rather than the basic standard of clinical care that would apply for any other presentation.[7]

The authors remain opposed to any treatment model designed to coercively alter the sexual orientation of bisexuals, gay men or lesbians. It is crucial to distinguish between sexual orientation and gender identity when the latter comes with an expectation for complex, irreversible medical interventions, described as 'affirmative'. If sustained, long-term benefits of medical and surgical transition could be clearly and independently demonstrated, it would be appropriate to offer these interventions early, but the evidence is not convincing.[8] Therefore it is reasonable to exercise therapeutic caution, especially in light of growing concerns about complications and regret,[9] particularly in younger patients.

Given government moves to criminalise conversion therapy in medical settings, the nature of 'barriers to treatment' must be clearly described.[9] New laws will need detailed supplementary guidance for the benefit of patients, doctors and the criminal justice system. We propose that organisations representing clinicians should help legislators make explicit that neutrally framed therapeutic or exploratory work is not conversion therapy, irrespective of how an individual ultimately feels about their own identity.

In the absence of evidence-based guidelines underpinned by solid research, we cannot make recommendations about treatment pathways, and do not advocate one particular model over any other. We draw readers' attention to the unexplained increase in referral numbers, the higher numbers of children and young people seeking interventions, and the shift in sex ratio,[10] as such demographic changes are significant and deserving of research and explanation. Doctors should 'first do no harm'. The bar for informed consent to life-changing, irreversible medical and surgical interventions is necessarily high.[9] Enhanced service provision and new care pathways should be informed by robust research in this patient group.

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Declaration of interest

None

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doi:10.1192/bjb.2021.78

Freedom to think should not mean freedom from evidence and experience

Evans made a number of inaccurate statements in his originally published article, which subsequently resulted in the publication of a corrigendum. Some of the inaccurate statements and implications for scholarship and clinical practice are referred to in our letter, which was first submitted on 23 August 2020. Gender identity is a pertinent and timely topic, given the current moral panic around transgender individuals. Evans[1] states several fallacies that risk increasing the stigma towards transgender and non-binary individuals. Throughout, motivated reasoning that seeks to describe transgender individuals as inherently disordered is apparent. This manifests in the very limited selection of evidence cited and in unsupported claims made contrary to the bulk of existing evidence.

It is also important to put the letter in context. The consensus among the World Psychiatric Association,[2] Royal College of Psychiatrists, American Academy of Child and Adolescent Psychiatry and American Psychiatric Association is that psychological treatments to 'suppress or revert gender diverse behaviours are unscientific and unethical'. The reports from these groups follow detailed review of the current literature.

Evans relies heavily on personal accounts and experiences reported by media organisations. Although each individual story deserves hearing, understanding and respect, there is an inherent danger to highlighting cherry-picked examples from blog posts or newspapers. These sources often have political standpoints or biases. The quoted Christian Institute, for instance, writes on their website that transgender ideology 'seeks to completely destroy the distinction between men and women that God in his wisdom has created', and the Sunday edition of the quoted *Times* has been forced to correct a number of inaccuracies in articles about the Tavistock after intervention from the press regulator.

The existence of a few examples of adverse outcomes does not lend support to the idea that affirming care is harmful. In any area of medicine or psychiatry there are always patients who regret treatment, but provided informed consent is obtained and the proportion remains low, that risk is deemed acceptable. What little legitimate research into detransition exists

https://doi.org/10.1192/bjb.2021.82 Published online by Cambridge University Press

finds a miniscule rate,[3] with the primary cause being lack of social support for the affirmed gender identity. By contrast, trans young people supported in their social transitions show radically reduced rates of internalising disorders compared with those that are unsupported.[4] The claim that transition is predicated on a 'fantasy that the body can be rapidly sculpted as a way of being rid of profound psychological problems' is spurious; the body need not be altered at all for these effects of affirmation to occur (the Olson study included children receiving no medical interventions; instead, inclusion criteria were that children should be affirmed in their identity by their families and healthcare professionals), and being trans is not a 'profound psychological problem' any more than homosexuality is.

It is also important not to conflate alleged failings of a specific institution or clinicians with that of an entire practice. Psychotherapists or psychiatrists not adhering to professional standards, such as those around informed consent, require a response of upholding good and agreed practices and laws, not stopping provision of care to those who seek it. It is also notable that not all consent violations are presented on an equal basis by Evans and those who share his viewpoint. Withholding access to care because a doctor personally disagrees with the informed choice of a patient for reasons based on speculation or ideology also violates informed consent, particularly where that decision has irreversible consequences for the patient, as in the case of withholding puberty blockade.

There is danger in not involving transgender perspectives on work that affects transgender individuals specifically. Work like this risks contributing to the known stigma and discrimination that the trans community already faces[5] and allowing the credibility of peer-reviewed science to be misused by transphobic groups to promote a harmful ideology. Journals, editors and reviewers have a responsibility to ensure that published material meets a minimum standard of rigour. Evans makes claims including 'there is considerable evidence that children are signing up to treatments with long-term implications, with very little real understanding of the consequences' and 'There is considerable evidence of children and adolescents changing their minds if given enough time and space to explore things' without providing references to this 'considerable' body of work; we are aware of no such evidence for the former, and the latter claim has been thoroughly debunked.[6] Similarly, the claim that 'a new diagnostic category, 'recent-onset gender dysphoria' [sic], mak[es] up a substantial proportion' of Gender Identity Development Service referrals is made without any citations to literature. 'Rapid-onset gender dysphoria' is a proposed diagnostic category, based on a single, flawed study.[7] It is not currently recognised for use in clinical settings.

There are common but false comparisons between gender dysphoria and body dysmorphia or body image disturbance in anorexia. Body dysmorphia is a preoccupation with a perceived flaw in part of the body. Transgender individuals do not falsely perceive their body to be different to how others perceive it, only that it is perceived (by themselves and/or others) in a way that does not reflect their gender identity. We think this is an important distinction and failure to appreciate it could lead to attempts at ineffective or dangerous 'treatments', much like the unethical and pseudoscientific conversion therapy targeting homosexuality, which is now widely discredited. It is also a common mistake to try to define these complex issues through our own professional lenses – whether labelling as a psychiatric disorder or as a psychoanalytic defence mechanism that unfairly pathologises gender identities that do not fit our traditional western belief systems. Psychiatry has a history of falling into this trap, and we would hope the profession could learn from its mistakes.

We accept that this was a 'special article' rather than original research and not a research article, but we do not think that this excuses it from the high standards of evidence expected in an esteemed publication. We would echo the call for greater research into psychiatry's role in ensuring transgender youth 'fulfil their potential in comfort' (https://www.rcpsych.ac.uk/pdf/PS02_18.pdf) and would recommend that this begins with the people most affected, listening to their concerns and values, and using scientific rigor rather than anecdote and ideology.

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Declaration of interest

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