

# Transgender medicalization and the attempt to evade psychological distress

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*Abstract:* In this paper the author argues that trans-identification and its associated medical treatment can constitute an attempt to evade experiences of psychological distress. This occurs on three levels. Firstly, the trans person themselves may seek to evade dysregulated affects associated with such experiences as attachment trauma, childhood abuse, and ego-alien sexual feelings. Secondly, therapists may attempt to evade feelings, such as fear and hatred, evoked by engaging with these dysregulated affects. Thirdly, we, as a society, may wish to evade acknowledging the reality of such trauma, abuse and sexual distress by hypothesizing that trans-identification is a biological issue, best treated medically. The author argues that the quality of evidence supporting the biomedical approach is extremely poor. This puts young trans people at risk of receiving potentially damaging medical treatment they may later seek to reverse or come to regret, while their underlying psychological issues remain unaddressed.

*Keywords:* attachment trauma, countertransference, detransition, dissociation, dysregulated affect, gender dysphoria (GD), internalised homophobia, transgender

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## Introduction

Any therapist who has published case material describing psychological aspects of gender dysphoria (GD) will be all too aware of the accusations of transphobia that can be levelled at them. Some therapists, trans people, and their allies seem to regard any psychological description of GD as inherently pathologizing and equate it with gay conversion therapy (MoU2). I will be arguing, however, that failure to address relevant psychological issues can result in trans people making unnecessary, permanent changes to their bodies, without adequate scientific justification for doing so (Biggs 2019; Heneghan 2019). This should be a major concern given the recent upsurge in numbers of (predominantly biologically female) young people both identifying as trans (Tavistock GIDS 2018) and subsequently desisting from that

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identification (Entwistle 2020; Shrier 2020). My use of relevant case material is seriously hampered by concerns about confidentiality (UKCP 2009, 3.4). But fortunately, the central theme of this paper was already addressed by the Roman poet Catullus as early as 50 BC in his poem (63) *Attis* (aestheticrealism.net Siegel E. translation).

### Trans-identification and the evasion of the ‘madness’ of dysregulated affect

#### *Attis*

As Catullus’ poem starts, *Attis* arrives on the shores of the Phrygian woods, sacred to the mother goddess *Cybele*:

It was there, impelled by madness, by rage,  
His mind bewildered,  
With sharp flint,  
He made fall from him the weight of his maleness. (lines 5-8)

The poem itself does not directly address the cause of *Attis*’ madness. But in the myth from which it is drawn, *Cybele* has fallen in love with *Attis*. So, she gatecrashes his wedding and drives him mad in a fit of jealous rage (Pausanias 160 AD).

As the poem continues, *Attis* and his similarly castrated band of followers, the *Galli*, rush off into the woods, cacophonously dancing through the night until they arrive at *Cybele*’s remote mountain shrine. Once there, they fall into an exhausted sleep. *Attis* awakens to find his madness gone (lines 55, 56, 66, 68). He wanders back to the shore and gazes longingly towards his former homeland. He is grieved by what he has done to himself.

What shall I now be called?  
A maidservant of the gods,  
An attendant of *Cybele*? (lines 97-100) Now, now what I did makes me sorrowful,  
Now, now, I wish that it hadn’t occurred. (lines 106-07)

*Cybele* is enraged and calls for her lions:

‘Come now’, says she, ‘come, go fiercely, let madness hunt him  
from here, make him, by the coming upon him of madness,  
take himself to the forest again – he who would be too free  
and get away from my rule’ (line 113).

One of *Cybele*’s lions arrives as the poem ends:

He rushed at him.  
*Attis* runs with mad energy into the woods.  
He was a handmaid in these woods all his life.  
Goddess, *Cybele*, great goddess, lady of *Dindymus*, let all thy fury  
be far from where I am, O my queen.

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Let it be others you drive into frenzy, others you drive into  
madness. (lines 123-27)

The Attis cult appears to predate Roman and even Hellenistic times (Frazer 1914), with Attis originally a Phrygian fertility god and Cybele (as Agdistis) a hermaphroditic pre-Olympian deity. No doubt the myths associated with the couple became distorted by the arrival of the patriarchal Greek and Roman cultures. It is Attis' attempt to evade both his madness and his former male identity that is my main concern in the present context however. To escape Cybele's wrath (loss of mother's love), Attis denies the reality of who he was and what he has done and comforts himself with the notion that 'He was a handmaid in these woods all his life' (line 125). If the early attachment to mother is too insecure, later separation from her can feel unbearable (West 2016). The difficulty can be compounded if she treats her child as a part of herself – perhaps her split-off dependent side or her missing phallus (Stoller 1985, p. 56) – rather than a separate person. On this reading of the poem (which chimes with my own clinical experience) it is possible to regard Attis' female identification as an attempt to evade the 'madness' of dysregulated separation anxiety.

### The therapist's evasion of psychological distress

A contemporary post-surgical Attis would be unlikely to grant me permission to write about her psychological issues, since she is 'content' with her female identification. So, I must ask my reader to imagine that a pre-surgical Attis has come to see me for psychotherapy, expressing the wish to medically transition. On the reading given, Attis' female identification constitutes an attempt to evade unbearable separation anxiety – itself probably a consequence of early relational trauma. My first task, therefore, is to avoid colluding with this evasion by simply 'affirming' the wish to medically transition. My second is to avoid challenging that wish too directly, thus risking the full wrath of Attis' resistance and jeopardizing the therapeutic relationship. So, it is important that I maintain my analytic empathy, neutrality and curiosity. If I manage to do this and a containing therapeutic relationship develops over time – and if the above reading is true – then sooner or later unbearable separation anxiety is likely to arise within the therapeutic relationship, perhaps in response to some real or imagined failure of empathy on my part (Winnicott 1974; Ogden 2014). This will hit Attis with the force of an impending breakdown and she is likely to hate me for it; as I am her for hating me. But this experience offers the opportunity of first re-experiencing and then regulating emotions associated with the original relational trauma via the containment, rupture and eventual repair of the therapeutic relationship.

This is a challenging process for both patient and analyst and only possible if the analyst is able to recognize and regulate disturbing elements evoked in the countertransference by encountering the patient's 'madness'. As Winnicott put

it: 'However much he loves his patients he cannot avoid hating them, and fearing them, and the better he knows this the less will hate and fear be the motive determining what he does to his patients' (Winnicott 1949, p. 69). He went on to cite the wish to evade such painful experiences as one of the reasons that the mental health workers of his day endorsed scientifically unjustified physical treatments, such as ECT and lobotomy. Perhaps similar processes are at work today with trans patients and their therapists. Both those who are too quick to affirm and those who are too quick to challenge their patient's wish to medically transition may be attempting to avoid experiencing distress in the countertransference. This leaves the patient less able to bear their own distress, which can result in them initiating medical treatment prematurely.

In practice a female identification such as that of Attis is likely to be reinforced by other factors such as an absence of adequate male role models to identify with. If this is due to unresolved traumas, such as paternal violence or abuse, these too are likely to be re-experienced in the transference/countertransference. This presents further challenges to the therapeutic couple. Withers (2015) writes more about the role of paternal trauma in trans-identification.

### The patient's evasion of psychological distress

#### *Chris*

When Chris, my first ever trans patient, woke up from the operation to remove his penis, the first thing he said was, 'I feel as if all my anger has been cut out'. We could say he had tried to deal with his dysregulated affect – his madness – by dissociating from it, projecting it into his penis, and cutting it off.

After living as a woman for nine years he came to realize this had not worked. He passed as a woman but was still subject to the uncontrollable rages that were part of what had driven him to identify as female in the first place. It was at this point, in the early 1990s, that he came to see me. By then he had decided to detransition – to attempt to return to living as a man. He still had the neovagina that his surgeon had constructed out of a piece of his gut, and he had stopped taking oestrogen. But his doctors had not yet realized that he needed to take the testosterone his body could no longer produce. As a result, he was mired in a deep, apathetic depression. His relationship with his girlfriend was suffering. He was uninterested in sex and unable to orgasm. He felt suicidal and socially isolated. Several years later, in order to escape the persecution of the trans community, he was forced to deny the reality of the experiences he had tried to share in a public blog. Despite all this, he somehow managed to persist in his wish to detransition, or 'revert' as Chris himself prefers to put it.

Chris desperately wished he had had analysis before undergoing irreversible physical treatment. Growing up, his mother had made it clear by her actions

that she could only love him if he identified as a girl. His father, who abandoned the family at four, had been a violent and abusive alcoholic. As a result, Chris had no positive male role model to identify with. He was also autogynephilic: sexually aroused by dressing up as a woman and imagining making love to himself in front of a mirror. He sent me the following email before a talk I gave, long after our work together had finished. He began by describing his autogynephilia and continued:

That was me until I orgasmed. Then I loathed myself, the clothes – everything about myself. Shame and self-loathing followed. *That* was when I needed an analyst. I decided to make myself immune. Always after orgasm rage followed. I destroyed whole wardrobes. None of this was ever explained to the psychiatrist at Charing Cross. I had fought hard to suppress the rage and shame, but I was still in a precarious position. However, I passed and that meant I had come to a degree of equilibrium. The hormones and surgery became my goal. I was a natural actor, so it was easy to pass for two years and then become a candidate for surgery. Nothing was ever interpreted. I was never challenged. That is a fearful way for patients to be treated...

Hope that is helpful. Consider it a gift of gratitude for the man I enjoy being now.

Chris's autogynephilia could be regarded, in part at least, as a defence against relational intimacy, and his mother's rejection of his male body made it hard for him to establish a securely embodied sense of self (Winnicott 1970). It would have been helpful if Chris had seen an analyst able to work effectively with such early relational issues prior to surgery. Instead he was offered a series of six psychological assessments at the Charing Cross Hospital and told that there was a nine-year wait for surgery. He decided to bypass the whole process and paid privately for surgery. Many of today's young people have also made 'gender affirming' medical treatment their goal. Unfortunately, the evidence base supporting the efficacy of such treatment is extremely poor.

### Young people: puberty blockers

Puberty blockers (Gonadotropin Releasing Hormone agonists or GnRHAs) are billed as a harmless, fully reversible treatment designed to prevent the trans-child from experiencing puberty in the 'wrong body' while buying time to decide whether to progress to full medical transition (Delamarre-van de Wall and Cohen-Kettenis 2006). In fact, they are powerful drugs originally prescribed to treat prostate cancer and precocious puberty. They work by blocking the effects of the body's sex hormones, mainly testosterone in the boy and oestrogen in the girl. This has led to their use to chemically castrate sex offenders (Biggs 2019, p. 50). So little is known about their long-term effects in gender dysphoric adolescents that their use remains unlicensed (*ibid.*, p. 41). Numerous studies suggest however that bone mass density is seriously compromised by them, leading to the risk of osteoporosis (Vlot

et al. 2017, PBS Newshour, 4 February 2017). A study of 30 children prescribed them for precocious puberty showed a 7% drop in IQ (Mul 2001). The authors declared this clinically insignificant, presumably because of the small sample size. Very little is known about their potential interaction with other drugs or their impact on adult sexual pleasure (Jontry 2018). Biggs (2019) has written a devastating critique of the 'science' supporting their use by the Tavistock Gender Identity Development Service (GIDS). Meanwhile, two talks I attended at the *Science of Gender Conference* (Tavistock GIDS 2018) raised further concerns.

In the first talk, Professor Sarah-Jayne Blakemore (2018) of UCL described the way that the emotional, cognitive and social brain networks develop during normal human adolescence. In a process *orchestrated by the sex hormones*, these brain areas diminish in grey matter and increase in white matter as neural networks are consolidated and the myelination of nerve pathways occurs. The relevant studies have yet to be conducted on humans, but it seems probable that puberty blockers will disrupt this process and thus impair adolescent emotional, social and cognitive brain development.

The second talk, by Professor Neil Evans of the University of Glasgow, described some of the results of the few animal studies conducted so far. These show that sheep given puberty blockers in adolescence are measurably less able to navigate a maze when tested a year after stopping the blockers (Hough et al. 2017). Fear and stress responses are also persistently affected (Robinson et al. 2014). Gene expression in the hippocampus, an area of the brain connected to spatial memory and embodied sense of self, is measurably changed on autopsy (Nuruddin et al. 2013). It is hard to imagine that these hormones would ever have been prescribed to adolescent humans (even off-label) if their availability had not been promoted as a human rights issue (Bilek 2018).

Furthermore, it seems that 95-100% of gender dysphoric adolescents prescribed puberty blockers continue with their medical transition (De Vries et al. 2011; Carmichael 2016, 2018) whereas an average of around 80% (Cantor 2017) spontaneously desist during puberty if left untreated. The gatekeepers at the GIDS (Carmichael, personal communication) have argued that this is because of their excellent diagnostic skills. But there are no objective scientific tests for gender dysphoria and young people know what to say if they have already decided they want medical treatment. Given their well-known impulsiveness, and the increasingly frequent testimony of detransitioners (Entwistle 2020; Shrier 2020; @piquestrans; redditt.com/t/detrans; detransadv.com), it seems that large numbers of young people are being allowed to travel a poorly evidenced, potentially unnecessary, irreversible, sterilizing, lifelong treatment pathway.

Psychotherapist Stella O'Malley (2018) described her own GD resolving spontaneously at puberty when her body confronted her with the difficult but incontrovertible evidence that she was in fact biologically female. She would almost certainly have been deprived of this experience had she taken puberty

blockers. She is now happily married, identifies as a heterosexual woman and has children, but believes she would have transitioned medically under current protocols.

### Society's evasion of young people's distress

There is a rapidly growing body of literature (Withers 2015; Patterson 2017; Ayad 2018; Bonfatto and Crasnow 2018; Lemma 2018; Littman 2018; Rustin 2018; Withers 2018b; Stagg 2019; D'Angelo 2020; Pick 2020) suggesting that psychological issues can play a crucial role in young people's trans-identification. These include difficulties coming to terms with puberty, other sexual difficulties including abuse, social isolation, affect dysregulation, alexithymia, anxiety, depression, self-harm, body dysmorphic disorder, attachment trauma, problems with triangulation and symbolization, as well as unconscious homophobia and autistic traits. A young person can all too easily adopt a trans-identity as a way of attempting to evade these difficulties.

Meanwhile, some online trans-activists reinforce that evasion by advising them how to go about getting the treatment they have already decided they need (Shrier 2020). In addition, parents may prefer to believe their child is suffering from some unknown physical condition best remedied medically rather than face the reality of their psychological suffering – and their own part in its etiology. In England, the past nine years have seen a 25-fold increase in referrals to the Gender Identity Development Service (Tavistock GIDS 2018), which acts as gatekeeper for endocrinological treatment. If a young person falls under the care of an affirmative therapist there, who simply supports the wish to medically transition without exploring its underlying causes, the evasion is further compounded. It seems likely that all these factors are contributing to the current 'epidemic' of trans children (see Marchiano 2019).

The scientific research purporting to justify current medical treatment is often funded by the very drug companies that profit from it. Delamarre-van de Wall and Cohen-Kettenis (2006) are the originators of the 'Dutch protocol' on which current GIDS practices are based. As they acknowledge in that seminal paper, 'The authors are very grateful to Ferring Pharmaceuticals for the financial support of studies on the treatment of adolescents with gender identity disorders.' Ferring supply the UK's puberty blockers (Biggs 2019, p. 44). They also donated heavily to the UK's liberal party (Electoral commission 2018), which strongly promotes a pro-trans agenda. Meanwhile a leading law firm and international charity are openly discussing how to promote the legal right of children to 'self-identify' as their chosen gender (see Kirkup 2019). There is not necessarily anything corrupt about this, but the profits from 'gender affirmative' treatment can be considerable. In the USA, at the time of writing, the puberty blocker Lupron-PED for instance costs

\$9,562.82 for a three-month supply (Lupron 2020). The parent company of Lupron's current manufacturers had to pay an \$875,000,000 settlement to the American Department of Justice in 2001 as compensation for corruptly promoting its use in prostate cancer (PBS Newshour 4 February 2017).

As I have remarked (2018c), in 20 years' time we are likely to look back on this as one of the darkest chapters in modern medical history.

Every person with GD is an individual, so it is difficult to generalize. It is generally agreed however, that sex is biologically determined, while gender identity emerges from a complex interaction of bio-psycho-social factors (D'Angelo 2020). In GD there is a mismatch (or dissociation) between the two. A person's subjective gendered sense of who they are is at odds with the objective biological sex of their body. Many people can live creatively with this mismatch and are not in need of any treatment. For those in whom it causes significant suffering, some sort of treatment may well be helpful.

There is no credible scientific evidence of a biological basis for GD and the GIDS have stopped screening for one (Butler et al. 2019). In this paper, I am arguing that under the circumstances, it is wiser to attempt to work with GD psychologically before resorting to potentially damaging physical treatment. This is especially true of young people who have so many changes to go through before eventually (if they are lucky) establishing a secure sense of adult identity in their mid- to late-20s (Arnett 2000). Before discussing this further however, I will make some preliminary observations about psychotherapy for gender dysphoric adults and about detransitioning.

### Detransitioning

As already remarked, the quality of research into the treatment of GD is generally extremely poor (Biggs 2019; Heneghan 2019). Nowhere is this clearer than in relation to detransitioning. When James Caspian attempted to conduct qualitative research into the subject at Bath Spa University, his proposal was turned down on the basis that it might attract negative attention from trans-activists and hence bring the university into disrepute (Caspian 2019). So, the whole area is seriously under-researched, and nobody knows quite how many people regret their medical treatment or why. Prevention of harm, and informed decision-making, are thus rendered virtually impossible (D'Abbrera et al. 2020). Unlike most other medical treatments, no double-blind trials, or long-term studies comparing different treatment modalities, have been conducted (Biggs 2019; Heneghan 2019). Instead potentially damaging, poorly researched medical treatment seems to be offered on the basis that it would be an infringement of a person's human rights to withhold it (Bilek 2018).

A study by Wiepjes et al. (2018) reports a 0.5% regret rate for 'gender affirming surgery' among the 'Amsterdam cohort' of trans patients. But 36% of participants in the study were lost to follow-up and it is fair to assume that



those dissatisfied with a treatment are less likely to return to the clinic providing it. In addition, those who died during the study were excluded from its statistics. However, we know (Dhejne et al. 2011) that suicide rates are around 20 times higher in a post-surgical trans population than in a group matched for age, sex and psychological disturbance. Suicides were not included in Wiepjes' figures, although it seems reasonable to assume that at least some of those who committed suicide regretted their surgery. The definition of regret used in Wiepjes' study was prohibitively narrow. It only included those who underwent a gonadectomy, expressed regret and returned to the Amsterdam clinic for sex-appropriate hormones. It did not include those who quietly desisted without reporting back to the clinic or those who regretted their surgery but decided to live with it. Nor did it include people like my ex-patient Chris who were silenced by the trans community. It did not include people who self-medicated, or those who trans-identified, started hormone treatment and then desisted before gonadectomy. It certainly would not include people like Attis. Regret, when it did occur in the Wiepjes study (table 4) was an average of 130 months after surgery. The recent surge of young trans people only began around 2011, so it is hard to know in 2020 how applicable Wiepjes' figures are to this cohort. At the time of writing (3 June 2020), the website [redditt.com/r/detrans](https://www.reddit.com/r/detrans) numbers 12,141 detransitioners and allies. Around 30% of these appear to be medical or social detransitioners. For all these reasons, the 0.5% regret rate seems likely to be a gross underestimate. Finally, the Wiepjes study is retrospective and has no control group to compare results with. So, while it is interesting, it does not provide scientific justification for the current practice of medicating trans-identified young people. D'Angelo (2018; 2020) and Entwistle (2020) make similar points.

Dr Az Hakeem is a psychiatrist and psychotherapist who ran psychotherapy groups for adults suffering from GD from 2001-2012 at the Portman Clinic in London. As he says in his book, *Trans*, speaking of detransitioners and regretters in his groups: 'This category of transgender persons was becoming the new silent and marginalized population with no voice or representation' (Hakeem 2018a, p. 147). They may feel ashamed about appearing ungrateful to the medical profession for the treatment afforded them – or afraid of letting down, or being attacked by, the trans community (ibid., p. 147). Consequently, they tend to drop-out of follow-up studies (Horváth 2018). The very human difficulty most of us have in admitting we have made a serious mistake probably also contributes to their absence from such studies.

It seems likely too, that those members of the trans community who are most active in silencing and denying the existence of detransitioners are attempting to police in others the doubts they cannot tolerate in themselves. If someone can bear to think about a thing, they can usually bear to let others talk about it. But if a person's sense of identity and social network are built around being trans, talking about doubts and regrets can be experienced as an existential and social threat.

### Psychotherapy groups for gender dysphoric adults

When Az Hakeem took over from his predecessor at the Portman Clinic in 2001, there were two distinct gender dysphoria groups. One group was for presurgical adults who tended to look forward with hope to their medical transitions. This group often presented an 'official' medical history designed to gain them access to the medical treatment they had already decided they needed. They typically downplayed psychological co-morbidities and claimed they had always been trans (*ibid.*, pp. 50-51). It was only by stressing a) that he was not a gatekeeper, b) that he was entirely neutral regarding the wisdom of medical transition, and c) that he was entirely separate from the services providing such physical treatment, that Hakeem was able to elicit a more honest history of this group's GD. Interestingly, but perhaps not surprisingly, this split in service provision seems to parallel the dissociation between these patients' minds and bodies previously postulated as a way of conceptualizing GD.

The second group had already medically transitioned but looked back with regret on the transition that had failed to resolve their dysphoria. Hakeem writes, 'Unsurprisingly, the resultant dynamic of this group was that of being stuck in a depressing, helpless and hopeless position without any prospect of escape' (*ibid.*, p. 149).

Hakeem's inspired idea of mixing the two groups together produced remarkable results. About a quarter of his participants had medically transitioned but were still gender dysphoric, while about two thirds were awaiting medical treatment. The rest identified themselves as drag queens, transvestites, etc. Hakeem reports that after a while, the post-surgical group of regretters became more hopeful (*ibid.*, p. 150). He also mentioned, almost in passing in a public lecture (Hakeem 2018b), that only two of the 100 or so pre-surgical patients he saw went on to medically transition. The other 98% gave up their desire for medical treatment.

This is extraordinary. Participants in his groups no longer wished to physically transition once they had encountered the reality of people whose GD had not resolved with medical treatment. They still needed the space to talk openly about the doubts stirred up by this experience – without jeopardizing their own prospects of medical transition. But Hakeem does not appear to have acknowledged the significance of his findings. As far as I can tell, to date, he has not even published them. Perhaps he wants to research other treatment parameters more thoroughly first. But to me it seems self-evident that, other things being equal, a life without sterilizing, potentially dangerous, expensive hormones and surgery is better than a life with those things.

Of course, Hakeem's groups are self-selecting, and his figures do not mean that 25% of people regret their medical transition. But until very recently, young people have been almost exclusively exposed to positive accounts of medical transition via support groups such as Mermaids and Gendered

Intelligence, online activists and media presentations. Hakeem's work, along with the increasingly frequent testimony of young detransitioners (Entwistle 2020, reddit.com/r/detrans etc.) begins to redress that imbalance.

### Young people: coaching and self-diagnosis

In this section, I will explore in more detail how I believe children are being misled into becoming sterile, drug-dependent, life-long medical patients. I would like to draw directly on my therapy practice for case material, however, ethical considerations would require me to ask my patient's permission to do so and it could be disruptive for a young person, already struggling with their sense of identity, to encounter my account of their therapy in print. There might be things I would need to say for a reader that my patients or their families would not be ready to hear. For this reason, I will draw on my experience in a general way and where necessary attempt to create a composite case by linking that experience with pre-existing case material.

My first point is that children have very often reached the conclusion that they are trans through a process of self-diagnosis. They may have previously had a feeling that things were not quite right. But something such as a *YouTube* vlog, TV programme, or someone they know coming out as trans, has suddenly helped them make sense of this feeling. As a result, they have self-identified as trans. After perhaps going on to watch some of the numerous *YouTube* stars celebrating the benefits of 'top surgery', 'T', and medical transition, they have decided that they too want such treatment. There is no shortage of online 'support' in effect coaching them how to get it.

*The Science of Gender Conference* at the Tavistock Clinic (2018) was sponsored by the drug company Pfizer and attended by three representatives of Ferring Pharmaceuticals. It was a mixed bag. There were some very thought-provoking and informative presentations, but others seemed to uncritically extoll the virtues of pharmaceutical interventions. Any mention of meaningful psychotherapy was conspicuous by its absence. The conference is reviewed by Withers (2018d).

One of the contributors, Professor Kaltiala-Heino (2018), a psychiatrist from Finland, spoke about something she called 'shared identity'. In the gender clinic where she works, she noticed numerous young people shared identical accounts of their childhood. Several of the biological females she assessed, for instance, claimed to have spent significant portions of their childhood wandering alone in the forest imagining they were male wolves. When I asked her about the significance of this, she said that she thought it was probably the result of online coaching. Helpful trans-allies were able to point out the kind of childhoods these self-diagnosed trans-adolescents required to qualify for the medical treatment they had already decided they needed.

In a ground-breaking paper, Lisa Littman (2018) described, via parent report, a potentially new gender dysphoria presentation, referred to as ‘rapid onset gender dysphoria (ROGD)’. Trans-activists seem to be threatened by the paper and attempted to discredit it (Wadman 2018). But I have certainly seen cases where gender dysphoria has occurred suddenly around puberty as well as other cases where its onset has appeared more gradually and was long-standing. Other clinicians, including Kaltiala-Heino, agree. For her, a biological female’s genuine childhood history of playing in the woods as a lone male wolf, would indicate a long-standing GD and therefore be more likely to qualify the patient for medical treatment than an adolescent rapid onset case. Some fictional histories are clearly just that. But less obvious online coaching can make effective psychological assessment virtually impossible. This can have catastrophic consequences for the patient, as Chris’s case shows. A large part of the problem is that self-identification as trans, which many activists and their allies regard as a human right (Bilek 2018), has become conflated with the diagnosis of gender dysphoria, which grants access to medical treatment. Those doctors and therapists who counsel caution regarding access to medical treatment then come to be wrongly perceived as opposed to trans rights.

I am not opposed to trans rights, but I do believe those rights must be balanced against children’s right to be protected from harm. The following case illustrates how easily a young person can be harmed if their self-identification as trans results in a wish to medically transition, which is simply affirmed by their therapist and online coaches.

### A case of female to male GD

Alex is a 16-year-old male-identified, biological female. At 13 Alex was diagnosed with gender dysphoria by the Tavistock GIDS. This meant that if ‘he’ and his parents so desired, he could have been prescribed puberty blockers. But he chose not to take them because of concerns about side effects, specifically low mood and fatigue. Alex already suffered from fatigue and a series of other psychosomatic issues such as insomnia, irritable bowel syndrome, lactose intolerance and an eating disorder. It seems Alex is alexithymic (Sifneos et al. 1976), that is ‘without words for feelings’ (from the Greek). This means that like many others on the autistic spectrum, he feels emotional discomfort in his body but finds it hard to articulate the emotional aspect of that discomfort verbally. This can create a challenge for the classical ‘talking cure’ and calls for a psychotherapeutic technique that attempts to identify the feelings behind the body sensations and translate them into words (see e.g. Withers 2003). Withers (2018b) has already commented on this case. But it is a specific aspect of it that concerns me here. The following is a description of part of a therapy session (Clinical material 2018).

He then spoke of how in the first years of secondary school he tried to fit in and it did not work out. He tried liking the same things as everyone but it was a 'dark time' in his life; he then found some very good friends who liked the same things he liked and realized he does not have to 'be normal' – and now no one thinks he is weird because he is a guy. Everyone thought he was really gay, really butch – but because now he is a guy it feels more 'normal'. He spoke of himself as being 'stereotypically a masculine person' and how this was perceived as weird by those around him. Now, I noted, perhaps Alex had got rid of that feeling of 'weirdness' and he has gained some sense of legitimacy as he is now known as trans. Alex nodded in agreement ...

In other words, Alex felt weird as a butch lesbian, but normal once he identified as a straight guy. It seems to me that this should raise alarm bells. A therapist who simply affirms Alex's trans-identification without trying to understand its origins is in effect practicing gay conversion therapy. And yet some 650+ therapists, counsellors and trans activists wrote to *Therapy Today*, the house magazine of the British Association for Counselling and Psychotherapy, the UK's largest therapy register, demanding:

concrete steps to ensure that all of its members are aware that non-affirmative stances towards gender identity are incompatible with membership of BACP.

(Brooks et al. 2018, p. 17)

Though it is true that many analysts have pathologized homosexuality – to the lasting shame of our profession (see e.g. Denman 2003, Hertzmann and Newbigin 2020 for a discussion of this) – none have advocated sterilizing gay people before. While I am not suggesting that anyone is deliberately doing so, it does seem to have become an unintended (or perhaps unconsciously intended) consequence of the trans-affirmative stance.

Alex's self-identification as trans appears to have originated, at least in part, from unconscious, internalized homophobia (Patterson 2017). A therapist simply affirming this trans-identification would be colluding with the homophobia and shepherding Alex towards life as a sterile, straight man.

I am pleased to say that when I met Alex's therapist at a meeting recently, they reported that Alex had still not medically transitioned or taken puberty blockers and was addressing their previously unconscious homophobia. Not all 'proto-gay' trans-identifying young people are as lucky with their therapists. While there are some excellent therapists there, the GIDS follows the World Professional Association for Transgender Health (WPATH) Standards of Care (2012). There is no mention of the unconscious – let alone the possible role of unconscious homophobia in trans-identification – in the whole 120-page WPATH document. And @LisaMacRichards (2019) demonstrates how the WPATH transgender standards of care are driven by bias and inadequate evidence.

### From Max to Maxine – and back again

In October (14, 21 and 28) 2018, ITV aired their three-part drama series entitled, *Butterfly*. It depicted the journey of an 11-year-old trans-identified child from Max to Maxine and recorded the impact of this journey on the family. After a long struggle, they were reconciled to Maxine's trans-identification and she finally received the puberty blockers she longed for.

The show made no attempt to explain the origins of Max's trans-identification. My experience as a therapist suggests however, that no child is likely to identify as trans, let alone attempt to cut off their penis – as Max did – without some psychological determinants. How did s/he come to hate this part of their body so much? Leaving this vital question aside for now, I will treat Max/ine in three different ways. Firstly, I will look at what might have happened if he/she had not received any puberty blockers or other medical treatment. Secondly, I will attempt to realistically describe the actual path Maxine is on, as depicted in the show. Thirdly I will draw on my therapeutic experience to describe a scenario in which Max/ine takes puberty blockers, has exploratory therapy, comes to understand the psychosocial origins of their trans-identification and desists.

#### Scenario 1: no physical treatment

I will not waste too much time on the first scenario. I have already run through its essentials in relation to the case of Alex. If Max/ine is not given puberty blockers he/she is more than likely to spontaneously desist from trans-identification during puberty (Cantor 2017). The most likely outcome would then be for Max to end up identifying as a gay man, though like Stella O'Malley (as described above) he could also turn out straight. There is also roughly a 20% chance of his dysphoria persisting (Bailey 2003; Cantor 2017) and like 25% of Hakeem's dysphoric patients, Max's GD could also persist even if s/he medically transitioned. We have no reliable way of determining which of these categories Max would fit into (Drescher and Byne 2013). Max, like Alex, might benefit from non-collusive, exploratory psychotherapeutic support during this process, but might find it hard to use this insofar as s/he has already set his/her heart on medical treatment.

Critics of both the watchful waiting and the exploratory approach would probably object that if Maxine does not get the puberty blockers that she needs to be her 'authentic self', she is likely to kill herself. This argument has consistently been weaponized by trans activists demanding easier access to medical treatment (Maynard 2020). The actual figures (Transgender Trend 2018; Biggs 2020) show that suicide is extremely rare among children of Maxine's age. Every suicide is a tragedy, but there appear to have only been four over the last 10 years among trans-identified children in the UK, all of them significantly older than Maxine. Even these four had not been

screened for co-morbid conditions such as depression. It seems naïve under the circumstances to suggest that feeling suicidal would be better addressed by puberty blockers than psychotherapy or anti-depressants. The threat of suicide does not necessarily justify a treatment ethically or scientifically.

### Scenario 2: from Max to Maxine

So, what will become of Maxine as depicted in *Butterfly*?

We know that she has started puberty blockers and is likely to remain on these until the age of 16. The cost of Lupron-PED for that period would be around \$150,000 (Lupron 2020) although the British NHS has access to cheaper alternatives via Ferring Pharmaceuticals. Puberty blockers create a 95-100% likelihood of continuation to full medical transition (De Vries et al. 2011; Carmichael 2016 & Carmichael 2018), that is, to opposite sex hormones from age 16 and sterilizing surgery from 18. Maxine will be unable to have biological children if she persists on this course. We also know that there is a 51% increased mortality rate for adult biological males 18.5 years after medical transition, largely through the increased risk of suicide, AIDS and heart disease (Asscheman et al. 2011). We do not know what proportion of this is due to treatment or to pre-morbidity. In the long term, Maxine is about 20 times more likely to commit suicide than a non-trans control group matched for psychopathology (Dhejne 2011). It seems unlikely that Maxine will be able to experience adult sexual pleasure having never gone through puberty. But if she does, any orgasm she has is likely to involve an essentially male ejaculation, possibly through a phantom penis (Chris, my ex-patient, personal communication). As already discussed, we do not know the full long-term side effects of puberty blockers on adolescent humans. The research has simply not been done, but we do know that bone density is likely to be compromised leading to an increased risk of osteoporosis (Vlot et al. 2017). We also know (Milrod and Karasic 2017; Laidlaw 2018) that halting Max's puberty will stop the growth of his penis, leaving it too small to turn inside out to create a neo vagina via the surgical procedure usually preferred. Once a neo vagina has been constructed, using a piece of Maxine's gut, it will have to be carefully dilated and disinfected daily because the body will treat it as a wound and attempt to close it up. Nor will it have the mucous membrane, sexual response, or friendly bacteria of a natural vagina. As a result, it will be prone to infection. Hakeem's book contains an informative if graphic account of care of the neo vagina (Hakeem 2018a, p. 119). But it also contains a chapter by Elizabeth Riley (2018) advocating the kind of 'affirmative gender care' (ibid., p. 79) for children that I am arguing increases the likelihood of medically induced harm.

To my mind, the problem with Riley's chapter and with programmes like *Butterfly* is that they encourage false hopes for the treatment and simplistic

explanations of the origins of gender dysphoria. Despite this, it is still possible that Maxine could be happier with early medical transition than without it. The problem is that we have no objective way of even diagnosing gender dysphoria, let alone knowing in advance who will and who will not benefit from medical treatment (Drescher and Byne 2013). Wouldn't it be wiser under the circumstances to try psychotherapy first and wait until full adulthood before resorting to physical treatment? It seems worth reiterating that 98% of adults attending Hakeem's therapy groups decided not to medically transition once their hopes and expectations had been tested against the reality of those whose GD had not been improved by it.

### Scenario 3: from Maxine back to Max

The writer of *Butterfly*, Tony Marchant, was advised by the trans-affirmative charity Mermaids. He asks us to believe that Max's identification as Maxine has no cause. It is just a given. There is nothing wrong with Maxine's family apart from the intolerance of her father, Stephen, and there is nothing wrong with Maxine apart from the effects of that intolerance. Maxine just happens to be trans.

This scenario stretches my credulity to the limit. So, I will draw on my therapeutic experience to create what I consider a more realistic, but also more genuinely hopeful, scenario. Let's imagine that Maxine takes her puberty blockers but sees a therapist who tries to understand the origins of the trans-identification instead of just affirming it. Perhaps this therapist manages, against the odds, to offer more than the statutory six diagnostic sessions usually provided by the Tavistock GIDS. Or perhaps Maxine's parents have paid for her to see a psychotherapist privately. This therapist sees Maxine one-to-one regularly and over the first 20 sessions her story gradually unfolds.

It becomes apparent that her mother, Kate, has turned Maxine (originally as Max) into her confidante. Kate is struggling with what she experiences as her husband Stephen's predatory sexuality. Perhaps Kate is gay but finds this hard to accept – or perhaps Stephen really is a bully in the bedroom. Kate warns Maxine at breakfast one morning that Stephen will probably be in a terrible mood because last night she had to refuse his demands for sex yet again. Maxine relates this incident to her therapist and goes on to say that she was disgusted to catch sight of her penis in the bathroom mirror before leaving for school that morning. An affirmative therapist would probably regard this as confirmation of Maxine's True Gender Self (Ehrensaft 2013). Maxine's therapist privately wonders however if her trans-identification could be the result of disgust with male sexuality. After all, Max/ine's closeness to mother depends on a shared view of Stephen's sexuality as predatory.



Over time, Max/ine goes on to describe how, as a child of seven, s/he very much admired a neighbour who was willing to play with him despite being several years older. But this boy, it transpires went on to sexually abuse Max, though Max did not fully understand the significance of this at the time. Max/ine's therapist decides to risk being struck-off for practising 'conversion therapy' (MoU2 2017). S/he asks Maxine if s/he thinks it is possible that the trans-identification could have originated from a sense of disgust at adult male sexuality, partly because of the experience with the neighbour and partly because of Kate's difficulty with Stephen.

Max/ine breaks down in tears and says that s/he hadn't thought about it like this before, but that this makes sense, and the thought scares him/her. Nevertheless, over the next few months he stops taking puberty blockers and gives up his female identification. There are enormous upheavals in Max's social life as many of his former friends and online trans allies desert him. Max feels isolated and anxious and not sure if he has made the right decision.

He continues in therapy but wavers between a growing sense of acceptance of his own male identity and a fear that he has done the wrong thing in giving up the puberty blockers and female identification. One day he brings a nightmare. He is in bed and a terrifying bear-like man covered in tattoos is raping him. He is not sure what the dream means, but wonders if the man could represent male sexuality, which he finds threatening, especially as his libido is returning since giving up the puberty blockers.

There is clearly still a long way to go before Max can fully reintegrate and enjoy this currently frightening aspect of himself. But the fact that he can have this dream and share it with his therapist gives genuine hope. Previously Max and his family had used trans-identification as a way of evading their distress. Now, as the analyst Thomas Ogden (2001) might have put it, a conversation appears to be developing at the frontiers of dreaming.

## Conclusion

This article has depicted two contrasting narratives regarding trans-identification and GD. The first narrative is supported by low quality research (Heneghan 2019; Biggs 2019; Horváth 2018) often funded by the very drug companies supplying medical treatment (Delamarre-van de Wall and Cohen-Kettenis 2006). At times it seems simplistic and naïve and reinforced by media presentations such as *Butterfly*, *YouTube* vloggers, trans-activists and 'affirmative' therapists. I have argued that this narrative results in young people with a variety of psychological problems self-identifying as trans and demanding the 'gender-affirmative' medical treatment they unconsciously believe will allow them to evade those problems. An army of 'woke warriors' stands ready to accuse anyone challenging this narrative of transphobia.

The second narrative is based on the experience of people who have either been through medical transition and regretted it or arrived at a more realistic assessment of what it can and cannot do (Hakeem 2018a). Medical transition may enable a person to ‘pass’ more easily as the opposite sex but not to change biological sex. GD may persist despite transition. Any other psychological issues it seeks to evade are likely to remain unresolved. The true number of people who are unhappy with physical transition is unknown but almost certainly much higher than ‘official’ estimates. Care of the body as a life-long medical patient brings its own difficulties, restrictions and discomforts. The long-term effects of treatment are largely unknown, though we do know it will cause sterility among other problems.

It would be easy to blame promoters of the first narrative for the fate of those experiencing the second. But if we are to prevent further harm, we must understand how it is that our society has allowed the first narrative to dominate our legal, therapeutic, educational and popular agendas (Reynolds 2018). Surely this must suit us for some reason. Speaking over 70 years ago about ECT and lobotomy Winnicott had this to say:

I also want to put forward the idea that these physical therapies express society’s unconscious reaction to insanity. This is by far the most difficult thing I have to say. I have reason to believe that the good results that can come from these physical therapies depend on this, that by them expression is given in an acceptable (because hidden) form to the unconscious distress society experiences in the face of mental illness.

(Winnicott 1947, p. 540)

Winnicott goes on to argue that working effectively with other people’s madness, requires us to be conscious of our own psychotic issues (Winnicott 1949). That can be extremely distressing. So, if Attis, Chris, Alex and Max have attempted to deal with their dysregulated affect (madness) by projecting it into their penises and breasts, then perhaps we have attempted to evade engagement with our own madness by endorsing their surgical removal. Such physical treatments may thus constitute an attempt to evade the responsibility of engaging compassionately with psychological distress, both our own and that of other people. It is sobering to realize that future generations could well view current treatment protocols for trans-identified young people as a form of ‘sexual lobotomy’ (Donym 2018).

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## TRANSLATIONS OF ABSTRACT

Dans cet article l'auteur soutient que l'indentification trans et son traitement médical associé peuvent constituer une tentative pour échapper à des expériences de détresse psychologique. Ceci se produit à trois niveaux. Premièrement, la personne trans elle-même peut chercher à éviter les affects dérégulés associés aux expériences telles que le traumatisme de l'attachement, l'abus sexuel dans l'enfance, les ressentis sexuels qui semblent incompatibles avec l'égo. Deuxièmement, les thérapeutes peuvent tenter d'échapper à des émotions, telles que la peur et la haine, évoquées par l'implication avec ces affects dérégulés. Troisièmement, nous, en tant que société, pouvons être animés par le souhait d'échapper à la réalité de tels traumatismes, abus et détresse sexuels en nourrissant l'hypothèse que l'identification trans est une question biologique, qu'il vaut mieux soigner de manière médicale. L'auteur soutient que la qualité des preuves en faveur de l'approche biomédicale est extrêmement pauvre. Ceci expose les jeunes personnes trans au risque de recevoir des traitements médicaux qui les endommagent, traitements qu'elles peuvent plus tard chercher à inverser, ou qu'elles regrettent, pendant que les questions psychologiques fondamentales restent sans attention.

*Mots clés:* traumatisme de l'attachement, contretransfert, dé-transition, dissociation, affect dérégulé, dysphorie de genre, homophobie internalisée, transgenre

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In diesem Artikel legt der Autor dar, daß die Transidentifikation und die damit verbundene medizinische Behandlung einen Versuch darstellen können, Erfahrungen mit psychischer Belastung auszuweichen. Dies geschieht auf drei Ebenen. Erstens kann die Trans-Person selbst versuchen, dysregulierten Affekten auszuweichen, die mit Erfahrungen wie Bindungstrauma, Kindesmißbrauch und ichfremden sexuellen Gefühlen verbunden sind. Zweitens können Therapeuten versuchen, Gefühlen wie Angst und Haß auszuweichen, die durch die Auseinandersetzung mit diesen dysregulierten Affekten hervorgerufen werden. Drittens möchten wir uns als Gesellschaft möglicherweise der Anerkennung der Realität eines solchen Traumas, Mißbrauchs und sexuellen Leidens entziehen, indem wir die Hypothese aufstellen, daß die Transidentifikation ein biologisches Problem ist, das am besten medizinisch behandelt wird. Der Autor argumentiert, daß die Qualität der Beweise, die den biomedizinischen Ansatz unterstützen, äußerst mager ist. Dies birgt das Risiko, daß junge Transsexuelle möglicherweise schädliche medizinische Behandlungen erhalten, die sie möglicherweise später rückgängig machen oder bereuen könnten, während ihre zugrunde liegenden psychologischen Probleme weiterhin unberücksichtigt bleiben.

*Schlüsselwörter:* Beziehungstrauma, Gegenübertragung, Detransition, Dissoziation, dysregulierter Affekt, Geschlechtsdysphorie (GD), internalisierte Homophobie, transgender

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In questo articolo l'Autore sostiene che l'identificazione trans ed il suo trattamento possono costituire un tentativo di eludere esperienze di disagio psichico. Ciò avviene

su tre livelli. In primo luogo, il soggetto trans può cercare di eludere gli affetti disregolati associati a esperienze quali attaccamento e trauma, abusi infantili e vissuti sessuali alieni all'io. In secondo luogo, i terapeuti possono tentare di eludere i sentimenti, come la paura e l'odio, evocati dal coinvolgimento con questi affetti alterati. In terzo luogo, noi, come società, potremmo tentare di evitare di riconoscere la realtà di tale trauma, abuso e disagio sessuale ipotizzando che l'identificazione trans sia una questione biologica, che va trattata al meglio dal punto di vista medico. L'Autore sostiene che la qualità delle prove a sostegno dell'approccio biomedico sia estremamente scarsa. Ciò mette i giovani transessuali a rischio di ricevere cure mediche potenzialmente dannose, i cui effetti potrebbero in seguito cercare di annullare o comunque rimpiangere di averle fatte, mentre i loro problemi psicologici di fondo rimangono irrisolti.

*Parole chiave:* trauma dell'attaccamento, controtransfert, detransizione, dissociazione, affetti alterati, disforia di genere (DIG), omofobia interiorizzata, transgender

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В статье автор обосновывает точку зрения, согласно которой идентификация с трансгендером и связанное с ней медицинское лечение могут представлять собой попытку избежать переживания психологического стресса. Это происходит на трех уровнях. Во-первых, сам транс-человек может стремиться избежать неуправляемых аффектов, связанных с такими переживаниями, как травма привязанности, насилие в детстве и чуждые эго сексуальные чувства. Во-вторых, терапевты могут пытаться избежать чувств, таких как страх и ненависть, вызванных воздействием неуправляемых аффектов. В-третьих, мы, как общество, можем стремиться к избеганию признания реальности травм, абьюза и сексуального дистресса, выдвигая гипотезу о том, что идентификация с трансгендером является биологической вопрос, к которому лучше всего подходить с медицинской точки зрения. Автор утверждает, что качество доказательств в поддержку биомедицинского подхода крайне низкое. Это подвергает молодых транс-людей риску получить потенциально опасную медицинскую помощь, о которой они впоследствии могут пожалеть, в то время как лежащие в их основе психологические проблемы остаются без внимания.

*Ключевые слова:* травма привязанности, контрперенос, детрансформация, диссоциация, дисрегулируемый аффект, гендерная дисфория (GD), интернализированная гомофобия, трансгендер

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En el presente trabajo, el autor argumenta que la identificación-trans y el tratamiento médico asociado puede constituir un intento de evadir experiencias de angustia psicológica. Esto sucede en tres niveles. Primero, la persona trans puede buscar evadir emociones disreguladas asociadas a experiencias como trauma de apego, abuso infantil, y sentimientos sexuales ego – no alineados. Segundo, los terapeutas pueden intentar evadir sentimientos, tales como miedo y odio, evocados al entrar en contacto con estos afectos disregulados. Tercero, nosotros, como sociedad, podemos desear evadir la realidad de semejante trauma, abuso y angustia sexual, al hipotetizar que la identificación-trans es un tema biológico, y mejor tratarlo medicalmente. El autor da cuenta que la evidencia que fundamenta el abordaje biomédico es extremadamente



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pobre. Esto supone, para las personas jóvenes trans, el riesgo de recibir tratamiento médico potencialmente dañino, que más tarde pueden buscar revertir, o del que arrepentirse mientras que los temas psicológicos subyacentes permanecen sin ser reconocidos.

*Palabras clave:* trauma de apego, contratransferencia, detransición, disociación, emoción desregulada, disforia de género (GD), homofobia internalizada, transgénero

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#### 跨性别认同以及规避心理压力的尝试

文章认为，跨性别认同以及与之关联的医学治疗是一种规避心理压力体验的尝试。这发生在三个层面。第一，跨性别的个体会试图规避失调的情绪，这些情绪关联着依恋创伤，儿童期虐待，自斥的性体验。第二，治疗师会试图规避一些感受，如害怕，恨，当他们跟随病人那些失调的感受时，这些感受就会被唤起。第三，我们，作为社会，试图回避承认这些现实存在的创伤、虐待和性压力，规避的方式就是假定跨性别认同只是一种生理的问题，最好通过医疗治愈。作者认为，支持这些生理医学取向的证据十分薄弱。这把年轻的跨性别人群置于危险境地，使他们接受了有潜在伤害的医疗干预，而他们过些时间可能想要转变回来，或是后悔进行了这些医疗处理，而与此同时，潜在的心理问题却没有得到处理。

关键词：依恋创伤，反移情，去性别转换，隔离，失调的情绪，性别焦虑症 (GD)，内化认同，跨性别

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