

‘Taking the lid off the box’: The value of extended clinical assessment for adolescents presenting with gender identity difficulties

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Abstract

As the number of young people referred to specialist gender identity clinics in the western world increases, there is a need to examine ways of making sense of the range and diversity of their developmental pathways and outcomes. This article presents a joint case review of the authors caseloads over an 18-month period, to identify and describe those young people who presented to the Gender Identity Development Service (GIDS) with gender dysphoria (GD) emerging in adolescence, and who, during the course of assessment, ceased wishing to pursue medical (hormonal) interventions and/or who arrived at a different understanding of their embodied distress. From the 12 cases identified, 2 case vignettes are presented. Implications for the development of clinical practice, service delivery and research are considered.

Keywords

Gender identity development, gender dysphoria, adolescents, gender identity development service, psychosocial assessment

Introduction

Young people presenting to the United Kingdom’s Tavistock & Portman’s Gender Identity Development Service (GIDS) are a diverse group and present requesting help with distress experienced as arising from a felt incongruence between their gender identity and their biological sex; in diagnostic terms, many meet the criteria for gender dysphoria (GD). The extent to which this can be understood as a normal variation of gender expression, a social construct, or a ‘pathology’ is a matter of ongoing debate (Vrouenraets, Fredriks, Hannema, Cohen-Kettenis, & de Vries, 2015). While broadly similar discussions could be had about the nature of any psychiatric diagnosis, the question about what is at stake – in the different ways we might describe or seek to make sense of

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this embodied distress – takes on a unique salience in a domain where young people, their families and clinicians, are facing complex decisions around possible medical interventions in physically healthy and developing bodies.

Gender identity difficulties in adolescence

Adolescence can be thought of as a complex adjustment to the major physical and emotional changes that go on in puberty. It is well known that it is a time of great turmoil, confusion and uncertainty, and that enduring these states of mind are crucial for development to occur (Waddell, 1998). The psychic tasks of this period are demanding, namely,

negotiating the relationship between adult and infantile structures; the transition from life in the family to life in the world; the finding and establishing of an identity, especially in sexual terms; in short, the capacity to manage separation, loss, choice, independence, and perhaps disillusionment with life on the outside. (Waddell, 1998, p. 126)

Peer groups become key sites for different aspects of an individual's personality to be explored; this is an important part of typical development, as well as containing the possibility for a gang-like mentality, whereby the development of the individual is derailed by the need for sameness and belonging. Crossing the threshold from adolescence to adulthood requires an in between period of trying out adult roles, conceptualised by Erikson (1968) as a 'psychosocial moratorium', essential if the adolescent is not to end up 'in a "social pocket" from which there is no return' (p. 156). An adolescent in GIDS has all of this to navigate, while simultaneously contemplating – indeed often actively requesting – medical interventions which intervene in puberty and may in many (as yet unknown) ways interact with these very developmental processes.

Difficulties in gender identity development emerge at different points in the life course, with some adolescents and their families citing these as emerging in childhood, while for others these may occur after the start of puberty, sometimes in the context of broader identity confusion and other psychological difficulties. Research on the developmental trajectories of young people with childhood onset GD is sparse, which is unsurprising given the low numbers of those presenting to specialist gender services until the early 2000s (Wood et al., 2013). However, taken together, prospective follow-up studies have shown that childhood GD is strongly associated with a lesbian, gay or bisexual outcome in adulthood and while estimates vary, the majority of participants in these studies did not seek out medical interventions for GD; the assumption being that gender dysphoric feelings requiring medical intervention receded around or after puberty (Ristori & Steensma, 2016). However, authors note important differences across studies (e.g. around inclusion criteria), which limits comparison. Factors contributing to persistence and desistence of childhood GD are still largely unknown (Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011); however, it seems that in some cases a period of questioning and exploring sexual identity may be the key (Steensma & Cohen-Kettenis, 2015).

Knowledge of the experiences and trajectories of young people who present with GD in adolescence specifically, is sparser still. Adult studies indicate that later onset GD, as well as biological maleness and sexual attraction to individuals of a different gender from the adolescent's biological sex, may predict a more challenging treatment course and outcome, and historically more late-presenting adolescents have been male (Leibowitz & de Vries, 2016). However, current referral patterns to child and adolescent gender identity clinics in the western world demonstrate a shift in the sex ratio, with many more female-bodied young people referred, especially in adolescence, in the context of an overall increase in the number, diversity and mental health

complexity of referrals (Aitken et al., 2015; Kaltiala-Heino, Sumia, Työljärvi, & Lindberg, 2015), including the observation that many young people seeking help from gender clinics are also neurodiverse and/or meet criteria for a diagnosis of an autism spectrum condition (ASC) (Glidden, Bouman, Jones, & Arcelus, 2016). Tentative hypotheses which emphasise primarily biological, social or psychological processes have been proposed to make sense of why young people with ASC may be at higher risk of GD, although they have rarely been tested (see Van Der Miesen, Hurley, & De Vries, 2016).

In a retrospective chart review of referrals to Finnish clinic over a 2-year period ($n=47$), Kaltiala-Heino et al. (2015) found that 65% presented with adolescent onset GD, defined as age 12 and above, and most ($n=41$) were female-bodied. The authors identified five distinct groups; the largest group developed gender identity development difficulties in the context of confused identity more broadly, with histories of social exclusion and persistent bullying when younger. In adolescence, they presented with social anxiety and depression, most often with self-harm and suicidal ideation (if not attempts); were socially and/or academically marginalised and had very high expectations that medical interventions for GD would solve their difficulties. A comparable profile – of young people with adolescent onset GD, significant psychological difficulties (histories of trauma, psychosis, body dysmorphic disorder and severe depression) and expressions of certainty about medical interventions being the only solution – has been observed in the gender identity clinic at the Toronto Centre for Addiction and Mental Health (Zucker et al., 2012). A retrospective chart review of referrals to GIDS 2009–2016 ($n=4148$) showed that the vast majority of referrals were adolescents, with the sex ratio favouring female-bodied young people (1:2.1) in this age group (Carmichael, 2018). There was a sharp increase in referrals, with referrals for male-bodied adolescents increasing by 55% on average each year and for female-bodied adolescents by 105% over this 7-year period (Carmichael, 2018). A significant proportion of young people in GIDS are also neurodiverse and may present with traits of ASC and/or a diagnosis. Between April 2011 and August 2018, 48% of children and young people who were seen in GIDS and whose parents completed the social responsiveness scale (SRS), a quantitative measure of autistic behaviours in children and young people, scored in the mild to severe range ($n=2073$). Ten per cent of female-bodied young people scored in the severe range, as did 7% of male-bodied young people. Taken together, these aspects signify a rapidly shifting context in the profile of many young people presenting to GIDS, which has prompted much discussion within the service and more widely about how best this group should be supported.

Dilemmas in assessment

The dilemmas around how and when to respond to requests for medical intervention come alive in particular ways when working with these young people. These are inherently ethical questions, as well as medical and psychological ones and views are often polarised (Wren, in press). A number of concerned parent groups characterise the willingness to provide such intervention to young people as the medicalisation of psychological and social ills. In relation to female adolescents, this is constructed as simply confirming an identity conceptualised as often the only viable escape route from the oppressive gender and sex-role stereotypes society applies to girls and women (Davies-Arai, 2018). A competing discourse, also represented by parent groups, promotes young people's rights to medical treatment and can be characterised in terms of its emphasis on the 'privileged access' they have to their own bodily experience; this arising in part from the contexts of a health care system and broader sociocultural milieu in which trans people have historically been pathologised and dismissed (Wren, 2014). The GIDS clinician has to navigate through these competing forms of knowledge and justice claims, always 'working at the edge' of the boundary between

mind and body. In doing so, there is an attempt to preserve a space for thinking and to hold a balanced view, which attends to complexity (Di Ceglie, 2008, 2009).

The current GIDS protocol suggests a psychosocial assessment of 3–6 sessions, meeting approximately monthly, although the number and spacing of appointments is flexible depending on the uncertainty and complexity of the young person's gender identity development. Early in the history of GIDS, the developmental approach to assessment was delineated in the service's therapeutic aims (Di Ceglie, 1998). Families are mostly seen by pairs of workers, providing the opportunity for a young person and their parent/carer/s to be seen separately as well as jointly for family work. The assessment is multi-faceted and aims to develop a broad picture of the young person's past and current gender identification in the context of their development across other important domains (family and peer relationships, education and emerging sexuality in adolescents). Particular attention is paid to any psychological difficulties the young person presents with and how these might impact on, or be impacted by, the trajectory of gender identity development. That is to say, the task is to explore and disentangle a variant gender identity which is primary, from one which might properly be deemed secondary to such problems (Marcus, Marcus, Yaxte, & Marcus, 2015). Particularly with neurodiverse young people and their parents, there is the need to explore how sessions may be structured and communication enhanced, to ensure meaningful participation in the thinking process for the young person.

The GIDS protocol around medical interventions is in line with current recommendations from the World Professional Association for Transgender Health and the Endocrine Society, which stipulate a staged approach, from most to least reversible interventions with sufficient time to assimilate developments at each stage. Following psychosocial assessment and provided that a young person is in established puberty and can give informed consent, they may be referred to the paediatric endocrinology clinic to undergo a brief medical assessment with a view to commencing hormone blocking treatment. This consists of gonadotrophin-releasing hormone (GnRH) analogues, which temporarily suspend pubertal development and is considered to be 'physically reversible' in the most basic sense that if medication is stopped, puberty recommences. This is considered a treatment in its own right and the intention is for there to be ongoing exploration, without the distress of further pubertal development. After at least a year, and at a minimum age of 16, some young people may proceed onto cross-sex hormones, which masculinise or feminise appearance and have effects on the body that are irreversible and may well compromise future fertility. No surgical interventions are available through the National Health Service (NHS) before the age of 18.

There is some evidence to demonstrate the beneficial effects of hormone blocking treatment on mental health and quality of life for a highly selected group of gender dysphoric young people (e.g. Kreukels & Cohen-Kettenis, 2011). However, this is a developing field and key questions remain: whether such treatment is best regarded as helpfully 'buying time' or indeed actively arresting development (Giovanardi, 2017). Internationally, there is a lack of consensus among clinicians themselves and common ethical aims (e.g. working in the best interests of the child) are interpreted differently (Vrouenraets et al., 2015). Current debates around the introduction of the new Memorandum of Understanding on Conversion Therapy (UK Council for Psychotherapy [UKCP], 2017) and how this might be applied in practice encapsulate this lack of consensus in a UK context. This raises key questions around what constitutes a 'good enough' assessment, what the nature and extent of 'exploration' should be, and what aspects of a given clinical encounter – between young people, families and clinicians and services – may influence decision-making around post-assessment pathways.

The present study

This study is not directly concerned with debating the relative pros and cons of hormone blocking treatment and is not suggesting that there are no cohort of young people for whom medical

intervention is a helpful and important way of managing gender-based distress. To our knowledge, no published studies have explored the assessment trajectories of young people in specialist gender services whose wishes around pursuing a medical pathway and/or gender identity diversified in the course of assessment. This study aimed to develop an initial understanding of those young people who presented to GIDS with GD emerging in adolescence, and who, during the course of assessment, ceased wishing to pursue medical (hormonal) interventions and/or no longer felt that their gender identity was incongruent with their biological sex, through (1) an overview from the authors' caseloads of their demographic and shared characteristics and (2) two more detailed case examples.

Methods

A practice-based evidence approach is appropriate in an area such as this, where large cohort and longitudinal studies are lacking. A joint case review of the two authors caseloads was undertaken as an initial scoping exercise.

Criteria for inclusion in the case review were the following:

Age 12 and above at outset of assessment;

Open case in psychosocial assessment phase, held by one or both authors over an 18-month period October 2015 – April 2017;

Met criteria for GD with an onset in adolescence (12 and above);

Actively requested medical interventions at outset of assessment;

Ceased wishing to pursue medical interventions and/or no longer felt that their gender identity was incongruent with their biological sex, during the psychosocial assessment phase.

Cases were excluded if

They attended for one session only before dropping out of the service;

They were a female-bodied young person who discontinued in their desire to pursue medical interventions only for the reason that they viewed this as offering little/no benefit in light of the fact they had already pubertally developed i.e. still maintained that they intended to access testosterone and/or surgical interventions in adult services without accessing hormone blocking treatment first;

They gave practical reasons for discontinuing in their desire to pursue medical interventions (i.e. unable to attend regular appointments at the service, for example due to travel distance) but still maintained that they intended to access this in adult services.

Written consent for the use of anonymous demographic and case characteristic data provided here was obtained from the young people and their parent(s)/carer(s) as part of the routine assessment process. A total of 156 cases met age criteria and were undergoing assessment in the specified time period (47 male-bodied young people; 109 female-bodied young people). Four cases were excluded due to dropping out after one session, 20 female-bodied young people were excluded due to intending to pursue medical interventions in adult services, 4 cases that gave practical reasons as to why they were not seeking medical interventions at that time were also excluded (two males; two females). Of the remaining 128 cases, 12 cases (9.4%) met criteria for GD emerging in adolescence, were actively requesting medical interventions at outset of assessment and ceased wishing to pursue medical interventions and/or no longer felt that their gender identity was incongruent with their biological sex.

Results

Table 1 shows the characteristics of the sample.

The mean length of the psychosocial assessment was 9.6 months (range=2–14 months). The mean number of assessment sessions was 6.6 (range=2–9 sessions). The mean number of individual appointments was 1.7 (range=0–4 sessions) and the mean number of family sessions was 5 (range=1–8 sessions), that is, on the whole, family sessions constituted much of the assessment. During the course of assessment, seven of the young people, all of whom no longer requested medical interventions also no longer felt that their gender identity was incongruent with their biological sex; the remainder continued in their trans identities but no longer desired medical interventions. Out of the 12 cases, the majority had not received a formal diagnosis of GD.

Case vignettes

Two cases were selected for more detailed case discussion; on the basis that both cases (one male-bodied and one female-bodied) presented with characteristics that were representative of the broader sample, in terms of having a diagnosis of an ASC and significant risk including suicidal ideation and self-harm. In both cases, the referral was presented in such a way as to assume that medical transition would be the primary intervention required to alleviate gender-based distress; however, they had not received a formal diagnosis of GD. The vignettes that follow have been anonymised and identifying details changed to preserve confidentiality. The pronouns used to refer to the young people reflect their preference post-assessment. Written consent for presentation of case vignettes was obtained from those young people and their parent(s)/carer(s).

Case 1

Referral. Alfie, a 14-year-old white British male-bodied young person, was referred to GIDS by his general practitioner (GP). The referrer made links between Alfie's 'determined desire to be female' and self-harming behaviour through cutting. Alfie, an only child, was living with his mother and her new partner and had occasional contact with his biological father. He was diagnosed with Asperger's Syndrome at the age of 11 and the referrer described his first gender dysphoric experience(s) around the age of 13, when he started expressing dislike around his secondary male sex characteristics and also tried out wearing his mother's clothes. Alfie attended a single-sex boys school and had experienced teasing from his classmates. The referral mentioned low mood and Alfie's mother's attempts to help him 'open up more'.

Assessment. The work consisted of seven face-to-face sessions (two individual and five family-based) over the course of 11 months, including a final review session. Alfie was not living in female social role at the start of assessment but was adamant about pursuing medical interventions (hormone blockers and subsequently oestrogen) and also spoke about hopes for facial and genital surgeries in future. Alfie conveyed clear distress around his body masculinising further, particularly his Adam's apple and his voice breaking. He also spoke often about his desire to 'shrink [his] feet', which he felt were 'too big for a girl'. In one session, early in the assessment, Alfie requested to be addressed by a feminine variation of his first name and feminine (she/her) pronouns. Clinicians took this up in that session; the clinical practice in GIDS being to join with and validate young people's preferred ways of relating. Clinicians also attended to his mother's puzzlement that he had made no such request at home, despite her frequent 'checking in'. There was no expressed desire to social transition. Alfie disclosed that he had been particularly anxious about coming out as trans to his mother, worrying that this might negatively impact on her relationship with her new fiancé, just a few months before

Table 1. Characteristics of the sample.

		N = 12
Referrer	GP	3
	CAMHS	9
Biological sex	Male	3
	Female	9
Age at referral	Mean (SD)	14.1 years (1.66)
	Range	12–16 years
Ethnicity	White-British	10
	White-European	1
	Mixed White British and Asian	1
Gender identity at outset of assessment	(Trans)male	6
	(Trans)female	3
	Non-binary	3
Diagnosis of ASC prior to attendance at GIDS	Yes	7
	No	5
Social responsiveness scale (ASC screening questionnaire during assessment ^a)	Normal range	1
	Moderate	0
	Severe	3
	Missing	1
Suicidal ideation at time of first assessment and/or within last 6 months	Yes	7
	No	5
Suicide attempt at time of first assessment and/or within last 6 months	Yes	2
	No	10
Self-harm at time of first assessment and/or within last 6 months	Yes	7
	No	5
Educational status	Mainstream school	9
	Pupil referral unit	1
	Not in education, employment or training	2
Social transition prior to attendance at GIDS	Yes	5
	No	7
Diagnosis of GD by referrer prior to attendance at GIDS	Yes	3
	No	9

GP: general practitioner; CAMHS: child and adolescent mental health services; ASC: autism spectrum condition; GIDS: gender identity development service; GD: gender dysphoria.

^aThe Social Responsiveness Scale (SRS) is a 65-item quantitative measure of autistic features in 4- to 18-year-olds across a range of severity. It is filled in by parents/carers as part of the psychosocial assessment. It is a validated measure and has been deemed appropriate for use in clinical settings and scores in the severe range are strongly associated with a clinical diagnosis of an ASC (e.g. Constantino et al., 2003). SRS results are provided here for those young people who did not have an ASC diagnosis.

their wedding.

To clinicians, Alfie presented as a tall, slim, young man with ‘indie’ style clothes, long hair and appeared older than his years. Alfie initially connected his cross-dressing and current gender-related distress in a linear way to conclude that he must be female. The clinicians working with the family experienced Alfie as a stereotypical male presenting young person and were curious to collaboratively explore how he made sense of his current gender expression and what his hopes might be in this regard. Clinicians subjective experience was that Alfie did not communicate in a way

which would align with a diagnosis of Asperger's Syndrome; this was consistent with Alfie's self-narrative, whereby he felt the diagnosis had been erroneously made at a time when he was struggling socially with making the transition to secondary school.

Early on in the assessment process, the clinicians who conducted the assessment focused on exploring the familial and socio-cultural contexts of Alfie's development, including the teasing at school, in which he was called 'gay' in the context of what he described as a macho environment. Alfie was one of very few men in his year group who had experimented with talking openly about diverse sexual orientations, which at times had triggered hostile responses from his classmates. Alfie communicated a sense of detachment from his peers and outside school he spent his time socialising with girls. It transpired that Alfie had been active in bringing up sexuality related discussions at school in a rather intellectual way, but had apparently given little thought to his own sexual feelings or sexual identity.

Alfie disclosed ongoing suicidal ideation without clear intent and long-standing disturbed sleep. In each session, the clinicians carefully assessed and explored Alfie's ongoing suicidal ideation and risk. This seemed to help develop a space in which Alfie could disclose his fears; he spoke about a recurrent dream in which his home was set on fire and he would watch his family dying. Exploring family relationships and transitions allowed for Alfie to make links between these and his more immediate worries and anxieties. His father's recent marriage had been called off at the last minute and his father's partner had cited Alfie as the main reason for this. Any attempt to explore Alfie's relationship with his father proved challenging as he responded as both hostile and dismissive.

The clinicians hypothesised that Alfie may have been struggling with his developing identity in broader terms, connected to attachment ruptures with his biological father, a sense of guilt around his father's failed second marriage and internalised shame in relation to the turbulence of his burgeoning puberty (Waddell, 1998). It was also important to think about the conscious and unconscious meaning of his mother's plans to marry her new partner. Joint supervision offered the space for the clinicians to reflect on their own markers of difference in relation to gender and sexuality, how these influenced the focus of the exploratory work and were acted upon in the room (Blow, Sprenkle, & Davis, 2007; Burnham, 2012).

Throughout the assessment process, the clinicians actively focused on the distress Alfie conveyed, while aiming to deconstruct and 'thicken' his narrative by focusing on the different contexts of his 'lived and told stories' (Pearce, 2007; White, 2001). Separate meetings with Alfie allowed for exploration around his relationship with his developing body (including him finding pleasure in masturbation) and his sexual fantasies, and how these connected to the reality of his body, including some unrealistic ideas about medically transitioning. Furthermore, the significance of Alfie choosing his mother's clothes specifically, and avoiding buying his own clothes when experimenting with a female gender identity was explored, including the possible role of social stigma. This was the case despite support from his mother and female friends from outside of school. Alfie's choice of his mother's clothes seemed to connect to their relationship, which in systemic terms could be described as 'enmeshed' (Minuchin, 1974). The assessment sought to provide Alfie with a safe space and time to explore and enrich his narratives about his gender, broader identity development and to individuate as a young person. Following discussions around these specific functions, Alfie and his mother cancelled their eighth appointment; subsequent written communication from his mother informed the clinicians that Alfie felt he no longer identified as female and did not need to attend.

A final review appointment took place 10 months later. Alfie had expressed some apprehension about attending but agreed with his mother's view that coming together for a final session might be helpful. On going to collect Alfie and his mother for the session, clinicians found them waiting in the corridor. Alfie had refused to sit in the GIDS waiting area, which seemed to symbolise his sense

that he no longer belonged there. Alfie had shaved his head, presented in stereotypically male clothes and was holding his skateboard. He spoke openly about continuing to feel confused about his identity and was still struggling with low mood, although his suicidal thoughts had decreased. However, in relation to gender, Alfie was reflective in talking about the ways he understood himself to be a vulnerable and sensitive young person, alongside the need to embody and perform masculinity differently across different contexts; to be read as a 'guy' in particular ways in public (Butler, 2004; Kimmel, 2004). He connected this to preserving his own safety as a non-stereotypically masculine young man. Clinicians understood these changes as signifying Alfie developing a more integrated sense of self. Alfie and his mother were clear that no further input from GIDS was needed; clinicians recommended that open-ended psychotherapy outside the service may be helpful.

Case 2

Referral. Louise – known then as 'George' – a 14-year-old white female-bodied young person, was referred to GIDS by Child and Adolescent Mental Health Services (CAMHS). The referral included information about Louise's diagnosis of GD, her social transition to male role 18 months ago and her wish to pursue hormonal treatment and future surgery to become 'fully male'. CAMHS had supported Louise in the community for 2 years following her inpatient admission for an atypical restrictive eating disorder and high risk self-harming behaviour, including a suicide attempt through a large overdose. She had presented in hospital as 'almost mute' having refused any therapeutic intervention and had not attended school for 2 years. Following long-standing social interaction and behavioural difficulties, she had received a diagnosis of an ASC. Louise had been bullied around her appearance at primary school. The CAMHS formulation posited that restrictive eating had developed in response to attempting to arrest her developing female sex characteristics. Louise lived at home with both parents and her mother had given up work to care for her and her younger brother, who also struggled with neurodevelopmental and behavioural difficulties. Louise had been clear from the first GIDS appointment that she was keen to access hormone blocking treatment and consequently, testosterone with the hope to alleviate her body-related distress.

Assessment. The work consisted of nine face-to-face sessions (two individual; seven family-based) over the course of 13 months. Louise's neurodevelopmental difficulties were immediately apparent and influenced the assessment structure and process; because of this it was necessary to explain to the family that the assessment may need to last longer than the GIDS protocol suggests. Louise spoke in very a matter of fact way about her understanding of hormonal interventions and was insistent that this was necessary for her to live in her body. She had already transitioned socially and had been using masculine (he/him) pronouns for more than a year.

To clinicians, Louise presented as a tall, slim androgynous young person. She had shaved her head and had multiple piercings. She emphasised that she chose to dress in 'stereotypically male' clothes and that she had not worn a dress for years. Louise informed her clinicians that she had been binding her breasts and had been 'packing' (wearing a prosthetic penis).

The clinicians adapted the structure of sessions to facilitate engagement with Louise and her family; short breaks offered Louise the opportunity to debrief with her parents, who would then communicate to the clinicians (initially, on her behalf) the areas that she would like to focus on. As the assessment progressed, Louise was increasingly able to communicate directly. This was supported through the use of more closed questions and visual aids, such as drawings, toy figures and action-based techniques (Brown, 2013), which served as a platform for safely externalising conversations around distress and exploring its meaning (White, 2001). Using White's (2007) ideas of positioning maps offered a more tangible framework to deconstruct and explore Louise's sense of

distress. Louise spoke openly about her experience of being subject to homophobic comments in secondary school, on the basis of her androgynous physical appearance. It soon became apparent that Louise had struggled with her developing body since the onset of puberty, primarily with having periods. A developmental framework offered the family the opportunity to reflect on past transitions and explore how Louise and her parents had managed these. Louise struggled with symbolic thinking and had been very much focusing on discussions about her distress within a 'landscape of action' (Segal, 1957; White, 1995); she talked about her 'symptoms of dysphoria' in a concrete and detached way. Separate sessions with parents offered the opportunity for exploration through 'landscape of consciousness' questions (White, 1995), around the meaning of the developing distress and Louise's sense of self in broader terms. This was further supported by the parents reflective capacity and their willingness to keep options around potential outcomes open.

It was hypothesised that Louise's distress may be helpfully understood in the context of her thinking style and anxieties around loss of control in relation to pubertal changes, specifically fear around menstruation, including a sensory sensitivity to the 'messiness' of this. Clinicians also wondered about feelings of shame, which feminist researchers have highlighted as intimately bound up with being socialised into inhabiting a menstruating female body (Roen, 2016). Clinicians focused on both acknowledging the reality of her distress and expanding the narratives available to Louise by exploring the ways in which her ASC and particular thinking styles, which shaped her understanding of gender diversity. It was decided that it would be helpful if the work were supported through a wider systems approach, so a professionals network meeting was arranged with local CAMHS (Davidson & Eracleous, 2009). GIDS clinicians formulated the meeting as an intervention in its own right and took up an expert/first-order position to communicate ideas around Louise's meaning-making of bodily related distress (Griffith, Griffith, & Slovik, 1990). Through this and together with the family, it was felt it may be helpful to offer Louise the contraceptive pill to manage periods for the time being (which she took up), as well as identifying ways to help her keep thinking about her experiences of her body and the process of growing up.

In the following GIDS appointment, Louise's mother informed clinicians that she was no longer interested in pursuing the GIDS medical pathway. Louise anxiously voiced her worry that communicating her decision could mean an abrupt termination of GIDS support. This was understood in the context of having formed a meaningful therapeutic relationship and possibly her worry that a sudden ending could also challenge the legitimacy of her status identifying as a trans man, where she found herself, in her words, 'at home' for the first time. It was thus agreed that GIDS input would continue in a mainly consultative role with the network. Some months later, Louise attended a GIDS appointment wearing a dress which was understood by the clinicians as a possible communication of a new found playfulness around exploring her sense of self, which seemed evident in her engagement in the therapy room. She was able to reflect on how this felt possible in light of her still evolving gender expression. Clinicians hypothesised that this shift had come about in part through the experience of a more contained support system which permitted Louise to move towards a position of safe uncertainty; a position which is not fixed, rather is connected to a state of flow and an evolving self-narrative (Mason, 1993).

After 9 months, Louise and her mother attended a review session. Louise took the lead to set the agenda for the meeting and shared that she had now started using her birth name again. She shared how she was still in the process of letting her wider family and social circle know that she would like them to start using feminine (she/her) pronouns again. She reflected on how throughout the assessment she felt she had been exploring her own sense of gender fluidity which had coincided with significant mental health difficulties. This had led her to feel that her (female) self had carried these painful experiences which needed to be got rid of; she reflected, 'I felt that I had always wanted to put that poor girl in a box and put the lid on top'. The clinicians extended Louise's own

metaphor to reflect on how she had been allowing herself to ‘take the lid off the box’ and explore its contents, and how along the way, identifying as trans had been an important aspect of her development by legitimising exploration of her gendered self. Louise shared how she was in the process of ‘coming out’ for a second time, now as a female-identified 16-year old and how this brought with it different challenges. At the same time, she spoke about her desire to gradually come off the contraceptive pill to explore again how she would cope with menstruation and how she was about to start working at a local cultural centre. Louise and her mother asked to be discharged from the service, as they now felt confident that Louise’s identity exploration no longer required specialist input and requested that the service updated the patient records with her birth name.

Discussion

The case review yielded cases of young people who were predominantly female-bodied with high levels of social communication difficulties, suicidality and self-harm. While a sex ratio favouring female-bodied young people, higher levels of mental health complexity and neurodiversity have been observed more broadly in referral patterns in GIDS and elsewhere (Aitken et al., 2015; Carmichael, (2018); Kaltiala-Heino et al., 2015; Van Der Miesen et al., 2016), the presence of these features was particularly pronounced here. It was striking that a clear majority of the young people had either an existing diagnosis of ASC or would be likely to obtain one; a higher number than would be anticipated in the context of the already observed elevated levels of ASC in GIDS cases. Assessment consisted of at least six sessions in most cases – at the upper end or beyond what the existing GIDS protocol suggests – although notably there was also considerable variation in assessment length. This may be illustrative of neurodiverse children needing more clinician-facing time to convey their experience due to their progressing through gender identity development along differing timelines or frameworks than neurotypical peers (Van Schalkwyk, Klingensmith, & Volkmar, 2015). This is in line with initial clinical consensus guidelines for this population, which recommend an extended diagnostic period and the need for clinical decisions to proceed more slowly due to the myriad ‘social, adaptive, self-awareness, communication and executive function complexities’ of this population (Strang et al., 2018, p. 107). The findings suggest further research and service development is needed on this theme, including greater collaboration across services to share learning and explore whether such young people may require different or adjusted assessment protocols. Interestingly, the majority of the young people had not received a formal diagnosis of GD prior to coming to GIDS, and it may be that this contributed to their capacity to engage with an extended and exploratory assessment process through which an individualised formulation could be co-created. Furthermore, discussions between comparable gender identity services internationally could help to shed light on the function and timing of providing a diagnosis of GD.

It was also the case that the majority of young people had not made a social transition. Longitudinal data examining the impact of social transition are sparse (Olson-Kennedy et al., 2016); existing studies have focused on those with childhood onset GD and drawing on limited case data, suggest that the process of re-identifying with one’s original gender role can potentially be stressful in terms of fear of teasing and feelings of shame around being ‘wrong’ (Steensma & Cohen-Kettenis, 2011). It is possible that for some of the cases identified in the case review, living in the gender role congruent with their biological sex was one factor, which facilitated the opportunity for meaningful exploration in the assessment phase as opposed to premature ‘foreclosure’ of identity (Marcia, 1966), although it was also the case that some young people who had already socially transitioned did feel able to live once again in the gender role congruent with their biological sex. For some young people (such as Louise, described above), social transition may be felt to be precisely the platform through which a meaningful exploration of different adult roles can occur

and/or may in the longer-term turn out to be a necessary and sufficient means through which to live life well as a gendered person. Furthermore research, including longitudinal studies, on decision making around social transition in GD adolescents would develop understanding of these issues. It would be valuable to extend this study by conducting a structured quantitative retrospective chart review of the case characteristics and trajectories of young people with GD emerging in adolescence, across the whole service. This would enable better understanding of the different clinical profiles and needs of young people seeking help from a national specialist gender service.

In both the cases described here, a number of common themes can be noted, including experiences of teasing/bullying (including of a homophobic nature) prior to the onset of GD, a sense of exclusion and isolation, difficulties in social communication and engaging with peers, distress in relation to awareness of a developing sexed body and difficulties separating from parents. In retrospect, these young people's initial determination to medically transition and the subsequent shift in this sense might be better understood in the context of a broader identity confusion (Kaltiala-Heino et al., 2015). Of course, there are multiple factors influencing outcome. However, it possible that in different ways for these two young people, the GIDS assessment provided a platform through which issues of homophobia and internalised shame, familial narratives and relational ruptures, and beliefs and fantasies associated with mid-adolescence (Dallos & Vetere, 2009; Newcomb & Mustanski, 2010; Waddell, 1998) could be meaningfully thought about and integrated into a story of who one is becoming. A limitation of this study is that it was not possible to explore the characteristics and/or experiences of those who met the inclusion criteria but did not stay engaged in the assessment process. Such an exploration may help to identify suitability of referrals to GIDS.

In conclusion, the adolescents included in this review met criteria for GD and initially requested medical interventions to resolve their difficulties. Over the course of the psychosocial assessment, they came to understand their distress and its alleviation (at that particular point in time) differently and eventually chose not take a medical (hormonal) pathway and/or identified their gender identity as broadly aligned with their biological sex. Of course, this is not the case for many other young people presenting to the service and it is important to hold onto the multiplicity of possible outcomes. The study highlights the need for the psychosocial assessment to nurture a space *in between* the internal and external worlds of these young people (Marchiano, 2018). Such an assessment would need to be properly located in a developmental framework which takes seriously the inescapable *in between-ness* of adolescence and joins with young people and their families to broaden the narratives available to them, to make sense of gender-based distress.

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References

- Aitken, M., Steensma, T. D., Blanchard, R., VanderLaan, D. P., Wood, H., Fuentes, A., . . . Zucker, K. J. (2015). Evidence for an altered sex ratio in clinic-referred adolescents with gender dysphoria. *The Journal of Sexual Medicine*, 12, 756–763.

- Blow, A. J., Sprenkle, D. H., & Davis, S. D. (2007). Is who delivers the treatment more important than the treatment itself? The role of the therapist in common factors. *Journal of Marital and Family Therapy*, 33, 298–317.
- Brown, P. (2013). Using reflecting role plays in reflecting teams. *Context*, 126, 27–30.
- Burnham, J. (2012). Developments in social GRRRAAACCEEESSS: visible-invisible and voiced-unvoiced. In I-B. Krause (Eds.), *Culture and reflexivity in systemic psychotherapy: Mutual perspectives* (pp. 139–160). London, England: Karnac Books.
- Butler, J. (2004). *Undoing gender*. New York, NY: Routledge.
- Carmichael, P. (2018). Sex ratio in children and adolescents referred to the gender identity development service in the UK (2009–2016). *Archives of Sexual Behavior*, 47(5), 1301–1304.
- Constantino, J. N., Davis, S. A., Todd, R. D., Schindler, M. K., Gross, M. M., Brophy, S. L., . . . Reich, W. (2003). Validation of a brief quantitative measure of autistic traits: Comparison of the social responsiveness scale with the autism diagnostic interview-revised. *Journal of Autism and Developmental Disorders*, 33, 427–433.
- Dallos, R., & Vetere, A. (2009). *Systemic therapy and attachment narratives: Applications in a range of clinical settings*. London, England: Routledge.
- Davidson, S., & Eracleous, H. (2009). The gender identity development service: Examples of multi-agency working. *Clinical Psychology Forum*, 201, 46–50.
- Davies-Arai, S. (2018). The transgender experiment on children. In H. Brunskell-Evans & M. Moore (Eds.), *Transgender children and young people: Born in your own body* (pp. 16–40). Newcastle upon Tyne, UK: Cambridge Scholars Publishing.
- Di Ceglie, D. (1998). Management and therapeutic aims with children and adolescents with gender identity disorders and their families. In Di Ceglie (Ed.), *A stranger in my own body: Atypical gender identity development and mental health* (pp. 185–197). London, England: Karnac Books.
- Di Ceglie, D. (2008). Working at the edge: Engaging in therapeutic work with young people with atypical gender identity development. *Neuropsychiatrie de l'Enfance et de l'Adolescence*, 56, 403–406.
- Di Ceglie, D. (2009). Engaging young people with atypical gender identity development in therapeutic work: A developmental approach. *Journal of Child Psychotherapy*, 35(1), 3–12.
- Erikson, E. H. (1968). *Identity: Youth and crisis*. New York, NY: W.W. Norton.
- Giovanardi, G. (2017). Buying time or arresting development? The dilemma of administering hormone blockers in trans children and adolescents. *Porto Biomedical Journal*, 2, 153–156.
- Glidden, D., Bouman, W. P., Jones, B. A., & Arcelus, J. (2016). Gender dysphoria and autism spectrum disorder: A systematic review of the literature. *Sexual Medicine Reviews*, 4(1), 3–14.
- Griffith, J. L., Griffith, M. E., & Slovik, L. S. (1990). Mind-body problems in family therapy: Contrasting first- and second-order cybernetics approaches. *Family Process*, 29(1), 13–28.
- Kaltiala-Heino, R., Sumia, M., Työlajärvi, M., & Lindberg, N. (2015). Two years of gender identity service for minors: Overrepresentation of natal girls with severe problems in adolescent development. *Child and Adolescent Psychiatry and Mental Health*, 9(1), Article 9.
- Kimmel, M. S. (2004). Masculinity as homophobia: Fear, shame, and silence in the construction of gender identity. In P.D. Rothenberg (Ed.), *Race, class, and gender in the United States: An integrated study* (pp. 81–93). New York, NY: Worth.
- Kreukels, B. P., & Cohen-Kettenis, P. T. (2011). Puberty suppression in gender identity disorder: The Amsterdam experience. *Nature Reviews Endocrinology*, 7, 466–472.
- Leibowitz, S., & de Vries, A. L. (2016). Gender dysphoria in adolescence. *International Review of Psychiatry*, 28(1), 21–35.
- Marchiano, L. (2018). The language of the psyche: Symptoms as Symbols. In H. Brunskell-Evans & M. Moore (Eds.), *Transgender children and young people: Born in your own body* (pp. 107–122). Newcastle upon Tyne, UK: Cambridge Scholars Publishing.
- Marcia, J. E. (1966). Development and validation of ego-identity status. *Journal of Personality and Social Psychology*, 3, 551–558.
- Marcus, L., Marcus, K., Yaxte, S. M., & Marcus, K. (2015). Genderqueer: One family's experience with gender variance. *Psychoanalytic Inquiry*, 35, 795–808.

- Mason, B. (1993). Towards positions of safe uncertainty. *Human Systems: The Journal of Systemic Consultation and Management*, 4, 189–200.
- Minuchin, S. (1974). *Families and family therapy*. Cambridge, MA: Harvard University Press.
- Newcomb, M. E., & Mustanski, B. (2010). Internalized homophobia and internalizing mental health problems: A meta-analytic review. *Clinical Psychology Review*, 30, 1019–1029.
- Olson-Kennedy, J., Cohen-Kettenis, P. T., Kreukels, B. P., Meyer-Bahlburg, H. F., Garofalo, R., Meyer, W., & Rosenthal, S. M. (2016). Research priorities for gender nonconforming/transgender youth: Gender identity development and biopsychosocial outcomes. *Current Opinion in Endocrinology, Diabetes and Obesity*, 23, 172–179.
- Pearce, W. B. (2007). *Making social worlds: A communication perspective*. Malden, MA: Blackwell Publishing.
- Ristori, J., & Steensma, T. D. (2016). Gender dysphoria in childhood. *International Review of Psychiatry*, 28(1), 13–20.
- Roen, K. (2016). The body as a site of gender-related distress: Ethical considerations for gender variant youth in clinical settings. *Journal of Homosexuality*, 63, 306–322.
- Segal, H. (1957). Notes on symbol formation. *The International Journal of Psychoanalysis*, 38, 391–397.
- Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry*, 16, 499–516.
- Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Gender transitioning before puberty? *Archives of Sexual Behavior*, 40, 649–650.
- Steensma, T. D., & Cohen-Kettenis, P. T. (2015). More than two developmental pathways in children with gender dysphoria? *Journal of the American Academy of Child & Adolescent Psychiatry*, 54, 147–148.
- Strang, J. F., Meagher, H., Kenworthy, L., de Vries, A. L., Menvielle, E., Leibowitz, S., . . . Anthony, L. G. (2018). Initial clinical guidelines for co-occurring autism spectrum disorder and gender dysphoria or incongruence in adolescents. *Journal of Clinical Child & Adolescent Psychology*, 47, 105–115.
- UK Council for Psychotherapy. (2017). *Memorandum of understanding on conversion therapy in the UK*. Retrieved from <https://www.psychotherapy.org.uk/about-ukcp/public-policy/conversion-therapy/>
- Van Der Miesen, A. I., Hurley, H., & De Vries, A. L. (2016). Gender dysphoria and autism spectrum disorder: A narrative review. *International Review of Psychiatry*, 28, 70–80.
- Van Schalkwyk, G. I., Klingensmith, K., & Volkmar, F. R. (2015). Gender identity and autism spectrum disorders. *The Yale Journal of Biology and Medicine*, 88, 81–83.
- Vrouenraets, L. J., Fredriks, A. M., Hannema, S. E., Cohen-Kettenis, P. T., & de Vries, M. C. (2015). Early medical treatment of children and adolescents with gender dysphoria: An empirical ethical study. *Journal of Adolescent Health*, 57, 367–373.
- Waddell, M. (1998). *Inside lives: Psychoanalysis and the growth of personality*. London, England: Karnac Books.
- White, M. (1995). *Re-authoring lives: Interviews & essays*. Adelaide, South Australia, Australia: Dulwich Centre Publications.
- White, M. (2001). Narrative practice and the unpacking of identity conclusions. *Gecko: A Journal of Deconstruction and Narrative Ideas in Therapeutic Practice*, 1, 28–55.
- White, M. (2007). *Positioning maps*. New York, NY: W.W. Norton.
- Wood, H., Sasaki, S., Bradley, S. J., Singh, D., Fantus, S., Owen-Anderson, A., . . . Zucker, K. J. (2013). Patterns of referral to a gender identity service for children and adolescents (1976–2011): Age, sex ratio, and sexual orientation. *Journal of Sex & Marital Therapy*, 39(1), 1–6.
- Wren, B. (2014). Thinking postmodern and practising in the enlightenment: Managing uncertainty in the treatment of children and adolescents. *Feminism & Psychology*, 24, 271–291.
- Wren, B. (in press). Ethical issues arising in the provision of medical interventions for gender diverse children and adolescents. *Clinical Child Psychology and Psychiatry*.

Zucker, K. J., Bradley, S. J., Owen-Anderson, A., Kibblewhite, S. J., Wood, H., Singh, D., & Choi, K. (2012). Demographics, behavior problems, and psychosexual characteristics of adolescents with gender identity disorder or transvestic fetishism. *Journal of Sex & Marital Therapy*, *38*, 151–189.

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