Child development theory: an inconvenient truth

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When you are born, it's decided whether you're a boy or a girl, based on the way your body looks. But for some people, looks can be deceiving and they're given the wrong gender.
https://mermaidsuk.org.uk/young-people/

When it comes to treating gender dysphoria, decades of knowledge about child and adolescent development and long-standing best practices in the field of psychotherapy have been abandoned.
http://gdworkinggroup.org/2018/11/12/how-i-work-with-rogd-teens/

1. Introduction

For decades, well researched and established theories around childhood and adolescent development, have driven practice in education, paediatric health care, social care, and many other areas of policy around children. However, almost from nowhere, this mainly uncontroversial, evidence-based approach has been usurped in the area of gender development, by an ideological and academic assertion, that, rather than a sex-based identity, a child has an innate and immutable gender identity. This theoretical construction maintains that each child is born with an existent fully formed adult gender identity, an entity/a soul/state of supernatural consciousness as it were, which apparently takes precedence over and, in some cases, seems to drive childhood development and adolescent maturation.

Since this (gender identity) construct has been applied to children, it has become an uncontested, normalised part of the discourse with startling speed, accepted by politicians, policy makers, doctors and academics alike. The disastrous implications on policy and the treatment of gender dysphoric children through gender affirmative models of treatment, is now well documented in the UK and USA. These include an unprecedented surge, particularly in the number of girls being referred, to clinics treating gender dysphoria in children, such as the Tavistock clinic Number of referrals | GIDS and emerging evidence about the harm of this approach by detransitioners - see The Ranks of Gender Detransitioners Are Growing. We Need to Understand Why (quillette.com) by psychotherapist Lisa Marchiano, also https://www.cambridge.org/core/journals/bjpsych-bulletin/article/sex-gender-and-gender-identity-a-reevaluation-of-the-evidence/76A3DC54F3BD91E8D631B93397698B1A# . And of course, in the testimony of Keira Bell herself to the High Court. NHS gender clinic 'should have challenged me more' over transition - BBC News

This article sets out to refute this social construction and its readily used articulation, the "trans child"- a narrative that asserts children possess an innate, predetermined gender identity - by peeling away the underpinning ideological presumptions. It will examine the evidence produced by decades of empirical child development research that shows that children and adolescents have a fluid sense of their own gender. It will establish that:

1. No child has an innate, immutable and predetermined gender identity as asserted by gender ideologists
2. Rather, a child develops a fluid and ever responsive sense of their own gender
3. A sense of gender is socially inculcated and may gradually develop, transform and coalesce into something more fixed and stable as the adolescent matures into adulthood.

It will examine the existing empirical research about how (a sense of) gender develops in children with reference to mainstream child development theories, established over the past century. It will then look at the main treatment models for children with gender dysphoria. It will argue that the affirmation model of treatment which assigns a "gender identity" to a child, is fundamentally unsound and experimental in nature, and that its role, rather than to heal a confused and troubled child, is to fix a gender identity chosen by an adult onto that child, when they are not properly able to understand to what they are consenting. This is a treatment based on ideology, not evidence, and as such is tantamount to a form of conversion therapy; that is conversion therapy as understood as applied to converting gay and lesbian people 'back' to heterosexuality through suppression of their sexuality. However, in this case it is the suppression of the fluid, sometimes playful, and dynamic sense of their own gender that a child tentatively develops, in favour of a fully formed fixed adult gender identity that is presented to them. This discussion is developed more fully below.

It will then be proposed that treatment for gender dysphoria in children be guided by the evidence that a child's sense of their own gender is fluid, and NOT fixed. That treatment must take full account of the developmental cognitive, emotion and physical pathways of children. Once we have these premises as the cornerstone to treatment, a therapeutic approach that takes account of physical and mental comorbidities, contextual safeguarding, and has a trauma informed approach would be a good starting point.

2. Sex and Gender – clearing up confusion

2.1 What is sex, what is gender?

Before starting the analysis, it is important to be clear about terms "sex" and "gender" particularly because these terms are very often used interchangeably. Unsurprisingly perhaps, this confusion between the words and their meanings is often used by those promoting gender identities. It is worth acknowledging along the way, how and why this situation originally arose for example, from embarrassment about using the word sex: "*The American public is surprisingly prudish about the word sex; it has now become commonplace to use the seemingly more genteel term gender when one really means sex*" https://academic.oup.com/edrv/article/42/3/219/6159361 The confusion has led to situations such as job application where an applicant may be asked, "what is your gender?" and be provided two tick boxes – male/female. To be correct, the form should of course ask, "what is your sex?"

To be clear about the terminology, this article will use the definitions for sex and gender from the World Health Organisation (WHO).

> *…. Sex, which refers to the different biological and physiological characteristics of females, males and intersex persons, such as chromosomes, hormones and reproductive organs*
>
> *Gender refers to the socially constructed characteristics of women and men, such as norms, roles, and relationships of and between groups of women and men. It varies from society to society and can be changed."*
>
> *http://www.who.int/gender-equity-rights/understanding/gender-definition/en/*

In short, gender according to the WHO is a social construct as opposed to sex which is driven by 23rd pair chromosomes - the allosomes consisting of two X chromosomes in most females, and an X chromosome and a Y chromosome in most males. The confusion that has been created between these terms has been used by proponents of gender ideology. Sadly, gender and sex are not the only terminological inexactitudes.

2.2 Is sex observed or assigned?

Another method to complicate matters has been utilised. Enter the concept of sex being "assigned" at birth, an "*inaccurate ideological concept*" according to Susan Bewley Professor Emeritus Obstetrics & Women's Health https://www.bmj.com/content/364/bmj.l245/rr-1?fbclid=IwAR0Bgv95QOfKjnvhGeeS7_LKjySUWLxC7-xrzx473tdkUpYepaSmkWGc4PI Formerly it was uncontentious to say that a baby is born with a fixed biological sex - either male or female - with a very small percentage being born as Intersex/with Differences in Sex Development (DSDs). For centuries sex was observed and recorded at birth. However more recently a vogue for stating that sex at birth is "assigned" has emerged. To understand the risibility of this statement, imagine a situation where a midwife who has just delivered a new born with male genitalia, then announcing, "*The sex I assign to this child is female!*" on the basis that they can see the babies "true" gender identity, and then recording this assignation as a birth record. Of course, the doctor and midwife observe the baby's sex as they have been trained, and then record the observation. There is no "assignation" about it, except with a very few children with DSDs, just as there is none in societies where female children have little value, where doctors are able to determine the sex of a foetus in the womb in order to abort an unwanted girl. However, this fantasy of sex assignation is something that Western policy maker and medical practitioners now dutifully trot out. But by cutting away at reality and inserting a linguistic falsehood, it allows the idea into the debate that biological sex is not observable, is instead assigned, and that it is thus, somehow, mutable.

2.3 Can a person change their biological sex?

Biological sex stays immutable throughout human life. There is no evidence that a person who is born male can become female whatever surgeries are undertaken. Surgically removing a man's penis just means that biologically the person is a male without a penis. However, this probably is not how that male without a penis will define themselves. Most likely they will want to be referred to as a trans sexual/woman. This terminology refers to what is commonly called their gender identity – the gender role that a person sees themselves, and how they present/express/perform that role to everyone else.

3. "Gender identity" – what it is and why we are where we are

According to the NHS website "*Gender identity refers to our sense of who we are and how we see and describe ourselves*." https://www.nhs.uk/conditions/gender-dysphoria/. Stonewall's version pushes the "born with a gender" narrative. "*A person's innate* (my highlight) *sense of their own gender, whether male, female or something else (see non-binary below), which may or may not correspond to the sex assigned at birth*." https://www.stonewall.org.uk/help-advice/faqs-and-glossary/glossary-terms.

These definitions may be appropriate for adults who consider that they have a fixed sense of their own gender, but for children, these meanings are unsuitable, a theme that will now be explored.

3.1 Why the fallacy of the immutable gender identity for the child matters

That a child has a fixed or innate gender identity that may be different from that of their sex is at the core of the treatment model for gender dysphoric children/"trans children" as practiced in the UK, USA and much of Europe. The following statement is typical of the approach. *"A child's gender development, meaning maturation of gender identity* (my highlight), *clearly begins in the intrauterine stage*" https://emedicine.medscape.com/article/917990-overview#a2 In this statement, in a mainstream medical outlet, there is no questioning of whether the concept of the gender identity exists, and there is no proof offered for its existence. (How would a female foetus even perform their gender identity to watching doctors?) There is a lack of proof because there is a lack of evidence for its origins and existence. Even Jack Turban, a doctor who is at the forefront of pushing gender affirmation treatment with claims that often cannot be substantiated https://medium.com/@JLCederblom/the-lukewarm-perjury-of-jack-turban-abridged-version-e10b0c420f8e can only come up with the following lukewarm endorsement. (my highlight)

> *Though the precise etiology of gender identity has yet to be identified, these studies together all establish that there is a strong innate biological basis for gender identity among transgender people.*

He admits that the precise origins of gender identity are yet to be found, but surely it is precision and settled science that is required if children are going to have life changing surgical interventions on account of the science? Particularly when there is irrefutable evidence gathered over decades that shows the opposite, that gender is an external social construct – something we will examine shortly. This is the abstract to an article, *The etiology of Gender Identity (*with my highlight).

> *This article reviews the current literature characterizing potential factors associated with the etiologies of gender identity. The PubMed database was searched for all literature that assessed key elements affecting development of gender identity. Current models attribute gender identity etiology to endogenous biology along with prenatal androgen exposure. However, no genetic loci or specific neuroanatomic regions have been consistently identified as the single explanation for transgender identity.* https://pubmed.ncbi.nlm.nih.gov/31027542/#:~:text=Etiology%20of%20Gender%20Identity.

To be clear, this is a literature review of articles sympathetic to the gender identity construct, yet they cannot find settled scientific proof for its origins. So, incredibly, despite the fact there is NO settled science to show it exists, the unproven hypothesis that each child has an innate gender identity is just accepted as routine, uncontroversial information.

This is a key fiction, because, if the concept of the innate gender identity remains uncontested, it paves the way for medical intervention. Why? Because it turns gender dysphoria into a chronic, disabling condition. The end point of this fallacy, is that it pathologises gender and allows the argument that the child needs medical treatment to "cure" this permanent, medical condition. However, the evidence shows that this condition will normally naturally resolve for most children as they mature http://www.sexologytoday.org/2016/01/do-trans-kids-stay-trans-when-they-grow_99.html

And there are decades of empirical research around the development of gender within children which show that the child's sense of gender is constantly changing. There is no innate and immutable gender identity within children. And without this pre-requisite there is NO justification for medical intervention for the vast majority of children.

3.2 Why we are where we are – The setting aside of decades of research into child development

So how has the situation arisen, that the treatment for gender dysphoric children is now based around nothing more than an unproven hypothesis/social construction, that a child has an innate and immutable gender identity that needs to be "cured" by medical practitioners. A construction that has now been embraced by large swathes of medicine? There are many explanations, including:

- the profit motive - US medical businesses wanting to expand a niche market. The "trans child" gives an emotional focus for business development. https://thehelenjoyce.com/a-wild-ride/
- the growing influence social media and the susceptibility of children and teenagers – See Shrier (2020) and Littman (2018)
- the impact of structural misogyny and homophobia on teenage girls, gay and gender non-conforming children. (Shrier 2020 and Joyce 2021) Related to this and of particular concern has been the recent rise in the number of girls being referred for treatment Number of referrals | GIDS.

These areas have been covered in depth by others, so this paper will focus on an area not much covered; the setting aside of established child development theory by ideological medicine i.e. medicine driven by ideology rather than evidence. A major medical driver for this has been the World Professional Association for Transgender Health (WPATH). It produces guidelines https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf which are widely followed by health professionals and others for treatment of transgender people. Treatment pathways for children with gender dysphoria are included, but crucially, in a manner that is based around adult concepts of gender identity.

The process is similar in many ways to that described by Caroline Criado Perez in *Invisible Women* (2019), but instead of the female being treated as if male, in this case the child is regarded as a "mini adult" rather than as a child. Thus, the statement from the guidelines that, *"Children as young as age two may show features that could indicate gender dysphoria*" (page 12) is not then balanced with a discussion about child development theory and the stage of gender development that a two year old will be at, along with analysis of the impact of the imposition of external gender constructs on the child. That a child has an adult gender identity is just assumed. These guidelines take no account of actual rather than ideological projections of children and childhood, and crucially fail to recognise that how a child understands their own sex and gender is not fixed and static but is a dynamic multi-faceted ongoing process that continues to evolve through childhood and adolescence. In summary, the guidelines are based around treatment for adults who may have a more fixed and settled sense of their own gender, and this assumption is projected onto children.

4. Medicalisation, adultification and the return of medical paternalism

When a search of transgender medicine is done on Google it is notable as we saw earlier, that even reputable providers such as the NHS or Mayo clinic append the construct of the immutable/innate "gender identity" onto children, which then allows them to make the case for medical intervention. Thankfully, this is now increasingly qualified by evidence of the drawbacks of puberty blockers and cross sex hormones, but there is no reference at all to the overwhelming amount of evidence that the child's sense of gender is fluid and subject to developmental phases. No context is given that shows gender is a social construct and how this might impact on children. Why might this be?

There are probably a number of interlocking themes underpinning this approach. The two most pertinent to this paper are medicalisation and adultification.

Medicalisation has been described as "*the process of taking non-medical problems and converting them into illnesses and disorders (Conrad and Schneider 2010)* https://bhma.org/diagnosis-are-we-medicalising-human-experience/ In this case we are taking children, who are growing up and pathologising their puberty and how they feel about their sense of gender. As we have seen most children gender dysphoria desists naturally because the difficulties resolve due to maturation etc. But increasingly any child, whatever age, who says that they are a different sex or gender to what they were born in, can expect the adults around them to proactively swing into a medically approved affirmative treatment model, which leads in time to hormones and surgery. Not to act in this way – a non-medical approach - can now be seen as a form of "conversion therapy" as children are not been immediately affirmed by medical practitioners in their chosen gender. In many ways we seem to have arrived at the situation where puberty itself, is now regarded as a medical problem to be overcome. As opposed to a natural developmental stage which any reasonable child may have misgivings about, especially in the fraught areas of their sexual development and the developing sense of their own sex and gender.

Childhood adultification within families occurs according to Burton (2007) when *"young people perform the "'heavy lifting' in families…with the intent of meeting a specific family need,"* Childhood Adultification in Economically Disadvantaged Families: A Conceptual Model on JSTOR Within this definition there needs to be an understanding of the family as a system. Children will sometimes be forced into roles and functions in families by adults around them to fulfil the needs of the family system. Traditionally this has been seen in a young girl taking on the role of a care giver. Inserting this systemic process into the gender debate, the same pattern can emerge. Thus, a family with a male child that is desperate to have a female may impose on their child (the process of adultification) their desires and virtually train their son to take on a more feminine persona. The child's agency to develop in the way they may wish is removed, as a young child in a family is desperate for parental approval and will do anything to gain it. This is not to deny that some children would naturally take on some of these aspects without adult pressure, but it is important to recognise that sometimes, within family systems, children can be forced into roles that they otherwise would not take up.

In respect of the medical profession the setting aside of childhood in favour of the "mini adult" returns the profession to a historic root. The following quote related to children in the youth justice system but its applicability to the medical situation with gender dysphoric children is clear.

> *The idea of distinguishing children from adults is a relatively modern concept. According to Ariès, 'in medieval society the idea of childhood did not exist' (Aries 1979, p.128). For a large period of history, children were simply viewed as 'mini adults'. In the context of children were convicted and sanctioned as adults…*
> *https://www.researchgate.net/publication/348780782_The_Adultification_of_the_Youth_Justice_System_The_Victorian_Experience*

The medical profession led by WPATH has decided, when it comes to gender issues, to ignore scientific research over the past century that distinguishes children from adults, and instead regard them as some type of "mini adult" with no reference at all to the different developmental stages around gender. Thus, if an adult has a fixed gender identity then the "mini adult" will also have one. Decades of child development research can thus be discarded.

In summary, treatment based around a gender affirmative model, hormones and surgery may be fine for adults who may indeed have a more fixed sense of their own gender, but for children such an approach is harmful and can be iatrogenic in nature. In other words, the treatment for gender dysphoria in children can cause harm to children. There is plenty of evidence and testimony to this end in the groups set up by detransitioners, among them Keira Bell, Detrans voices, L.M Watson, and also on detrains reddit. The damage being done to children and adolescents is sadly, to be expected, because the treatment model is fundamentally flawed. It is based around an ideological projection of a child as being a "mini adult", rather than empirical research done with children. It is a return to medical practice from the Nineteenth Century when the child was legally and developmentally indistinguishable from the adult. They were just "mini adults". This is not the progressive medicine that its advocates seem to believe, but rather smacks of old-fashioned paternalism.

5. "Born in the wrong body": How the concept of the innate gender identity for children has played out in public

From the 2010 until 2020 there was a message pushed by organisations such as Mermaids and Gendered Intelligence that a child was born with an inherent immutable gender that is different from that of their sex and that, therefore, incredibly, the child could be, "born in the wrong body". No scientifically plausible evidence to support this assertion was ever published; however, it was a keystone of the overall narrative about why children who suffered from gender dysphoria were "trans children". They were "trans" because somehow due to circumstances never explained, they had been "born in the wrong body", and this situation needed to be rectified by invasive medical procedures, just as if they were a child born with a congenital heart defect requiring surgery to save their life. This claim was often pushed alongside the idea of a male and female brain, that somehow, and the how was never explained, a boy could be born with a girl brain and vice versa. Gina Rippon in her book, *The Gendered Brain* (2019) dismantled this idea of the sexed brain, so, lacking any proof, the "born in the wrong body" statement became one of belief. In effect they were suggesting that the gender identity of the child was akin to a soul.

> *Within current debates, if gender identity becomes uncoupled from both biological sex and gendered socialisation, it develops an intangible soul-like quality or 'essence'. As a pure*

> *subjective experience, it may be overwhelming and powerful but is also unverifiable and unfalsifiable*

Sex, gender and gender identity: a re-evaluation of the evidence | BJPsych Bulletin | Cambridge Core

Interestingly, in this belief they found themselves aligned with some religious groups and people such Adam Groza associate professor of Philosophy of Religion who have likened gender identity to having a soul:

> *Gender is not a social construct. Rather, gender is divinely instituted, and it's an essential aspect of personal identity.*

https://erlc.com/resource-library/articles/3-fatal-flaws-in-the-gender-as-social-construct-position/

The gap between the belief in a fixed and immutable gender identity and the gendered soul is not as wide as some who advocate for "trans children" would like to think.

Anyway, the undoubted success in the proselytising of this weird quasi-religious belief was due to the tactics that were used to normalise the underpinning ideas. How this coup occurred is well described here https://www.spectator.co.uk/article/the-document-that-reveals-the-remarkable-tactics-of-trans-lobbyists. However, through 2017 to 2020 once this narrative started to be discussed openly in the mainstream and social media it was ridiculed as it was completely lacking an evidence base. Then, in a volte face of startling speed, Mermaids retreated from this message which had underpinned their position, stating that of course they never meant that children were **actually born** in the wrong body, this was just a way of illustrating what transness was to the general population – silly old us for not understanding such a difficult concept! See their statement here. https://mermaidsuk.org.uk/news/do-you-still-use-the-phrase-born-in-the-wrong-body/ Importantly though, the related fiction of the immutable gender identity has managed to persist, despite having lost its central support pillar.

So, if a child is not born with a gender identity (an there is no settled evidence to show this) where does the sense of gender originate? The WHO definition of gender, as a social construct, gives a large clue. Gender is a social construct that originates outside the child. As a construct the child adapts to the challenge of the gender, adapting to different parts of the challenge at different times in their development. I.e. just like any other external challenge they face. Fortunately, how the process of gender formation occurs has been studied for many decades by child development scientists and from this empirical research a clear and agreed narrative has evolved about how a child's sense of gender develops as they grow up. We do not need to speculate about gendered souls. There are decades of empirical research to explain the development of gender in children, which will now be explored.

6. Key themes and figures in child development theory

In this section a brief summary of child development theories will be provided as relating to the concept of gender and children. These can broadly be split into Cognitive and Social Learning models. These theories provide a rich and deep theoretical and empirical evidence source for

understanding how a sense of gender develops in children and point the way to how treatment for children with gender dysphoria should now head.

6.1. Cognitive models

Jean Piaget – continuous adaptation and schemas
A Google search will provide hundreds of articles on Piaget. This one by S.A. McLeod https://www.simplypsychology.org/piaget.html provides a good summary:

> *Jean Piaget's theory of cognitive development suggests that intelligence changes as children grow. A child's cognitive development is not just about acquiring knowledge, the child has to develop or construct a mental model of the world. Cognitive development occurs through the interaction of innate capacities and environmental events, and children pass through a series of stages.*
>
> *Piaget's stages are:*
> ***Sensorimotor stage**: birth to 18-24 months*
> ***Preoperational stage**: 2 to 7 years*
> ***Concrete operational stage**: 7 to 11 years*
> ***Formal operational stage**: ages 12 and up*

Here Piaget's stages of growth are set out. These have been studied internationally over decades and they still hold up. McLeod then writes.

> *To Piaget, cognitive development was a progressive reorganization of mental processes as a result of biological maturation and environmental experience. Children construct an understanding of the world around them, then experience discrepancies between what they already know and what they discover in their environment*
>
> ***Schemas***
> *Piaget claimed that knowledge cannot simply emerge from sensory experience; some initial structure is necessary to make sense of the world. According to Piaget, children are born with a very basic mental structure (genetically inherited and evolved) on which all subsequent learning and knowledge are based. Schemas are the basic building blocks of such cognitive models, and enable us to form a mental representation of the world.*

Here we are introduced to the idea a childhood *schemas* which simply are a way of children organising information so they can understand the world around them.

The Process of Adaptation
Jean Piaget (1952; and also Wadsworth, 2004) viewed intellectual growth as a process of adaptation (adjustment) to the world. This happens through assimilation, accommodation, equilibration and equilibrium (Again adapted from McLeod)

Assimilation
Piaget defined assimilation as the cognitive process of fitting new information into existing cognitive schemas, perceptions, and understanding. Overall beliefs and understanding of the world do not change as a result of the new information.

This means that when you are faced with new information, you make sense of this information by referring to information you already have (information processed and learned previously) and try to fit the new information into the information you already have.

Accommodation
Psychologist Jean Piaget defined accommodation as the cognitive process of revising existing cognitive schemas, perceptions, and understanding so that new information can be incorporated. This happens when the existing schema (knowledge) does not work, and needs to be changed to deal with a new object or situation.

In order to make sense of some new information, you actual adjust information you already have (schemas you already have, etc.) to make room for this new information.

Equilibration
Piaget believed that all human thought seeks order and is uncomfortable with contradictions and inconsistencies in knowledge structures. In other words, we seek 'equilibrium' in our cognitive structures.

***Equilibrium** occurs when a child's schemas can deal with most new information through assimilation. However, an unpleasant state of disequilibrium occurs when new information cannot be fitted into existing schemas (assimilation).*

Piaget believed that cognitive development did not progress at a steady rate, but rather in leaps and bounds. Equilibration is the force which drives the learning process as we do not like to be frustrated and will seek to restore balance by mastering the new challenge (accommodation).

Once the new information is acquired the process of assimilation with the new schema will continue until the next time we need to make an adjustment to it

Thus, for Piaget the child was a key actor in their own development. And in relation to the sense of gender, according to this theory, the developmental stages could never support the concept of a fixed gender identity. Rather a child's sense of their own gender (their *gender schema*) would go through the process of *adaptation* when new information that was relevant to gender entered their world. This new information would require *assimilation*. Then the processes of *accommodation*, *equilibration* and *equilibrium* would take place. Piaget saw this as an endless cycle. In relation to gender, according to Piaget's theory, the child's schema of their own gender is a constantly evolving cycle of adaptation as the mind responds to new information. There is nothing fixed about gender identity in this theory of childhood development.

6.2 Lawrence Kohlberg's Theory of Gender Development

The following extracts have been taken a slightly edited from https://www.verywellmind.com/an-overview-of-gender-constancy-4688620 by Arlin Cuncic. She too shows that Kohlberg uses the idea of schema, this time it was directly related to sex and gender of the child.

> *A gender schema model proposes that children develop their gender identity* (sic) *through internal motivation to conform to what society expects based on their biological sex. However, Kohlberg argued that this motivation was first dependent on the child passing through a number of stages of cognitive development.*
>
> *This pattern of cognitive development was seen to take place between the ages of two and seven years old, during which time children grow to understand that their sex cannot be changed. Once children reach this stage of development, Kohlberg argued that they would be motivated to watch how they were expected to behave and act in accordance with that gender role. In this way, Kohlberg maintained that children would not develop an understanding of gender roles until they had learned that sex remains constant throughout life.*
>
> ***Kohlberg's Stages***
>
> ***Stage 1: Gender labelling (by age 3)***
> *In the gender labelling stage, children can say whether they are a girl or boy as well as the gender of other people. However, they do not understand that this is a characteristic that can't change over time, like the length of someone's hair or the clothes that they are wearing.*
>
> ***Stage 2: Gender stability (by age 5)***
> *In the gender stability stage, children start to realize that boys will grow up to be dads and girls grow up to be moms, etc. However, they still don't understand that gender can't be changed by changes in appearance or choice of activities.*
>
> ***Stage 3: Gender constancy (by age 7)***
> *By about age 6 or 7, children begin to understand that sex is permanent across situations and over time. Once they develop this understanding, they begin to act as members of their sex.*

Here again we have research this time by Kohlberg showing again that a child's sense of their own gender continues to develop throughout childhood. As with Piaget, there is nothing fixed about their gender identity. It changes as new information becomes apparent. As Cuncic writes;

> *Instead, their gender identity development depends on their sense of being male or female, which grows in stages that match their cognitive development. And, these stages closely parallel the theory of Piaget regarding children's cognitive development.*

In order to attain gender constancy, children must move through three stages (Slaby & Frey, 1975). First, children must accurately identify themselves and others as boys/men or girls/women. Second, children must grasp gender/sex stability, the understanding that one's sex remains stable over time.

That is, understanding that a baby girl will become an adult woman, and a baby boy will become an adult man. Third, children must understand gender consistency, a more sophisticated level of constancy than gender/sex stability. Gender/sex consistency refers to the understanding that despite superficial changes, a boy will remain a boy and a girl will remain a girl. For instance, even if a boy wears a dress, he will still remain a boy. His sex remains the same.

6.3 Carol Martin

This line of research has continued by others such as Carol Martin and Charles Halverson who in 1981 presented a new account of gender typing that drew on the ideas of earlier cognitive developmental accounts but included considerably more detail about the exact cognitive processes involved in gender development (Martin and Halverson, 1981). They proposed that the emergence of stereotypes in childhood was the perfectly normal consequence of children's information-processing. Stereotypes, in this view, are simply an efficient way of handling and predicting large amounts of information. Think of Piaget's schemas.

And again in 1989 Martin wrote how children stereotype gender changed with age

> *When children were asked to predict how much the characters in a story would like masculine and feminine toys the younger children relied only on the sex of the character to make their judgements (Martin, 1989). They predicted that a boy character would like to play with trucks regardless of the information given about that character's interests. By contrast, the older children took into account both the sex of the character and the 'individuating' information about that particular character. So they would predict that a girl who is described as having counter stereotypical attributes (e.g. likes playing with airplanes) would be less likely to want to play with a doll than a stereotypical girl. This kind of flexibility is likely to be the result of changes in children's cognition, such as an increased understanding of masculinity as distinct from maleness and femininity as distinct from femaleness, and an increased ability to draw on several sources of information (e.g. both sex and idiosyncratic interests) simultaneously. Younger children, with a more simplistic gender schema that links certain activities with boys and certain other activities with girls, seemed to rely only on the character's sex when inferring his or her toy*

6.4 Social learning models

There are a number of social learning theorists. For reasons of space this paper will focus on two Bandura and Mischel to give an idea of how social learning interacts with the sense of gender in children.

Albert Bandura's social-cognitive theory is a more recent version of social learning approaches that highlights the active role of children in their observational learning. He wrote "*Fortunately, most human behaviour is learned observationally through modelling: from observing others one forms an idea of how new behaviours are performed, and on later occasions, this coded information serves as a guide for action.*" Bandura believed that the conditioning and reinforcement process could not sufficiently explain all of human learning. For example, how can the conditioning process account for learned behaviours that have not been reinforced through classical conditioning or operant conditioning According to social learning theory, behaviours can also be learned through observation and modelling. By observing the actions of others, including parents and peers, children develop

new skills and acquire new information. Bandura's child development theory suggests that observation plays a critical role in learning, but this observation does not necessarily need to take the form of watching a live model. Instead, people can also learn by listening to verbal instructions about how to perform a behaviour as well as through observing either real or fictional characters displaying behaviours in books or films.

This model can easily transcribe into a dynamic area that is gender development where children learn about gender through observing others – both peers and adults

Walter Mischel is most famous for the *marshmallow test* on children. The results of this feed into his social learning approach which suggests that children's gender development is a product of their social experiences. This theoretical approach focuses on reinforcement of gender-typed behaviour by parents and peers, and on children's observation of gender stereotypes in the world around them. Again this is a highly dynamic framework for gender development an explains how social experiences can quickly impact on the sense of gender. This theme is explored by Lisa Littman in her paper on Rapid Onset Gender Dysphoria Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria (plos.org)

6.5 Summary of this section

In this section we have seen is that there is wide agreement, across different models, over many decades and in different countries, that a child's sense of their own gender develops in line with their body and their mind throughout childhood and adolescence. These models also find support in the extensive and developing research now being conducted in brain plasticity and children's development which examine how the brain is continuously evolving. Brain Plasticity and Behaviour in the Developing Brain (nih.gov). These show that the sense of gender within the child is in a constant state of flux responding to cognitive and social learning prompts and stimuli. It is not detached from other processes of maturation but is intricately bound in with them. In addition, there are other theorists such as Eric Erikson Erik Erikson | Psychosocial Stages | Simply Psychology who researched the changes that individuals go through in their lifetime. He again showed that the development of our identity is dynamic and driven by internal and external changes. In short, our sense of gender is far from immutable, instead the process of developing a sense of one's own gender is incredibly dynamic and is subject to all kinds of changes and influences – both internal and external.

Importantly none of these theorists in all their research into gender found anything that resembled an immutable gender identity. While all aspects of the child's development were observed changing and shifting to internal changes and external stimuli, in contrast the child's gender identity would have stayed constant and never varying. **As the one aspect of the child that never changed from childhood, through adolescence to adulthood, the immutable gender identity would have been obvious and observable.** In effect the whole of childhood development would have revolved around it, just as planets orbit around a sun in the solar system**.** But of course, the immutable gender identity was never discovered, despite all the research, because it does not actually exist in the child. Its existence is as a social construct – a projection of a child typology – for those who will benefit from this construct.

We now have the well evidenced research conducted over decades to show that the notion of the immutable gender identity in a child is an ideological assertion – a construct - unproven by scientific enquiry. We also have childhood development models which demonstrate how the sense of gender emerges and changes throughout childhood. In the next section we will look at how treatment for gender dysphoric children is currently established in the UK and see how the model is based around the construct of the "mini adult" with a fixed gender identity.

7. Gender affirmation care

7.1 what it is

Gender affirmative care is now the backbone to the treatment regime in European countries and North America for children with gender dysphoria. This excerpt from the BMJ explains the process.

> ***Treatments options for Gender Dysphoria***
> *The World Professional Association for Transgender Health (WPATH) Guidelines, on the clinical care of transgender adolescent, set out three stages of gender-affirming interventions with progressive levels of irreversibility:*
>
> *Stage 1, puberty suppression*
> *Stage 2, gender-affirming hormones*
> *Stage 3, gender-affirming surgery*
>
> Gender-affirming hormone in children and adolescents | BMJ EBM Spotlight

The most commonly used puberty suppressors/blockers are gonadotropin-releasing hormone (GnRH) agonists, which inhibit the release of sex hormones, including testosterone and oestrogen. The gender-affirming hormones/cross sex hormones taken are oestrogen and testosterone. The impact of these is summarised below

> *There are a large number of unanswered questions that include the age at start, reversibility; adverse events, long term effects on mental health, quality of life, bone mineral density, osteoporosis in later life and cognition. We wonder whether off label use is appropriate and justified for drugs such as spironolactone which can cause substantial harms and even death. We are also ignorant of the long-term safety profiles of the different GAH regimens. The current evidence base does not support informed decision making and safe practice in children.*
>
> *Gender-affirming hormone in children and adolescents | BMJ EBM Spotlight*

The stages are self-explanatory with the intention of stage 1 preventing the child reaching puberty supposedly to "buy time". However, as evidence from the original Bell -v- Tavistock judgment (judiciary.uk) the use of these drugs is no "pause button" but rather an irreversible step. Picture a set of points on a railway track where the line divides into two. One line, via puberty blockers, leads to a life of cross sex hormones and medicalisation, while the other leads to the natural process of maturation of the child's/adolescent's sense of their own gender. Puberty blockers are the railway points that switch the track of the child and thus their direction in life. There is nothing reversible once the train has gone past that set of points.

7.2 The problems with the gender affirmative approach

The major issues with this approach are now becoming increasingly public. The current gender affirmation policy is based upon low grade evidence which is experimental in nature. NICE in their most recent analysis of treatment by hormones concluded, and it is worth quoting in full, with my highlights:

> *The key limitation to identifying the effectiveness and safety of gender-affirming hormones for children and adolescents with gender dysphoria is the lack of reliable comparative studies.*
> *All the studies included in the evidence review are uncontrolled observational studies, which are subject to bias and confounding and were of very low certainty using modified GRADE. A fundamental limitation of all the uncontrolled studies included in this review is that any changes in scores from baseline to follow-up could be attributed to a regression-to-the-mean.*
>
> *The included studies have relatively short follow-up, with an average duration of treatment with gender-affirming hormones between around 1 year and 5.8 years. Further studies with a longer follow-up are needed to determine the long-term effect of gender-affirming hormones for children and adolescents with gender dysphoria.*
>
> *Most studies included in this review did not report comorbidities (physical or mental health) and no study reported concomitant treatments in detail. Because of this it is not clear whether any changes seen were due to gender-affirming hormones or other treatments the participants may have received.*
>
> 20210323_Evidence+review_Gender-affirming+hormones_For+upload_Final.pdf

Thus, we have treatment pathway for children and adolescents that is experimental in nature and lacks even medium grade evidence to support it. It is also based upon a fallacy that a child has an immutable gender identity, and that this gender identity needs to be affirmed at the earliest possible opportunity to alleviate life-long distress.

In contrast, the evidence shows that a child and young person's sense of their own gender continues to evolve as their cognitive and executive functions develop. In this context fixing a child at a point of their gender development cannot be seen as practice driven by good quality evidence or even be seen as ethical practice. Indeed, there are weighty questions about how pre-pubescent children can truly consent to gender fixing treatments as the Bell case surmised. Gender fixing in children should be seen for what it is, a "treatment" based on ideology. Another (emotive) term that can be used is conversion therapy, a theme that will be explored now.

8. Affirmation treatment as conversion therapy

Stonewall's definition of conversion therapy:

> *Conversion therapy (or 'cure' therapy or reparative therapy) refers to any form of treatment or psychotherapy which aims to change a person's sexual orientation or to suppress a person's gender identity. It is based on an assumption that being lesbian, gay, bi or trans is a mental illness that can be 'cured'. These therapies are both unethical and harmful.*
>
> https://www.stonewall.org.uk/campaign-groups/conversion-therapy

If it was shown that a child had a gender identity, just as with a fixed sexual orientation, it would be an arguable case to state that preventing that child from expressing their true gender identity was conversion therapy. In light of the evidence from child development theories that the sense of gender in children is fluid and ever changing, instead it is now perfectly arguable to state that the parties actually engaging in conversion therapy are in fact the adults who are seeking, to quote Stonewall, "*suppress (*the child's*) gender identity."* As we have seen, the child's sense of their gender is far from fixed, right through to adulthood, so "suppression" now takes the form of preventing the next stage of gender development taking place. In other words, **gender affirmation treatment is a form of conversion therapy because it entails the suppression of the natural development pathway of the child to discovering their own sense of gender.** Instead, adults stop the development of the child's sense of gender at a stage that suits them, before the child can properly understand what is being done to them. To explain, here is an illustration.

A five year old boy Mike, with the tacit support of his parents who always wanted a girl child, is experimenting with carrying handbags and wearing dresses. He sees that when he performs in this way the more his parents laugh and smile with him and appear to love him more. He decides one day after receiving approving hints from his parents, that he wants to be known as Michelle. The parents (as described above in the section on adultification), take that cue, run with it and now insist that Mike is actually a girl. They ply Mike/Michelle with dresses and other pink and girly toys in effect trapping Mike/Michelle in an experimental gender phase that he can no longer escape from. Mike/Michelle cannot risk the disapproval of his parents as like any five year old he is dependent on them.

Ten years later Michelle confides to a mental health nurse in hospital after a suicide attempt, that she really is not a girl and that she feels has been forced down the path by the need for approval by her parents. The nurse listens to Mike and in a number of sessions discusses these difficult feelings. She supports Mike as he reaches out to his parents about his change of feelings towards his gender and about how he now wants to openly express the gender that he feels within himself. The parents then report the nurse for practicing "conversion therapy" on their child, to her employer, who dismisses her for gross misconduct.

Who actually has been practicing conversion therapy here? Is it really the nurse or is the parents of the five year old who pressured their child to take an identity that would please them, and supressed the developments that would have naturally occurred*?*

Mike according to child development theory would have in all probability ended his gender experimentation and desisted back to his birth name, as his sense of gender and sex matured with his cognitive processes. Just as boy dressing up a dinosaur will similarly desist in due course from

that exploratory activity. By taking one gender phase that suits their adult needs/desire as a fait accomplit, the parents are now (in Stonewall parlance) “supressing the gender identity” of the child by not allowing the child to desist naturally from the gender with which they were experimenting. Their activities in the form of gender affirmative care, the use of pronouns and gender stereotypical clothing and toys are forcing a gender identity onto their child, which they may well no longer feel comfortable with. What choice does a five year old have but to go along with this practice?

Medical affirmation of gender only makes the gender fixing more explicit. Puberty blockers prevent the pre-pubescent child from developing their sense of their own gender as this very personal matter ceases to be their prerogative but becomes the property of the adults around them. The developmental processes are frozen where the adults want them, as the drugs prevent further pubertal development. The child is thus fixed in a “gender identity” that suits the adults around them which they have been unable to properly consent to. Cross sex hormones and surgery are the final affirmation of this fix. And all of these can occur before a child or adolescent has reached full maturity and so can properly understand what is being done to them.

Who benefits?

So who does the affirmation/conversion process benefit? There may indisputably be some teenagers who are persistent in their gender dysphoria, who benefit from such approach. But at this time, when there is no recognised externally validated test for gender dysphoria, it is hard to separate them out from the children who would in all probability desist. And giving unnecessary and harmful treatments to these children does not benefit them, and actually causes harm, so we are left with the unedifying answer that it is the adults around the gender dysphoric children who are the main beneficiaries of gender affirmation. This group can be split into three:

- those who benefit financially (esp in the USA) – I.e. pharmacists, doctors, endocrinologists, surgeons etc who get paid to “affirm” the child and then conduct money making procedures on them
- those who benefit academically and career wise – academics and journalists who have “data” and monetise it to show the upsurge in “trans children”
- emotionally needy adults who see in “trans children” a validation of their behaviours.

We already know that a child’s sense of gender continues to develop throughout childhood, so any attempt to suppress the continuous and ongoing changes in how a child perceives their own gender **IS** in Stonewall’s terms, “supressing the true gender identity” of that child. So rather than regarding gender dysphoria in children as an “extraordinary“ condition, and thus requiring a matching extraordinary treatment pathway, it should be treated in the same evidence-based manner as other conditions such as eating disorders or body dysmorphia in children. We should recognise that how children react to gender structures changes over time and that there should be a range of therapeutic approaches tailored to that individual.

9. Proposed treatment pathway

Rather than going against all accepted child development theory in seeking to fix gender dysphoric children in a gender stage, this paper will suggest a treatment pathway that is less ideological, and more evidence based.

The way forward - Therapeutic interventions

That some children suffer from gender dysphoria is indisputable. The argument has been how to treat them. This paper, having spent a long time examining the roots of gender dysphoria and how it should not be treated, will propose that therapeutic interventions are the best evidenced treatment model, if only because they treat the actual child as opposed to a social construction that is convenient and useful for adults. To surmise thus far, the evidence that should drive treatment for gender dysphoric children:

1. **A child's sense of their own gender is in constant flux and is not fixed.**
   As we have seen a child's sense of their own gender continues to develop in line with cognitive, social learning and other factors. There is no evidence to show that a five year old's sense of their gender is immutable and remains the same until and through adulthood.

2. **There is abundant evidence that children with gender dysphoria suffer from other health comorbidities.**
   Gender dysphoria must not be separated out from other aspects of child and adolescent health. The linkages are explored in articles such as Transgender medicalization and the attempt to evade psychological distress - PubMed (nih.gov) also https://www.tandfonline.com/doi/abs/10.3109/09540261.2015.1073143

3. **There is emerging evidence that children who have suffered adverse childhood events (ACEs) use gender dysphoria as a coping mechanism.**
   Such as Frontiers | Attachment Patterns in Children and Adolescents With Gender Dysphoria | Psychology (frontiersin.org)

4. **There is evidence that many children suffer from confusion and pain about their own sexuality and familial pressures around this issue are being diverted into treatment for gender dysphoria.**
   Frontiers | A Follow-Up Study of Boys With Gender Identity Disorder | Psychiatry (frontiersin.org) The high number of gay children accessing the Tavistock clinic https://journals.sagepub.com/doi/abs/10.1177/1359104514558431 led clinicians to talk in terms of the service being used by homophobic parents to "*trans the gay away*" It feels like conversion therapy for gay children, say clinicians | News | The Times

In an article https://quillette.com/2021/02/04/first-do-no-harm-a-new-model-for-treating-trans-identified-children/ Susan and Marcus Evans lay out the groundwork for such treatment. They write

> *This is why a thorough and general therapeutic assessment should aim to establish a picture of the individual's personality, family dynamics, cognitive deficits, and possible psychiatric disorders. Then an extended psychological approach should assess and attempt to understand the meaning of the patient's presentation. Importantly, this includes an understanding of the family and social context in which the gender incongruence has emerged. It involves an appreciation for the less conscious factors that underlie gender identity.*

There are plenty of therapist who take this approach. It is one also espoused by Levine in Reflections on the Clinician's Role with Individuals Who Self-identify as Transgender (springer.com). Amongst practicing therapists is Sasha Ayad. She has a useful website full of ideas about treatment https://inspiredteentherapy.com/about/ and a page which specifically lays out her treatment pathway. http://gdworkinggroup.org/2018/11/12/how-i-work-with-rogd-teens/. She writes that a sense of gender,

> *… is complex and dynamic. It is influenced by biological, environmental, and personal factors; these include familial, social, sexual, emotional, psychological, and subconscious factors.*
>
> *The clinician's job is to gently help clients move beyond simplistic gender clichés to a place of deeper self-discovery, regardless of where that leads.*

Quite why the evidenced based therapeutic approach to working with gender dysphoria in children was jettisoned so quickly in favour of an overtly medicalised approach is something that social historians will be analysing in future years. But these therapeutic models provide the basis for an evidenced based treatment for gender dysphoria.

10. Conclusion - first, do no harm

In this paper we have examined mainstream theories of childhood development and seen that there is no evidence that a child has an innate gender identity. Neuro scientists, even now, when using advanced brain mapping techniques, cannot find evidence for this hypothesis. If such a thing existed, it would have been simply uncovered by the mass of empirical research conducted over decades into child development. Why? Because it would have been the one constant in a child's cognitive development that was fixed and never changing, and it would have stood out. Rather, we have seen that the child's sense of their own gender develops in the same way as their other cognitive processes, guided by their changing body, hormones and the social landscapes in which they are active participants. As a consequence, the gender affirmation treatment model can be seen as no more than a crude attempt by adults to control the development of gender "identity" in children, to supress the natural developmental processes. And thereby fix a child in the gender stage that affirms the ideological beliefs of the adults around them. A more clear-cut case of conversion therapy it would be hard to find. Gender affirmation treatment should be part of any ban on conversion therapy proposed in legislation.

As to the future I would suggest that treatment for gender dysphoric children must:

- be based around the evidenced needs of real children rather than ideological constructions of the child designed to affirm adults
- recognise that gender is an external construct that impacts children and ensure treatments pathways take that into account
- Ensure that all factors (comorbidities) that influence a child and adolescents' sense of their own gender are part of treatment
- be centred around developmental phases of childhood.

There are no reasons to revert to experimental treatments, as the evidence base for treating children is clear. Therapeutic approaches, as they are with similar conditions such as body dysmorphia, anorexia and the like, must become the key first intervention. And only when it is evidence, rather than ideology, that underpins practice, can we honestly say our approach to treatment of gender dysphoria is driven by the premise, "first, do no harm." That is a bare minimum.

Further related areas of research

The research into child development casts serious doubt on the ability for a child to be able to consent at age 9/10 to block their own puberty. In order to consent they need to fully understand the treatment and its consequences being proposed. Child development theory would strongly suggest that no chid would be in a position to be able to properly consent to this treatment.

Postscript

This article was written by a social worker who cannot risk their name being attached to an evidence-based piece of work that is seen as gender critical. Social Work England continue to discipline social workers who hold these views.

I hope one day soon that the ideological factors and prejudices that stand against such an evidence-based approach will have faded into well-deserved obscurity, and this article can be published under my name. Until that day I continue to fight against gender ideology and its tragic impact on children, particularly those that are gay, gender non-conforming and who are vulnerable in other ways to the predations of this adult ideology.

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