An Analysis of the Cass Review

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Introduction

Written and produced in the UK, it is a document that is an "*Independent review of gender identity services for children and young people*". Led by Dr Hilary Cass, it sets out to be "*about what the healthcare approach should be, and how best to help the growing number of children and young people who are looking for support from the NHS [National Health Service of the UK] in relation to their gender identity*.

In other words, to be the UK version of Standards of Care (SOC). Up until this report, the SOC for those with issues of GI have be promulgated by the World Professional Association for Transgender Health (WPATH). WPATH that took over from the Harry Benjamin International Gender Dysphoria Association which had produced and supported the first SOC for transsexuals[1] in the 1980s – as those with gender dysphoria (GD) were known then.

I had originally planned on a section-by-section discussion of the Review but after realizing it was going to end up being a major project of significant proportions, I am limiting myself to specific aspects that I think play a fundamental role in the outcome of the Review and in how it is perceived by others.

[1] Despite some social discomfort or rejection of this term, it is the appropriate term for those diagnosed with GID or GD

Cass Review - Introduction

> *This Review is not about defining what it means to be trans, nor is it about undermining the validity of trans identities, challenging the right of people to express themselves, or rolling back on people's rights to healthcare. It is about what the healthcare approach should be, and how best to help the growing number of children and young people who are looking for support from NS in relation to their gender identity.*

One of the major sociological issues of the last decade has been the explosion of people, primarily minors, asserting that they are trans, or transgender. The opening of the Review states it is not this explosion that matters, but rather how the healthcare system (of the UK) addresses those asserting such an identity seeking specific medical support.

It is imperative that healthcare systems recognize, evaluate and diagnosis patients in order to adequately address their needs. Defining who is a patient or not is the first step.

> *Clinicians who have spent many years working in gender clinics have drawn very different conclusions from their clinical experience about the best way to support young people with gender -related distress. Some feel strongly that a majority of those presenting to gender services will go on to have long-term trans identity and should be supported to access a medical pathway at an early stage. Others feel that we are medicalizing children and young people shoes multiple other difficulties are manifesting through gender confusion and gender-related distress.*

This dichotomy of approaches is an indication that the underlying condition is poorly understood, if not even defined, and suggests that there is no clear understanding of what constitutes appropriate treatment for it.

This was not a problem prior to the explosion of patients presenting themselves as trans and seeking medical care. For decades, the definitions, while evolving somewhat, were relatively consistent as was the general treatment protocols. So, what changed?

> *This is an area of remarkably weak evidence, and yet results of studies are exaggerated or misrepresented by people on all sides of the debate to support their viewpoint. The reality is*

that we have no good evidence on the long-term outcomes of interventions to manage gender related distress.

Because for the five to seven decades prior to 2015, the number of people seeking treatment for GID/GD was very small. Typical study sizes were often well under 100, sometimes under 15. For decades the number of patients in most countries numbered in the hundreds per year at most. Only in the last 20 years as the number begun to grow and even then, amongst minors it was almost unheard of .

A recent study concluded that more than 80% of children and teens that 'wished to change sex' changed their minds by their later teen years was based SOLELY on the following question: "Did you ever wish you were the opposite sex?" The study was of thousands of students – not those suffering or diagnosed with GID/GD, but rather, a general population. Yet it got significant media and social attention as definitive evidence that 'GID and GD were something teens grew out of'. There is no value to this study as it relates to GID/GD, the treatment of those with either, or the outcomes.

Based on a single Dutch study, which suggested that puberty blockers may improve psychological wellbeing for a narrowly defined group of children with gender incongruence, the practice spread at pace to other countries. (See Appendix A)

Let me parse that a little: "puberty blockers", "may", "narrowly defined group of children". Each of those qualifiers has a significant influence on what may be understood from the study.

Puberty blockers inhibit the body's ability to produce significant levels of hormones that begin the process of puberty, sexual maturity. They have been around for more than 30 years and have been safely and effectively used during that period. The use was not, is not, ever intended to prevent puberty, only delay it for a period of time. For those with precocious puberty, they might be on them for several years until an appropriate, reasonable time to start their normal puberty. In the study referenced, they were used to delay puberty until such time as the appropriate cross sex hormone was introduced to start a puberty of the opposite sex. At the time, delaying puberty from 12-13 until 16 was considered acceptable for that 'narrowly defined group of children'.

What was that 'narrowly defined group'? Those diagnosed with GID/GD. I do not think the use of PBs for 4 years is a reasonable approach. Delaying puberty for a year, to complete a full, objective differential diagnosis may be helpful within the defined cohort. If the diagnosis is valid, consistent with the patient's history, and will full consent of the patient and the parents, then moving to hormone replacement therapy (HRT) and stopping the PBs is the appropriate treatment protocol. This would be consistent with the decades of previous experience with adults.

This was closely followed by a greater readiness to start masculinising/feminising hormones in mid-teens, and the extension of this approach to a wider group of adolescents who would not have met the inclusion criteria for the original Dutch study.

So, the process WAS to move from PBs to HRT at/about 16. But the organizations, the medical clinics, expanded their protocol to those "who would not have met the inclusion criteria for the original Dutch study". The clinics were not following patient selection protocols associated with the study. This would disassociate the clinical results from the Study's original findings. It is not the study, or the protocol that is at fault if other clinics and clinicians fail to adhere to the protocol and realize a different outcome.

I have been disappointed by the lack of evidence on the long-term impact of taking hormones from an early age; research has let us all down, most importantly you [young patients].

For decades, those with GID/GD were called transsexuals. In other words, those that transitioned from one sex to the other. Male-to-female (MTF) or female-to-male (FTM) were the short-hand used to label those diagnosed by the medical community specifically focused on that cohort. Much of that diagnostic criterion has remained constant for decades. However, in the 1990s, a change in terms began that pulled two very different groups into the same 'umbrella'. Transvestites and transsexuals were grouped together as transgendered. Over time, transgender has come to mean anyone gender-non-conforming (GNC). There was some pushback amongst transsexuals and the LGB community that accepted transsexuals. The use of transgender became popular after 2000-2005 and by the 2010s it was the common term used across social, cultural, and medical communities. But transvestites and transsexuals have very different medical needs and very different approaches to societal acclimation.

…the fastest growing group identifying under the trans umbrella is non-binary, and we know even less about the outcomes for this group. Some of you will also become more fluid in your gender identity as you grow older. We do not know the 'sweet spot' when someone becomes settled in their sense of self, nor which people are most likely to benefit from medical transition.

Because there is no definition of the condition or clear method to identify patients. Why are non-binary individuals being considered as part of the patient cohort? If a condition is changing over time, what factors are involved?

By 2016 the transgender community, or trans community, was arguing that the process of diagnosing and medically controlling HRT was harmful to trans patients who desperately wanted access. This worked well with those clinics that were no longer following previous patient selection protocols. As long as the patient claimed they were trans, it was sufficient for clinics to prescribe PBs and/or HRT. And trans has come to mean whatever the patient deems it to mean in their own situation.

No longer would you need research, or even have the opportunity for it, and that led to many abuses that eventually prompted the Cass Review.

Cass Review - Language

Probably one of the worst aspects of modern attempts to understand a complex situation is to alter the language that existed at its beginning. Yes, language changes over time, but to ignore the temporal understanding of the words is to risk introducing meaning never intended, or even contradictory to the original terms.

> *There is no consensus on the best language to use around this subject. The language surrounding this area has also changed rapidly and young people have developed varied ways of describing their experiences using different terms and constructs that are relevant to them.*

No clear definition of the condition being addressed, and no clear method of diagnosing patients leaves clinicians approaching care in a haphazard, inconsistent manner. Whatever terms or language a patient may use, it is up to the clinician to have a set of standards, for diagnosis and for treatment.

> *The Review tries as far as possible to use language and terms that are respectful and acknowledge diversity, but that also accurately describe the complexity of what we are trying to articulate.*

Rather than establishing clear definitions, the Review appropriates the social constructs that, like the teens themselves, are fluid and changing.

Gender incongruence

> *Gender incongruence is the term used in the International Classification of Diseases Eleventh Revision (ICD-11) (World Health Organization, 2022) to describe "a marked and persistent incongruence between an individual's experienced gender and the assigned sex". It has been moved out of the "Mental and behavioural disorders" chapter and into the "Conditions related to sexual health" chapter so that it is not perceived as a mental health disorder. It does not include references to dysphoria or dysfunction.*

This defines the condition. What it specifically excludes is a primary condition and addresses only the symptoms, distress or dysfunction. By excluding references to dysphoria or dysfunction, it removes the reasoning for medical intervention or treatment. Using this definition suggests the 'persistent incongruence' is a matter of personal expression and choice. It is more beneficial to consider the definition of the term used during the period from well before the circumstances that precipitated the Cass Review. Especially if the terms have changed.

> *The discordance between biological sex and gender identity has been conceptualized in multiple ways in the scientific literature: Transsexualism (DSM III), Transgenderism, Gender Identity Disorder (DSM IV and ICD X), Gender Dysphoria (DSM V), and Gender Incongruence (ICD XI). Although these definitions differ from each other in some nuances[2], they all have in common the reference to the discordance pointed above. For this reason, in this article, we will use the concept of "Gender Incongruence" to refer to any of them.*[3]

Using the phrase "an individual's experienced gender" suggested that the issue is a matter of socialization or learned understanding. Prior to the recent decade, patients stated that their awareness of incongruence occurred at very early ages. Research suggests that most children are aware of their own gender identity by four, far sooner than most socialization or educational situations occur. While the vocabulary of most children is too rudimentary to articulate how they feel, a notable percentage of children do articulate very clearly that they are incongruent – that they are actually the 'other sex'.

Why does the definition matter? Without a consistent definition, subsequent studies may not be addressing the same issues, the types of participants could be very different, and the outcomes unrelated to previous studies.

> *In the chapter on adolescents of the Standards of Care for the Health of Transgender and Gender Diverse People (8th edition), the following is stated: "A provider's key task is to assess the direction of the relationships that exist between any mental health challenges and the young person's self-understanding of gender care needs and then prioritize accordingly" [32]. In this sense, the study of the factors associated with gender incongruence is a contribution to clinical assessment, even more so considering that: "[…] mental health can also complicate the assessment of gender development and gender identity-related needs. For*

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[2] A diagnosis of 'transsexualism' appeared first in DSM-III in 1980. This version also included a childhood diagnosis: gender identity disorder of childhood. As research about gender incongruence/gender dysphoria increased, the terminology, placement and criteria were reviewed in successive versions of the DSM. Changes in various aspects of the diagnosis, however, were not only based on research. Social and political factors contributed to the conceptualization of gender incongruence/gender dysphoria as well.

[3] https://pubmed.ncbi.nlm.nih.gov/36913426

example, it is critical to differentiate gender incongruence from specific mental health presentations, such as obsessions and compulsions, special interests in autism, rigid thinking, broader identity problems, parent/child interaction difficulties, severe developmental anxieties [...], trauma, or psychotic thoughts. Mental health challenges that interfere with the clarity of identity development and gender-related decision-making should be prioritized and addressed"[4]

If there is no consistent definition or understanding about what is being evaluated, the conclusions are invalid.

Cohen-Kettenis and Pfafflin (2010) recommended the DSM-5 diagnostic label be changed from gender identity disorder to gender dysphoria. They contended that the new term would:

1. *clearly express the heart of the problem, the discontent with one's physical sex characteristics and/or assigned gender, and not be applicable to gender variant individuals without this discontent;*
2. *be dimensional - it should be possible to have more or less complete forms of the condition;*
3. *allow fluctuations, i.e., increase as well as decrease overtime, and, finally;*
4. *it should be acceptable and non-stigmatizing to those who fulfill...the revised diagnostic criteria (p. 506).*

I had proposed gender dysphoria as the new diagnostic label previously (see Moser, 2008). The concept of "gender dysphoria" satisfies the attributes enumerated above and has the advantage that it can be resolved. The DSM-5 gender dysphoria diagnostic criteria, unfortunately, do not satisfy those attributes. After treatment (i.e., hormones, surgery, and/or support) an individual's gender dysphoria can dissipate. At that point, it is no longer necessary (or helpful) to label these individuals with that mental disorder. The DSM-5 does not allow for the resolution of gender dysphoria specifically, although there is a post transition specifier to justify "continuing treatment procedures that serve to support the new gender assignment''(APA, 2013, p. 453).[5]

Simply put, you have those that are dealing with a life-long dysphoria vs those that just want to change.

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[4] ibid
[5] ibid

Gender dysphoria will be used here to describe a persistent desire to become the opposite sex (Zucker, 2010).

In the DSM-5-TR definition gender incongruence has to be associated with clinically significant distress or impairment of function. Younger children with gender incongruence may not experience dysphoria, but it commonly arises or increases as they enter puberty.

Very seldom does a child with incongruence not experience dysphoria. It is how it is expressed that has a bearing on how it is, when it is, diagnosed. Parents, siblings, and peers all have an impact on how a child reacts to the world. If they start to show distress, or anxiousness, and try to express some aspect of incongruence, parents, siblings and peers will seek to get them to change their behavior or dismiss it as some other issue. The child can, often does, become alienated from others to various degrees. The child learns to hide their incongruence. Puberty pushes the issue to the forefront.

Clinical distress, or dysphoria should be considered a symptom rather than a condition itself. It is like saying drunkenness is the condition while ignoring alcoholism. Of high blood sugar is the condition without considering diabetes. Gender dysphoria (GD) is a symptom of gender incongruity. Treating dysphoria disregards the underlying condition.

Within the report, we use the term gender incongruence as defined above, and gender related distress to describe the feelings that commonly arise or intensify during puberty and lead to a young person seeking help from the NHS.

So, the Review discounts, or ignores, patients that express dysphoria prior to puberty. If this is the focus, then any discussion about care for the pre-pubescent is beyond the scope of the Review. It is rejecting its own focus on children (see below). Unfortunately, the Review ignores this throughout.

Age Descriptors

*The term **child is used to refer to pre-pubertal children** **[emphasis mine]** and young people to refer to under 18s who have entered puberty. The report also refers to adolescents when discussing the stages of brain development, and both adolescents and youth where the study being described uses these terms. Young adults refers to those between the ages of 18 and 30.*

Trans, Transgender, Gender Non-Conforming, Non-Binary

> *During the lifetime of the Review, the term trans has moved from being a quite narrow definition to being applied as an umbrella term to a broader spectrum of gender diversity. This report uses 'transgender' to describe binary transgender individuals and 'non-binary' for those who do not have a traditional gender binary of male or female. The term 'gender non-conforming' is used to describe those individuals who do not choose to conform to traditional gender norms and 'gender-questioning' as a broader term that might describe children and young people who are in a process of understanding their gender identity. The term 'trans' is used as the umbrella term.*

Notice what word is missing from this listing? Transsexual. There is no suggestion previous to this glossary type section that transgender is a term used for those with gender incongruence. Even if an argument can be made the connection exists in DSM and ICD, the inclusion of a broader spectrum of patient presentation will dilute or even invalidate conclusions based on medical outcomes.

Cass Review : Summary and Recommendations

1. *The aim of this Reivew is to make recommendations that ensure that children and young people who are questioning their gender identity or experiencing gender dysphoria receive a high standard of care.*

If pre-pubescent children are excluded, per the definition above, then their evaluation and standards of care should not be part of the Review. By equating those that are questioning themselves to those with a clinical diagnosis, the evaluation of initial and treatment protocols will be incompatible. And any standard of care will have to distinguish between clinical approaches.

2. *Yet from the start, the Review stepped into an arena where there were strong and widely divergent opinions unsupported by adequate evidence.*

If you cannot even agree upon the terms, or the type of patient that is being considered, what headway do you think is possible?

3. *Within this context the Review set out to understand the reasons for the growth in referrals and the changing epidemiology, and to identify the clinical approach and service model that would best serve this population.*

And an argument can be made that lacking those adequate definitions and lacking an understanding of the population involved, any response was going to fail to address the problem and get stuck upon the symptoms.

4. *There are conflicting views about the clinical approach, with expectations at times being far from usual clinical practice. This has made some clinicians fearful of working with gender-questioning young people, despite their presentation being similar to many children and young people presenting to other NHS services.*

Because there are conflicting views about who the actual patients are or should be and how those views affect any clinical practice. This is an area where a background, or training, would be necessary to begin to establish a treatment plan. Lacking the background or training, clinicians should refrain from treating this population. Understanding where similarities exist in actuality instead of just by appearances is a necessary step in treatment.

5. *Although some think the clinical approach should be based on a social justice model, the NHS works in an evidence-based way. Summary and recommendations Whilst navigating a way through the surrounding 'culture war', the Review has been acutely and increasingly aware of the need for evidence to support its thinking and ultimately the final recommendations made in this report.*

I can't imagine anyone with a serious understanding of the underlying medical condition to think that the SJM is valid or useful. Medicine should be based upon evidence and outcomes. If social cultural issues had any impact on the results would be alarming.

6. *When the Review started, the evidence base, particularly in relation to the use of puberty blockers and masculinising/feminising hormones, had already been shown to be weak. There was, and remains, a lot of misinformation easily accessible online, with opposing sides of the debate pointing to research to justify a position, regardless of the quality of the studies.*

Primarily, only the Dutch study had sufficient numbers to offer a foundation for basing further study. It was by no means the only study, but one of sufficient numbers to reject what has previously been a consistent rejection of studies into gender incongruity treatment and etiology. Given there was little actual use of puberty blockers and cross-sex hormones amongst those 14 and under prior to 2010, the absence of studies is not surprising. And, given the size of the population likely to be clinically diagnosed is extremely small, finding patients to evaluate would be difficult. Most likely there are clinicians and mental health professionals with individual experience across their patient cohort that could provide guidance, but few organizations would rely upon such small sample sizes to make broad recommendations.

7. *To understand the best way to support children and young people, the Review's ambition was therefore not only to understand the existing evidence, but also to improve the evidence base so that young people, their families and carers, and the clinicians working with them have the best information upon which to form their decisions.*

One could argue that improving the evidence base would require an active attempt to enroll patients in a well-specified study with clear definitions. That is not what the Authors did. Finding existing studies and applying a rigorous set of definitions to find the best practices from them would have been a beneficial use of the Author's time.

8. *To scrutinise the existing evidence the Review commissioned a robust and independent evidence review and research programme from the University of York to inform its recommendations and remained cautious in its advice whilst awaiting the findings.*

Discussion of the findings from the University of York are within. However, the Authors reached the following conclusion:

9. *The University of York's programme of work has shown that there continues to be a lack of high-quality evidence in this area and disappointingly, as will become clear in this report, attempts to improve the evidence base have been thwarted by a lack of cooperation from the adult gender services.*

The definition of high-quality evidence is for later in the discussion. The lack of cooperation from adult services seems inconsistent with the goal of addressing children and young people's care. Finding that the University of York was unable to accomplish the goals laid out for it by the Authors, the rejected its findings. [#10 ommitted]

11. Hearing directly from people with lived experience and clinicians has provided valuable insight into the ways in which services are currently delivered and experienced. This has contributed to the Review's understanding of the positive experiences of living as a trans or gender diverse person, as well the uncertainties, complexities and challenges faced by children, young people, their families and carers, and those working in and around services trying to support them.

Rejecting the conclusions of studies and turning directly to patients requires clear guidelines as to which patients are being engaged, and what parameters they fit into, for determining quality outcomes. Given the statement above, one can assume neither was accomplished or adhered to.

Like the Report's organization, I will break out the following truths/findings of the Review:

Section 1: There are children and young people, families and carers all trying to make sense of their individual situations, often dealing with considerable challenges and upheaval.

Section 2: The length of the waiting list to access gender services has significant implications for this population and NHS service delivery.

Section 3: Generalisations about children and young people questioning their gender identity or experiencing gender dysphoria are unhelpful. People are individuals.

Section 4: Young people's sense of identity is not always fixed and may evolve over time. There should be no hierarchy of gender identity or how this is expressed, be that socially or medically. Nobody should feel the need to invalidate their own experience for fear it reflects badly on other identities and choices.

Section 5: Whilst some young people may feel an urgency to transition, young adults looking back at their younger selves would often advise slowing down.

Section 6: For some, the best outcome will be transition, whereas others may resolve their distress in other ways. Some may transition and then de/retransition and/or experience regret. The NHS needs to care for all those seeking support.

Section 7: The care of this population needs to be holistic and personal. It may comprise a wide range of interventions and services, some of which can be delivered outside NHS specialist services. Independent review of gender identity services for children and young people

Section 8: There remains diversity of opinion as to how best to treat these children and young people. The evidence is weak and clinicians have told us they are unable to determine with any certainty which children and young people will go on to have an enduring trans identity.

Section 9: Many primary and secondary care clinicians have concerns about their capacity and competence to work with this population and some are fearful of doing so given the surrounding social debate.

Section 10: Our current understanding of the long-term health impacts of hormone interventions is limited and needs to be better understood.

Section 11: Young people become particularly vulnerable at the point of transfer to adult services

With regard to Summary Item #3, the Report notes a significant increase in the number of patients referred to the NHS Gender Identity Service (GIDS). The data provided only goes through 2016, but the number of patients in GIDS totaled 1,766 out of the UK population of 65.61 million, or .00269%. One of every 37,151. Of these, there were 138 female and 131 male prepubescent patients and 1,071 female and 426 male adolescents.

Because puberty blockers are a major factor in the call for, and the concern of, the authors, the population under consideration numbered 269. I am not saying the population is too small to be properly considered for the appropriate health care. I am saying that the population the Authors have available would be deemed too small to be 'high-quality'.

While the number of patients did grow significantly, it was the change in ratio that alarmed those outside the medical community initially. Prior to 2010, the historical ratio of males seeking medical transition to females had been between 70/30 and 80/20 depending on country. Prior to 1990, the ratio was closer to 95/5. But by 2016, the ratio had flipped to 33/66 male to female; Without a corresponding understanding of why there was a surge in medical cases amongst females.