The International Journal of Psychoanalysis

(2020). Int. J. Psychoanal., (101)(5):1031-1038

First do no harm

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> *Every social order creates those character forms which it needs for its own preservation …*
>
> *The character structure … is the crystallization of the sociological process of a given epoch. (Wilhelm Reich)*

What I have to say will be divided into three sections. In the first, I will elaborate on what I have learnt about the healthcare of children suffering from gender dysphoria, focusing on the serious clinical and ethical concerns that I, like many others who have become involved in this field of work, have come to recognise. I will go on to discuss the socio-cultural factors that may be relevant to understanding the sudden huge increase in children and adolescents being referred to specialist centres. Finally, I will examine some of the characteristics of a peculiar form of thinking or, more precisely, non-thinking, that seems to have come to dominate the discourse in this area.

The understanding/knowledge that I have been developing comes from a number of sources, including my engagement with colleagues in the UK, other European countries (particularly Sweden), Australia and the USA.

First, I need to state an important rider – and the fact that I have to do so is symptomatic of the highly charged atmosphere in which discussions of this area take place, resulting in important and often highly motivated misunderstandings. Questions about the appropriateness of medical and surgical intervention, most particularly in children, need to be kept entirely distinct from questions of discrimination. I say this as there is pressure for these two matters to be elided, and I will return to this later. We are all appalled by the violent hatred that many trans people have to suffer and indeed we may have some psychoanalytic thoughts as to its sources. I also need to make it clear that I can see that for *some* individuals, medical transition is the only reasonable option.

Concerns regarding the understanding and treatment of trans children

It is vital to differentiate gender dysphoria from transgender – the former refers to deep feelings of discomfort with the sexual body that has multiple sources and multiple appropriate therapeutic approaches. “Transgender” refers to those individuals who have completed or are embarking upon medical and surgical interventions aimed at altering their gender identity. However, services pressured by trans lobbies and by an increasingly hegemonic zeitgeist fail to discriminate between the two, with disastrous consequences.

There are multiple routes to gender dysphoria – the list is long but would include the presence of various psychological disorders including depression or autistic spectrum

*Although I am a consultant psychiatrist at the Tavistock and Portman NHS Trust, what is written in this paper reflects only my own views and should not be misunderstood as reflecting those of the Trust.

disorder,[1] children who, for multiple and complex reasons, live a lonely and isolated life, feeling that they just have no place in the world, and are psychically lost and homeless. Serious family disturbance is common, often with intergenerational transmission of major trauma such as child abuse in the mother/maternal line (sometimes a source of the mother's not wanting a girl child). Some families have suffered other major traumas, for example families where the death of, say, a female child brings her brother to seek transition to support the identification with the dead sibling.

A very important causal route, well described in the literature, is related to homosexuality. It is not uncommon for a lesbian girl, for example, to think that because she is attracted to the same sex that she must ‘really’ be a boy. Some children who show characteristics of being gay/lesbian find that this is not tolerated by the family (often very overtly, but equally often in a more subtle even unconscious way); the children internalise this intolerance of their sexual orientation, which becomes manifest as hatred of their own sexual bodies.

Many clinicians are clear that a significant number of these children, if helped in a proper manner, would end up being gay or lesbian without having undergone transition. This also illustrates the way that gender as a category has come to obscure discussion of sexuality.

The massive increase in referrals of children and adolescents to the Tavistock Gender Identity Development Service (GIDS) is shown below. This increase has continued in and the latest figure I have is 2590 (2018–9).

This massive increase in referrals has caused services (in UK and Europe) to make use of staff who have low levels of knowledge and skill as regards complex disorders in childhood. Many will have had little or no previous exposure to complex serious disorders in childhood. Most do not regard themselves as psychoanalytic services, and in some major services it is a small minority who have any substantial psychotherapeutic experience.

Other issues of concern that many raise include:

huge caseloads, well over 100 being not uncommon, often seen only for a few widely spaced meetings;

unresolved serious ethical issues of what constitutes informed consent in minors;

risks to young children and adolescents of hormonal and surgical interventions without adequate assessment time or thinking space – particularly important given the lack of any evidence for safety of the medication[2] and given that nearly 100 per cent of pubertal children started on so called 'Puberty Blockers' progress to opposite sex hormones, and thus are on the road to surgery. At some centres 50% of children referred start on medical treatment.

services submitting, indeed encouraging submission, to the powerful politicized lobby and social media. Fears of being called "transphobic" close down space for thought, doubt and exploration.

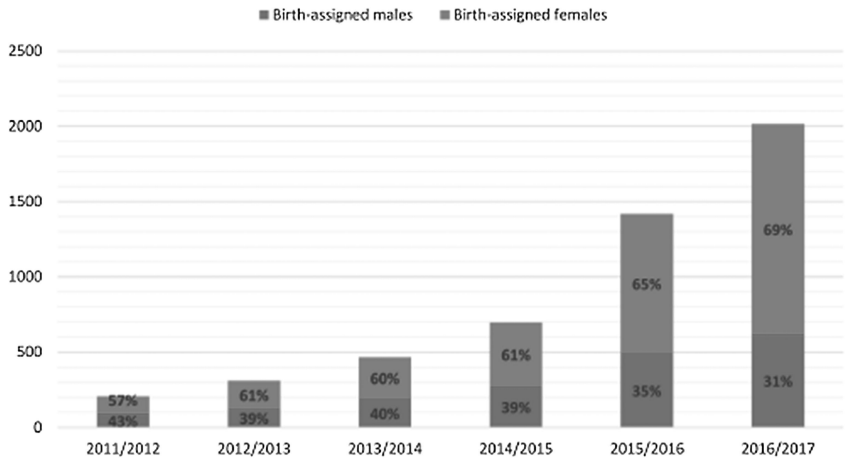
Thus, while it is clear that we are dealing with a highly complex problem with many causal pathways, and in any case no single causative factor, gender services tend towards a damaging simplification. This is for various reasons, not least the huge increase in caseload and long waiting lists leading to pressures to process the children using a procedural model rather than one aimed at understanding the individual case in any depth. Of course, alignment with affirmative lobbies (that is, lobbies that seek to "affirm" the wish to change gender, tending to see it only as a positive choice to be encouraged) acts as an ideological support for this simplification.

Many services lack any understanding of, and are overtly hostile to, any thought about the unconscious issues. Even thinking about cause is very often regarded as an act of hostility – for the only acceptable explanation is that the child is *literally* in the wrong body and all suffering is secondary to this "fact". It needs to be borne in mind that there is absolutely no evidence for this assertion.

Sudden increases in trans and the factors underlying it

I have shown in Figure 1 the clear geometric increase in referrals, but I would like also to draw attention to the rising proportion of natal females presenting to the service—a relatively new phenomenon.

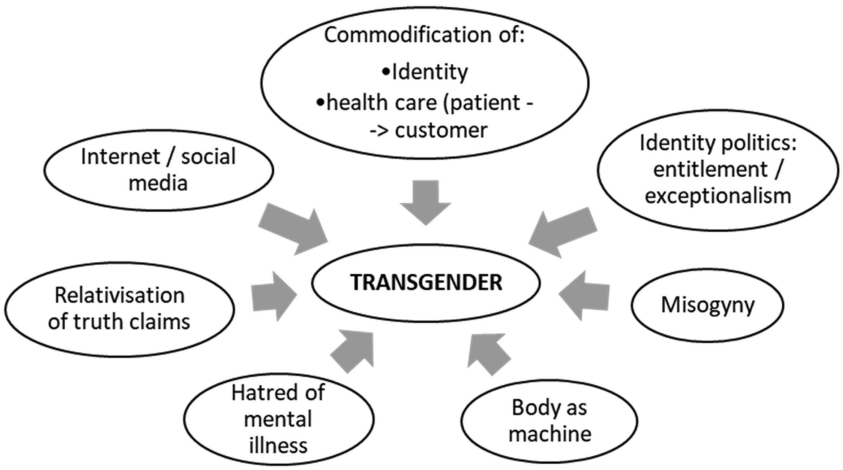
Figure 1.. Referrals to the Gender IdentityDevelopment Service by birth-registered gender, April 2011 to April 2017.



It must, I think, be clear that such a rapid escalation of cases, the increase in natal females, the sudden appearance of so called "rapid-onset gender dysphoria", cannot be explained by individual factors alone, nor is it likely to be caused by a large number of individuals feeling free to "come-out" in this new "liberal" atmosphere. It is therefore regrettable that treatment for children and adolescents has been increasing exponentially, without inquiry into this broader determining socio-cultural context and with no real knowledge of the consequences, as there is no adequate follow-up data

What I offer here is only a preliminary sketch of some of the factors that may be relevant to this sudden change (Figure 2).

Figure 2.. xx.



First, the ever-increasing penetration of the market form into all aspects of life reaches deep into the psychology of the person, reformulating identity so that identity comes to manifest features of the commodity form; it moves from being something that one lives with, struggles with over time, to a more transient structure that, somewhat like a commodity, is exchangeable. Commodity exchange, because of its extraordinary rapidity, supports the illusion of instantaneous transformation. It should be clear that I do *not* mean that a trans person just chooses a new identity, without any painful struggle, but only that this underlying sociocultural change acts as a tendential force influencing the way we all think.

This transformation is increasingly expressed in the relation between doctors and patients, which degenerates into a perverse form, a celebration of customer-hood (misunderstood as democratisation). The distinction between need and wish here evaporates. We have been used to a world where a patient requests X treatment, but the professional can disagree, introducing a triangulation that may be welcomed or resisted. However, powerful social forces misrepresent this triangulation as only representing a kind of patriarchal power play, and where this is successful, externality collapses.

Second, overburdened child mental health services that cannot cope with the combination of increasing demand and cutting of resources are stretched to breaking point (for the UK situation, for example, see The Association of Child Psychotherapy report *A Silent Catastrophe* [3]). Faced with children suffering complex serious disorders, it is understandable that any mention of gender problems can result in referral to specialist gender services, and in the process, complex disorders (now filtered through the prism of gender) can be left

completely unaddressed. This can also lead to a damaging foreclosure of the ordinary turbulence and confusion of adolescence.

Third, another major change is to be found in transformation of political life so that identity politics (race, gender) moves into a dominant position. This movement started off life as liberal and progressive but then (and this has been brilliantly discussed by feminist and black theorists[4]) it twists and turns, coming to manifest the very characteristics it sought to challenge; it becomes fixed, narrow, all determining and tyrannical; critical engagement is recast as the enemy to be silenced.

Fourth, the increasing recourse to medical and surgical intervention enacts a breakdown in the boundary between the bodily self and technology.

As Rosine Perelberg has put it:

> *the scale to which technology has penetrated the human body (is) worldwide. If Foucault's writings were ground-breaking indicating the control that society has exercised over the body, it seems that now there is a step further taken in that the new technologies and new form of capitalism takes over the production of the body itself. (Perelberg, 2020)*

Finally, I think that in our current conjuncture we are witnessing a growing misogyny. What I have in mind here is this: from World War II up until the late 1970s a strong femininity, expressed by the increasing theorisation and respect for maternal caring, and in the British context the creation of the Welfare State, maintained a certain social dominance. However, that version of strong caring has been re-presented in its perverse form, the "nanny state", a contemptuous attack on femininity.[5] This is both expressed and reinforced by ideological forms that promote the delusion of the autonomous man, seeking to service only his own needs, enacting a hatred of all forms of dependence. This growing misogyny may be having profound effects on girls and, in conjunction with more individual factors, supports the internalisation of this hatred of femininity, transformed into a hatred of their female bodies.

The internet/social media are major determining forces, occupying a position that is *both* causal and also the vehicle for other causes. Through a kind of viral social contagion,[6] children who feel lost in the world become radicalised online, join trans groups that provide them at last with an identity and social belonging

and also an explanation for all their suffering. Further, because of its overwhelming ubiquity and power, it is the medium through which the other factors listed above are transmitted at speed and with no obstruction.

This factor is of considerable importance in the very marked increase in the occurrence of so-called rapid-onset gender dysphoria, where the onset is sudden, sometimes literally from one day to the next. There is considerable evidence of social contagion in schools.

A peculiar mode of thinking

I will here elaborate on some aspects of the peculiar form of thinking that has come to dominate the discourse in this area.

1035

As I think I have made clear, thoughtful engagement is treated as a kind of enemy and this is certainly the experience of many clinicians working in gender services. The wish to think over time and understand why a particular child has developed gender dysphoria comes to be seen as an expression of "transphobia", creating a paranoid universe, a world where "You are either with me or against me", that is, there is no room for a mind that just wants to think about things. This intolerance of doubt and thought that characterises certain kinds of mental states here leaks out and becomes a force in the social realm.

The term "transphobia" has, for our community, a particular unfortunate resonance, namely, the homophobia that is a part of our history. I have in mind that dark history of conversion therapies for homosexuals (particularly, although not only, in the USA); I believe the fear of repeating this has interfered with our capacity to think through these issues and has led us to turning a blind eye. But it is vital to distinguish between conversion therapy and a wish to think. As I see it, the rapid decisions as regards the provision of medical and surgical intervention *is itself* a form of conversion therapy – like the past "treatments" for homosexuality, it seeks to refashion the body as the only permissible solution to painful conflicts about gender. It brings about transformations in the body, converting it in order to satisfy often insufficiently examined individual, family and social agendas.

Finally, the possession of a particular identity is taken as supplying one with a peculiar kind of higher authority. If, for example, a person says "as a gay man, or Jewish man, or disabled man, or black woman", it would be reasonable to accept that such a person, because of their specific experiences, will enrich any

discussion of the world with which they identify. But this does *not* bring entitlement to an unquestioned higher authority. That is, by belonging to X or Y group, my views as to what is true of the world, particularly about the group to which I belong, remain as open to question as the views of any other person. This assumed "higher authority" can exhibit a kind of entitlement, an entitlement not to be questioned, that is, a demand to be exempt from the ordinary canons of what counts as good judgement (there can be no personal or group sovereignty over what counts as true). There is here, I believe, a link to the more generalised undermining of truth value that is characteristic of our age.

One wonders if the peculiar intransigence of these beliefs might at times a result of the awareness of doubt, doubt that is disowned and projected into the other, who then must be silenced.

If we take it as a fact that gender identity is socially constructed, then there is a paradox at the heart of the trans phenomenon. The apparent freedom/liberation it expresses is totally undermined by locating all possibility of change only concretely, in material alteration of the body, rather than in the mind.

There has been a peculiar regression in thinking. In our contemporary world we are generally tolerant, even celebrate, a certain fluidity in expression of gender and sexuality. We are less interested in who a person goes to bed with, less bothered by a man being somewhat camp or a woman being unfeminine. This exists alongside a toleration of certain limitations arising from the body. In the ideology of the militant trans lobbies, there is a peculiar rigidity of gender identity coupled with a belief in the total fluidity of the body, a most peculiar reversal. This is coupled with a peculiar essentialist mode of thought, that is, gender identity is confused with anatomical sex and so is seen as biological and fixed rather than psychological, social and fluid.

Beatrix Campbell captures this well:

> *The sexual revolution wrought by feminist and gay activism has, of course, changed the political landscape in which trans lives can be lived. It co-exists with the commodification of gender archetypes and the reinstatement of seemingly polarised and parodic masculinities and femininities.*

Here I have described how thinking becomes the enemy to be destroyed – nothing should stand in the way of an unobstructed pathway to irreversible medical and surgical procedures that will result in a lifetime of medication whose long-term consequences remain unknown.[7]

I will end with a story:

As a medical student I attended a lecture by Professor Hans Eysenck on electric shock treatment to decondition gay men. In the discussion a young gay philosopher asked if there were not ethical matters that needed consideration. Eysenck responded that these men were suffering as a result of being homosexual and had sought help. We have, he said, the technology to relieve them – there is no further ethical consideration. The questioner suggested a thought experiment. Let us imagine, he said to Professor Eysenck, that you are an orthopaedic surgeon and that one day a man approaches you complaining "I cannot bear my arm, it is ugly, I never know what to do with it, my wife also hates it, look it's covered in bruises as I always knock it, could you please remove it." Well, said the questioner, I think you might send him to a psychiatrist to find out what is wrong in the relation between the man and his arm; you would not say – we have the technology to relieve him of his suffering and so proceed to amputation. There was a deafening silence in the room. The point here, of course, is that the homosexual man who seeks treatment of this type is *not* sovereign over decisions as to what afflicts him – for there are individual, family, social determinations (including living in a world where hatred of homosexuality would be a daily experience) that affect him some of which may be beyond his awareness.

However, the last time I told that story I was disturbed to learn that in the USA there *are* surgeons who *will* amputate under these conditions; here patient-hood has collapsed completely into customer-ship, and so wish transcends any conception of need, externality is annihilated.

It is indeed strange to be living in a world where, I receive a referral to my clinical service from a plastic surgeon of a man who has asked for surgery on his nose, and the surgeon informed the patient that there was nothing wrong with his nose, but with his relationship to it. After a year's psychotherapy, the man gave up his wish for surgery, having understood the complex identifications that underlay his belief. Meanwhile, elsewhere, a person with acute gender dysphoria, within only a few consultations, may well find agreement to change her name, commence medication and thus be heading for surgical removal of her breasts and genitals, any questioning foreclosed.

Many years ago, if your television seemed not be functioning, you would use various controls to reset it. But sometimes a message from the broadcaster appeared, “Do not

adjust your set, there is a problem with the signal.” A version of this made its way into a popular political slogan of the 60’s, “Do not adjust your set, reality is disturbed.”

However, the current predicament is much darker than this. Serious questions have been raised concerning the ethics and safety of many of the medical and surgical treatments that are being commonly applied, treatments that may be offering medical solutions to psychological problems.

It is hoped that this discussion may be part of the start of a critical engagement. There is now much broader debate in the media than would have been possible only a few years ago, so the pendulum may be starting to swing the other way, but there are many beleaguered colleagues who are struggling to maintain thought and ethical responsibility, and they would greatly value our support.

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