GQC Consultation: Additional Information for Education and Medical Professionals

GUIDE TO QUESTIONS

Question 3

It is helpful for education or medical professionals responding to this consultation to identify this.

Question 22 and 24

In our main guide for supporters, we suggest responding that the guidance should instruct schools never to agree to use pronouns for a child that correspond to the opposite sex. Neither should they agree to a change in the name used for a pupil in a way that affirms them as the opposite sex.

You might like to add some further detail in your responses to these questions. We have some suggestions below, but do write from your own professional perspective and use your own words:

The core symptoms of gender dysphoria in childhood rarely exist in isolation; usually the symptoms are associated with psychosocial stressors and psychiatric disorders.

In children aged twelve and under who have been diagnosed with gender dysphoria, up to 21% meet criteria for an anxiety disorder, 44% have a significant psychiatric history, and 9% have attempted suicide:

> Frew, T, Watsford, C and Walker, I, 'Gender dysphoria and psychiatric comorbidities in childhood: a systematic review', *Australian Journal of Psychology*, 73(3), 2021, pages 255-271, DOI: 10.1080/00049530.2021.1900747

In 12-18 year olds experiencing gender dysphoria, other mental health issues are present in 22 to 78%. Depression ranged from 30 to 78%, anxiety disorders from 21 to 63%, and suicidal ideation from 12 to 74%:

> Thompson, L, Sarovic, D, Wilson, P, Sämfjord, A and Gillberg, C, 'A PRISMA systematic review of adolescent gender dysphoria literature: 2) mental health', *PLOS Glob Public Health*, 2(5), 2021, DOI: 10.1371/journal.pgph.0000426

Individuals who identify as transgender or gender diverse have much higher rates of autism diagnosis, related neurodevelopmental and psychiatric conditions, and autistic traits, compared with those who do not:

> Warrier, V, Greenberg, D M, Weir, E et al, 'Elevated rates of autism, other neurodevelopmental and psychiatric diagnoses, and autistic traits in transgender and gender-diverse individuals', *Nature Communications*, 2020, DOI: 10.1038/s41467-020-17794-1

This increases their vulnerability to concrete thinking, where all psychological distress and social problems are projected onto the sex of their body. This brings a fixation on transition as the solution, often encouraged by online chat groups that identify anything and everything as a sign the person 'is transgender'. Such conversations may also be taking place in school 'Pride Youth Networks', set up by the now collapsed charity, Educate and Celebrate, and similar pupil societies, as well as in peer groups. Trans identification is often clustered and teachers have observed 'social contagion' in friendship groups, and older pupils 'grooming' younger ones.

It is clear that children who are making requests of schools regarding their gender are a vulnerable group. Current statutory safeguarding guidance for schools, Keeping Children Safe in Education, needs to be updated to remove the assertion that: "*The fact that a child or a young person may be [LGB]T is not in itself an inherent risk factor for harm*" (paragraph 203).

Research does not indicate any benefit of social gender transition in ameliorating mental health issues in gender dysphoric young people:

> Morandini, J S et al, 'Is Social Gender Transition Associated with Mental Health Status in Children and Adolescents with Gender Dysphoria?', *Archives of Sexual Behavior*, 52(3), 2023, pages 1045–1060, DOI: 10.1007/s10508-023-02588-5

> Sievert, E D, Schweizer, K, Barkmann, C, Fahrenkrug, S, Becker-Hebly, I, 'Not social transition status, but peer relations and family functioning predict psychological functioning in a German clinical sample of children with Gender Dysphoria', *Clinical Child Psychology and Psychiatry*, 26(1), 2021, pages 79-95, DOI: 10.1177/1359104520964530

The results in earlier studies unequivocally show that gender dysphoria remits after puberty in the vast majority of children. These studies are summarised in the introduction to Steensma et al. (2011) (see below).

At the core of social transition is the use of pronouns and names which ensure the child's beliefs about their gender are given concrete form and affirmation in the way others relate to them. This is psychologically significant, as reported in the Cass Review's Interim Report:

> "*...it is important to view it [social transition] as an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning*".

Social transition in schools creates a barrier to desisting from cross-gender identification. It also makes it more likely that children will seek out treatment with puberty blockers, which further reduces the likelihood they will desist. Steensma et al. (2011) found that the experience

of puberty was a key factor in gender dysphoria not persisting:

> Steensma, T D, Biemond, R, de Boer, F, Cohen-Kettenis, P T, 'Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study', *Clinical Child Psychology and Psychiatry*, 16(4), 2021, pages 499-516, DOI: 10.1177/1359104510378303

It is dangerous for a teacher to make a decision that social transition should be pursued. They are not competent to identify this as the appropriate response to the child's needs. This action could mask underlying serious psychological problems, leaving them unaddressed, while putting the child onto a pathway that leads to progressively radical steps that could cause long-term and profound harm, without providing any other benefit to the child.

Accounts from some detransitioners identify initial feelings of euphoria accompanying transition that a new self is created which appears to leave the problems behind; however, the unresolved underlying mental conflicts and difficulties re-emerge over time. This can drive the individual to take further, more invasive and irreversible steps in pursuit of transition, such as cross-sex hormones and even surgery, ultimately to discover that the underlying problems remain unaddressed.

Both cross-sex hormones and surgery produce irreversible changes which reduce or remove fertility, reduce sexual function and in the case of mastectomy, remove the ability to breastfeed. Serious complications of genital surgery are common. Yet, statistical analysis confirms that cross-sex hormone treatment is not associated with any change in mental health:

> Bränström, R and Pachankis, J E, 'Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study', *American Journal of Psychiatry*, 177(8), 2019, pages 727-734, DOI: 10.1176/appi.ajp.2019.19010080

Surgical treatment is also not associated with any change:

> Correction to Bränström and Pachankis, *American Journal of Psychiatry*, 177(8), 2020, pages 727-734, https://doi.org/10.1176/appi.ajp.2020.1778correction

Guidance for schools should spell out clearly that teachers must never affirm a child's belief that they 'are trans', or that social transition is the solution, nor should they facilitate social transition at school.

Question 42

The guidance does not address the use of breast binders by female pupils. These can cause irreversible damage to developing breast tissue, as well as damaging the skeleton, sometimes resulting in rib fractures, and restricting breathing.

> Peitzmeier, S M, Silberholz, J, Gardner, I H, Weinand, J, Acevedo, K, 'Time to First Onset of Chest Binding-Related Symptoms in Transgender Youth', *Pediatrics*, 147(3), 2021, DOI: 10.1542/peds.2020-0728

Shortness of breath and overheating are some of the most common health outcomes of binding, and these are likely to be exacerbated by physical exercise, such as in PE lessons. If worn by a pupil who suffers from asthma, a breast binder could further restrict breathing in the event of an asthma attack and make the pupil unable to use an inhaler properly. It could also pose a risk in the event of an epileptic seizure. A first aider may not be aware the pupil is wearing one.

Schools need to be alert to this harmful practice and take steps to minimise risks, including by developing a protocol to sensitively direct pupils to remove them, and provide a private place for them to do so. Breast binders are sometimes supplied to pupils in plain packaging in order to prevent parents being aware of them. If schools become aware of breast binders being supplied in this way, they should treat it as a safeguarding concern and report it to social care.