is distinct from biological sex, but I do not think changing gender identity (through social transitioning or medical and surgical interventions) changes the material reality of biological sex. It was at until recently often stated, and trans lobbies such as Mermaids supported this position, that children can be born in the wrong body – as if there is some kind of congenital gendered something which can be at odds with the biological sex. I am pleased that this essentialist position has been abandoned.

The automatic affirmation of the need to alter the concrete reality of the body to conform to the new gender identity is to collude with the illusion that bilateral mastectomy, removal of ovaries, prescription of testosterone and the creation of an artificial penis – turns a biological female into a biological male. Somewhat paradoxically, it seems to me that these surgical interventions support the idea that gender is established not by social construction but by anatomy.

Avgi sees transitioning, as extending gender fluidity - my view is that irreversible potentially damaging medical and surgical interventions are not an appropriate way of helping young people establish their gendered identity. Avgi is quite right in stressing that watchful waiting is not 'not doing anything'. But I believe that trying to support and help these children manage normal puberty is far less harmful. Avgi asks if I am interested in how patients presenting with a demand for transitioning managed to get into analysis – of course I am and indeed have been involved in such clinical discussions. But, again, this is not relevant to GIDS or other clinics I know of where analysis is most definitely *not* a possible treatment –and even psychoanalytic psychotherapy is only very rarely offered.

'Allowing our patients to choose their own life paths' seems at first unarguable. But again, these are children and young people in a highly charged state with multiple co-morbidities who are not in a position to understand or consent, to quietly weigh up the pros and the cons etc. Clinicians have discussed how many couldn't even bear to think about later infertility or anorgasmia and all the other implications (can *any* child of 12 really consider such matters?). This was the view of the Judicial Review which as I have said was very well reasoned.

Avgi quotes various professional and academic organisations whose guidelines do not support the court's decision. I am not really sure of the relevance of this. The Tavistock GIDS service could be described as one of the world's foremost specialised services for Gender Dysphoria in children and adolescents. Their guidelines were found to be inappropriate to this patient group, by the court. I have just heard that the Karolinska institute in Sweden, which has very much favoured the medical pathway and affirmation have issued a new policy statement as regards treatment of gender-dysphoric minors in Sweden. It has ended the practice of prescribing puberty blockers and cross-sex hormones to gender-dysphoric patients under the age of 18. I expect our organisations will follow suit.

Avgi suggest that there was conflation in the Judicial Review Court proceedings of Puberty Blockers and cross-sex hormones (CSHs). This is not the case. There was no conflation and I believe any reading of the judgement would make that clear. It was however accepted that a massive change had taken place in the pattern of progression from

PBs to CSHs. In the past the majority came off PBs (i.e., desisted). Now, 98% go onto CSHs. Thus starting the children on a PBs is de facto starting them on a pathway which only a tiny minority will leave. Thus issues of consent to PBs are freighted with this knowledge. Further, commencing children on PBs supports the belief that puberty is unmanageable and also supports (even colludes with) the feelings of hatred and disgust of the sexual body. Being on PBs has the effect of making puberty ever more frightening. Thus, commencing children on PBs which may be viewed as an action that is self-reinforcing, a position the court supported in its judgment.

Avgi states that PBs are fully reversible. There is no evidence to support that statement as there has been at no proper follow up study. Restricting the term 'reversibility' to whether or not puberty commences when the PBs are stopped is, in my view, a narrow and inappropriate use of the term. For a child to enter puberty at a time when her brain, body, her psychology and socio-cultural context are all primed and ready for this change cannot be regarded as the same thing as puberty commencing many years later. As I have said the body cannot be treated as if it's a video machine which can just be paused and restarted. This argument in any case is I think irrelevant given that 98 of children do not stop PBs but progress to CSHs.

Avgi suggests that given that puberty blockers have been used for other unrelated conditions, 'the claim that we are in completely uncharted territory is exaggerated'. My view is that this wider use (for which they were originally intended) in prostate cancer and precocious puberty has little relevance to the risk of prescription of these drugs to normal children (normal in the sense that that have no demonstrable bodily illness), and its misleading to suggest otherwise. Even the director of GIDS has acknowledged this[4]. Moreover, serious concerns as to the effects of PBs on bone and brain development have become a real concern.[5]

Avgi did not understand the parallel I made with anorexia and maybe it was not clear. My point is that we do not affirm a child with anorexia as having a normal weight, as we recognise that she has a form of body dysmorphia. My view is that many of these young people have similar dysmorphia in relation to their sexual bodies and, as we cannot know whether this is the case, it is best to not affirm but wait before putting them on a pathway which has, as I have explained, irreversible consequences which they may later regret.

Avgi asks if I think of the term 'trans' is as invalid. My view is that it is not appropriate or helpful to think of a child or young person with Gender Dysphoria as being 'trans', instead

[4]Polly Carmichael, the Director of GIDS has stated:

> "The blocker is said to be completely reversible, which is disingenuous because nothing's completely reversible. It might be that the introduction of natal hormones [those you are born with] at puberty has an impact on the trajectory of gender dysphoria." See: Guardian, 12 September 2015; https://www.theguardian.com/society/2015/sep/12/transgender-children-have-to-respect-who-he-is

[5]Carl Heneghan, Editor in Chief BMJ Evidence Based Medicine, (EBM), Professor of EBM, University of Oxford & Tom Jefferson, Senior Associate Tutor University of Oxford, Visiting Professor Institute of Health & Society, Faculty of Medicine, Newcastle University have stated:

> "Little is known about the safety profile in the context of gender dysphoria, particularly the long-term effects, and use is based largely on the effects of treatment of central precocious puberty … .Problems within these studies, however, make it difficult to assess whether early pubertal changes regress under GnRHa treatment and whether prolonged puberty suppression is safe. … .
>
> An Archive of Diseases in Childhood letter referred to GnRHa treatment as a momentous step in the dark. It set out three main concerns: 1) young people are left in a state of 'developmental limbo' without secondary sexual characteristics that might consolidate gender identity; 2) use is likely to threaten the maturation of the adolescent mind, and 3) puberty blockers are being used in the context of profound scientific ignorance."

of maintaining openness and fluidity, as this forecloses the matter in a damaging way. (Of course, in our dealings with the child it may well be important to accept their self-definition whilst maintaining internally an independent attitude). Avgi is critical of my using the term 'trans ideology' and maybe I need to be clear about what I mean. I am referring to the way that policy and clinical work has been, in a planned manner, captured (and this process of capture has been recently subject to careful study) by organisations that have a very clear ideological agenda - such as ensuring that all children who say they are trans should be immediately affirmed (in the UK this became part of schools' policy, although fortunately this has now been changed). The way I see it, there has been a transformation from what started life as a kind of liberal minded and emancipatory discourse into a form of tyranny. Many clinicians and academics have described how this has resulted in an inability to express their views, pursue research or have papers published ('no-platforming') which present a different view[6]. Clinicians in GIDS and in other similar services in other countries have described an atmosphere of intimidation acting to shut down of any debate.

In the UK the Lesbian Gay and Bisexual (LGB) alliance have broken away from LGBTQ+ as they believe their own struggles have been usurped and undermined by this movement. As I have stated, many children and young people who present with Gender Dysphoria suffer from internalised homophobia and if supported without medical intervention will mature into non gender conforming Gay and Lesbian people. The LGB alliance state, and I would agree, that these medical and surgical interventions, can be viewed a form of conversion therapy for gay and lesbian children.

[6]This is part of a wider cultural change in the direction of intolerance which I cannot further discuss here.