A qualitative study into how clinicians within a Child and Adolescent Mental Health Service think about Gender Dysphoria and what their experiences are of working therapeutically with children and young people suffering from it.

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ABSTRACT

Over the last decade a significant increase has occurred in referrals to the specialist Gender Identity Development Service (GIDS) located at the Tavistock and Portman NHS Foundation Trust. However, research into Gender Dysphoria (GD) specifically within children and young people (0-18 years) has not seen the same rise. In addition, more young people suffering with GD are also seen within Child and Adolescent Mental Health Services (CAMHS) across the United Kingdom. This study therefore aimed to explore how clinicians within a CAMHS think about GD and what their experiences are of working therapeutically with children and young people suffering from it.

A literature review was conducted to enable learning and understanding of what theoretical and empirical knowledge has already been established within the field of GD. Special focus was placed on the psychoanalytic literature, due to the professional background of the researcher, alongside available empirical studies that consider the experiences of professionals working with individuals with GD.

Second, a small-scale qualitative study was performed to explore the research questions, semi-structured interviews were conducted with twelve CAMHS clinicians from various professional backgrounds. The data analysis, utilising thematic analysis, yielded 12 themes and 45 sub-themes which are outlined, described and discussed in detail.

The findings highlight the complexity, confusion and constant changes in diagnostic terms and definition of GD as well as the therapeutic work with young people suffering from it. One main finding was that possessing both theoretical and practical experiences is key, which the professionals interviewed stressed needs to be shared with others. A great appetite for further training, knowledge and discussions was noted alongside and in order to address the uncertainty being reported by the participants. The study concludes that, further research and training is required in the field of child and young people with GD.

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CHAPTER 1

INTRODUCTION

This research project is an inquiry into how clinicians within a Child and Adolescent Mental Health Service (CAMHS) think about Gender Dysphoria and what their experiences are of working therapeutically with children and young people suffering from it. The definition for Gender dysphoria provided by the National Health Service (NHS, 2020) is “a term that describes a sense of unease that a person may have because of a mismatch between their biological sex and their gender identity. This sense of unease or dissatisfaction may be so intense it can lead to depression and anxiety and have a harmful impact on daily life”. This is therefore the understanding the researcher has used throughout the project and Gender Dysphoria will be referred to as GD.

The CAMHS team that this project involves is based in a predominantly rural county within England. The service they provide is across the whole county which stretches more than 1000 square miles. The population largely consists of white British occupants with over 90% recorded in the last census ("Census 2011 - Inform", 2021). Unfortunately, this survey did not include any exploration around gender reassignment but was planned to be involved in the survey conducted recently in the spring of 2021. The Gender Identity Research and Education Society ("Individual Help", 2021) estimates that 1% of the county’s adult (sixteen years or over) population experience some degree of gender diversity but what the estimates are for children and young people is unknown. Nevertheless, the Gender Identity Service

(GIDS) at the Tavistock and Portman NHS Foundation Trust, London reported that 1% of their referrals for children and young people originated from the county in which this study was conducted, indicating figures may be similar ("Referrals to GIDS by county - a Freedom of Information request to Tavistock and Portman NHS Foundation Trust", 2019).

The researcher was placed within the CAMHS team as part of their five-year clinical training as a Child and Adolescent Psychoanalytic Psychotherapist. They joined the psychotherapy department within this team and was based with them four days a week. Initially the researcher had an experience that focused only on the psychotherapy department. However, as their training progressed this broadened to the wider CAMHS team that they were part of and involved increased experience of working with clinicians from professions outside of psychotherapy.

Background and rational

GIDS originated within St George's Hospital, London in 1989 and was then transferred to The Tavistock and Portman NHS Foundation Trust in 1996. It is a Tier 4 specialist service provided by NHS England that offer assessments and treatment for children and young people up to the age of 18 years old. Referrals can be made by general practitioners (GPs), paediatric services and Child and Adolescent Mental Health Services. All referrals are screened by the London team and have historically been seen there. However, they have recently begun to provide satellite clinics in Leeds, Birmingham and Exeter.

The number of young people presenting with GD has significantly increased over the last decade. In 2020-2021 GIDS received 2383 referrals ("Number of referrals", 2021), over 25 times more than in 2009-2010 ("Gender Identity Development Service statistics”, 2017). Due to the demand for this service, the waiting time for initial appointments is currently approximately three years ("How long is the wait for a first appointment at GIDS?", 2021). As previously mentioned, many of these referrals come from CAMHS. Whilst they are on the GIDS waiting list, being assessed by them, and receiving treatment there, they may also continue to be seen by clinicians in their local area. This is often in order to explore their gender identity and possible comorbidity and to help increase awareness and understanding of the individual’s inner world whilst addressing other areas of distress.

The increase in referrals for children with GD has undoubtedly been very high in the last decade. The researcher’s personal interest has developed in proportion to this. They have been curious about the increase in the referrals and the impact it has on these young people, their families and the clinicians who support them.

Multi-disciplinary working has been expressed to be essential in the effective treatment and assessment of these young people (Bonfatto & Crasnow, 2018). The GIDS offers specific assessment and medical treatment for GD whereas, the CAMHS teams offer broader services to these young people which often includes their GD alongside other comorbidities. However, the aims of what the different teams offer can often greatly vary. It has been expressed that communication among professionals involved with these young people is vital. It can be challenging at times due to location and different ways of working but the advantages are testament to this. It has been found that working in a multi-agency way improves the overall experience for the young people and their families by “reducing stigma (e.g. by combating problems at school such as bullying), increasing understanding by finding a common language with which to explore gender and the early identification and intervention for mental health or other problems" (Eracleous & Davidson, 2009, p.49).

Previously it has been mandatory that patients' referrals remain open to their local CAMHS team alongside a referral to GIDS, and it left the researcher wondering about the clinicians seeing them who are not considered specialists in this field. During the researcher's time with the CAMHS team they have witnessed some of the experiences and complexities that come with working with these children. Therefore, the researchers curiosity in finding out more about the understanding and experiences within a generic CAMHS team rather than a specialist service, shaped the aim of this research project.

Aims and research questions

This study aims to explore three main research questions. The first considers how clinicians conceptualise GD and define it based on their professional training and clinical experience. The second explores their thoughts around the increase in the number of referrals to GIDS and whether they have experienced a similar increase within their services. The final considers their own experiences of working clinically with young people experiencing GD (0-18 years), their families and professionals (including GIDS) around them.

Thesis Overview

In the chapter that follows, Chapter 2, the results of the literature review will be reported. This will begin with the available literature considering the development of diagnoses and the GIDS, followed by the review of the psychoanalytic literature regarding GD, and finally with the review of empirical research.

In Chapter 3, the empirical research study will be presented, starting with the outline of methodology. This includes the design and rationale for the project focusing on recruitment, data collection and analysis. Throughout it is considered what has been decided on and why by the researcher. Chapter 4 presents the findings and Chapter 5 concludes the thesis with a discussion that brings these together with the literature.

Please note that all interviews were conducted prior to the recent high court judicial review regarding GD patients receiving hormone blocking treatment and therefore this process will not be considered within this study.

CHAPTER 2

LITERATURE REVIEW

Literature review

A literature review was conducted to enable learning and understanding of what concepts and both theoretical and empirical knowledge have already been established within the field of my research thesis. This chapter begins by introducing the history of the diagnosis of Gender Dysphoria (GD) and the Gender Identity Development Service (GIDS) so as to provide the reader with a comprehensive background to both these areas. The review of the identified and appraised literature will be presented in two parts; the first focusing on the psychoanalytic theory regarding GD and the second on research studies aimed at exploring professionals' understanding and experience around it. The Psychoanalytic Theory review considered ideas and concepts from this perspective alongside the evolution of these views over time. The empirical research review focused on the evidence and limitations of previous studies. It primarily focused on literature about the understanding and experience of working with the population.

Introduction

Gender Dysphoria and the Gender Identity Development Service.

Diagnosis

The definition for GD provided by the National Health Service (NHS) (2020) is "a term that describes a sense of unease that a person may have because of a mismatch between their biological sex and their gender identity. This sense of unease or dissatisfaction may be so intense it can lead to depression and anxiety and have a harmful impact on daily life" (NHS, 2020, para.1).

The way GD has been described and named has varied over the last century and a summary of this can be found in Table 1 below. Despite psychiatric and medical theorising about transsexual and transgender presentations beginning in the 19th Century, cases of GD were considered to be very rare until the middle of the next century and at this time were considered psychopathological. As early as 1923, Marcus Hirschfeld, a German physician, was the first to distinguish between homosexuality, transvestism, and transsexualism. His description of transsexualism spoke of adopting the gender role that is opposite to their gender whilst holding a conviction that they were assigned to an incorrect gender. Nevertheless, those distinctions were not broadly accepted until decades later. For example, in Europe in the 1920s, sex reassignment surgery (SRS) began being provided but, again, greater awareness of GD did not occur until the media reported on George Jorgensen's transition to Christine in the United States (US) in 1952 (Drescher, 2014).

At this point, SRS became more available, leading to greater awareness of gender identity and an increasing number of people feeling able to express their wish to change from their gender assigned at birth to the opposite. In 1968, the first diagnosis was provided by the International Classification of Diseases (ICD) version eight and was labelled "transvestitism" (WHO, 1968). This diagnosis was separated from that of personality disorders and categorised under sexual deviance. However, the meaning of transvestitism was unclear and was being used in connection with SRS. This indicated it was a wish to change genders, which is incongruent with the modern day understanding of this term being more in relation to enjoying only dressing as the opposite gender. The distinction between the two was later recognised in 1975 in the ICD-9 (WHO, 1975) after the Diagnostic and Statistical Manual of Mental Disorders (DSM) (DSM-II, APA, 1968) was published in 1968 and used the term “transsexual”. This was acknowledged as different to “transvestitism”, which involves an enjoyment of wearing clothes of the opposite gender, rather than feeling they are or want to change to the opposite gender.

In 1980, the DSM-III (APA, 1980) added recognition that not only adults could suffer with it but added “gender identity disorder of childhood” into their diagnostic system. In their revision seven years later, they grouped adolescence and adulthood together whilst categorising it as a disorder usually first evident in infancy, childhood or adolescence. Yet, it continued to be clustered with paraphilias and sexual dysfunctions. It was only in the 1990s, with the update of DSM-IV (APA, 1994) that the diagnostic term “gender identity disorder” was introduced and thereby separated the diagnosis into “in adolescents or adults” and “in children”. The DSM changed the term again in 2013 in its fifth version to “gender dysphoria” (APA, 2013). The use of the term ‘dysphoria’ instead of ‘disorder’ was used to acknowledge the distress people suffer whilst also trying to reduce the stigma associated with it (Zucker, Cohen-Kettenis, et al., 2013).

The various changes occurred, both in terms of the diagnostic terms used and surrounding its definitions, this highlights, an ongoing debate as to whether GD, and issues around gender, should be considered a mental health diagnosis. The researcher agues that this has not been fully resolved amongst health professionals and those experiencing it, contributing to stigmatisation as well as conflicts as to when, what and how treatment(s) should be offered. As with other phenomena, the researcher is concerned that if the diagnosis is not categorised this way, it could lead to the loss of help, support and treatment within health services. Interestingly, in 2018 the ICD-11 (WHO, 2020) renamed the classification once more to “gender incongruence”, again separating children from adolescents and adults, but removed it from the “mental and behavioural disorders” chapter. They recategorized it under “conditions related to sexual health” instead. The criteria for the latest DSM and ICD classifications can be found in the Appendix 1.

Table 1: Gender diagnoses in the ICD and DSM

Year	ICD	DSM	Parent category	Diagnosis name
1965	**ICD-8**	**-**	Sexual deviations	Transvestitism
1968	**-**	**DSM-II**	Sexual deviations	Transsexualism
1965	**ICD-9**	**-**	Sexual deviations	Transvestism
				Trans-sexualism (sic)
1980	**-**	**DSM-III**	Psychosexual disorders	Transsexualism
				Gender identity disorder of childhood
1987	**-**	**DSM-III-R**	Disorders usually first evident in infancy, childhood or adolescence	Transsexualism
				Gender identity disorder of childhood
				Gender identity disorder of adolescence and adulthood, non-transsexual type
1990	**ICD-10**	**-**	Gender identity disorders	Transsexualism
				Dual-role transvestism

				Gender identity disorder of childhood
				Other gender identity disorders
				Gender identity disorder unspecified
1994	**-**	**DSM-IV**	Sexual and gender identity disorders	Gender identity disorder in adolescents or adults
				Gender identity disorder in children
2013	**-**	**DSM-V**	Gender dysphoria	Gender dysphoria in adolescents or adults
				Gender dysphoria in children
2018	**ICD-11**	**-**	Conditions related to sexual health	Gender incongruence of childhood
				Gender incongruence of adolescent or adulthood

Gender Identity Development Service (GIDS)

Just before ICD-10 was released, Domenico Di Ceglie, Consultant Child and Adolescent Psychiatrist, and Peter Hill, Professor of Child and Adolescent Psychiatry, began discussions about the care of children and adolescents suffering from Gender Identity Disorder. Together they set up the GIDS in the department of

Child Psychiatry at St George’s Hospital in London and began seeing patients there in September 1989. Di Ceglie wrote a set of therapeutic aims and code of conduct for this particular patient group, which are still abided by today. These include “the unconditional acceptance and respect for young people’s gender identity” with a focus on providing a space for exploration of gender, the impacts on general development and a consideration of the options open to them ("Our Gender Identity Development Service", 2021, para. 4). David Grant, Paediatric Endocrinologist from Great Ormond Street later joined them and offered to run a paediatric liaison clinic seeing children and families seeking help for questions around gender identity. The GIDS transferred to the Tavistock and Portman NHS Foundation Trust in 1996, and the team was comprised of Child Psychiatrists, Clinical Psychologists, Psychotherapists, Social Workers, and Paediatric Endocrinologists which continues to be the case to this day.

Once a referral is accepted within GIDS, an assessment process begins, which involves four to six meetings with the child and their parents. These vary from offering individual sessions for the child and/or including the parents and families. During these sessions, clinicians and patients explore the nature and characteristics of the young person’s gender identity. Areas of emotional functioning, peer and other social relationships are explored as well as the intellectual functioning of the young person. Moreover, the strengths and weaknesses of their family functioning are evaluated, and in addition, information is given about the possibilities and limitations of treatments (Coleman, Bockting, et al. 2012). Following the assessment, recommendations are made for a treatment plan and follow-up assessments of the child. It is thereby acknowledged that multi-disciplinary communication with the child’s local network, including CAMHS, is crucial at this point (Bonfatto & Crasnow, 2018). It may be recommended that medical intervention is inappropriate, required only in part or something the young person subsequently elects not to pursue.

If the young person chooses to pursue medical treatment and it is deemed appropriate for them to do so in order to alter their biological gender, one option of treatment available to them would be a medical intervention beginning with hormone blockers (gonadotrophin-releasing hormone analogues). These are administered by injection to inhibit the production of sex hormones, which halts pubertal development. To be considered for this treatment the young person must have reached Tanner Stage two of puberty, which marks the beginning of physical developments because of hormones (WPATH, 2012). Hormone blockers are reported to be a physically reversible intervention, in that once you stop taking the blocker normal puberty will resume (WPATH, 2012).

After around twelve months of receiving hormone blockers, young people over sixteen years of age can be offered cross sex hormones also known as gender affirming hormones (i.e. oestrogen or testosterone). These are the hormones of the gender they would like to transition into and result in physiological changes within the body. Oestrogen causes breasts to grow whereas testosterone results in a deepening of the voice and growth of facial hair. These hormones are reported to have irreversible effects including infertility being highly likely. Throughout these processes, assessments are ongoing with the young person and their families to assess capacity for consenting to these treatments. There is also a hope from the service that these young people are able to access therapeutic work from their local services during this time. As a child and adolescent service, they do not offer any surgical interventions therefore this is only an option once a person has turned 18 years old and has transferred to adult services.

There have been many changes over the last two years as to how consent is gained for hormone blockers, with the suggestion of consent needing to be gained from The High Court. However, this has recently reverted back to the understanding that children, their parents and the multi-disciplinary team within GIDS can make decisions around whether this is appropriate without gaining permission from a court of law ("Accessing puberty blockers – latest information following legal rulings in 2020 and 2021", 2021). More information about this important debate and the resulting process of change can be found online and will not be part of the scope of the present thesis.

The search method used will now be outlined followed by a review of psychoanalytic literature and empirical research into this area. The aim of this review was to consider how psychoanalytic theory has developed alongside gaining an understanding of the research into this area that has predated the current study.

Method

The searches were conducted across databases including PsychINFO, PEP and SocINDEX. In terms of part one, piloting the search, it became apparent that the terms and synonyms used needed to be expanded especially in relation to GD. As pointed out above, GD has historically been referred to with many different terminologies. As such all of these needed to be included and the final selection of search terms were "gender variant", "gender variance", "gender incongruence", "gender identity disorder", transgender, transsexual*, "gender dysphoria" and GID.

Part two of the literature review focused on how psychoanalysis has conceptualised GD and how this has changed over the years and included search terms psychoanaly*" "psychotherapy*" and "psychoanalytic psychotherapy" in addition to the previously mentioned terms for GD. All 916 papers were skim read for relevance and overall, 889 of the papers were excluded. Exclusion criteria were studies that specifically focused on psychoanalytic technique of working with these patients and studies that considered non-binary presentations. Twenty-seven papers were reviewed in full and their theories will be summarised.

Part three of the literature review focused on empirical research that addressed clinicians' understanding and experience of working with the patient group. The GD search terms that were mentioned previously were used alongside terms for experience and/or understanding and clinicians. The search terms used to look at the former were experience*, consider*, reflect*, understand*, sense, comprehend*, perception, theorise or conceptualise. The ones used for clinicians were clinician, profession*, therapist, physician, psychology*, psychotherapy*, nurs*, psychiatr* or practitioner as these all covered the professions of the participants within this study. Initially the search yielded nearly 100,000 results. Limiters of full text, English as the language and empirical studies were used. This only halved the resulting studies and in order to further narrow the search, the search terms used for clinicians were searched for within the titles of the papers. This resulted in 112 studies. Their abstracts were read to ascertain relevance of the article. Excluded were studies that focused on sexuality within LGBTQ (lesbian, gay, bisexual, transgender and queer). Despite this possibly being an interesting area to include in future research, further studies were omitted due to them being centred around educational professionals rather than health professionals. The final search revealed seven studies. The first three looked at "trans as a subgroup of LGBT" whereas the remaining four considered "the T in LGBT as a focus in its own right" and therefore the critical evaluation of these will be separated in this way.

Results

Part One: Psychoanalytic literature

Psychoanalysis has always been interested in the psychic processes that underpin gender and many have considered how gender identity is constructed. As this thesis is primarily focused on when a person specifically feels uncomfortable with the gender assigned to them and is contemplating medical intervention to physically transition to the opposite gender, as outlined above, this review focused on these aspects within the psychoanalytic literature. Due to current word limitations, it will be assumed that the reader is familiar with psychoanalytic theory surrounding sexuality and gender development, which are important in relation to this topic but cannot be summarised here.

It was interesting to find that in the first half of the twentieth century, GD was rarely reported on in psychoanalytic writings. It appeared the first time in 1911 when Freud wrote about his analysis of Schreber's memoirs in his paper "psychoanalytic notes on an autobiographical account of a case of paranoia" (Freud, 1911). In this he discussed Schreber's belief that he must transform from a male to a female to redeem the world and restore harmony by becoming God's wife. Freud suggested that Schreber was suffering from megalomania as a result of delusions of persecution regarding homosexuality. He suggested that to ward off homosexual impulses, and the feelings of paranoia Schreber was experiencing as a result of these impulses, that transitioning into a female was his only option. This was considered a debilitating psychopathology, which remained the belief around GD for many decades within psychoanalytic thinking.

Over half a century appeared to pass before GD was more directly referred to in the psychoanalytic literature, and at this time it was termed “transsexualism”. Stoller was one of the first psychoanalysts to conceptualise GD. He wrote a succession of papers in which he considered the origins of the presentation, which were continually referred to subsequently (Stoller, 1964, 1966, 1968). He argued that the earliest stages of gender identity were a result of parental attitudes towards their infant’s gender, especially the mothers’ own sexual orientation (mostly unconscious) and how this shaped the relationship with her children, in particular her son. As such, when considering the specificity of these relationships he suggested that transsexualism was a result of an “excessive mother-son symbiosis” (1968, p.307) that involves the mother not allowing her child to separate from her. Stoller argued that in such cases the absence of a father was highly determinative, as the mother lacked a partner who could prevent this symbiosis. He furthermore proposed that in addition, these mothers struggled to contain their expressions of bisexuality and with the amount of mother-infant body contact would produce a male who thinks he is a female. This continued to be a highly thought of consideration and laid the foundation for psychoanalytic theory of GD for decades after. It appears that Stoller is moving away from the distinction between unconscious sexual development where the external world, for Freud, did not matter and is conceptualising based on both unconscious identification and the reality of an absent father, acknowledging that the external environment does matter and influences child development including sexuality.

The review has shown, that the focus within the psychoanalytic tradition, remained purely on male to female transsexuals for nearly three decades. It made the researcher wonder whether this was rooted in Freud’s focus on conceptualisation of male development as the origin for understanding females. Stoller's theory of this presentation being a result of the mother son relationship also continued to be the underpinning. Socarides (1970) suggested that alongside the separation anxiety stirred up by the mother-son-relationship, that there may also be a fear of engulfment by her. He agreed with Freud that it is a psychotic mechanism of denial against homosexual feelings and therefore considered it a sexual perversion.

What is important to consider here is that the emerging and prevailing psychoanalytic view or understanding of perversion or 'what gets perverted' stands in contrast to how the term was used and understood in society and the prevailing culture at the time, and still today. The meaning of 'deviation from the norm' was not viewed with a moral lens, rather the opposite, when Freud (1905) or Socarides (1970) talked about a denial against homosexual feelings as a perversion, it implies that having homosexual feelings is common.

However, because the use of the term perversion in society is more often associated with moral deviations, it may be a word that sits uncomfortably with many of us. For example, within the Oxford English Dictionary perversion is defined as "behaviour that is thought to be strange and not acceptable, especially when it is connected with sex" or "the act of changing something that is good or right into something that is bad or wrong". However, within the psychoanalytic tradition Freud (1905) defined perversion as a deviation from the normal *aim* of sexual intercourse and the heterosexual romantic relationship. He argued that this deviation was common and therefore universal and that individuals should not be criticised for it. Stoller (1986) continued this thinking and stated that "we no longer need to define a perversion according to the anatomy used, the object chosen, the society's stated morality, or the number of people who do it" (p.4). Relating this to individuals experiencing GD, Limentani (1989) stressed that the main characteristics of the perversion is the turning away from an intolerable “truth” that for individuals experiencing GD is centred around their gendered body. “Truth” here needs to be understood as a given rather than something strange or wrong, yet, understandably, the individual and everyone around them move within the prevailing societal and cultural norm, which they will have identified as well, and as such the word ‘intolerable’ refers to that conflict. What becomes clear is the complexity involved, which will be embarked on and became clearer below.

Ovesey and Person (1973) suggested that in order to alleviate the extreme anxiety of separation that occurs early in life, the child uses the fantasy of symbiotic fusion with the mother to avoid the perceived danger. Rather than the fear of castration that Freud previously suggested (1909) they argued that these children suffer with a fear of not being castrated as castration would result in the separation from their mother that they wish for. Like the early psychoanalysts, they also thought of it as a psychopathology or neuroses. Siomopoulos (1974), however, was one of the first to offer a different explanation around the connection to homosexual feelings. He suggested that it was not a denial of such feelings but, as he put it, a “class reversal” (p.208) to that of female to enable these sexual feelings to be more acceptable. There seemed to be a shift from pathologizing this presentation to it being a solution for feelings that were considered a perversion at this time.

In the 1970s, Stoller went on to expand his conceptualisation of this topic further. He suggested a difference between “primary transsexualism” and “secondary transsexualism” (Stoller, 1975). The former was believed to stem from the particular mother-infant-relationship as he had previously outlined. However, he now claimed that this manifestation was not a pathological type of transsexualism and could therefore be changed with surgery. Secondary transsexualism, on the other hand, he believed to stem from a variety of sources all of which are pathological in nature and therefore surgery would be harmful to the patient as he believed they need analysis instead. There seemed to be a pull to try and create a diagnostic criterion that would help professionals to decide what would be most helpful. This shift in consideration was probably related to what was going on in the psychiatric world at the time. Changes in diagnosis from transvestitism to transsexualism were taking place as awareness was increasing regarding how to think about this presentation which may have sparked an increase in the curiosity surrounding when surgical solutions may be appropriate within the psychoanalytic world.

It was Limentani (1979) who expanded the field by considering female to male transsexuals. He also highlighted the increase in people presenting this way, suggesting it was due to “the publicity afforded to sex change operations and the unwelcomed glamorization of such operations” (p139). He continued with the theory that transsexualism in boys is due to separation anxiety and the child’s “chosen” path of dealing with it, or rather avoiding it. So in his view it is a defence, as such as if these boys would say: “I am not afraid of being separate; I have mother with me, I am really her”. However, when considering girls who present this way, Limentani argues it was a more serious disturbance, not “simply” denial any longer. He suggested that for girls it is focused on the desperate need to have a body of their own to claim so as not to be engulfed by their mother. He seemed to be specifically referring to mothers in a similar way to previous theorists where the relationship is very intense and driven by the mother’s needs, therefore resulting in the fear for girls of being consumed by this without a way of separating.

Coates and Person (1985, 1990) point out that empirical research had shown that transsexualism in childhood often emanates into homosexuality, whereas most gay men do not experience GD. Therefore, they considered in more detail what type of mother may result in this type of child and difficulty. When conducting their study in 1985, in which they evaluated twenty-five “extremely feminine boys with DSM-II diagnosis of gender identity disorder of childhood” (p. 702) for presence of behaviour disturbances, social competence and separation anxiety. They found that most mothers felt fear, anger and devaluation of men and therefore struggled to allow the masculinity of their sons (1985). The child’s fathers were often found to be absent and inadequate; in their study, all mothers of a gender dysphoric boy did not experience their husbands as a concerted partner. The author found that due to profound stress during the early years of the child’s life that mothers were often depressed, angry and withdrawn whilst alternating with an intense connection based on their needs rather than the child’s. As the authors argued, this resulted in disorganised attachments between mother and child that left their male child experiencing separation as a threat of total annihilation (Winnicott 1962). To defend against such intense fears of annihilation, Coates and Person (1985) suggest that boys’ resort to reparative fantasy of self-fusion with their mothers. These boys therefore maintain internal ties with their mother whilst also protecting her from the rage they feel regarding their inaccessibility, instead projecting it on to maleness. The authors were the first psychoanalysts to consider the anger that might be involved in this presentation and the development of GD.

Although not dissimilar to other psychoanalysts previously thinking and writing about the subject, McDevitt (1995), more specifically discussed the mother’s preference of girls and therefore her son’s wish to have a feminine identity to guarantee himself of her love. Therefore, although rooted in the same fear of object loss and separation, McDevitt considered it to stem from a different preoccupation within the mother.

A further finding of the review was that many of these early theorists based their theories on single case studies. Stein (1995), for example, presented a specific young boy who experienced his father’s death at the age of five. He believed that this boy experienced oedipal guilt and anxiety due to this loss of his father. In Stein’s view, the boy felt it to be a punishment for his greed and therefore wanted to identify as a woman to gratify regressive wishes and be punished to ease his guilt. Gilmore’s (1995) case, was the first girl to be reported who had psychoanalytic treatment for her GD. She was an adopted child whose adoptive mother deeply struggled with her own failure of biological motherhood and according to Gilmore therefore more widely as a woman. Her husband also could not rejoice in femininity. Gilmore suggested that in this specific case the child relied on an organising phantasy that attempted to repair her disrupted early relationship with her adoptive mother by becoming a boy that may not stir up such unbearable feelings for the parents. Blumenthal (1998) also presented a female to male gender dysphoric child who also had a similar mother to those previously described in the literature. However, this young girl had a physically and psychologically abusive brother and Blumenthal suggested that she became hyperaware that boys and men captured and held her mother’s attention through their negative behaviours. Therefore as an organising defence against maternal loss and unavailability, Blumenthal argued this child identified as a boy whilst also allowing aggression to be acceptable.

The psychoanalytic method of enquiry has primarily relied on single cases studies, which began the question as to the generalisability of the authors’ interpretations of these. This is of course important for any phenomenon, but the researcher would argue in particular with regards to GD it has not led to a cohesive and substantive understanding. Nevertheless, the present review highlights that the turn of the twenty-first century brought about a change in the conceptualisation of GD within psychoanalysis. Chiland (2000), for example, pointed out a need to move away from studying single cases and to study more carefully and systematically how other children in similar situations fared and reacted. They had multiple experiences of children with GD and reported a huge variety that they felt the available theories did not do justice of explaining. She saw similarities to Stoller's experiences of these families; however, they began to question why these children respond to this type of parental experiences this way when others do not. She concluded through her observations that a psychological approach had been difficult up to now due to the narcissistic nature of this presentation and therefore the accessibility of it to psychoanalysis had been limited. Corbett (2009), on the other hand, acknowledged the shift in society specifically regarding feminism and argued that this impacted on how we conceptualise it, whereas according to him, the concept of psychoanalytic understanding of masculinity had not moved on. He also disagreed with other analysts that separation is impossible for these children, especially for boys. He argued that despite the difficulty for these children, they can find a way to separate from their mothers.

Ehrensaft (2011) considered a very different conceptualisation of GD's origins and reported that these children simply "come out" to their parents and parents are then left with a way to respond. She believed that this is something that comes to a child rather than is shaped by their relationship with their parents and that this happens early on in their life. She, however, does not address the issue that GD has been found to originate at different times in people's lives. She followed Winnicott's (1965) thinking regarding an early kernel of true self that a child needs to be allowed to express their true self whilst their parents need to mirror and reflect this back to them for successful development. As such, she argued that when there is a cognitive dissonancy for parents, it is accordingly reflected back to their child. She also acknowledges that the difference between the child and the parents is very different to any other time of otherness. Trans children do not share being a minority with their parents like other minorities do (e.g. race, ethnicity, religion) and therefore can not guarantee the love and support that other minorities may receive through the sharing of this experience, which can stir up fear and anxiety.

The review revealed that many other questions continued to arise in psychoanalytic literature regarding GD especially over the past ten years. Goldner (2011) argued that we as professionals are "still deeply disturbed by any efforts towards confounding that gender and crossing over to the "other" one" (p159) and acknowledges that it is often pathologized but asks the important question of whether the actual problem we see in it, is their problem, or whether it is ours. She appeared to be one of the first psychoanalysts who challenged the profession and began to question whether GD is any different to any other body modification or cosmetic surgery that may be more accepted. Lemma (2012) also took a position of curiosity rather than the previous stance of normalising or pathologizing. She suggested that transsexual individuals demonstrate a developmental challenge that we all negotiate but that may have possibly managed in the most extreme manner. In her view we all find compromise solutions for how we transform the body we have and "personalise it" (Winnicottian term 1970). This therefore incites a search for the "right" body to relieve the incongruity they experience at the level of the body self; to mirror "the person who is me, who is only me" (Winnicott, 1970, p271). A year later

Lemma (2013) argued that the primary objects of these children may not have mirrored and contained this incongruence between the body and the subjective experience of gender. As a result it has remained un-mentalised and therefore disrupts self coherence causing the pursuit of surgery and their “true body” to relieve them of the intolerable experience of feeling dissociated from their given body.

Saketopoulou (2014) acknowledged the long history of pathologizing GD and argued that it has often been attempted to be “treated” especially by psychoanalysis. However, she reported research findings that have highlighted that treatment does not work, citing studies carried out by Menvielle (2012) and de Vries, Cohen-Kettenis, Drescher and Byne (2013) and therefore proposed that as a profession we need to develop an increased attempt to try to understand the phenomena. In accord with Saketopoulou, Ehrensaft (2014) recommends an affirmative approach that she feels needs to be both appropriate in theory and practice. The underlying principles of this for her are that gender in all its variations is a sign of health, not illness; the clinical goals are not to “fix” gender but to provide the space for children to explore and establish their authentic gender self. She criticises previous attempts and argues that we now have a discourse and language which should enable us to speak in a way that was previously not possible. Her thinking has particularly struck the researcher as interesting and formed my interest in approaching clinicians now in order to explore whether we do, as shown later in this empirical study

However, reviewing Withers (2015) paper in that respect was interesting, as he expressed a concern, questioning whether we really can think and talk about it openly and freely when a fear of pathologizing is still so dominant. Historically, GD has been considered abnormal in identity development and therefore something that should be treated which has left most people who experience this feeling unable to express their true selves or share some of the struggles they experienced. The reconsideration of our thinking and perceptions of GD over the years has resulted in an understanding that it is part of an ordinary course of development surrounding identity. However, as emphasised earlier, such an understanding still stands in contrast to prevailing societal or cultural norms and attitudes and it needs to be acknowledged that experiencing GD can still be very distressing for individuals as they continue to experience stigma surrounding their identity. It may take a few more generations for it to become fully accepted within society. Related to this, as GD is now not considered pathological or wrong, Withers questioned whether is it still acceptable to explore and ask questions about it and whether curiosity and enquiry in this area is still perceived to be pathologizing someone. These are important, yet complex questions given that we could say we are in a period of transition. Withers felt the anxiety was a barrier to being able to explore things whilst also feeling it was important. Similarly, Lemma (2018) questioned whether external modification of a body can completely erase the internal conflict. In line with both Ehrensaft and Withers, she wonders how we can have conversations to explore the internal conflict without seeming discriminatory. Despite her questioning as to whether this is possible, she makes a strong case for anyone who experiences GD to take time to reflect and explore all aspects, including their inner and outer world. She points out that she was not convinced that the purely external modification to be congruent with their subjective experience could erase conflict internally. On the other hand, Schiller (2018) argued that the issue cannot be all internal. For him “the wish “to be-seen-as” indicates that there are social structures that exceed the individual” (p245). Based on the observations of the recent psychoanalysts, the researcher would argue that it feels inappropriate to focus on either the internal or the external in isolation.

Most recently, after having summarised the varying considerations of GD, Saketopoulou (2020) suggests that any generalisations are unsatisfactory due to the varying presentations, histories and developmental lines. She stresses the importance of both professionals and theorists to adopt a stance of curiosity and guides us not to question “why is someone trans?” but “how is someone trans?” (p.1020). She argues that we have oversimplified our consideration of what goes on psychically for these young people and that we have not kept up with the various changes around gender in general. Therefore, according to her, we cannot truly hypothesis as to what is going on for individuals with GD. We need to start by understanding them better. In his recent paper ‘First do no harm’ Bell (2020) gives an overview of the complexities when considering GD. He provides examples of the many vicissitudes it can stem from, including psychological disorders, isolation, feeling psychically lost and homeless, family disturbances and trauma and homosexuality. He also points to the increase of this phenomenon and for the first time offers possible reasons for this, which include the commodification of identity and health care, identity politics including entitlement or exceptionalism, misogyny, the body as a machine, hatred of mental illness, relativization of truth claims and finally the growing impact of the internet and social media. He also expressed a belief that the wish to think, explore and taking time to do so, appears to be treated as the enemy in our current health service and is often seen as an expression of transphobia. He believes this to be the biggest barrier to our capacity to think about these issues that can lead people to turn a blind eye. However, he makes the vital distinction between conversion therapy and a wish to think which many share.

In conclusion, the present literature review has highlighted that psychoanalytic theory has made significant and vital steps allowing us to move from a very pathologizing stance to a more curious one concerning GD. However, despite this a lot remains unresolved resulting in a lack of understanding and continued stigma surrounding it that culturally we have a long way to go with.

In summary, later theoretical developments have deviated from the suggestion that GD is a way of warding off homosexual impulses, as Freud (1905) and others suggested initially, and considered it being rooted further in an individual's identity. Yet, along the way, a culture of blame seemed to have arisen whereby the mother's attitudes and attachment to their infant, specifically in relation to boys, was suggested to be the root of his difficulties (Stoller, 1964, 1966, 1968; Socarides, 1970; Ovesey and Person, 1973). This has now shifted but unfortunately it took over fifty years to diverge from focusing only on male-to-female transgender people and to consider what may be going on for natal females. As more curiosity developed around why all homosexual individuals do not develop GD and why some children do not identify this way despite having similar mothers, there appeared to be a shift in psychoanalytic writings. This move away from the associations with homosexuality may have coincided with the change in legalisation of same sex relationships in 1967 (in the UK). At the turn of the 21st Century, previous theories began to be challenged and a question raised as to whose problem it really was, theirs or that of psychoanalytic professionals. It is noteworthy that not long before this the GIDS moved from a environment where physical symptoms were the main consideration to one where psychological, and ultimately psychoanalytical, thinking was more prominent which in all likelihood would have had an impact on consideration given. Overall, the literature review revealed that psychoanalysis as a means to treat GD did not work and there was an awareness that a better understanding was thus needed. However, as the curiosity increased and the space to explore was desired, a fear of this being perceived as pathologizing or transphobic seemed to take hold as Bell (2020) pointed out. As Barkai (2017) reported, it also has been previously argued that older views may continue to exist and therefore continue to taint the psychoanalytic atmosphere surrounding GD. It has also been noted that when considering the historical psychoanalytic treatment of homosexual patients, the narrow-mindedness and homophobic stance has been acknowledged and criticised. However, in the evolution of conceptualisation and approach to GD this has not been the case. This leaves the researcher wondering whether something remains unresolved in this field of thinking that has not allowed for a more distinct turning away from a detrimental approach. As a result, the researcher argues that this topic is something the psychoanalytic world needs to continue to grapple with, and to do so, a wider consideration rather than purely single case studies needs to remain.

Part two: Empirical research

Trans as a subgroup of LGBT.

Three of the seven studies reviewed considered GD from a broader perspective of LGBT. The first study was a qualitative study conducted by Israel, Gorcheva, Walther, Sulzner and Cohen (2008). They explored participants experience with the focus being on what they considered to be helpful and unhelpful therapeutic experiences for LGBT individuals. Semi-structured interviews were conducted with 14 participants whereby consideration was given to the clients they have worked with, why the client may have come to see them, the environment or setting they worked in and descriptions and consequences of helpful and unhelpful situations they have experienced with LGBT individuals. All participants were mental health professionals from a variety of backgrounds including social workers, psychologists and counsellors. Initially 65 participants agreed to take part and of those 14 were selected due to diversity; it was not made clear on what grounds these were chosen and why only 21.5% participated. The aim of their study was to identify patterns that exemplify therapists' descriptions of helpful and unhelpful situations with these patients. The findings showed that it is helpful to patients when professionals are knowledgeable, appropriate and affirming to individuals. The clinicians in their study maintained that a positive therapeutic relationship is crucial as opposed to a judgemental, indifferent, cold or disaffirming one when working with such a patient group. The findings also showed that therapists who have experience of working with lesbian, gay and bisexual individuals may not be familiar with the needs of trans individuals and may therefore need assistance or training in this area. Overall, the authors concluded that experience with LGB does not transfer to trans individuals. Across the participant group they found that clinicians had experience of working with only two trans individuals, resulting in the experience levels being low. The researchers acknowledged that a larger scale study was needed with the possibility of focusing on each subpopulation of LGBT, especially on trans. It is evident that this is vital, as acknowledged by the researchers, as the experiences of other areas of the LGBT community can be very different to those who are trans and therefore cannot be generalised for them as this would result in lack of understanding and inappropriate approaches.

Another study drew on interviews with primary-care nurses and physicians about their experience with “transgender health care” to improve insight and make suggestions for occupational therapy practice. Beagan et al (2013) conducted a qualitative study to obtain data from semi-structured interviews with 12 primary care nurses and 9 physicians who had clinical experience of working with lesbian, gay and bisexual patients. In spite of not collecting data from occupational therapists an aim of the study was to use the findings to inform this profession's work with this patient group which appeared to be a flaw of the study. Additionally, having experience with GD was not a necessary requirement to take part despite this being considered the focal patient group, which also appears to be a major design flaw. Furthermore, it was not made clear how their participants were recruited to the study. Thematic analysis, which appears appropriate for the particular research question, was used to analyse the data. The authors found that participants felt uncertain about "transgender care" and shared a wish for more specialised knowledge around it despite their experience with other areas of the LGBT community. However, when reviewing the study it was unclear whether this was due to a lack of experience in this area or a lack of knowledge. The participants expressed a concern around the use of pronouns. If they did not feel confident using these they feared their patients would perceived them as judgemental or resistant. Suggestions of key elements for best practice were reported from the findings, which included the need for collaboration with patients, acknowledging stigma, ensuring inclusive systems and procedures, navigating health care and providing holistic care. Advocacy for these patients was also felt to be a vital part of the care provision. The importance of positivity, educating others and reducing negativity was also emphasised by the authors.

A year later, Johnson and Federman (2014) utilised a quantitative approach to consider training, experience and attitudes of psychologists only working with LGBT veterans. Online surveys were used that included 52 questions that covered demographics, training experiences, current practice, attitudes, knowledge, self-reported competence and need or interest for training. 384 responses were received following an email being sent to 2294 perspective psychologists. The authors found that there was minimal training in sexual orientation and gender identity, and experiences overall were limited. Furthermore, respondents reported that training on general diversity was fourteen times more likely than training around trans identity. 92% of participants stated they do not ask their patients about gender identity and 35% had never had a trans client. On the whole it was found that psychologists had limited experience and training. However, they also found that age was a significant factor with older psychologists having even less training and younger ones being more affirmative, which could be a promising sign that things are improving with knowledge and acceptance growing. The area the participant lived in also had an impact as to whether they were affirmative or had received training, which could indicate a variety in the need for understanding depending on location. Only 37.2% felt competent working with trans individuals when asked to self report this and it was felt that more training was needed.

Most importantly, however, is to note the very low response rate in this study, which was only 18%. The researchers rightly discussed their findings cautiously questioning whether those who responded did so out of an interest in this area and therefore severely biasing the sample and reducing generalisability of their findings. This study was found to be interesting when considering the experiences and attitudes towards individuals but focused on professionals with a very specific cliental and therefore needs further research to consider individuals who are not veterans which may also improve the response rate if widening the inclusion criteria.

The T in LGBT as a focus in its own right.

The review also revealed that there seemed to be a turning point of trans becoming the focus as its own subgroup rather than part of a broader consideration of LGBT for some studies published more recently. The following four studies demonstrate this.

A striking aspect of the review was that there was a gradual recognition of the lack of experience, training and self-perceived competency with these participants. Dispenza and O'Hara (2016) used quantitative methods to explore what correlates to self-reported counselling competencies among psychologists and mental health practitioners. They recruited 102 participants from a multicultural conference they attended. This may suggest that they have an interest and or experience of diversity that has drawn them to this conference initially. The Sexual Orientation Counsellor Competency Scale (SOCCS; Bidell, 2005) was modified to use prompts for transgender rather than lesbian, gay and bisexual and were completed by participants. Alongside this, the Social Desirability Scale-17 (SDS-17; Stöber, 2001) was used to control for social desirability bias where a participant may present themselves more favourably. It was found that participant's identity related variables contributed to competency, especially sexual minority, race or ethnic minority and eight or more years' experience of working with these individuals. Interestingly, participants from sexual minorities were found to be more likely to have knowledge, adequate skills and affirming attitudes. They also perceived themselves as more competent when working with transgender and gender nonconforming (TGNC) individuals. Participants were found to bring aspects of their own identity to help establish required knowledge to enable them to provide competent care. The study also revealed that individual, institutional and society stigmas were a significant barrier to developing competencies and from this the researchers recommended that everyone working with TGNC individuals should consider their own gender biases. The researcher concluded that this is a vital and significant suggestion to current and future work in this area that should be considered and facilitated further. It may have been helpful if the researcher had suggested ways in which this could have be achieved.

Whitman and Han (2017) used a mixed method design to also consider clinician competencies specifically around strengths and limitations for working with TGNC individuals. 53 mental health care providers were recruited which included psychiatrists, psychologists, doctoral psychology students, counsellors and social workers. Recruitment was via an email sent to various university programmes with students and others who received it and forwarding it on to others that may be interested. They also used the modified SOCCS mentioned above, alongside a TGNC knowledge assessment where nine terms needed to be matched with a definition and The Social Desirability Questionnaire (Crowne & Marlowe, 1960) was used in a similar way to SDS-17. Three vignettes were used that expressed implicit and explicit GD and Gender Non-Conforming (GNC) to explore how comfortable and interested participants were and how likely they were to refer on to another professional. The study found that participants were highly comfortable and confident working with TGNC individuals, however, most saliently, they were slightly more comfortable when there was no dysphoria involved in the presentation. It was reported there was more worry about the use of pronouns when this was the case. Overall, 78% matched the terms and definitions correctly with students scoring significantly better because they are more aware of correct vocabulary. There was a high level of awareness of experiences, challenges and concerns that TGNC individuals may have, but despite this, there was still some stigmatising views held by participants. This was presented in the vignettes where 11% expressed feeling GD is unnatural and immoral, 23% felt TGNC individuals were not as stable or healthy as those with cis-gender identity and 11.3% felt it is a mental illness or sin that can be treated. Despite these views all participants felt competent to assess the needs of TGNC individuals with between 50% and 84% feeling competent to counsel them. They were also less aware of the impact of cis-privilege on the therapeutic alliance and outcomes. The findings also highlighted some justifications for comfort levels that cause harm therefore indicating blindness to personal biases, inappropriate comfort despite lack of competency and pathologizing gender. As part of the discussion worries were expressed about microaggression and subtle forms of discrimination and the consequences. Therefore, the importance of awareness of personal biases relating to TGNC and how that might manifest was stressed by the authors similarly to Dispenza and O'Hara (2016). They suggested that improved education and awareness particularly regarding TGNC experiences and non-pathologizing was important. This study included many methods of data collection and although yielded interesting findings it was difficult to be clear and join them together in a coherent way leaving the researcher confused in comparison to the previous studies. Nevertheless, the considerations recommended are vital in this area.

Couture (2017) focused on preparedness in her study rather than on competency. Through a quantitative approach she measured the preparedness levels of college mental health clinicians working with transgender students. This was the only study found in the present review that included working with under 18s, although the age range was between 17-20. 84 college mental health counsellors were recruited by email through a counselling education listserv and the American College Counselling

Association. The participants completed 29 survey questions that included Likert scales ranging from zero (non-prepared) to three (better prepared than average). This contained subscales including clinical interviewing and assessment skills, counselling ethics, personal and community awareness and education on transgender issues. The study found that participants felt moderately prepared for working with transgender students, interestingly and contrary to Dispenza and O'Hara (2016) and Whitman and Han (2017), with no significant difference based on years of experiences they had. The researcher thus concluded that there was a need for being more prepared. They also emphasized that being knowledgeable about gender identity issues was a professional duty that everyone should uphold and education and training resources would need improvement to allow for this. They also acknowledged an awareness of experiences of discrimination, substance abuse, violence, non-suicidal self injury and suicide and lack of parental and family support for these individuals. Although this study had begun to consider experience with younger individuals, which is an improvement, it is concluded that it brought very little in the area of new ideas. It was also conducted during the summer vacation rather than during term time which limited the responses and demonstrated a lack of thought in the planning stages of the study.

The most recent study identified by the present review was the only to consider the experiences of counsellors working with specifically trans clients. Salpietro, Ausloos and Clark's (2019) qualitative study used a transcendental phenomenological approach. They recruited 12 professional counsellors who had experience of working with at least one trans client. 10 were recruited through an email server for counsellors and two were purposefully sampled due to knowledge of their work. 10 of the participants were female along with the same identifying as white meaning this sample lacked diversity. Semi-structured interviews were conducted to explore the essence of the counsellor's experiences and what they felt made them competent in this area. The authors found that challenges in treatment included societal and family barriers that affect engagement and compliance with treatment. For learning experiences participants were found to learn from personal experiences through connections to trans people, a commitment to learning and seeking out additional training and literature, the importance of self awareness when working with this client group and the importance of clinical consultation and supervision. Participants identified three areas of essential knowledge which included awareness of own knowledge of gender including using this knowledge and continuing to learn. Another area was the importance of knowing about medical transitioning, with the third being counsellor skills. These skills included the importance of strong therapeutic alliance, the use of person-centred and affirmative framework, working with family systems was discussed as being vital alongside discussing approaching discussions around the client and counsellor's own gender identity and advocate for trans clients. As most studies reviewed here, they also suggested this research also acknowledged the need for more education and knowledge which could be approached through consultations, supervisions and resources. It is evident that this study began to provide a wider and more specific perspective whilst giving suggestions for how the gaps in working in this area could be positively addressed.

In conclusion, the empirical research began by focusing on GD as a wider sub-group of LGBT culture and sexuality. The approach was to consider experiences to provide insight and guidance before recognising that the experiences of LGB individuals does not translate to the work of transgender individuals. It is likely that this approach was taken due to lack of awareness, understanding and experience at this time in comparison to other areas of LGBT where professionals may have felt more comfortable considering and discussing. When explored in more detail, training and experiences were found to be limited and much less available than for other areas of diversity. However, it was reported that younger professionals had received more training and were more affirmative, which appeared to suggest a shift in the right direction. As the focus became more on the T in LGBT the competency that professionals felt when working with this group of individuals was highlighted as lacking. Many used their own identity, personal experiences and drive to seek knowledge to educate themselves. This appears to be as a result of the lack of experience, research and discussions. Though, similarly to psychoanalysis the fear of stigmatisation was recognised as a barrier to feeling competent. Overall, these studies acknowledged the importance of increased education and training alongside a need for awareness of gender biases, subtle microaggression and discriminations to be considered more significantly.

Conclusions

In conclusion, the scoping literature review highlighted significant changes in diagnosis of GD, an increased volume of children and adolescences accessing services for GD issues, changes in psychoanalytic theory of the topic, but overall, a dearth of formal research studies. As was emphasised, many different adjustments in terminology have been made leading from the diagnostic term of “transvestitism” to the current use of “gender dysphoria”. This has involved a recognition of the difference between sexuality and gender alongside a subsequent awareness of the distress individuals experience when they identify this way. The stigma attached to the previously used terms has also been acknowledged and the impact that this may have on people. A more sensitive approach seems to have enabled people, children and adolescents included, to feel more able to be open about their identities and therefore seek the help they may need. With regards to psychoanalytic understanding of the issues, however, the review highlighted a history of focusing on the mother-child relationship, blame and pathologizing. There has been a shift away from thoughts of “fixing” or “treating” to a more curious stance that acknowledges that you cannot generalise presentations and origins of GD. However, with this has come a worry of how professionals can be curious and explore with young people without seeming discriminatory and this can become a barrier to doing so and being about to think.

With respect to empirical research, the review has clearly highlighted a lack of studies, and as such stresses the importance for more formal research studies to match the increasing awareness of its presentation in children and young people attending mental health services. The literature review could not find any research conducted with professionals working with transgender individuals under the age of seventeen or conducted within the United Kingdom. It is curious as to why that is. One possible explanation might be that there is something more uncomfortable and anxiety provoking surrounding children and young people experiencing these feelings in comparison to adults. In psychoanalysis, it is theorised that anxiety results in unconscious defences against threats to our self. Hollway and Jefferson (2013) refer to a ‘defended’ subject in which we become invested in discourse that provides protection against such anxieties and therefore supports our identity. This kind of defence can “significantly influence[s] people’s actions, lives and relations” (Hollway and Jefferson, 2013, p.17). As a result, the researcher wonders what might be being avoided in relation to GD in under 18s especially when under 16s are not considered able to give consent to treatment. This therefore requires adults around them to give consent and may stir up all kinds of anxiety in parents and professionals. The impact of this could result in an avoidance of consideration and research within the area of young individuals.

Of the few studies reviewed, none drew on links to psychoanalytic theory or included participants from this profession. The focus of the authors was primarily on the experience to provide guidance or on how competent professionals felt rather than exploring professionals’ conceptualisation and experience of working with such patients in greater depth. Therefore, the present research study that will be reported next, addresses an important gap.

CHAPTER 3

METHODOLOGY

Design

This study is an explorative study that aimed at gaining a greater understanding of the clinicians' viewpoints, their experiences, and theories about gender and GD in young people. This also included the difficulties they have experienced and the thinking behind the treatment offered based on their training and clinical experiences. Therefore, qualitative methodology was chosen to answer the study's research questions that focus on exploring, understanding, and describing experiences (Turpin, Barley, Beail, Scaife, Slade, Smith & Walsh, 1997; Ashworth, 2003). As such, a quanitative research design would have been inappropriate.

Semi-structured individual interviews were carried out, designed to explore these research questions (see Appendix 2 for the interview schedule). Consideration was given as to whether individual interviews or focus groups would be preferable. It was decided that individual interviews would allow for a deeper understanding and further exploration of beliefs and experiences. Within a group it was felt that discussing personal views and experiences may not feel as safe. Controversies may have arisen within a focus group if conflicting views or experiences were expressed, which would have distracted from the questions and aims of the research. It was thought that, in individual interviews both a relationship and a safe space could be built allowing for open thinking, discussion and sharing of experiences. As the particular topic is something that is often not freely spoken about individual interviews were therefore more appropriate, in addition to providing more time for each participant and being less influenced by the views of others.

Furthermore, deciding to utilise a semi-structured interview allowed for flexibility and exploration of new areas of thought, opinion and experience that might evolve, as well as, enabling space for participants to share knowledge and experience that they have accumulated over time. Open questions began generally, asking how the participants define and understand GD. The questions then moved onto the national increase in these cases, their own personal experience and the sense they made of this. Before concluding with their own personal experiences of working with patients, families and the Gender Identity Development Service, the opportunity was taken to gather their thoughts on what might help or benefit them within their service when working in this area in the future. It was hoped by gradually moving towards something more personal that it may enable the participants to feel more at ease about sharing their honest perspective. It is believed that the approach allowed for each individual's exploration of the topic, alongside flexibility for follow-up questions to explore emerging views in more depth. A conversational reflection around the topic was encouraged throughout.

Procedure

Participant Recruitment

It was decided that an email would be the best course of recruitment to minimise the pressure individuals felt regarding participation. Participants were recruited via email, which was sent to the whole of the CAMHS service with the detailed information sheet attached. Both can be seen in Appendix 4 and 5 respectively. The email was sent to the whole service to ensure as many employees as possible were contacted rather than a more selective approach of only the people the researcher came into contact with or knew well. This also allowed for a perception of less pressure for people to take part. By sending it to the whole service, it was hoped that a variety of professional backgrounds and experiences would be included. This was important to the study as a variety of professional backgrounds reflected the multi-disciplinary teams (MDT) that generic CAMHS are constructed of. As highlighted in the introduction to the literature review, it has been mandatory that patients' referrals remain open to their local CAMHS teams alongside the referral to the specialist GIDS, and as such, a whole range of clinicians worked with these young people. Whether or not the services were set up with that in mind is not known, however as Bonfatto and Crasnow (2018) have stressed the benefits and importance of MDTs in the effective treatment and assessment of young people experiencing GD. Since the aim of the present study was to explore the views of those who work with these individuals in generic CAMHS on a day to day basis, it was felt important to include this varied range of clinicians rather than focusing on one particular professional group, for example, psychotherapists only. Therefore, in the present study this group of participants reflect, by virtue of being part of a MDT, a homogenous group. Consequently, the researcher did not endeavour to explore or analyse the material by professional groups.

It had been agreed that, if needed, information would be given during team meetings but this did not need to happen as recruitment in response to the email was fruitful.

Inclusion/exclusion criteria were that all participants needed to be still working within the service and have at least two years experience within a CAMHS team to ensure they were fully established within their role and caseload. It was assumed that each had an interest in the topic and therefore had chosen to engage in the interviews due to this. Participants also needed to have had experience of working with young people with GD within the role. It was important that they could share their real-life experiences and reflections on this rather than merely expressing their perceptions of what it might be like. However, amount of experience in either years or number of patients was not predetermined.

The recruitment email only needed to be sent out once as a positive response was received. All participants felt they had received enough information from what they had initially received and therefore informed consent was gained (see Appendix 6) and an interview arranged with each of them. Once consent was gained, it was made clear that any information used for the purpose of the research project about them would be de-identified. Informed consent was also gained for information regarding cases they chose to discuss during the interviews with the agreement that they would be responsible for anonymising these and talk about them in a non-identifiable way.

Participants

A small opportunistic sample of twelve participants were recruited to the study. It was opportunistic in that recruitment stayed open for as long as possible to meet the practical requirements of the course when efforts to recruit into the study needed to stop rather than capping the number of participants prior. According to Braun and Clarke’s (2013) and Terry et al (2016) 12 interviews are adequate to generate enough data to demonstrate meaningful patterns within a small-scale project such as this. However, it is important to bear in mind that a small-scale qualitative project cannot make claims to be able to generalise these result findings. This includes not being able to generalise to other MDTs since they also tend to vary in terms of size and professional representatives. As such, the current study very much focused on the view and experience of a group of clinicians working in CAMHS in the south west of England.

Participants were from a range of professional backgrounds with an approximately even representation. Professional backgrounds included Child and Adolescent Psychoanalytic Psychotherapy, Counselling, Mental Health Nursing, Psychiatry and Clinical Psychology. The age range of participants was 26-59.Overall half of them were aged between 45-55 years with an average of 43 years. Half had between 2-10 years of work experience within CAMHS with an average of 14 years . Seven of the participants were female and five were male, giving a fairly even balance of gender. Overall, eleven of the participants were from a White ethnical background and one was from a Black African ethnic background.

Detailed information regarding participant demographic information can be found in Appendix 7.

Data collection

Initially it was planned that all interviews would be done face to face within the participant's usual place of work. However, due to the COVID-19 pandemic, five of the interviews were conducted by telephone. Video interviews would have been preferable, however, due to interviews being conducted very early on in the pandemic the trust within which they were taking place had not verified a confidential platform for video calls to take place therefore this was not possible. Being a faceless interviewer was not ideal as it may have hindered the development of the relationship but under the circumstances it was the only other option. Where possible face to face interviews were the preference but this was not always possible due to COVID restrictions around different teams coming into contact with each other.

The interviews lasted between 40 and 70 minutes. Thought was put into the size of the room they were conducted in so as not to add to the pressure felt when talking about this topic.

The study was conducted with the CAMHS team that the researcher worked. Although it may have been considered better to have conducted it within another trust where there were no prior relationships built, this was not possible at the time and these were the participants available and accessible to the researcher. It was considered of greater importance to begin conversations and exploration by undertaking the study to inform future research and thinking.

As the researcher’s training post was currently within the same CAMHS team as the participants, they knew the majority of them to varying degrees due to working with the trust for five years; only one participant had had no prior contact with the researcher. This was taken into consideration when planning the project and it was decided that having a relationship was not to be part of the exclusion criteria due to the following reasoning. If a participant had previously had contact with the researcher, they were asked to approach the interview as if the researcher knew nothing about them or their clinical work. Consideration was given to dual role of being a colleague and a researcher to the participants. For the participants the researcher was a colleague and it was considered that they may feel more able to be open due to the already established relationship. However, this also may have hindered their openness to discuss the topic if they felt the researcher had a specific view point. This topic had not been previously discussed with them in depth outside of the researcher role so it was hoped this would not be an issue. Nevertheless, choosing to conduct research in this area infers an interest that was unavoidable. With the participant that the researcher was not a direct colleague of, the initial relationship was not there but it was felt this could be built within the interview and openness could be encouraged in different ways.

All interviews were audio recorded and transcribed verbatim by the researcher. The pros and cons of audio recording were considered during the planning of the project. A Dictaphone was used to audio record to prevent the possibility of third-party access that may have been an issue with a computer or smartphone. Any method of audio recording could have been considered, and at times during the interview was noticeably, a disruptive third presence. However, it was felt that the ability to replay the recording and it remain unchanged repeatedly was crucial and invaluable, unlike memories. Whilst the researcher performed the transcribing process they replayed the recording multiple times to ensure the transcripts were word for word accurate of the interview. Grammar adjustment was only used when it was clear within the recording, such as full stops at the end of sentences. This process allowed the researcher to become initially familiar with the data set.

Ethical considerations were discussed with participants in writing and before agreeing to participate. It was agreed that in the event of adverse or unexpected outcomes that the researcher would offer to end the interview or stop recording, reschedule the interview if needed and debrief. However, none of them needed to be stopped or rescheduled. All participants were made aware that their team, support structures, and supervisors were available if needed. If participants did not feel able to use this support, information was provided in a debrief email for the trust’s confidential counselling service which they could self-refer. Debrief emails were sent out to all participants on completion of their interview (Appendix 8). This included the contact details of the researcher, their supervisor and the Head of Academic Governance and Quality Assurance. All participants were made aware that they could withdraw from the project up to three weeks after the interviews without any consequences. This time scale was chosen due to the possibility that analysis of the data may have begun and therefore this would no longer be possible. None of the participants chose to withdraw.

Ethical approval

Ethical approval was gained through the Tavistock Research Ethics Committee (TREC) ON 24TH April 2020 and the Gloucestershire Health and Care Foundation Trust Research and Development team on 14th May 2020.

Participant and Client Data Security and Confidentiality

Care has been taken to protect and maintain security and confidentiality for the participants and any of their patients referenced with any data collected and reported. Minimum personally identifiable information was recorded and the participants' names and contact details were only available to the researcher if they were needed. Any information that was needed to be made available to others for supervision and support were made de-identified. However, participants were made aware that quotes will be used during the write up and people who know them well may recognise them by documented thoughts and opinions they have expressed. All electronic data was stored on a password-protected computer. All paper documents were transferred to the computer and securely destroyed. Audio recordings will be destroyed after the completion of the project. Whilst other data from the study will be retained, in a secure location, for five years. All was explained to participants and written informed consent was sought.

Data Analysis

Reflexive Thematic Analysis (Braun & Clarke, 2006, 2020) was the chosen method of analysis for this study, due to its accessibility, flexibility and compatibility to be used within most theoretical frameworks (Terry, Hayfield, Clarke & Braun 2017). Furthermore, Terry et al (2017) have stressed, the sample size falls within the recommended sample size for a professional doctorate project suggested to be between 6-15 participants.

Before deciding onto which approach to settle, thought was given to a range of qualitative methodologies, including grounded theory, thematic analysis and interpretative phenomenological analysis (IPA). Reflexive thematic analysis was chosen as it was felt most appropriate to explore the themes presented by participants and because it "emphasises the importance of the researcher's subjectivity analytic *resource,* and their reflexive engagement with theory, data and interpretation" (Braun & Clarke, 2020, p3). This was important because as previously mentioned the researcher was training in child and adolescent psychoanalytic psychotherapy and therefore was interested in considering the study from this perspective when discussing the findings in relation to literature later on.

The aim of this type of analysis is to identify patterns in the material and to use themes to approach the research (Braun & Clarke, 2006). This way of analysing assumes the researcher's mind is clear but not empty as inevitably knowledge and experience is always carried within. Therefore, an inductive approach was used when analysing the data by using "new eyes" to look at what was presented alongside the aim of immersing the researcher in the material. An inductive approach aims to provide a detailed description of the data whilst enriching the understanding rather than rationalise or fabricate hypotheses. Braun and Clarke (2006) recommend that all research findings should originate from a theory-free position and are then put together and understood in consideration of their theoretical background. The researcher therefore followed this suggestion and tried to look at the data with a free mind before building up the themes in relation to the literature. The researcher specifically chose to complete the data analysis before beginning the literature review to prevent the data being contaminated by previous theory and research. Braun and Clarke (2006) also recognise that thematic analysis is a useful method when exploring an under-researched area, such as GD is.

The rich qualitative data was analysed following the six-phase framework described by Braun and Clarke (2006):

Stage 1. Familiarising oneself with the data: This began in the transcription process and subsequent reading and rereading enabled familiarisation with the data. Some notes were made during this phase of any initial ideas and early impressions.

Stage 2. Generating initial codes: The data was approached line by line across the whole data set and interesting features were coded to organise it into meaningful chunks. A list of codes was made (see Appendix 9) and data relevant to each code was also collated (see Appendix 10 for examples). A review of the codes was conducted and some were modified to ensure they reflected the data meaningfully.

Stage 3. Searching for themes: The codes were examined and it was considered which fit together into a theme. All data was gathered that was relevant to each initial theme.

Stage 4. Reviewing themes: The themes were checked in relation to the data extracts previously collated and the entire data set. Some of the initial themes became subthemes and others became main themes with the possibility of subthemes being part of them. At this stage credibility checks were carried out by the research supervisor. This separated some themes but also combined others. A thematic map of the themes was constructed, each section of this map can be at the beginning of each research question in the findings.

Stage 5. Defining and naming themes: Each theme was considered in relation to what it conveyed, the question it responded to and how this contributes to the overall story. Clear names and definitions were generated for each of them.

Stage 6. Producing the report: Rich extracts examples were selected and considered in relation to the research question before being written up as part of the findings.

Reflexivity

Throughout the process, the researcher paid attention to their self and the feelings evoked in them. Although this is an area of interest for them, they ensured that they were not guided by this to the best of their ability and focused on the research questions and the deepening of the understanding they were gaining from the study. As an individual researcher it was especially important to consider the impact of this. Individual supervisions and supervisory groups were used throughout the process to ensure biases were limited as much as possible. Although multiple coders can be encouraged for “coding reliability” (Boyatzis, 1998), given the scope of this study this was not achievable. In addition, Braun and Clarke (2006) reported that although another researcher coding data may be helpful, it does not guarantee increased accuracy. Codes were therefore considered with the researcher’s supervisor and the small research groups to ensure they were appropriate and grounded in the data. Triangulation was also gained during the process of searching for themes for the same reasons.

Finally, a table summarising the themes and sub-themes was produced that includes the frequency of themes and subthemes across the group as a whole. As Maxwell (2010) has pointed out, this enables the findings to remain rooted in the data and prevent biases and interpretation that could contaminate the findings. Whilst some scholars and researchers view this as “force-fitting of data into categories” and thereby eroding the richness of qualitative data (e.g. Nadin and Caseell, 2004, cited in Cloutier and Ravasi, 2021, p.113), others stress the usefulness of it to support data analysis and sense-making, including ensuring trustworthiness (e.g. Cloutier & Ravasi, 2021). It is the latter approach that was followed in the present study. Looking at the overall percentage of how much a theme or sub-theme covered the groups’ understanding or point, gave the researcher a sense of its overall trends or importance of a theme. It is hoped that by using a table and frequencies of themes will, as Cloutier & Ravasi, (2021) have stressed not only function as a communication tool, but moreover provide some indication of the validity or robustness of the data backing the resulting findings.

Please note that all interviews were conducted prior to the high court judicial review regarding patients receiving hormone blocking treatment and therefore this will not be considered within this study.

CHAPTER 4

FINDINGS

This chapter presents the findings derived through Reflexive Thematic Analysis, as outlined in the previous chapter. Furthermore, given the number of themes and sub-themes, it is important to stress that the reported theme structure might not have reached its final end point but might be indicative of an as-yet underworked analysis. This will be commented on further in the discussion below.

It is important to keep in mind that the analysis was guided by three high-level research questions as outlined above. Table 2 summarises these including its frequency and shown schematically for each question in Figures 1,2 and 3 respectively. Overall twelve themes emerged in the data with forty five subthemes. Each of these will be presented in detail below with some quotations to demonstrate. Examples of further quotations for each can be found in Appendix 10.

Table 2

Question	Theme	Subtheme	Subtheme prevalence
1: How do CAMHS clinicians conceptualise and define GD?	What is GD? 100%	Being in the wrong body.	58%
		Dissatisfaction with their body.	50%
		Dissatisfaction with	50%

		their gender.	
		Uncertainty.	42%
		Class between internal and external.	33%
		Finding an identity.	33%
	Origins of GD. 100%	Is GD mental health related?	42%
		Uncertainty.	33%
		Impact of past experiences and relationships.	33%
		Societal influences.	25%
	More than just GD? 92%	Wider difficulties.	67%
		Comorbidities.	58%
		Way of expressing other difficulties.	42%
2. What is CAMHS clinicians' experience and understanding of the increase in cases of Gender Dysphoria?	Experience of increase in cases. 92%	Experience of increase.	58%

		Expected to see more of an increase.	17%
		No increase.	8%
		Uncertain.	8%
	Growing knowledge, awareness and conversations. 75%		75%
	Online and societal changes. 100%	Influence of social changes.	83%
		Internet.	50%
		Historical impact of binary social constructs.	42%
3: What is CAMHS clinicians' experience of working with GD?	Uncertainty. 100%	How to define and think about experience.	50%
		Easing the uncomfortable.	33%

		Language.	25%
	Complexity of working with GD. 92%	Approaches to working with GD.	92%
		Making assumptions, getting it wrong and offending.	92%
		Difficult to work with, think about and explore.	92%
		Difficult to stay with and comparisons to other conditions.	83%
		Complexity.	75%
	Confidence in working with GD. 100%	Lack of training, consideration and having to learn from experience.	100%
		Doubting capabilities.	50%
	Needing more space. 100%	More space, time and exploration with patients.	83%
		More space, time	100%

		and exploration within the service.	
	Powerful experience and emotions when working with GD. 100%	Fear, concern and worry.	100%
		Sadness, upset and distress.	83%
		Pressure.	75%
		Anger.	67%
		Enjoyment, pleasure, honour and privilege.	67%
		Curiosity.	50%
		Anxiety.	50%
		Helplessness and uselessness.	42%
		Shock.	25%
	GIDs and ambivalence. 100%	Lack of involvement with GIDS.	100%
		Frustration with GIDS.	92%
		Leaving it to the specialist versus	83%

		keeping it local.	
		Admiration of GIDS.	58%

Research question 1: How do clinicians conceptualise and define GD?

All participants considered how they conceptualise GD and what are its origins. Three themes were identified; “What is GD?”, “Origins of GD” and “More than just GD?”.

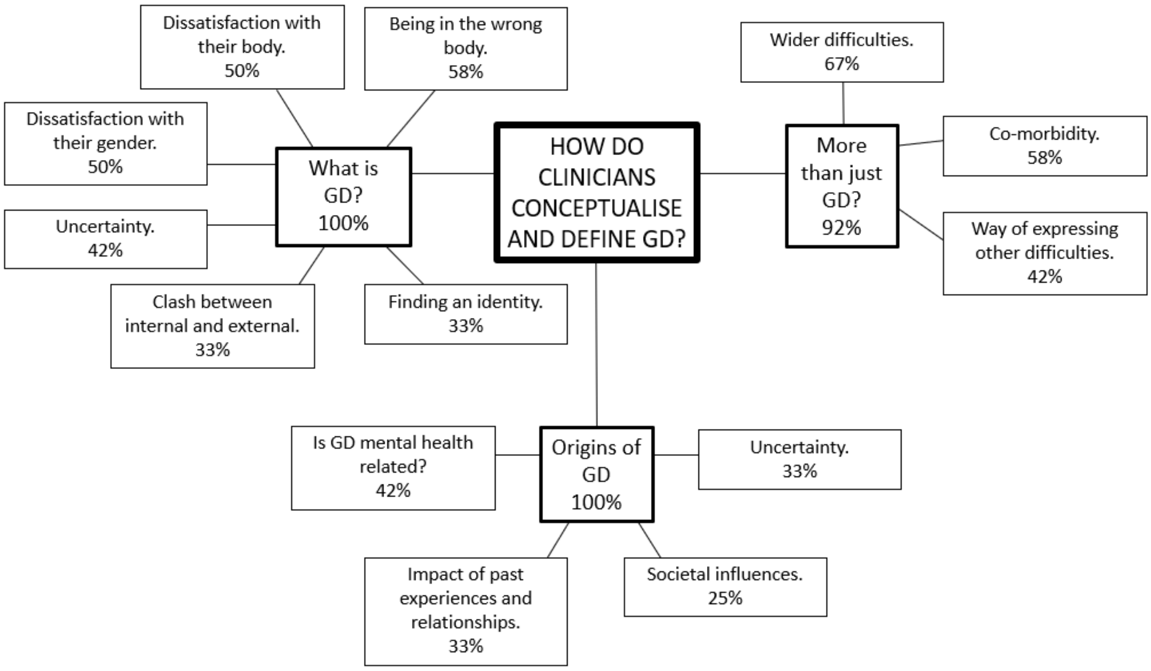

Figure 1. Themes and subthemes for question 1.

What is Gender Dysphoria?

All participants were asked what they thought GD is, with the main focus being on the difference in the external body to how patient’s feel internally. The responses were defined in a variety of ways including; dissatisfaction in relation to the body and it’s appearance (50%), being in the wrong body (58%) and the clash between the mind and body, or the internal and external (33%), as the quotations shown below exemplify.

> *‘are really dissatisfied in their body’ P2.*
>
> *‘I guess my understanding of gender dysphoria is where someone feels that their biology…genetics and biology doesn’t match how they feel about themselves. So and they feel like they’re trapped in the wrong body in a way so the way’ P4.*
>
> *‘I would say that gender dysphoria is an expression of a temporary or longer experience of gender incongruence in the young person by that I mean their internal worlds and external worlds may be in conflict’ P5.*
>
> *‘belief that they are in the wrong body’ P11.*

Whereas, half described their understanding as being dissatisfied with their gender more specifically and the parts of their body that display their gender. At times there seemed to be an uncertainty whether their unhappiness was associated with the body or the gender and whether these are truly separate. The idea of socially assigned constructs regarding gender was also introduced and the impact this can have on the way young people perceive themselves in relation to this as the following quotations highlight.

> *‘they were born into the wrong body which sorry the into the wrong gender’ P9.*
>
> *‘an uncomfortable sort of sense of being that a person might have between their actual gender and their preferred gender. Just sort of incongruence’ P11.*
>
> *‘it simply means you’re not comfortable you’re not happy with your gender assignment or the gender society has assigned them’ P12.*

Other’s (33%) reported that alongside the focus on the body or gender that there is something broader regarding a wish to find an identity or where a young person might fit. This seemed to be centralised in finding something for them internally rather than or in addition to wanting to change themselves externally, as demonstrated by the below quotations.

> *'I've also worked with and heard about many young people who…for all kinds of reasons there is an exploration for them about their identity' P9.*
>
> *'they describe it as not feeling that they were born in the right body or have the right identity' P10.*

Five participants also expressed an uncertainty around whether they know what GD is and really understand it:

> *'I'm really unclear on what constitutes dysphoria' P3.*
>
> *'I don't think anyone really knows for sure' P4.*
>
> *'there is a lot more to understand' P9.*

Although there was some agreement between participants in certain areas, findings showed that there is not a clear understanding of how GD is conceptualised. As shown next, uncertainty was also found when the participants were asked about the origins and possible routes of this conditions, which all participants considered.

Origins of Gender Dysphoria

> *'I think I've been very curious it…where's this coming from or what's this about' P7.*
>
> *'I guess you know for me I don't know where it starts' P10.*

Some (25%) suggested that GD may be due to societal constructs around gender. This included the roles society dictates, the stereotypes around gender and how gender traits are viewed by wider society. Some felt that the way society perceives gender and expects people to behave in association with these constructs may have impacted these young people's sense of identity, as the following quotations demonstrate.

> *'I also think there's…a sense of who we are and how we fit in to the world in terms of our identity…and socially constructed ideas of*

> *what's male and what's female and I think they're quite archaic ideas" P4.*
>
> *'the gender we are assigned with has for such a long time been seen as entirely rigid' P9.*

Some (33%) suggested that it may be due to dynamics in personal relationships as the below quotation exemplify. Often these relationships were within families and may have been a result of dynamics between them and another family member. Some of what was presented was specifically around abusive past experiences within these relationships.

> *'all four of the cases I have had their gender is going towards the perpetrator's gender' P3.*
>
> *'young people I've worked with that have been sexually abused that they had made a clear decision to identify with the other gender because of safety issues because of the trauma' P7.*
>
> *'it felt safer to be a girl because in his mother's mind it was a very dangerous thing to be a boy' P5.*

Whilst others (17%) felt clear that GD is not a result of the trauma or abuse a young person has experienced. They also presented the issues that can occur when this stance is taken by professionals.

> *'certainly for some people it is hugely important but it isn't the reason why they want to change gender' P9.*
>
> *'had suffered extreme abusive childhood…it couldn't be clearer to me that it was absolutely separate to this' P.10*

42% of participants wondered whether GD was mental health related, as their own questions raised highlighted:

> *'I don't know whether it was related to mental health' P1.*
>
> *'is gender dysphoria a mental illness? Or is it part of an expression of a young person' P5.*

However, in relation to that question, some participants (25%) expressed concern about stigmatisation if it was considered a mental health condition. Whilst others thought about how GD impacts wider mental health rather than the other way around. Both are demonstrated by the following quotations.

> *'don't want to turn people who have gender dysphoria into people with a mental disorder' P12.*
>
> *'we are trying not to stigmatise people for their experiences' P1.*
>
> *'gender is a huge part of our every day so if you had questions about it it would impact your mental health' P3.*

More than just GD?

When considering how to define and describe GD, 92% of participants suggested that for the patients they had seen there was more than just this condition present for them. Most participants (67%) wondered whether GD was part of wider difficulties for these young people:

> *'it might just be a thread amongst other threads of difficulties' P3*
>
> *'it has never been the only thing that they've presented to me. It's always as part of a collection of things when you drill down' P6.*
>
> *'I haven't had anyone that's just been referred purely because of gender identity, there's always been other aspects' P7*
>
> *'my experience is that dysphoria never occurs on it's own' P12.*

Alongside this, participants (42%) presented the theory of GD being a label that gives reason for their wider difficulties. A suggestion was given of it providing an explanation for their difficulties in a way that has not felt otherwise possible. That is not to say that GD is not something they are suffering with but sometimes participants felt it is masking other difficulties as shown by the following quotations.

> *‘they might have a different difficulty and it comes out as gender difficulties…they thought they had gender difficulties but actually it was sexuality…it was actually more acceptable to have gender difficulties’ P3.*
>
> *‘I think that the gender is an outlet for other difficulties’ P3.*
>
> *‘asked her why and she said just because I know I can, that option is there to express my distress in that way’ P11.*

The breadth of the participants’ responses seem to reflect the complexity of the condition and from their experience’s participants felt that it is often only part of a wider picture for these young people. As a reflection of this participants (67%) also discussed co-morbidity for their patients. In some cases, this was discussed generally, and with others in relation to Autism Spectrum Condition (ASC). As a CAMHS clinician it was also suggested that they are usually seen only if they have other mental health concerns:

> *‘we don’t see it as a mental illness…and therefore a lot of young people that we see unless there is comorbidity difficulties we don’t necessarily offer them treatment’ P2*
>
> *‘there’s usually other things alongside to get into CAMHS so usually there’s other stuff too. A lot of them there’s been self harm, depression, anxiety, family issues’ P7.*
>
> *‘we do see a lot of history of gender dysphoria with Autism Spectrum Disorder’ P12.*

Research question two: What is their experience and understanding of the increase in cases of Gender Dysphoria?

All participants considered their experience and understanding of the increase in GD cases. Three themes were identified regarding this; “experience of increase in cases”, “online and societal changes” and “growing knowledge, awareness and conversations”.

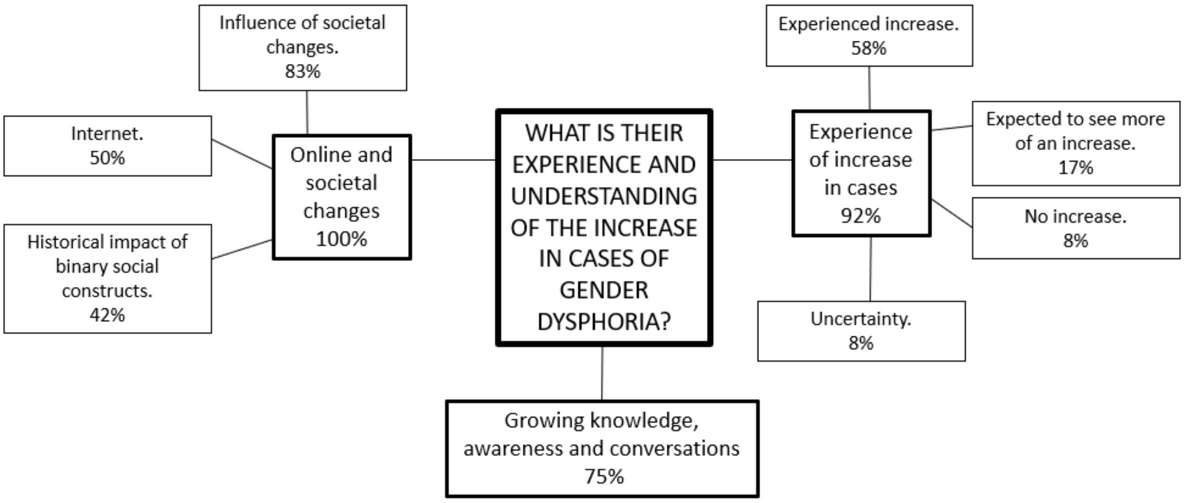

Figure 2. Themes and subthemes for question 2.

Experience of increase in cases

This sub-theme was present in 92% of interviews when participants were asked to consider whether they had seen an increase in cases similar to what GIDS have experienced. It was identified that most had experienced an increase but for some this was only initially:

> *‘[I saw an increase], yes initially’ P1.*
>
> *‘it has become much more frequent and I think you know in terms of the levels of referrals we are seeing…there are many, many more people being referred’ P9.*
>
> *‘over the years there’s been a steady increase in numbers of referrals for identity disorders, gender identity disorders or dysphoria’ P12.*

Two participants had expected to see more young people presenting this way than they did in reality, the below quotations demonstrate this belief. They had been aware of the increase in this type of presentation, the referrals to GIDS and therefore expected to see a similar trend in their clinical work. It was also felt that the increase they had seen was not as significant as GIDS have experienced.

> *‘I haven’t actually worked with as many as I thought I would have’ P5.*
>
> *‘I think it’s…relatively rare despite you hear[ing] the quote number of referrals’ P.13*

One participant presented that some had not seen an increase or any differences in referral rates. Whilst another expressed uncertainty as to whether they had experienced an increase or not. The participants questioned whether this was due to changes in protocol of how young people are referred to GIDS and not having to come from CAMHS:

> *‘I couldn’t say that the people I’ve worked with that I have seen a rise or decrease…equally this may be because we don’t see it as a mental illness’ P2.*
>
> *‘I’d say it’s not changed, it’s changed? lets say it’s changed because there’s more access to services, a little bit?’ P7.*

Online and societal changes

92% of participants felt that the increase in referrals to GIDS has been due to a shift in societal views of GD. It was also identified that access to the internet and the information that it can provide has had a significant impact on the prevalence.

Nearly all participants (92%) reported that they thought societal changes had had an influence on the increase in GD. Within society an increase in flexibility around gender and a shift in acceptance was presented. Participants (83%) reported that more acceptance of gender diversity and normalisation of a gender continuum had resulted in more young people identifying this way as the following quotations demonstrate.

> *‘socially constructed ideas of what’s male and what’s female and I think they’re quite archaic ideas and there [is] something that is more current that is around gender being more fluid’ P4.*
>
> *‘I think society has moved to it being very acceptable’ P1.*
>
> *‘the fact they are coming forward I think says something about a society shift saying that they want to…support these kids and recognise that the way they were being treated just because they feel this way’ P8.*

Further, a considerable number of participants (42%) presented how historic views around GD has previously impacted people who experienced GD:

> *‘there wasn’t a way to articulate it in a safe way so it was probably went more underground and then people probably came out as older…But at that time to [be] trans or to be a different gender wasn’t really acceptable’ P7*
>
> *‘people would have suffered in silence for much much longer…my experience would have been that they would have come out much later in life’ P5.*

Half of participants reported the internet and social media had also had an impact. It has allowed young people to explore and test out different identities and ways of being, before approaching the subject with people closer to them. There was a sense of online communities who validate their feelings and allow young people not to feel alone with their experiences. It also has provided an increased amount of information and knowledge that young people now seek to discover. All of which are demonstrated by the below quotations.

> *‘I think also social media…validating and offering voice to those experiences so you’re not alone you have other people’ P7.*
>
> *‘the wider promotion of an external presentation through social media…[a] freely available audience for one’s expression…there is something about entertaining or attracting about that if it’s used in social media as a way of actively expressing those aspects of ourselves that we are testing out in reality’ P5.*

> *‘I think with technology I think there’s much more access to more information. I think that’s potentially…facilitated more openness around...people understanding their experiences’ P4.*

Growing knowledge, awareness and conversations

During this part of the interview 75% of participants spoke of how they felt the increase in referrals and cases was due to an increase in knowledge, understanding and hypervigilance about GD. They felt there was a greater level of awareness with more exploration and conversations regarding the subject.

> *‘people are much more likely to talk about those things because there are conversations going on…there is a momentum which slowly gets built up as people begin to understand that this is something [to be] taken seriously…and I think as a society there are now discussions that would never have happened twenty years ago’ P9.*
>
> *‘I think the more people know about something the more they are hypervigilant to…the experiences of it’ P3.*
>
> *‘I think there’s much more information and knowledge base now’ P4.*
>
> *‘The awareness has increased not because it wasn’t there before it, simply that people see that the dysphoria is there now’ P12.*

It was identified that the prevalence increase may be due to more information and knowledge being available. However, the idea that the acceptability of conversations and increased exploration more widely may have allowed for openness that was not previously possible was also presented. Therefore, leaving it unclear which direction the increase has originated from.

Research question three: What is their experience of working with GD?

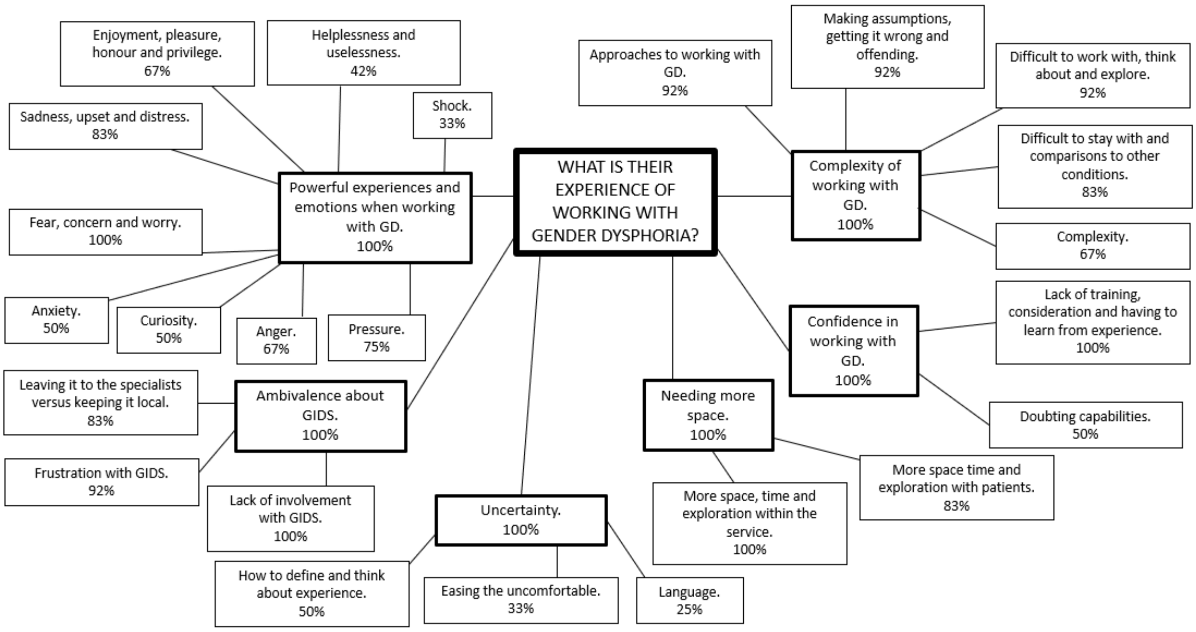

Figure 3. Themes and subthemes for question 3.

The analysis of this question yielded six themes with a variety of subthemes appearing in each. As with the other two questions, a striking finding was that all participants expressed an uncertainty as to how to define and think about their experience of working with GD patients, as exemplified in the quotes below:

> *'I don't really know what I'm doing…you are sort of on the backfoot a little bit and you're scrabbling around trying to think about how do I do this' P1*
>
> *'I felt unequipped' P4.*
>
> *'a sense of what am I doing? Do I know what I'm doing? Am I out of my depth? P9.*

Alongside this uncertainty, ways in which clinicians manage or ease this was also evident:

> *'I have some resources that I use because I guess my confidence in this area isn't as much as with other difficulties' P3.*

> *‘I’ve gone off and read about it because I felt kind of underprepared or out of my depth at times or not really understanding the nuances of it so I read stuff around it’ P4.*

The language used was also something that caused clinician’s uncertainty. They presented the dilemma of being unsure how to use language around GD and the variety of descriptions and labels that are used as the following quotes demonstrate.

> *‘I think there’s a real lack of clarity around the language that is used’ P5*
>
> *‘you’re a therapist [you try] to get the language right and to take the lead from the young person about the type of language they want to use and I found a massive variation around that across the young people so I’m really hesitant about it’ P10.*

Despite the overall uncertainty, when asked to think about it, participants did talk about their experience of working with this patient group. The emerging themes and subthemes are presented below:

Approaches to working with GD

92% of participants identified the ways in which they approach GD. It is was predominantly by taking the lead from the patient and focusing on their experiences, rather than being driven by their own assumptions or biases. The importance of providing space to see what topics arose was prioritised:

> *‘they bring their own stuff and I just go with what they bring rather than a pre-conceived idea of what you should do with them’ P1*
>
> *‘just get with the person and talking about their lived experience’ P2.*
>
> *‘I’m not interested in what my theory about that is, I’m really interested in what is that young person’s theory about why they have these feelings and that’s the bit I focus on’ P10*

It was presented clearly that participants were not aiming to ‘treat’ the GD and were more aiming for congruence within patients that enables a more comfortable state of being, as the following three quotations highlight.

> *‘the intension was not to treat him for wanting to be a girl’ P5.*
>
> *‘I don’t agree with anyone thinking they can cure this’ P8.*
>
> *‘I guess the end goal after all of it is congruence’ P3.*

Accordingly, the participants reported that an overarching part of this was offering containment to the patients, the adults around them and seeking it for themselves from supervision, as three participants pointed out:

> *‘I think there’s a lot of containing the adult’s stuff…if the adults are more contained then hopefully the young person will be freer to just explore’ P7*
>
> *‘they come to me not knowing and if I say I don’t know either but I’m willing to explore with you and this is kind of like a safe space to do that I think that’s been quite helpful’ P3*
>
> *‘part of that struggle is about having the appropriate supervision’ P5*

Making assumptions, getting it wrong and offending

During the interviews 92% of the participants presented their worries about making assumptions, getting it wrong or offending their patients. The concept of saying something that may be wrong or perceived as discriminating was something that was focal to these conversations:

> *‘I feel like I’m not explaining myself, I feel like I’m being really judgemental…it is a big worry for me…I get so nervous about it’ P2*
>
> *‘I’m not intending to be offensive or get it wrong I’m trying to learn with you I guess that I feel like…quite a lot of people can be scrutinised for being offensive’ P3*

> *‘there is very much a fear of getting it wrong and that the kick back from getting things wrong as we try and understand can be powerful’ P5*

An awareness was expressed of the impact of these anxieties. These kinds of worries can be a barrier to being able to explore with these young people and say what clinicians might want to as the below quotations demonstrate.

> *‘I’m questioning everything that is coming out of my mouth because I don’t want to be offensive…and I think that is a really, my major barrier with all of it’ P3*
>
> *‘I can’t imagine it would be would have been as helpful at all if we had all just sat there and just…completely agreed with everything…and felt too scared almost to say well actually I’ve got a slightly different view or position on it.’ P6*

However, getting it wrong is inevitable and the way this is managed is important. A transparent approach was felt to be best that acknowledges something being wrong to allow it to be thought about:

> *‘it really mattered that I noticed when I got it wrong…so they know you take it seriously really…acknowledging that I’m probably going to get this wrong, I’m a bit clunky with this so bare with me so there’s an understanding.’ P7*
>
> *‘you feel, oh my god, one thing wrong and what happens then? But I think, that one thing wrong, if you’re honest about that it’ P8*

Difficult to work with, think about and explore GD.

The majority (92%) also reported a difficulty of working with these young people. The biggest challenge for them was the lack of engagement and exploration by patients and families as the following quotations exemplify.

> *‘there is sometimes some difficulties in engagement and I think…that then frames your sort of way of working with people when you find they are like that’ P1.*

> *‘the family network around this young person shut down very quickly when they realised they might need to do lots of other thinking’ P5*

At times the difficulty is in relation to what it is like to be in the room with young people with GD and what occurs in the relationship and transference. Others found the expectations or the processes challenging, whilst some focused on the family around the patient rather:

> *‘it sometimes felt painful because there was so much silence…it was a very difficult amount of silence’ P1.*
>
> *‘and I was aware of this young person trying very hard to encourage me to feel irritated by his presentation…and it was very difficult for him to believe that I could tolerate and accept those expressions of his way of identity…the transference experience you know professional and personally was a very unpleasant place to be’ P5*
>
> *‘they’ve made up their mind and I think that’s what’s tricky about it and then expect me to do something that’s impossible, offer them hormone therapy’ P2.*
>
> *‘I’ve found it really difficult working with the families when the young person has gender difficulties or gender dysphoria’ P3.*

For some, the presentation of GD has been historically uncomfortable and despite this changing over time were able to offer this initial challenge within the work:

> *‘I remember working with my first case twenty five, thirty years ago and thinking just finding it really uncomfortable I mean it was so challenging’ P9.*

In relation to this, the difficulty to think and talk about GD more widely was also introduced by four participants:

> *‘why on this particular presentation can we not do what we ordinarily do in our practice so yeah we have to be able to think about some of these difficult things at risk of at risk of saying things that may be other people don’t agree with.’ P11.*
>
> *‘I don’t really think too much on it’ P6 .*

> *‘as clinicians we are not all able to stop and think about the complexities of what might be going on’ P5.*

Difficult to stay with and comparisons to other conditions

When exploring GD, 83% of participants appeared to find it difficult to purely focus on GD as a specific condition. It was often compared to other conditions or the differences between them were minimised. There is a sense that other conditions are easier to sit with and think about as the following quotations demonstrate.

> *‘I mean I’m sure there are some people who would say it’s because…we now recognise it a little bit like if you were to go back X number of years and think about ADHD…if you speak to the older generations they’d say it wasn’t a thing in my time ADHD they were just naughty children or whatever’ P6*
>
> *‘it’s the same as working with any other family really, it’s not different. It’s just they are different issues and different emotions that we associate with different issues and different questions to ask. But it’s not that different.’ P2*
>
> *‘it’s not any different from other [treatment]’ P5.*

It was hard for participants to remain focused on GD and this possibly reflects the complexity and difficulty involved in this area.

Complexity

67% spoke of the complexity of working with GD more broadly. Working with them, their experience, the understanding and the pathways are all perceived as complex:

> *‘I think its just a bit of a rabbit hole I think, gender in general’ P3*
>
> *‘it’s not straight forward but I think that’s the experience’ P4.*
>
> *‘I guess it has taken so long for us to get our heads around how we are working with patients who experience [GD]’ P5.*
>
> *‘I think we’ve got too many pathways to be honest with you. We’ve got too many. We split children into pathways and that’s not how*

> *children are…I think there's a lot of children that don't fit into neat pathways' P7.*

As previously discussed, part of the complexity around GD was felt to be the presented concept of there always being other aspects of difficulty around these patients. See subtheme "More than just GD".

Confidence in working with GD

All participants presented the theme of confidence around working with GD. The two subthemes identified will now be presented.

Lack of training, consideration and having to learn from experience

All participants expressed a lack or complete omission of GD from their professional and wider training. Historically, and to some degree currently, the subject appeared to be seen as irrelevant or not considered within the normal scope of professional training with a continued lack of post qualification personal development training, as the following quotations show.

> *'[in] my training we never really looked at gender' P3.*
>
> *'No. there was no specific training in my training experience around the complexities of gender dysphoria and working with children with experiencing gender incongruence' P5.*
>
> *'it didn't seem to be formally part of training…I don't remember it ever being mentioned' P6*

Therefore, many clinicians have had to do their own research which has left some dissatisfied with the literature found. As a result, clinicians often appear only to have the option to learn from their own experience of working within this field as a way of managing the present abyss:

> *'so I sort of did my own research really' P1*

> *'so my experiences have been learning a lot, having to go away and self teaching myself, reading around and linking with other people that had clinical experiences… I think I've learnt the most form the young people I've been working with' P4*

> *'some articles where my response was this is rigid, this is based on a misunderstanding of how people experience the world and feel about themselves and to some degree some of that was a way that some…pathologized people rather than understood them' P9*

> *'I have yet to read a really good theory around gender dysphoria that I could sign up to myself' P10*

Many clinicians were found to wish for more information and guidance to be provided than what they have received:

> *'I'd hope for some training in the service given because I don't feel like I'm the only one that thinks that gender is the rabbit hole expression' P3.*

> *'information is invaluable and that information might change and so keeping up to speed with that I think is really helpful' P4*

> *'I have had remarkably little training and I could probably do with a lot more' P9*

There is a surprising lack of consideration in profession trainings and post qualification that leaves clinicians wishing for more guidance. There was some acknowledgement that it may depend on when you were trained. However, this remains an ongoing issue, too. Although many have tried to seek information for themselves they often found it whollya unsatisfactory.

Doubting capabilities

Half of the participants found they doubted their capabilities when working with this patient group as the below quotations show. As previously mentioned some were not sure what they were doing. Others were unsure if they were actually being helpful to the patient.

> *‘usually I just question whether it’s been helpful’ P3.*
>
> *‘I also remember questioning…whether that was helpful or not’ P4.*
>
> *‘when I have a referral I do think oh no, I’m not going to be able to help because I don’t understand it to be honest’ P3.*

There was also a sense of either being a specialist or knowing nothing. It leaves clinicians feeling that because they are not part of a specialist clinic and had no formal training or guidance that they know nothing about GD or what to do with it:

> *‘I think when we see gender in a referral we go oh we’re not the specialist service for gender that needs to be with specialists’ P3.*
>
> *‘with anything if you dispatch it to the specialist service you kind of devalue then what’s offered locally. It makes people not feel confident, it’s an expert thing. I can’t do this’ P7.*

Needing more space

All participants presented the need for more space. Two subthemes were identified around this and will now be presented.

More space, time and exploration with patients

83% of participants presented needing more space, time and exploration with patients during the interviews. They expressed the importance of communication and exploration with them as the quotations below explain.

> *‘I’m like well I’m not taking gender identity off the table guys but…lets see if we can…understand all that stuff and then if it’s still there then I’ll think about a…referral.’ P6*
>
> *‘I suppose my position is more like lets be alongside these young people and let them explore and see where it takes them and so I think there’s something about adults accepting young people’s need to explore themselves’ P7*
>
> *‘for others that where they are quite clear that they were born in the wrong body, in the wrong sex that they have the opportunity to explore’ P9*

It was also acknowledged that the space to think is needed for patients to be able to explore. It again was important that this space included a broader scope than just focusing on GD, as other aspects of the patient's life may be missed with this approach:

> *'on one hand I feel by focusing on gender we are missing part of the point if that's the only thing we focus on' P2*

> *'I'm willing to explore with you and this is kind of like a safe space to do that I think that's been quite helpful' P3*

Some felt it was important the extended length of time this can take needs to be allowed for and recognised. The complexities of GD indicates a long exploration:

> *'I don't think exploring identity in any way would be brief work' P3.*

> *'we are treating the whole patient, this is not something that can be done quickly' P5*

More space, time and exploration within the service

It was also clear that all participants also wanted more provision within the service they work, as the below quotations demonstrate. It was reported that there is a lack of conversations within the service resulting in the thinking not being congruent. It was felt that more attention needed to be paid to this area and what practically could be achieved.

> *'there does not feel a sense of any discourse, discussion, enquiry, joined up thinking, shared experiences as a discipline' P5*

> *'I guess if it could be included on any kind of wider team training and things like that…kept on people's radars' P6*

> *‘we probably need to think more about how we see gender and where it sits and the assumptions we perhaps make…we kinda need to integrate more I think and join together more in our thinking’ P7*

The biggest request was for more guidance from the service as was mentioned previously (see subtheme ‘lack of training, consideration and having to learn from experience’) alongside the suggestion of peer group discussions, reflections and supervisions being a helpful way of continuing conversations regarding GD:

> *‘so reflecting on the emotional experiences but also reflecting on resources and what is helpful and also yeah people’s other experiences and whether mine are the same…I think I need to be able to draw on other clinicians experiences’ P4*
>
> *‘having access to some peer group supervision around this area where you can compare cases would be really helpful’ P10*

If this were to happen, it was recognised that how it was managed and the safety of these conversations is paramount. The hope was that it would allow for more exploration whilst also considering and addressing prejudices and unconscious biases that were offered, as shown by the quotations below.

> *‘there is so much personal reaction within each clinician…there may be some very different responses and I think that you know it would be really helpful [to] unconsciously pick out prejudices against these referrals…it needs to be handled very well for me [to] experience it the way I would like to experience it’ P5*
>
> *‘a safe space with people who…you can have some really quite rich debate [with]’ P6 ‘if people are able to reflect and be curious about it and yeah I suppose that’s the bit I’d like to see happen that we can find a way of just being able to think about it and not being polarised.’ P11*
>
> *‘I think we probably need more discussion in teams…because my guess is people will have quite different views about it and that needs to be out in the open really’ P7*

Powerful experience and emotions when working with GD

All participants presented the powerful experience and emotions that are evoked in varying degrees when working with patients with GD. The most common (100%) was regarding their fears, concerns and worries with a wide range of different reasons, especially around rushing things regarding exploration and treatment processes:

> *'I think sometimes the adults' anxiety about doing the right thing can push the young person into one thing or another and…I don't know if it's the right thing' P2*
>
> *'support this young person and see how they go without having to push them one way or another or feel like you have to do one…like holding the anxiety so this young person can develop in the way they want to at the pace they want to' P7*

There is also a concern about patients generally transitioning and receiving appropriate treatment:

> *'feel fearful for them that anybody…could sign up for a young person to come down this medical route at such a young age' P11*

Some (33%) reported a more general worry about patients especially when it came to suicidality:

> *'gosh you know it's just hard and worrying about them just thinking god I hope they're ok' P7*
>
> *'there was also the continuing theme of would she kill herself? Would she still be alive the next time I saw her? And because her suicidality was really powerful and the two were very much interconnected.' P9*

The majority (83%) of participants felt sadness for their patients and their experiences:

> *'I always usually feel sad, sadness that people feel so dissatisfied with who they are' P2*
>
> *'really painful…very moving. I mean I've cried over both of them and the thoughts and the things they've told me and the challenges they've had to face' P8*

> *‘I felt sad and that’s probably the overriding feeling I’ve felt. A real sadness for them’ P11*

The concept of pressure was presented by 75% of participants. The gravity of the wish for a quick cure or relief from their distress was dominant. The push was mainly coming from adults around them and the level of anxiety they felt around wanting to relieve what is occurring for a growing number of young people as demonstrated by the following quotations.

> *‘there was so much anxiety in the family and the network that this could be cured and cured quickly and that [what was being offered] was considered to be too lengthy and something that would not have provided the quick relief’ P5*
>
> *‘Unfortunately this society is not a society that gives time and you are expected to be doing things at the speed of light in situation of life that is quite very fluid.’ P12*

Clinicians also offered concerns about the amount of pressure on young people who present this way. There is a worry that if a young person wishes to change their gender that they will be pushed to do so whether they continue to feel this way or not.

> *‘I would worry that might make a young person feel they have to go down a particular route and they have to identify a particular way’ P7*
>
> *‘it was the response of everyone around her…I felt frustrated because…everyone is pushing her down this route and it was hard to…stop that from happening…I held a meeting at school trying to get them to go at her pace’ P11*

The enjoyment, pleasure, honour and privilege that clinician’s feel when working with these young people was presented by 67% of participants. Many enjoyed working with them and the journey that they have been on together as exemplified by the following quotations.

> *‘personally it’s very enjoyable work’ P5*

> *‘I enjoy it just because I find it really interesting to be curious about what it’s like for that young person’ P7*
>
> *‘I’ve loved working with each of my [GD] patients that I’ve worked [with]’ P8*

Others (25%) found them likeable and some to point felt love for their patient.

Alongside this, maternal feelings were also evoked in them:

> *‘I so enjoyed the young people, I found them [a] likeable bunch of kids and that’s probably a bit of a generalisation but that was my experience working with them.’ P11*
>
> *‘I love both the patients I’ve got. I find them so really alive and real and authentic’ P8*
>
> *‘probably feeling quite maternal towards a lot of them’ P7*

There was a great sense of honour and privilege that patients could open up to the clinician and talk about their GD. On occasions this was the first time they had spoken to anyone which had enormity to it as the following quotes demonstrate.

> *‘I’m struck by being really honoured and privileged to be able to meet with somebody that feels they can open up and have that conversation with myself’ P4*
>
> *‘I felt quite honoured that they trusted me with that piece of information because they didn’t know what reaction I was going to give them and in some cases it was the very first time they had uttered the words’ P8*

67% of participants also offered their feelings of anger around this work. This was especially in relation to being left with anger at the end of sessions and anger for what these young people are trying to process and manage:

> *‘that constant sense of being left with intolerable levels of anger’ P9*
>
> *‘I genuinely felt really angry. I felt angry for them, on their behalf’ P10*

Some (17%) felt anger towards parents and carers about the way they were managing their young person's distress:

> *'having to manage my sense of fury with them about the fact that I felt that they were seriously letting this child down because they couldn't manage the uncomfortable feelings that this issue evoked in them' P9*

50% of participants presented the anxiety they felt. It is an anxiety provoking area to work with and many of them felt anxious and apprehensive about it, as demonstrated by the following quotes.

> *'I feel quite apprehensive because I think that it's quite an uncertain territory for me I think' P3*
>
> *'I think the reality is that the anxiety, the uncertainty for me was always at it's greatest before I'd met them, before I'd started working with them' P9*

The adults' anxiety is often higher than the patients specifically in the parents and the networks around them:

> *'so much concern is often stirred up in the external world; schools, parents, families, others, doctors, the level of anxiety and concern around that can often be much higher than within the patient in my experience' P5*
>
> *'a coming out to make clear they are going to be this or that and I think that's more about the adult's anxiety about definition rather than the young person. I think young people certainly of my experience of them are much more open to that idea than the adults are' P7*
>
> *'there is a lot of worries that [GIDS]are just going to get a young person in for a first session and stick them straight in for surgery and stuff. I'd have to do lots of managing anxieties from parents that that's what's going to' P1*

50% of participants presented their professional curiosity about their patients and GD more generally. They felt curiosity was important and allowed for freedom of exploration as the following quotations show.

> *'I didn't know much about it I think it allowed me to be generally quite curious…I think being genuinely curious can just free that up a bit' P1*

> *'I definitely don't have any answers and exploring it together and just being curious.' P3*

> *'I enjoy it just because I find it really interesting to be curious about what it's like for that young person and I don't I don't ever assume one young person is going to be the same as the next it's more coming alongside their experience which I find really' P7*

> *'takes a lot of disentangling, a lot of patience, a lot of curiosity' P5*

42% of participants experienced feelings of helpless and were uncertain as to whether they were being helpful. This was especially around not having the answers that patients were looking for:

> *'Maybe feeling a bit helpless maybe I don't know whether that's quite the right word and I think some of those might be the young people's feelings that I've absorbed as well but some of them were probably mine as well' P1*

> *'utterly hopeless, helpless, at times very… there's a lot of helplessness especially if they can't get the support that they want' P8*

33% of participants covered their feeling of shock as demonstrated by the quotations below. One spoke of their shock when a patient reverted back to their biological gender. Whereas two others offered their shock of prejudice still being present.

> *'I was really shocked and parents were really shocked because we got them to a place where they were accepting of having a son and she now wants to be referred to as her birth name so I was really shocked at that' P3*

> *'I've been really shocked by clinicians that hold really strong assumptions and beliefs and yeah which I found quite challenging' P4*

GIDS and ambivalence

All participants presented GIDS and ambivalence in relation to it. Four sub-themes were identified and each will described in more detail.

Lack of involvement with GIDS

When considering experiences of working with GIDS 92% of participants presented a lack of involvement from them. On the whole, the experience was of little to no contact:

> *'Other than being at a conference and presenting alongside the GIDS service you know I've had very little contact with them.' P5*
>
> *'very very little contact unfortunately' P11*
>
> *'with the other two you really didn't know what was happening and you really had to make a real effort to find out…it was like [the patient was] the one that kept me in touch rather than the Tavistock' P10*

When they had tried to have more involvement it had been difficult to link up with GIDS in the way they might have liked:

> *'I think the dominance of the Tavistock model and the difficulties they've been facing is very difficult for us to link in with' P5*
>
> *'it just felt like you were just there to be the provider of the [therapy], they weren't interested in what was happening you know didn't link you in at all' P10*
>
> *'They said they would get in touch and they haven't been in touch' P11*

It was acknowledged that this has a negative impact on the patient's therapeutic journey by one participant. Whilst another expressed a wish to work more closely:

> *'someone was really upset because the decision to start hormone had been delayed and they had been told it was because they were waiting for a letter from me to say that I didn't think that there were any barriers and no one had communicated with me that there should have been a letter' P10*

> *‘as a service I think it would be really helpful with GIDS to have maybe a review set in or an update every now and again so there’s a bit of sharing information both ways’ P7*

Frustration with GIDS and treatment

92% expressed frustration with GIDS including the lack of joined up working from them. Another frustration was around the training they provide and clinician’s experiences of attending such events, as exemplified by the following quotes.

> *‘I know they have offered some kind of training here…but…I have actually have been reticent to go…it’s basically like teaching you to suck eggs’ P2*
>
> *‘I couldn’t be honest in the session and I was sort of astounded…I was scared of asking questions…I felt silenced’ P11*
>
> *‘yeah I went to a few of their training sessions but I wasn’t overly impressed by them’ P4*

There was also some frustration around the length of GIDS waiting list. This can be difficult for patients and often leaves clinicians to contain this or the patient with nothing:

> *‘I guess my fear would be that that young person is on a waiting list for maybe say eighteen months or two years or whatever without not a throughout assessment’ P6*
>
> *‘what we’ve often thought about is the young person’s frustrations and irritation that the waiting lists are so long…a lot of the ones I’ve had were twelve, thirteen, maybe a bit older that by the time they’ve had such a long time on the waiting list that then how do they transfer over to adult services’ P1*

Some (25%) participants also felt frustrated when their specialism had been recommended by GIDS. There was a sense the referral might not have been right for the patient but has been requested for young people to continue with their journey in GIDs.

> *‘saying well unless they have treatment from the [local] team or a [therapist] we are not sure we can move forward with this and sometimes that makes some sense but mostly I don’t think it does’ P9*
>
> *‘the recommendation is that they need local [therapy] and we are therefore tasked with that task and that always feels odd to me’ P10*

Others also found it frustrating that they were not clear what GIDS do:

> *‘I don’t even know what they do at Tavistock really, what’s the difference?’ P2*

Leaving it to the specialists versus keeping it local

The consideration of dynamics of a specialist services that is separate from local CAMHS was presented by 83% of participants. Some expressed concerns around there being a specialist service and the impact this has on devaluing local services. The importance of local services and them remaining involved was also offered. Participants 7 and 12 were especially concerned by this:

> *‘With anything if you dispatch it to a specialist service you kind of devalue then what’s offered locally. It makes people not feel confident, it’s an expert thing, I can’t do this…I think you need local conversations at local levels with parents and children about it…So that’s a worry that young people are off to clinics that are specialist somewhere else I just think that takes them out of context that they’ve grown up in and I’m not sure we are doing them a good service with that’ P7*
>
> *‘I feel sad that the local team were made to look like what do you know…I think they need the local services…It’s very very vital.’ P12*

Some (42%) participants considered reasons why referring to GIDS may be seen as the easier option due to the complexities around these patients as the below quotations demonstrate.

> *‘I think it’s a hot potato so it may be easier as a CAMHS service to go oh I’ll refer you to a specialist centre’ P7*

> *‘under immense pressure of sheer number coming through the door the temptation might be to go oh yes this is gender dysphoria and refer to the Tavistock and discharge from CAMHS’ P6*

> *‘I think there is a tension given to people who struggle with gender but I also think that we leave a lot to Tavistock that maybe we don’t need to’ P2*

Having both services involved can also leave clinicians confused about what their role in and whether this is different to that that GIDS is providing:

> *‘I’m not sure which bits the Tavistock do and which bits am I doing as well…I was still a little bit unclear quite how much I was talking about stuff here which must be really hard when being in two services at the same time’ P1*

Admiration of GIDS

Half the participants were more positive about their experiences with some presenting an enjoyment from working with GIDS as demonstrated by the below quotations. Some found them to be helpful, supportive and kept them informed. There was a recognition that things are better when close working can happen.

> *‘I’ve enjoyed it…mostly I’ve found them supportive and helpful’ P9*

> *‘joint working was really good and the staff were always helpful…sort of bounce things off them so I always found them really supportive’ P1*

> *‘I linked with the care coordinator…she would keep me informed about the rest of the treatment that was going on…Yes, its really important. I would say that it helped with the outcomes ’ P10*

CHAPTER 5

DISCUSSION

By interviewing a variety of clinicians representative of members of a MDT within the CAMHS service they work in, the researcher aimed to explore three main research questions. The first considered how clinicians conceptualise Gender Dysphoria and define it based on their professional training and clinical experience. The second explored their thoughts around the increase in the number of referrals to GIDS and whether they had experienced a similar rise within their work. The final considered their own experiences of working clinically with young people (0-18 years) experiencing GD, their families and professionals (including GIDS) around them. For each of these questions, the findings will now be briefly summarised and discussed in relation to the researcher's sense making of them, what was interesting about them and how they related to the literature that has been previously reviewed and presented.

Research question one: How do CAMHS clinicians conceptualise and define Gender Dysphoria?

Participants' consideration of how they conceptualise and define GD yielded three themes: *what is Gender Dysphoria? What are its origins?* and *there being more than Gender Dysphoria for most young people they see.* When considering what GD is, it was generally concluded that it was the difference between the external body and the internal identity of the patient. This was described in a variety of ways including; dissatisfaction with their body and appearance, being in the wrong body, and a clash between the mind and body. The variety of ways of describing what it is seemed to reflect the uncertainty around the specifics of this presentation. Some also described it as a *dissatisfaction with their gender* rather than their body's appearance, which left the researcher curious about whether the physical body and a person's gender can be seen or understood as truly separate. In many ways the body can be an observable representation of one's gender and the dissatisfaction with the appearance being described in relation to this and the lack of integration between the two, however, others would describe them as separate. Yet, there was some similarity in what the participants were reporting and what Lemma (2012) was suggesting regarding individuals searching for the "right" body when their current one clashed with their internal sense of their gender. As a result, individuals are seeking a solution of physical transition to align the two.

It was noticeable that these descriptions and explanations came with a hesitancy at times, with some participants more explicitly expressing an uncertainty around whether they know or understand quite what GD is. Overall, the findings showed that there was not a clear understanding of how GD is conceptualised by clinicians and the variety appeared to the researcher to demonstrate the lack of clarity surrounding this presentation. Despite it being so prevalent among children and young people within society more recently ("Number of referrals", 2021), the understanding has not developed at the same rate. It could be argued that this is a reflection of a defence against what is uncomfortable and an avoidance of thinking due to this. This crucial deficit has left the researcher noting that the patients CAMHS clinicians work with , at times, have a better understanding than the professionals around them do, which makes them a vital contact in order to provide knowledge and understanding. Whilst also arguing that as professionals we all have a responsibility for learning and trying to explore areas that does not rely on others to teach us.

The second theme of considering origins of GD demonstrated different theories that participants held about where this presentation initiates. The main two theories based the origins within society and the constructs it holds around gender, and then more specifically within the dynamics of personal relationships. Some felt that society’s expectations regarding behaviours specific to each gender has a significant impact on our sense of identity. Participants felt that when this expectation does not match how we feel inside and how we naturally behave, then this could result in us wanting to change our gender to fit more congruently. This finding is in line with Coates and Person’s (1985) argument around constructions of masculinity or femininity within others having an impact on how individuals view themselves. Most of the participants in the present study, however, centred this on society as a whole rather than on focusing on the mother-infant relationship specifically as psychoanalytic theorists have pointed out (Stoller, 1964, 1966, 1968, 1970; Socarides, 1970; Ovesey & Person, 1973; Limentani, 1979; Coates & Person, 1985; Coates, 1990; McDevitt, 1995; Stein, 1995; Gilmore, 1995). It could be concluded that to avoid a sense of blame or criticism that it is easier to base origin with a wider group than a single individual or couple. Freud (1905), however, theorised that gender development is a direct result of our relationships with our parents. As part of the phallic phase of psychosexual development we experience the Oedipus Complex and an identification with one of our parents resolves this and builds the foundations of our gender identity. Although, society may have influenced the parent’s expression of their gender is paramount, by focusing on society as a wider group removes the importance of the parent child relationship. However, one participant (8% of the total sample) spoke more specifically about the mother’s difficulties with their child’s gender in the present study. This mother had negative associations to masculinity, which, in line with some of the psychoanalytic theories (e.g. Coates & Person, 1985, 1990) appeared to have impacted her child and resulted in a wish to be a girl rather than a boy.

Participants also reported their observations regarding GD being rooted in dynamics within personal relationships that individuals have experienced. For some this was related to abusive relationships and an unconscious identification with the persecutor being safer than remaining the gender they were as a victim. This finding stands out and has not been considered theoretically or found empirically in the literature. However, it would suggest an unconscious moving away from a position of vulnerability that has all been located in the gender of their body at the time of the abuse.

As summarised in the literature review, psychoanalytic theorists specifically focused on the parent-child attachment and the intensity of this impacting one’s ability to separate (e.g. Stoller, 1964, 1966, 1968; Ovesey & Person, 1973; Limentani, 1979). Nevertheless, it left the researcher wondering whether, to some extent, the mother-child relationship described by the psychoanalysts in their case studies, could perhaps now be considered emotionally abusive, and a further investigation into the specificity of the nature of these relationships might therefore be interesting in that respect. Having said that, the participants in this study were more overtly referring to physical or sexual abuse. Blumenthal (1998) described something similar within his case study, where the child recognised that males in their family captured attention through their negative and abusive behaviours in a similar way to how the participants within this study described some of their patients. However, it needs to be acknowledged that not all participants reported such beliefs. Some participants (17%) felt strongly that abusive experiences were not the root of GD and the researcher wants to emphasise that such assumptions without clear evidence can be very damaging for individuals and their journey through transitioning.

All participants wondered whether patients with this presentation were experiencing a mental health issue. This finding may be a direct result of all participants working in CAMHS. However, it seemed to have added an important element in that clinicians were concerned of the impacted a possible mental health problem may have on these young people. The third theme demonstrates that participants believed that there is often more than just GD going on for these young people. Findings suggested that it may be an acceptable label to use for other things they might be struggling with, including their sexuality. For example, some participants felt it was easier to present as transgender rather than to come out as homosexual, similarly to the theorisations of Freud (1911), Socarides (1970) and Siomopoulos (1974). The researcher would argue that the current participants' conceptualisation comes closest to Siomopoulos's (1974) concept of "class reversal" in that patients are wishing to change their gender to fit in with their heterosexual desires, rather than with an avoidance of homosexuality (e.g. Freud, 2911; Socarides, 1970).

It is interesting to notice that the considerations around comorbidity may have been to do with the fact that individuals are only currently seen in CAMHS if they report comorbid mental health problems. However, this has not always been the case and some of the experiences that participants referred to related to times that were prior to this change. As a result the researcher argues that this may be a more common observation.

Overall, this study appears to be the first to consider professionals' perspectives on the understanding and conceptualisation of GD more systematically. Surprisingly, reviewing the empirical research literature revealed no previous research attempts to this effect. Further systematic research will now be needed to see whether current findings hold true in other CAMHS teams and can thus be generalised across the population of CAMHS professionals.

Research question two: What is CAMHS clinician's experience and understanding of the increase in cases of Gender dysphoria?

In light of the significant increase in referrals to GIDS over the last decade or so ("Gender Identity Development Service statistics", 2017), the aim of this study was to also explore participants experience of this. The data analysis yielded three main themes: *experience of increase in cases, online and societal changes and growing knowledge, awareness and conversations*. Mirroring the overall trend, most participants had experienced an increase, but some of these were reported only initially and as having become less more recently. This is an interesting finding, as the referrals that GIDS are receiving have not slowed down. It could as such be argued that this is either due to changes in processes of referrals as previously mentioned, or it may mean that less young people are being seen by CAMHS who are referred to GIDS and are instead referred to their local CAMHS due to reported mental health issues. Some participants expressed that they expected to see more cases of GD than they have during their working life. Furthermore, many acknowledged that even if they had seen an increase it has not been as significant as that experienced by GIDS. This left the researcher wondering why this is. Is it due to processes changing and other routes of referral to GIDS being available? Is it because, despite being classified as one with ICD and DSM, it is not a mental health condition and therefore individuals do not need a service from CAMHS? It also sparks a curiosity around the need and nature of a specialist service that is not local. Do these children and young people not need the support of their local services despite it being a complex journey if they are transitioning? This will be covered further below when considering question three.

All participants expressed a view that the increase in referrals was due to online or societal changes. All said that society has made significant shifts regarding its views of GD. An increase in flexibility and acceptance in others has been observed by participants and seems to reflect many changes within society including, the evolving view of sexuality. As previously mentioned, it could be argued that it is easier to focus on society as a wider group than consider a more individual stance. In relation to this finding it may be easier to consider society’s acceptance and flexibility than their own which may or may not be inline with what they perceive to be the case. By doing so the participants are protecting themselves from possible criticism. The researcher reflected on the expanding number of Pride events around the world, that began due to the Stonewall riots in New York in 1969, where a demonstration broke out against criminalisation of homosexuals, drag queens and transgender people. These events have been running since 1970 and are not exclusive to the LGBTQ+ (lesbian, gay, bisexual, transgender, queer and others) community but also increasingly include their cis-gendered and heterosexual supporters. Unfortunately, there are countries where it is still illegal to be transgender (e.g. Brunei, Indonesia and Sri Lanka) but nevertheless, these are very few now and the acceptance has massively increased across most of the world.

The access to the internet and as such more available information was felt by the present participants to have had a significant impact on this shift and the increase in individuals presenting this way. Among previous researchers and psychoanalytic writers reviewed, Bell (2020) was the only one to have offered some thinking around this increase and his suggestions for possible reasons included the accessibility of the internet and social media. As the most recent piece of literature that was reviewed, the researcher was curious as to whether the origins of the increase are beginning to be thought about more. The study participants indeed suggested that the internet and media in general has increasingly promoted and included transgender individuals, beginning with the aforementioned George Jorgensen transitioning to Christine in the US in 1952. Conversely to Limentani's (1979) negative view of this media display as "glamorization", participants felt this was positive and it allowed for a testing out of other identities and validating feelings young people are experiencing. This could thus be an important finding, as it also provides a space for individuals to find a community and therefore not feel as isolated. It related to Ehrensaft's (2011) observation that transgender individuals were often found as not being able to share their experience as a minority with their family members, which can leave them feeling alone. As such, online communities and support can provide this in a broader way. However, when considering Social Networking Sites, Balick (2014) suggests that an inconsistency of proximity and distance can be created. It can create proximity with those that are at a greater physical distance, which can be a positive, but also creates a greater sense of distance and isolation from those who are usually closer, such as family. If this is considered in light of these young people not being able to share their feelings of being a minority with their family this could result in them potentially feeling more alone whilst having this support at a distance (online).

This appears to be a new line of enquiry within empirical research, as no other study was found to consider the frequency of working professionally with this presentation. Also, there was no acknowledgment of the reported increase in frequency of this presentation in any of the studies reviewed, which made the researcher wonder whether other countries have indeed experienced the same significant vicissitudes that the UK has given that all the studies reviewed came from other countries.

Johnson and Federman (2014) were the only ones that referred to a shift in society. They reported that younger professionals were more affirming and had accessed more training. This may indicate, as participants of this current study had suggested as well, that newer generations of professionals have grown up in a society that encourages the acceptance of transgender individuals and an exploration of knowledge and understanding that hopefully will bode well for the future.

Research question three: What was CAMHS clinicians' experience of working with gender dysphoria?

The analysis of the participants' experience(s) of working with GD revealed one overarching theme named *uncertainty*. This may be a true reflection of their overall experience or may be as a result of the projections from patients. It could also be a combination of the two. However, it is important to consider what unmanageable feelings get projected into clinicians by their patients which may be a reflection of their experiences. This theme very much overlapped with the previous research questions about the definition of GD, and on reflection it left the researcher wondering about the impact the various changes in diagnosis and theory that were reported in the literature review, had on the professional world. With frequent changes and adjustments, due to all professions trying to grapple with this topic, it can leave us all finding it difficult to quite know how to define and conceptualise GD. Alongside this, it is important to consider that this may reflect what is being stirred up by this topic and a possible avoidance of knowing due to the complexity previously mentioned. Yet, as Saketopoulou's (2020) argued, trying to generalise can also feel unsatisfactory given the huge number of variations in presentations and histories. However, it begs the question as to how we find a middle ground between not wanting to come up with the one overarching definition that tries to place all individuals suffering from GD in the same box, whilst at the same time trying to understand the phenomenon and the various presentation more systematically. This wish for something clearer appears to be a parallel process to that of the process of transitioning and therefore resolving the internal conflict that the mind is experiencing due to the body. None of the authors in the literature reviewed seemed to share this uncertainty, apart from Beagen et al (2013) who specifically identified uncertainty regarding transgender care in his study. However, the recurrent theme of *lack of competency* found in some of the empirical research (e.g. Johnston & Federman, 2014, Whitman & Han, 2017, Couture, 2017) could be understood as a form of uncertainty.

It was very interesting to notice that some of the participants found it initially difficult to think about their experience(s). Despite this, a rich conversation about their confidence, the complexities, powerful experiences and their experience of GIDS emerged as the interviews progressed. In line with the findings reported by Johnston and Federman (2014), and Couture (2017), the present study highlights a lack of confidence, or competence, or preparedness as previous researcher referred. All clinicians reported a lack of training before and after qualification into their professions. This void had led participants to do their own research but, as was the researchers' own experience when reviewing the current literature, they were met with a dissatisfaction around the literature they found. Couture (2017) argues that it is our professional duty to educate ourselves and seek out training, however, it begs the questions as to what to do when there is a real lack and uncertainty as to where we seek it. It highlights the urgent need for more research that can be drawn upon. Whilst the current participants stressed the importance to have learned from their direct experience with patients, they were still left with a wish for more information and guidance.

Their reported lack of knowledge appeared to leave at least half of the participants doubting their capabilities in line with what Johnston and Federman (2014), and Couture (2017) expressed as not *feeling competent or prepared*. Many felt they were not sure what they were doing but took the lead from their patients in their endeavours to gain knowledge about the topic. Most were keen to not make assumptions and tried to be aware of unconscious biases that might get in the way. The safest way to achieve this seemed to be by allowing the patient to take the lead in the sessions and follow their explorations. In this sense, participants were clear they were not trying to "treat" or "fix" the presentation, which tallies with Saketopoulou's (2014) argument that this does not work and Ehrensaft's (2014) emphasis that our work with these individuals should not be about "fixing" them. These findings thus appeared to contrast to the participant's in Whitman and Han's (2017) study, where 11.3% reported that GD can be treated. It left the researcher wondering whether political acceptability prevented a genuine expression of participants' true views within the current study and whether assumptions had been made regarding the researcher's stance in this area which may silence more controversial opinions. It begs the question whether when society is more accepting of presentations of GD, it would be more difficult for people to be open about opinions that are conflicting. However, important is that if these are not thought about or reflected upon, such views may have enormous unconscious impact on patients that may go unnoticed or not monitored.

Similarly to Salpietro et al (2019), current participants emphasised the importance of working with the adults and professionals around them as such they stressed that the role of containment is vitally important. Within psychoanalytic theory containment for another is being a vessel for projections and feelings that are then digested before being returned to them in a more manageable form. The origins of this thinking were surrounding the mother-infant relationship (Bion, 1962). However, it is an important aspect of many relationships and in this case offering containment to the adults around individuals. Anxiety in the adult network around these patients was found to be common and therefore highlights something that needs to be carefully supported and thought about. By containment being offered to them it enables them to be able to manage and therefore support the individuals experiencing GD. However, it raises the question as to whether the anxiety is something more common with patients under the age of eighteen and as all the empirical studies, bar one, were regarding adults, anxiety may not have been as prevalent. Another important finding of the current study was the participants' fear of doing something wrong or being perceived as discriminatory. This was a significant fear for participants as they did not want to offend or upset their patients. Beagan et al (2013) and Whitman and Han (2017) found this fear to be specifically around the use of pronouns when talking to patients, whereas this study found it to be wider reaching than that. That said, participants were also aware and sensitive to the impact these anxieties can have and that it can result in a barrier to conversations and explorations. This finding appears to relate to Lemma (2018) and Bell's (2020) discussions around how we can continue to explore and discuss when these fears become too much and become a barrier to our capacity to think. Despite this, participants agreed that getting it wrong was inevitable and at times something we all do as professionals with our patients. The anxiety of doing this, though, was reported as greater when working with this group of individuals, which was interesting and left the researcher wondering why this might be and that further research into this might shed some light into it. Nevertheless, an approach of being honest and recognising that when we get it wrong was something participants felt to be important.

Alongside the uncertainty, a sense of difficulty was found when the participants described working with these patients, thinking about them and exploring their feelings and experiences with them during the interviews. Participants expressed a lack of engagement but did not hypothesise as to why. The researcher was left wondering whether their uncertainty around engaging with professionals may have been down to the concern that they are trying to be discouraged from the path of transitioning, although this may not always be conscious. Salpietro et al (2019) argue that societal discriminations and family unacceptance create barriers to individuals engaging. Although these are direct experiences, the researcher was left wondering whether the same barrier could occur when an individual experiencing GD perceives or expects this type of experiences from professionals. It may also be deemed that clinicians are in a position of power regarding decisions surrounding transitioning which therefore creates an uncomfortable dynamic that may result in a reluctance to share and be vulnerable.

In trying to make sense of the clinician's difficult in thinking about GD, psychoanalytic theory may provide possible explanations. These could include a fear of pathologizing (Withers, 2015) and again, the fact that there exist such a variation of presentations (Chiland, 2000, Saketopoulou, 2020). However, for the researcher, it appeared to be something more about this presentation that resulted in an unconscious, or possibly at times conscious, moving away from it. It was difficult to stay with the condition during conversations which resulted in GD being compared to other conditions, for example ADHD, ASC and anorexia. The difference between this patient group and others, that participants might come across in their working lives, was minimised. In addition, there was a sense of it being easier to sit with other conditions than the one currently being explored. This left the researcher wondering whether this was connected to the sub-theme of complexity or whether there was something closer to feeling uncomfortable or anxiety provoking that was being avoided. It ran through almost all aspects of their experiences including working with patients with GD, their understanding of it, the pathways for treatment on offer to patients and the other difficulties they observed patients experiencing as mentioned previously. None of the literature reviewed noted or approached this complexity around GD that was found to be such a significant part of the current findings and future research needs to unpack this further. When considering the lack of confidence regarding capability described in the empirical research, the researcher is left wondering whether this could be rooted in the complexity of GD that was found in the current study.

A noteworthy area of the complexity participants spoke about, that, again, has not been found previously reported, was regarding the powerful experiences and emotions they experienced when working with patients with GD. A wide range of emotional responses were reported with the most common being fear, concern and worry. These feelings were particularly dominant when considering children and young people transitioning and receiving treatment, significantly so when the process is rushed. This is not to say that participants felt that it should not be made available to children and young people but there was a concern expressed that exploration and consideration was not be fully allowed before life changing decisions were made. Connected to this was the feeling of pressure on participants to be able to provide a quick ‘cure’ or relief for their patients. Unfortunately this was not something they were able to do and often added to the sense of uncertainty around what to do when they could not provide what was so desperately wished for, to be able to offer the physical treatment of hormone blockers and replacements. They were left feeling as if they were withholding or inadequate which inevitably adds to a lack of confidence as previously mentioned, especially when there isn’t a space for consideration of the unconscious dynamics at play.

Another powerful emotion many participants reported was sadness for their patients and their experiences. Some of this related to the dissatisfaction patients felt within themselves regarding their body and its gender but also to the discrimination and challenges they faced. This has previously been reported on in other studies (Israel et al, 2008, Beagan et al 2013, Couture, 2017). However, a greater depth of consideration regarding the emotional impact on them and those working with them has not been investigated. In addition to sadness, anger was also a commonly reported emotion. Some of this was again, as a result of knowing about their patients’ experiences. However, participants also reported anger in relation to the transference and countertransference relationships with patients where at times there was a pull to feel angry towards the individual or more simply being left experiencing and containing the anger that the young person did not feel safe to experience themselves. As a result of the varying professions there will have been a fluctuating understanding of the impact of transference and countertransference that it is argued needs support and help to manage.

On a more positive note, participants also reported enjoyment, pleasure and expressed honour of working with these patients. For some this was about how likeable they were and how maternal they felt towards them. It is important that countertransference is considered surrounding these feelings and what participants are being invited into that the patient may not be getting elsewhere especially when thinking about the isolation and distance young people may have from their families. Whereas for others, it was about the magnitude of patients being able to talk to them about their feelings in an honest and open way that, who for some, they had not verbalised to anyone before. There was a sense of respect for these young people expressing their distress in a way that could leave them really vulnerable. Alongside this there was a substantial amount of curiosity within the participant group regarding experiences, understandings and how to approach this kind of work. Curiosity was found to be vitally important as it allows for exploration that participants reported they felt was needed. These may just be some of the powerful experiences and emotions that can occur when working with this patient group. Further, the researcher believes that this demonstrates the complexity on a much deeper level than previous studies and theories have thus far covered. It also presents the need to consider the impact of this work on clinicians, who may therefore need increased support.

As can be seen from the findings there is a noteworthy emotional impact of working with young people experiencing GD that does not appear to be addressed. It is therefore unsurprising that participants were left wishing for more space, time and exploration with patients and as a service is an important one. There was a common wish for more communication, exploration and conversations to happen within their work with patients and other professionals. Similarly to that of the suggestion of Lemma's (2018) participants argued that exploration with patients can take time and that it is thus important that this time is being provided. They argued that whilst within pressured and busy services this can become lost but needs to be kept in people's minds. It was found that conversations were lacking within this service and participants felt this resulted in thinking not being joined up between clinicians. With regards to these conversations it has been discussed previously what the barriers may be to increased exploration with patients and it has left the researcher wondering whether some of these barriers also may prevent professional discussions too. It can be argued that if we do not share the same view as our professional peers or do not feel confident with our understanding or thoughts this can limit how open we are with others therefore creating a lack of coming together to share. Where this may become stuck is in considering how we overcome this possible barrier. The participants of this study suggested that peer discussions, reflections and supervisions may be helpful. The researcher concludes that the option of a psychoanalytically informed work discussion is vital for professionals working with these young people. A work discussion group provides experiential learning with small and stable groups of professional workers (Bradley and Rustin, 2008). It is a space where the emotional impact of experiences at work are central and the conscious and unconscious feelings evoked are considered. These groups provide containment for the professional so that they can provide it for people that they work with. Jackson (2008) found that when used within work settings it helped professionals to not feel alone with a difficulty or dilemma, it allowed them to share things whilst feeling more confident and helped them to gain an understanding of what unconsciously could have a negative impact on their work. The researcher therefore concludes that a work discussion group would be highly beneficial space for professionals working with young people with GD.

They also acknowledged the need for there to be safe spaces made available where people can be honest without judgement and share their thoughts alongside possibly what goes on for them unconsciously, that they may not be aware of. For this to be open, honest and beneficial for all involved it was found that prejudices and unconscious biases need to be available to awareness similarly to Dispenza and O'Hara (2016), Whitman and Han (2017) and Salpietro et al's (2019) recommendations. Despite the similarity, the findings of this study provided suggestions on how this could be approached, in that group discussions and supervisions may help professionals to share experiences and opinions. A formal forum is needed to be facilitated by someone who could sensitively manage the unconscious biases at play.

As part of the consideration of professional contact when it comes to GD, this study reports varying findings surrounding participants experiences of GIDS. On the whole, this was focused on the limited involvement participants had had with GIDS as there was little or no contact from them despite them seeing or waiting to see mutual patients. This was disappointing and frustrating for participants and was felt to have a negative impact on the patients they were seeing. As the benefits of multi-disciplinary working have previously been discussed when young people are being seen by GIDS, (Bonfatto & Crasnow, 2018), it is a shame that this was the case for the current participants. It could be argued that this lack of communication may be a reflection on how busy their service is, or it may also be due to the pressure of the length of their waiting list, which also caused participants frustration. Despite this the researcher is curious what is being avoided on each side regarding coming together especially when the benefits of doing so are unknown. This study clearly indicates that these conversations are not being had. Consequently, it leaves professionals unsure what their processes are. Nevertheless, half of the study participants reported admiration for GIDS and what they do and acknowledged that situations where they have worked more closely with the service have provided a much better experience for the patient.

Alongside this, participants reported their feelings regarding there being a specialist service, GIDS, within the UK. It was found that participants felt this devalued what could be offered by the local services when they believed them to be vitally important to each young person's journey. However, they were also able to recognise, due to the complexity and magnitude of emotions stirred up around them, that sometimes it may be easier for clinicians to rid themselves of the responsibility by referring to GIDS. The researcher felt that the only way for this to be solved was for local CAMHS services to be able to work closer with GIDS and the clinicians within it. However, when they are so busy and have so many children to see it can feel difficult to know where to begin to help services feel less separate.

Critical evaluation of the current study and direction for future research

The results of the present study need to be considered in light of several limitations. Firstly, The sample involved 12 participants from the same CAMHS team, working in a single county within the UK. Whilst the aim of the study was to recruit a range of professionals to represent a MDT which is typically working with these individuals within CAMHS, results are limited to this particular group and cannot be generalised to other MDTs or services. As such, there would be value in replicating this study with a larger sample size to incorporate the view of other professionals making up an

MDT. A bigger and more diverse sample size in future research could, moreover, help to understand the accuracy and allow for consideration of cultural factors. The aim of the current study was not to extrapolate findings to particular professions, however, future research with a larger sample size and as such sub-group representative, might want to do that in order to look for potential differences between different professions. This leads to a discussion on whether a MDT team can be viewed as a homogenous group or indeed whether this is useful to do. The present study proceeded from the premise that it is, however, further research is needed to explore that question in and of itself. Nevertheless, within the 12 participants, five different professions were included, which resulted in a wide range of perspectives that covered most of CAMHS clinicians' professional backgrounds.

Alongside this, all of the participants volunteered for the study and therefore the current study utilised a "self-selected" sample. It could be assumed that they had an interest in the area to begin with to offer to participate. However, given the lack of research in this area, it was believed that by beginning with people who have an interest in this area may in fact begin conversations and encourage research more widely. Alongside this, although it attempted to be mitigated against in ways previously mentioned, due to the researcher being a colleague of the participants it cannot be ruled out that interviews and analysis were not influenced by this.

A further limitation of this study was that the researcher was the only person conducting the data analysis. The impact of this was attempted to be combatted by regular individual and group supervision to discuss the emerging themes and in order to prevent biases. Thematic analysis seemed the most appropriate analysis for this rich dataset in particular as the topic had not been explored much before. However, as this area of research grows, grounded theory and interpretative phenomenological analysis could be considered. This may enable a greater insight, understanding and theorisation into some of the findings of this study in future research. Most importantly, the number of themes and subthemes derived at might be indicative of an underworked analysis. Due to time constraints and having to work towards a strict deadline, this may have been the case. Yet, these are in response to three high-level research questions. The researcher emphasised the equal importance of each to understand the breadth of conceptualisation and experience. This is a vastly under researched topic and therefore the theme structure serves as a starting point to guide further research from here on. This study provides a new voice and therefore it is important to share all parts of that voice at this time.

Despite the limitations, this was the first study that explored CAMHS clinician's conceptualisation of GD. Furthermore, most empirical studies found were conducted in the US leaving a massive gap in formal research carried out in this country

Following on from this study, it would be interesting to carry out research comparing the findings to see whether there are differences in conceptualisation and experiences for professionals depending on their location. Although varied professional backgrounds were included in the participant group, the scope of the research did not allow for a comparison between the different perspectives, which could be a rich exploration in the future.

The researcher is aware of an unpublished study that explored clinician's views of their roles within GIDS. But, due to being unable to access this, the researcher is unaware of whether this included their conceptualisations or experiences of GD. If it did, then it may be interesting to compare the two studies. However, if it did not research the thoughts and experiences of clinicians in a more specialist role could add richness to the topic.

The researcher is aware that there are more studies regarding patients experiences who have GD (e.g. Kaltiala-Heino, Bergman et al, 2018; Jessen, Haraldsen & Stänicke, 2021; Jessen, Wæhre et al, 2021) than with professionals working with them. Comparing the two experiences may help to understand both sides of the conversation and consider what may help both parties to improve the experiences of each.

The current participants stressed a significant appetite for change that needs to be considered. As mentioned above, participants said that changes within and between services need to happen for things to improve, for clinicians and the patients to feel safer and for the right care and treatment to be delivered. The results of the present study have shown, that safe and honest discussions need to be able to be had within services that include considerations around experiences and possible biases that could have an impact on the way we work. The implications for services in the future as such are that more collaborative working between local CAMHS services and GIDS is vital to ensure best professional practice.

Conclusion

The findings from this study yielded so many rich and interesting areas for discussions that could have been explored further, but the space available for this was limited. However, the complexity and uncertainty around GD was prominent throughout. This was present in the ability to conceptualise whereby it was not clear whether this was a direct result of the lack of clarity around GD and the slow development in understanding or whether unconscious defences were protecting individuals from what may be uncomfortable. Alongside this, and in much greater depth, the complexity of the experience of working with GD was expressed at length. To some extent it was easier for participants to share something they could own, their experience, compared with their understanding and conceptualisation of the presentation. However, it also highlighted the powerful nature of this work.

As a result, there was a great appetite for further training and knowledge in the area, possibly to relieve the uncertainty that the thematic analysis revealed as a main finding. However, it leaves the researcher aware of the lack of cohesion and agreement regarding GD. Although, it is recognised that there are more specialist clinicians working within GIDS, it is unclear who would or could provide the level of knowledge and training individuals are looking for? This area appears to be constantly changing and it can be hard to keep up. Even whilst conducting this study several changes occurred that the researcher found themselves at times overwhelmed by and difficult to make sense of. To be able to provide the training clinicians are looking for, more cohesion would definitely be needed.

In order to achieve that, the researcher strongly believes that discussions need to be increased between all professionals involved with working with these young people, whether they are specialists or not. This may need to begin within each CAMHS service but also should be expanded in relation to other services and GIDS. If this does not happen and if communication between services is not improved, these young people will not receive the level of care they need. It appears we become easily paralysed by the concerns we have about asking questions and this being perceived as being discriminatory, and as such it is important to combat this paralysis. We may find we could eliminate the uncertainty that this study has found to be such an important aspect for clinicians currently working with these young people by coming together to develop a more coherent understanding.

More importantly, the powerful nature and emotional impact of the experience's participants were reporting identifies an unmet need for clinicians. Throughout the findings and discussion the importance of containment was highlighted in order for clinicians to be able to manage what is stirred up in them, projected into them and their unconscious reactions to individuals experiencing GD. If containment or a space to explore these aspects of the work are not available it could have detrimental consequences to professionals and the young people they are working with. Therefore, it is vital that supervision, support and psychoanalytically informed work discussion groups are available to everyone working with this patient group to ensure that best practice is adhered to.

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APPENDICES

Appendix 1

DSM V diagnostic criteria for gender dysphoria

Children:

A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months’ duration, as manifested by at least six of the following (one of which must be Criterion A1):

A

1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one’s assigned gender)
2. 2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing
3. 3. A strong preference for cross-gender roles in make-believe play or fantasy play
4. 4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender
5. 5. A strong preference for playmates of the other gender
6. 6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities

7. 7. A strong dislike of one’s sexual anatomy
8. 8. A strong desire for the primary and/or secondary sex characteristics that match one’s experienced gender

B The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as congenital adrenal hyperplasia or androgen insensitivity syndrome)

Adolescents and adults:

A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months’ duration as manifested by at least two of the following:

1. A marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
2. A strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
3. A strong desire for the primary and/or secondary sex characteristics of the other gender
4. A strong desire to be of the other gender (or some alternative gender different from one’s assigned gender)

5. A strong desire to be treated as the other gender (or some alternative gender different from one’s assigned gender)
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s assigned gender)

The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as congenital adrenal hyperplasia or androgen insensitivity syndrome)

Specify if:

Posttransition: the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen – namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male; mastectomy or phalloplasty in a natal female)

ICD 11 Diagnostic criteria for Gender incongruence

For adolescence or adulthood

Gender incongruence of adolescence and adulthood is characterized by a marked and persistent incongruence between an individual´s experienced gender and the assigned sex, as manifested by at least two of the following:

1) a strong dislike or discomfort with the one’s primary or secondary sex characteristics (in adolescents, anticipated secondary sex characteristics) due to their incongruity with the experienced gender;
2) a strong desire to be rid of some or all of one’s primary and/or secondary sex characteristics (in adolescents, anticipated secondary sex characteristics) due to their incongruity with the experienced gender;
3) a strong desire to have the primary and/or secondary sex characteristics of the experienced gender.

The individual experiences a strong desire to be treated (to live and be accepted) as a person of the experienced gender. The experienced gender incongruence must have been continuously present for at least several months. The diagnosis cannot be assigned prior the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.

For children:

Gender incongruence of childhood is characterized by a marked incongruence between an individual’s experienced/expressed gender and the assigned sex in pre-pubertal children. It includes a strong desire to be a different gender than the assigned sex; a strong dislike on the child’s part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The incongruence must have persisted for about 2 years. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.

Appendix 2

Interview schedule

<u>Semi-structured interview schedule for clinicians working with or have worked with cases of Gender Dysphoria.</u>

Title: An inquiry into how clinicians within a Child and Adolescent Mental Health Service think about Gender Dysphoria and what their experiences are of working therapeutically with children and young people suffering from it.

Welcome: explanation of it being a semi-structured interview lasting between 60 and 90 minutes. Remind them that they are welcome to talk freely about the topic of how the think about and have experienced Gender Dysphoria in their clinical work. Explain that they can discuss specific cases (past and present) that may feel relevant.

Defining Gender Dysphoria:

- How would you describe Gender Dysphoria? Given private or shared opinion?
- What is your understanding of it?

Thinking about Gender Dysphoria:

- Based on your training and experience, how do you think about Gender Dysphoria?
- This may not be the same for everyone?

Your experience:

- Have you experienced an increase in the amount of cases of Gender Dysphoria that you see?
- What sense do you make of this?

Increase in referrals to GIDS:

- What is your understanding of why there has been such an increase in referrals to the Gender Identity Development Service over the last decade?

Working with cases of Gender Dysphoria:

- What has it been like to work with a child or children with Gender Dysphoria?
- How has it been for you during sessions?
- How has it left you feeling following sessions?
- What has been like working with the family around them?
- What has it been like to work with GIDS (if this has been the case)?
- Now reflecting on that, how does it feel?

Future:

- What might help or benefit you when working with these cases in the future?

End:

- If gave shared opinion to defining GD, ask to describe again in own words.

- Anything not asked but would like to mention?
- Thank them for taking part.
- Any questions or want any further information to contact me.
- Signpost them to colleagues, supervisors and senior staff who are within the clinic at that time if they need support following the interview discussion. Send debrief out to them.

Appendix 3

Ethical approval

The Tavistock and Portman NHS
NHS Foundation Trust

Quality Assurance & Enhancement
Directorate of Education & Training
Tavistock Centre
120 Belsize Lane
London
NW3 5BA

Tel: 020 8938 2699
https://tavistockandportman.nhs.uk/

Janine Laxton

By Email

3 February 2020

Dear Janine,

Re: Trust Research Ethics Application

Title: An inquiry into how clinicians within a Child and Adolescent Mental Health Service think about Gender Dysphoria and what their experiences are of working therapeutically with children and young people suffering from it.

Thank you for submitting your updated Research Ethics documentation. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

Please be advised that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

If you have any further questions or require any clarification do not hesitate to contact me.

I am copying this communication to your supervisor.

May I take this opportunity of wishing you every success with your research.

Yours sincerely,

Best regards,

Paru Jeram
Secretary to the Trust Research Degrees Subcommittee
T: 020 938 2699
E: academicquality@tavi-Port.nhs.uk

Appendix 4 – Recruitment email for interviews

Subject title: Would you be interested in talking about Gender Dysphoria?

The Tavistock and Portman NHS
NHS Foundation Trust

Dear all

I am about to embark on my Doctoral Research Project as part of my Child and Adolescent Psychotherapy training. I am contacting you to see if you would be interested in taking part.

The project title is: An inquiry into how clinicians within a Child and Adolescent Mental Health Service think about Gender Dysphoria and what their experiences are of working therapeutically with children and young people suffering from it.

I am interested in exploring clinician's thinking and experience of working with gender nonconforming children and young people (0-18 years). I am hoping this may also provide clinicians with a space to consider and reflect on what it is like to work with these children and adolescents and learn from this for their own practise.

I would like to invite anyone who works within Level 3 CAMHS, has at least two years experience within a CAMHS team and has had experience with working with gender nonconforming children and adolescents (0-18 years) to take part in an interview to discuss what it has been like. These interviews will be guided by me and last between 60 and 90 minutes. They would take place within your usual place of work.

If you would be interested and willing to take part please find attached a participant information sheet for your information.

Kind regards,

Janine

Appendix 5 – Participant information

The Tavistock and Portman NHS
NHS Foundation Trust

An inquiry into how clinicians within a Child and Adolescent Mental Health Service think about Gender Dysphoria and what their experiences are of working therapeutically with children and young people suffering from it.

You have been given this information sheet to invite you to take part in a research project. This information sheet describes the study and explains what will be involved if you decide to take part.

What is the purpose of this study?

As part of this study I want to explore how clinicians think about and experience young people with issues around gender or Gender Dysphoria (GD).

Who is conducting the study?

My name is Janine Laxton.

I'm a researcher working for Gloucestershire Health and Care NHS Foundation Trust and training to be a Child and Adolescent Psychotherapist at The Tavistock and Portman Centre. This project is being sponsored and supported by The Tavistock and Portman Centre and has been through all relevant ethics approval (TREC). This course is overseen and certified by The University of Essex.

What’s involved?

Explanation: purpose of and background to research

The number of young people presenting with GD has significantly increased over the last decade. The Gender Identity Development Service (GIDS) received nearly 26 times more referrals in 2017-2018 than in 2009-2010 (*Gender Identity Development Service statistics*, 2017). Due to the demand for this service, the waiting time for initial appointments is currently twenty months ("About us | GIDS", 2019). Many of these referrals come from Child and Adolescent Mental Health services (CAMHS) and alongside their time on the waiting list, being assessment and receiving treatment from GIDS they may continue to be seen by clinicians in their local area. This is often to explore their gender identity and possible comorbidity, to help increase awareness and understanding of the individual’s inner world whilst addressing other areas of distress.

Multi-disciplinary working has been expressed to be vital in the treatment of these young people. The Gender Identity Development Services offers specific treatment for Gender Dysphoria including the possibility of medically transition. Whereas, CAMHS teams offer broader service to these young people that often includes their Gender Dysphoria alongside other comorbidities. However, the aims of what each team offers can be very different but equally important to the specific and complex nature of Gender Dysphoria. Therefore, the focus of the project will be on how professionals think about these children, what their experiences are of cases of gender variance and what can be learnt from this for all involved in their care.

What will participating in this project involve?

The project is an inquiry into how clinicians think about GD and what their experiences are of working therapeutically with these young people (0-18 years) is. For this you will be invited to take part in an individual interview. This will mainly be for you to talk freely about the topic with some prompts from myself. During the discussion I would be interested to hear about how you think about (from your training and experience clinically) issues around gender or gender dysphoria and what your personal experience is of working clinically with this group of young people.

All interviews will last between 60 and 90 minutes and will be audio recorded. These interviews will be aimed to be conducted face to face, however, if this is not possible due to COVID-19 they will take place via telephone or video link.

If it is possible to complete the interview face to face it will take place at your usual place of work to try and suit everyone involved.

No extension to your usual working hours will be necessary.

Do I have to take part?

No, it is completely your choice whether or not you take part in the study. If you agree to take part, you can withdraw without giving any reason at any time up to three weeks after the interview. This timescale has been decided as the data will then be being processed and analysed. If you decide to withdraw all data collected or about you it will be destroyed immediately.

Criteria to take part in the study:

- Currently working for Gloucestershire Health and Care NHS Foundation Trust’s Child and Adolescent Mental Health Service.
- At least two years experience within a CAMHS team.
- Have previous or current experience of working with gender non-confirming patients aged 0-18 years.

What will happen to any information I give?

The Tavistock and Portman NHS Foundation Trust is the sponsor for this study based in the United Kingdom. I will be using information from you in order to undertake this study and will act as the data controller for this study. This means that I am responsible for looking after your information and using it properly. I will keep identifiable information about you from this study for 5 years after the study has finished. The interview will be audio recorded and transcribed by myself.

Your rights to access, change or move your information are limited, as I need to manage your information in specific ways in order for the research to be reliable and accurate. To safeguard your rights, I will use the minimum personally identifiable information possible. I will use your name and the contact details you provide only to contact you about the research study. I am the only person who will have access to information that identifies you. I may be assisted in the analysis of this information by senior colleagues, but they will not be able to identify you and will not be able to find out your name or contact details.

Quotes from the transcript will be used in the write up of the project but these will be de-identified. However, please note, it is possible that other colleagues who know you well may recognise you in some of the quotes used, although every effort will be made to prevent this. Any extracts from what you have said that are quoted in the research report will be entirely anonymous.

All electronic data will be stored on a password protected computer. Any paper copies will be kept in a locked filing cabinet. All audio recordings will be destroyed after completion of the project. Other data from the study will be retained, in a secure location, for 5 years.

If you would like more information on the Tavistock and Portman and GHC privacy policies please follow these links:

https://tavistockandportman.nhs.uk/about-us/contact-us/about-this-website/your-privacy/

https://www.ghc.nhs.uk/privacy-notice/

You can find out more about the legal framework within which your information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, Irene Henderson: IHenderson@tavi-port.nhs.uk

There will be limitations to the confidentiality of information provided if it is deemed yourself or someone else is at risk.

What will happen to the results of the project?

The results of this study will be used in my Research Dissertation Project and Doctorate qualification. It may also be used in future academic presentations and publications.

I would be happy to send you a summary of the results if you wish. Please contact me to request this if it of interest to you.

What are the possible benefits of taking part?

There will be no direct benefits for you. However, by taking part you will be given the opportunity to consider this growing area of practise. It is hoped that it will provide a space for you to consider and reflect on your experience in a way that may be helpful for future work.

Are there any risks?

No, there are no direct risks. However, I am aware that it may be a challenging topic that involves possible unconscious beliefs which some may find uncomfortable. If needed details of a confidential service you can access will be provided.

Contact details

I am the main contact for the study. If you have any questions about the project or would like to discuss this further please don't hesitate to contact me. My contact details are:

Janine Laxton

Email: Janine.laxton@ghc.nhs.uk

Telephone: 01242 634050

Address: Evergreen House, Charlton Lane, Cheltenham, GL53 9DZ

Alternatively, any concerns or further questions can be directed to my supervisor:

Dr Felicitas Rost

Email: Frost@tavi-port.nhs.uk

If you have any concerns about the conduct of this research, the researcher or any other aspect of this research project please contact Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk).

Thank you for considering taking part in this study and taking the time to read this information. If you are willing to take part in the research please complete the consent form provided

Appendix 6

Consent form

The Tavistock and Portman NHS
NHS Foundation Trust

Project title: An inquiry into how clinicians within a Child and Adolescent Mental Health Service think about Gender Dysphoria and what their experiences are of working therapeutically with children and young people suffering from it.

Name of researcher: Janine Laxton

- I____voluntarily agree to participate in this research project. ☐
- I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
- I understand that my participation in this study is voluntary and that I am free to withdraw, without giving a reason, at any time up to three weeks after the completion of the interview. ☐

- I understand that the interview will be digitally recorded and transcribed as described in the participant information sheet. ☐

- I understand that the information I provide will be kept confidential, unless I or someone else is deemed to be at risk. ☐

- I understand that direct quotes from the audio recording may be used in this research study but will be made anonymous to the reader and held securely by the researcher. ☐

- I understand that it is my responsibility to anonymise any examples referring to cases I chose to discuss during the interview. ☐

- I understand that the results of this research will be published in the form of a Doctoral research thesis and that they may also be used in future academic presentations and publications. ☐

Contact details:

Researcher: Janine Laxton Email: Janine.laxton@ghc.nhs.uk

Supervisor : Dr Felicitas Rost Email: Frost@tavi-port.nhs.uk

Participant's Name (Printed):___________________________________

Participant's signature:____________________________ Date:____________

Thank you for agreeing to take part in this study.

Your contribution is very much appreciated.

Appendix 7

Demographic details

Age of participants				
Age in years	**25-35**	**35-45**	**45-55**	**55-65**
Number of participants	2	2	6	2

Ethnicity					
Ethnicity	**White British**	**White Irish**	**White Welsh**	**White Other**	**White African**
Number of participants	8	1	1	1	1

Gender		
Gender	**Female**	**Male**
Number of participants	7	5

Professional Backgrounds					
Professional Background	**Child and Adolescent Psychoanalytic Psychotherapist**	**Counsellor**	**Mental Health Nurse**	**Clinical Psychologist**	**Psychiatrist**

Number of participants	3	2	2	3	2

Years of experience in CAMHS							
Years	**2-5**	**6-10**	**11-15**	**16-20**	**21-25**	**26-30**	**31-35**
Number of participants	3	3	1	2	1	1	1

Appendix 8

Debrief

The Tavistock and Portman NHS
NHS Foundation Trust

Dear….

I am writing to thank you for your contribution to my Doctoral Research Project. I hope you found it as interesting as I did.

If following taking part there are any issues that are concerning you I hope that you can access the support network around you (colleagues, supervisor and managers). However, if this isn't possible there is a confidential counselling service provided by Gloucestershire Health and Care NHS Foundation Trust:

Counselling at Working Well

Counselling can be an informal, yet highly effective way of sorting out problems before they become unmanageable. It provides a safe, consistent space for a qualified and experienced counsellor to support you and explore anything you might be finding difficult or that is causing you concern or distress. The service is paid for by your Trust for use by individual members of staff or staff groups. The service is also available for immediate family members as well.

You can self refer as follows:

Gloucestershire Health and Care NHS Foundation Trust employees – call Working Well on 01452 894480 (8:30 – 16:30) or email workingwell@nhs.net and say you want to book some counselling sessions. The receptionist will take your contact details and discuss your availability; you need to commit to 7 appointments at the same time and day every week for 7 weeks. The receptionist will not ask why you want to come.

If you have any questions or would like further information here are my contact details:

Email: Janine.laxton@ghc.nhs.uk

Phone: 07816555189

If you have any concerns about how the study has been conducted please contact myself, my supervisor Dr Felicitas Rost (FRost@tavi-port.nhs.uk) or Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk).

Kind regards,

Janine Laxton

Appendix 9 – List of codes

A
A space to explore GD within the service would need to be handled well
A level of anxiety is helpful to stop you making assumptions
A lot for parents to get their head round what it means for them
A lot of helplessness in patient's experiences
Abnormal social communication
Abuse acted as a barrier for transition
Abuse isn't the reason people want to change their gender
Abusive parents
Abusive unacceptance
Absorbing the patients feelings
Acceptance important
Accessibility of things online massively changes things
Acknowledging biological and preferred gender from the outset
Adapting approach/skills to GD
Adult anxiety about doing the right thing can push the young person into something they aren't ready for
Adult around the child finding it difficult to manage, like, understand or accept the expression of GD
Adults around network needing quick relief from feelings stirred up by patient's GD
Adult services more dismissive than CAMHS around GD
Adults more anxious about gender fluidity than young people
Adults needing to accept the need to explore more
Adult services feeling unknown
Ages ranging from six to seventeen
Agony of not being accepted
Alarming
All been tricky
All cases been on GIDS waiting list but not actively seen

All feels very new and recent

All girls school embracing GD

All girls school making adjustments for GD pupils

Allowing conflicted feelings for parents

Allowing expression of frustration

Allowing time

All patients contemplating suicide during GD journey

Always been a collection of things when start to explore

Always other things going around, never purely just GD

Ambiguous topic

Am I being helpful?

Anger at how normalised GD has becomes

Anger that carers couldn’t manage their uncomfortable feelings around GD

Anger towards views of GD group

Angry that had to accepted rules and regulations around GD

Anxiety about getting things wrong

Anxiety and concern can often be much higher in people around the patient than within the patient

Anxiety around GD dominates and influences what offered by CAMHS

Anxiety can block understanding the unconscious around GD

Anxiety in the family about decisions young people were making

Anxiety in the network around these young people

Anxiety in the network influencing and dictating what is being asked of CAMHS

Anxiety of parents in treatment

Anxiety provoking

Anxious and uncertain before meeting someone

Appreciative of other clinicians

Archaic ideas around gender

Are adolescents too young to be making life changing decisions?

Are clinicians who have had personal analysis more equipped to work with these patients?

Are people jumping on the band wagon?

Are the feelings different to other patient groups?

Are their two genders or more?

Are we trying to treat GD?

As a CAMHS service run the risk of representing an intolerance to GD

As knowledge increases so does referrals

As knowledge increases so does understanding

As part of academic programme heard a talk from someone from mermaids

Assuming it’s something you feel or decide on slowly

Assuming others have a lot more knowledge than they do

Assumption that abusive experiences have been a determining factor in the wish to change gender

Attending to the worries creates further concerns

Authenticity feels very important

Autistic spectrum

Avoiding exploration

Avoiding training from GIDS

Awareness has increased as people now see the dysphoria

Awareness of amount GIDS have to do

Awareness of the parents struggle

Awareness of the recording

Awareness of the third

Awareness of what they bring to the work

Aware of the impact carers views had on young person

B

Balancing the feelings of the parent and child

Based in identity exploration

Became transgender to follow homosexual desires

Becomes less charged the more people are aware of it

Being able to portray a different identity online

Being born in the wrong body

Being born in the wrong gender

Being curious

Being gotten rid of

Being in a room with them was difficult

Being left with a lot of things following sessions but no different from any other work

Being left with a sense of how complicated things are for them

Being left with a sense of how rigid the world can be

Being left with intolerable levels of anger

Being left with intolerable levels of anxiety

Being seen as offensive is a barrier

Being the first person patient had told

Belief that to be the best mother had to join their child and affirm their transition

Believe have too many pathways

Believe identity disorders need intervention

Believe social media has played part in increase

Believe that should give GD time and allow other factors around to be properly dealt with

Believe that society would like to wish GD away

Believe time and support can change dysphoria

Between binary constructs

Big dilemma for them when parents aren't accepting

Binary constructs

Biological perspective of gender

Biology and how feel about themselves don't match

Biology/physiology is only part of gender

Biological versus who feel they are different

Black and white thinking

Blaming on ASD

Born in the wrong body

Brief about contact with GIDS

Briefly touched on in professional training in an optional workshop

Broader scope gives a sense of who someone is

Bullying

C

CAMHS don’t want to deal with the politics

Can be an uncomfortable conversation that need to have with them

Can be a postcode lottery as to what young people receive

Can be hard to understand unconscious drives

Can be helpful without understanding

Can be perceived as an intolerant service if want to explore things

Can be very provocative

Can personal views be shared when being recorded

Can young people know during adolescence what route they want to take?

Can’t relate to personal experience

Care homes wanting young people to hide away

Cases have been profound for them on a personal level

Cases in CAMHS rarer than quoted numbers imply

Challenging changing external body rather than internal processes

Challenging patient's belief is upsetting for them

Challenging them

Challenging to confront parents about their part to play in GD.

Challenging to hold back assumptions sometimes

Challenging to work with GD

Challenging when parents believe more about sexuality than gender

Change can be shocking

Changes in societal thoughts

Change of terminology

Changes to protocol within CAMHS

Changes towards something more flexible in society

Changes towards something more fluid

Changing supervisors due to idea of

conversion therapy

Chronic lack of sense of self

Clinging on to old child

Clinging to structure to feel less anxious

Clinging to the label

Clinicians focus on different things with GD

Clinicians judging parents for not being accepting

Clinician knows the patient better than anyone

Clinician needing to bring expression of male potency

Clinicians not able to stop and think about complexities of GD

Clinicians not talking about these cases much

Come to realise many reasons why someone might have GD

Common FTM to have experienced sexual abuse

Comorbidity

Comparing experiences with other clinicians

Comparing it to other conditions

Comparing to other conditions

Comparisons with sexuality

Complex histories

Complicated families

Complicated process to decide how working with these patients

Complicated process to understand

Concentrating on the patient’s experience

Concerns about GIDS being a specialist clinic

Concerns about GIDS being at the Tavistock due to historical treatment of gays

Concerns about ethics of GIDS

Concerns about how GD may be received by others

Concerns about how other clinicians might respond to some of the feelings stirred up by these patients

Concerns around assumption abuse is the reason for GD

Concerns around it being considered treatable

Concerns about policies and procedures in social care
Concerns around the family
Concerns for persons safety when have GD
Concern in the network around the patient
Concerns about CAMHS service condoning an intolerance of GD
Concerns that amount pressure from amount of referrals to CAMHS might mean tempted to just refer to GIDS and discharge
Concerns that post op suicide rates are still very high
Concrete thinking in the patients
Confidence in knowing not in the right body
Confident in general CAMHS skills
Conflict between internal and external states
Conflict of internal and external worlds of patient
Conflict with parents
Confused what to do with them

Confusion
Confusion about different services
Confusion, fear and terror were very vibrant in their relationship with patient
Confusion for patients
Confusion of services and responsibility
Connection with autism
Consequences of patient’s choices
Considered a specialist
Considered highly political
Considered important part of training caseload
Considering experiences leaves with a mixture of feelings
Considering family dynamics and upbringing
Considering impact of past experiences
Considering parental perspective
Considering patient perspective
Considering what would be like for themselves as a parent
Consider what the CAMHS service

offer and why

Consider whether clinician’s views are impacting how we work with GD

Constant looking for something that’s going to make you feel whole

Containing

Containing function of GIDS

Containing the adults so they can be containing for the young person

Containing the anxiety in the network around patients

Containing the frustration

Continuum of genders

Controlling parents

Conversations reduce difficulties

Could only stay in foster family if stayed their biological gender

Creating a safe space to think

Crying for the patients thoughts, experiences and challenges

Curious about GIDS perspective

Curious about differences between all girls and all boys school approaches to GD

Curiosity about it

Curiosity about their fluctuations in feelings

Curious about patient’s journey

Curiosity about what GD is about

Curiosity about what it means for the patient

Curious about what social context means for a young person feeling able to explore their gender

Curiosity about where GD has come from

Curiosity about whether it is more manageable for girls to identify as boys than vis versa

Curiosity about the patient’s experience

Curiosity allows freedom

Curiosity important

Curiosity seen as discrimination

Curiosity is helpful

D

Decrease in cases now

Decision to take medical treatment is

their own

Deeply affected by these patients

Defining gender can be confusing

Defining gender dysphoria

Defining terms feels important

Definitions are inadequate

Deflecting from personal views to other’s suggestions

Deflecting to other conditions

deflection from personal thoughts

Devaluing what can be offered locally by referring to GIDS

Didn’t feel able to ask questions or being honest during GIDS training

Didn’t pursue therapy due to the thinking that needed to be done

Didn’t see themselves the way their body physically presented

Difference between external presentation and internal sense of conflict

Difference in ability to come out socially

Differences in how define gender

Differences of adult services

Different between issues around gender and sexuality

Different experiences may be had with different disciplines or clinicians

Different language of patients, professionals and people around them?

Different parental reactions

Different reasons for identifying this way

Different terms used to describe

Difficult and tricky relationship with patient

Difficult area of practise

Difficult experience working with GD

Difficult for parents

Difficulties when in a single sex environment and have GD

Difficult to challenge

Difficult to change ingrained perceptions around gender

Difficult to define gender

Difficult to describe GD

Difficult to explore gender
Difficult to explore with the families
Difficult to explore with the patients
Difficult to give personal view
Difficult to know what constitutes GD
Difficult to link in with the Tavistock/GIDS
Difficult to question gender
Difficult to quite know how to describe GD
Difficult to sit with not knowing
Difficult to support people whilst struggling with own prejudices and fear of offending
Difficult to stay with this condition
Difficult to think about and hold onto thoughts about it
Difficult to work with the families
Difficult to talk about gender
Difficult when challenge them
Difficult when GIDS don't work closely on cases
Difficult when they don't want to explore

Difficulty around gender
Difficulty around identity
Difficulty working with families
Digesting what is going on for patient in isolation
Dilemma of whether want to change the expression of gender
Disagree with affirmation of GD without challenging
Disagree with entitlement patients express
Disagree with GIDS being in London rather than nationwide
Disclosure of GD felt big for the patient
Discomfort with gender and body remains constant
Dismissed by parents for supporting young person
Dismissive of some more fluid identities
Dissatisfaction of the body
Dissatisfaction to point of wanting to alter
Dissatisfaction with gender

Dissatisfaction with sense of self

Dissatisfaction with who are as a person

Dissatisfaction with who they are feels mind blowing

Discussions changed view and made them more unsure

Distressing telling family

Diversity doesn’t matter

Diversity within the group

Doesn’t feel ok to ask questions about GD treatment

Doesn’t seem to be any evidence-based approach within CAMHS to GD

Doing own research due to interest

Done reading around the topic

Don’t agree with young people going down the medical route

Don’t believe it is a biological/neurological difference but how it is managed

Don’t feel decisions should be made just by specialists

Don’t feel it is helpful to refer everything to GIDS

Don’t feel like belong in their body

Don’t feel London would understand parents or young people from other areas of the UK

Don’t feel responsible for making decision about medical treatment

Don’t feel the politics of history has been explored properly yet

Don’t feel there is any good theory around GD

Don’t feel sex reassignment surgery is the answer

Don’t fully understand an awful lot about it

Don’t need to fit into stereotypes anymore

Don’t really give GD much thought

Don’t think having a specialist clinic is helpful

Don’t think there is a way of curing GD

Don’t understand GD

Don’t want people who have GD to be turned into people with a mental disorder

Don’t want to get it wrong

Don’t want to rush into anything

Done own reading around the topic

Doubt capabilities

Doubting understanding

Do they disagree with the option of changing genders?

Double deprivation

Drawing on personal upbringing to understand

During training focus was more on gay identification than gender

Dysphoria about body versus belief that in the wrong body

E

Each case needs to be thought about completely uniquely

Easier to be transgender than gay

Easier to delegate to specialist service than sti with the uncomfortableness of GD

Easier to find definitions/explanations

Easier to sit with other conditions

Easier to talk about other conditions than GD

Easier to work with GIDS when the waiting list was shorter

Easily misunderstood

Eclectic mix of people around them personal life

Effective supervision vital

Embrace difference in personal life

Emotional rollercoaster of talking about their GD

Emotional that patients can think and talk about it with them

Encouraging young person to share with family

Enormity of the impact of medical interventions

Enjoy the work with GD patients

Enjoy considering the defences at play

Enjoyed reflecting on a case with the focus point of GD

Enjoyed the space during the interview to reflect on past cases

Enjoyed working with GIDS

Enjoying helping them reclaim their biological gender?

Enormity and agony of what the patient holds onto till they can speak to them

Enter complex journey

Erections experiences as painful, distressing, without pleasure and abnormal

Euphoria following sessions

Excellent that exploration and treatment is possible

Expectations of GIDS changed over time

Expected to be the expert

Expected to see more cases of GD

Expect differences between clinicians seeing them

Expecting to get it wrong at times

Experienced a huge increase in referrals

Experience of many GIDS staff moving on due to scandal

Experience of parents driving the wish to change gender

Experienced process as a rollercoaster

Experiencing GIDS as distant

Experimenting with gender should happen at school not at home

Exploring can be uncomfortable for patients

Exploration of identity

Exploration important

Exploring gender versus wanting to transition

Exploring identity is a lengthy process

Exploring it together with patients

Expressing GD for some of them means belonging to a group

Expression of GD varied depending on who patient was with

F

False sense online may class with reality

Families causing ethical dilemmas

Families constructing gender roles

Families not accepting

Families not allowing expression of identity

Families projecting difficulty into the patient

Family acceptance
Family acceptance hardest part
Family and network not wanting treatment to take too long
Family dynamics having an impact on their sense of identity
Family influences
Family perception of gender
Family refusing to have any contact with patient due to GD
Fascinated by difference in people
Father didn’t speak to them for months
Father left due to child’s GD
Fear of being influenced by new research
Fear of being perceived as discriminating
Fear of being perceived as judgemental
Fear of GD being contagious
Fear of getting it wrong
Fears of impact GD will have on them at school
Fear of impact on patient if get something wrong
Fear of judgement around whether capable as clinician
Fear of litigation for medicating a minor during their transition
Fear of negative suggestions online such as suicide being a good way out
Fear of saying something unacceptable
Fear of saying the wrong thing
Fear of telling family
Fear of them killing themselves
Fears about adult services
Fears around school following strong political agendas and not being flexible enough to allow young person to grow
Fear of being experienced as repulsive or dangerous male
Fear of difficult conversations about gender
Fear of exploration
Fears of feeling uncomfortable
Fear of getting it wrong
Fear of media discussions around it

Fears of not understanding

Fear of stress of GD killing a family member

Fear of talking about gender

Fear of taking GD external to the clinic space

Fears of what people can find online

Fearing being perceived as discriminatory

Fear that being unethical

Fear that young people will complete transition

Fear that sit on GIDS waiting list without a thorough assessment

Feel a deep sadness for these young people

Feel a lot of pressure to tow the political line

Feel angry that medical treatment is offered to young people

Feel an honour that patients can think and talk about it with them

Feel a specific GD clinic would be helpful

Feel been given impossible task

Feel big difference between GD and GID

Feel decisions and conversations need to happen at a local level not just with specialists

Feel diagnosis and treatment of GD is very very blunt and not scientific

Feel doing them a disservice if just referring them straight to GIDS

Feel don’t understand GD

Feel GD is a genuine disorder that people suffer from

Feel GD is met with a concrete response

Feel GIDS is caught up in something

Feel had some chances to explore ideas around GD in many areas of life

Feel have very little knowledge about transitions

Feel have limited experience

Feel hopeless where there is domestic violence and trauma

Feel in the wrong body

Feel it is a powerful, political stance to not acknowledge a young person’s gender preferences

Feel it is important the varying clinicians views should be out in the open

Feel it is often part of a defence

Feel it’s cruel to not acknowledge a young person’s gender preferences

Feel like people are blindly signing up to medical transitions

Feel like they have a lot more to understand about GD

Feel like they know a bit about GD

Feel lucky that may not see them for a while when they are frustrated with things moving slowly

Feel peer group supervision would be helpful

Feel privileged to get to know them so well

Feel sad that as local teams we were made to look like we know nothing

Feel sad that now young people being seen at GIDS don’t have to be seen locally

Feel silenced

Feel society rushes things and doesn’t give enough time

Feel there has been an increase but unsure

Feel they need support from local services, not just GIDS

Feel this presentation stops exploration of honest thoughts and feeling

Feeling angry

Feeling angry for them

Feeling anxious with patients

Feeling apprehensive

Feeling awful for the patient

Feeling CAMHS could do more

Feeling deeply sad for the young person due to their family’s reaction

Feeling frustrated by the language and terminology

Feeling have been helpful when progress is evident

Feeling held by clinician

Feeling helpless

Feeling honoured and privileged to

have people open up and talk about their GD
Feeling honoured that patients could trust them with information about their GD
Feeling honoured to work with these patients
Feeling inefficient
Feeling in the wrong body
Feeling irritated by patient
Feeling like don’t have the right identity
Feeling like don’t know
Feeling like don’t know what doing
Feeling like lost their daughter
Feeling like the patients have nowhere else to take it
Feeling maternal towards patients
Feeling muddled about what GD is
Feeling ok with how young people feel changing
Feeling overwhelmed
Feeling out of their depth with patients
Feeling parents need to be help locally with communities who understand
Feeling patronised by GIDS training
Feeling really strongly that shouldn’t be referring children to GIDS in London
Feeling sad about their loneliness and isolation
Feeling sad and fearful for the young people
Feeling sad for the patient
Feeling that they were born in the wrong body
Feeling unable to have conversations that want to
Feeling uncertain
Feeling uncomfortable about dysphoria
Feeling uncomfortable in their own skin
Feeling unfair
Feeling unprepared with patients
Feeling unsettled by how difficult the world can be for these patients.
Feeling unsure what is going on
Feeling useless
Feeling very angry for them

Feeling very protective of them
Feeling very sad for these young people
Feelings towards patient depended on whether felt genuine or a game
Feeling very very worried about patients when parents are unaccepting
Feels a big risk of others disagreeing when honest about this topic
Feels a massive responsbility
Feels bit responsibility when you are the only person they are their true self with
Feels concerning not to know what’s going on
Feels like a long road ahead
Feels massive to parents
Feels more of a mainstream conversation for teenagers now
Feels society is uncomfortable with gender being more fluid
Felt conflicted working with parents of GD patients
Felt GD was separate to sexual abuse for young person
Felt in the know with GIDS
Felt like a massive learning curve
Felt pressured not to think
Felt rules and regulations stopped thinking around GD
Fight to have it recognised
Find GD and run with it but may not be the route
Finding a group
Finding an identity
Finding hard when patient is rigid
Finding it bizarre
Finding it hard to describe GD
Finding pronouns difficult
Finding themselves being more thoughtful about parents than the child
Find it overwhelming that patients feel like this
Finding explanation for their feelings
Finding it really difficult with parents
Finding patient's expectations hard
Finding group culture of GD unusual and interesting
Finding work with GD daunting

Find it very difficult in sessions

Fixed versus fluid

Fluidity around gender feels more realistic

Fluidity of gender

Fluidity of gender has changed hugely over their lifetime

Focusing on defining terms

Focusing on gender misses other parts

Focusing on how difficult it is for parents

Focussing on parents distress rather than young person’s

Focusing on sexuality

Focus on getting referral to GIDS

Foster carers fearing encouraging something wrong

Foster carers feeling uncomfortable with GD

Foster carers finding GD shameful

Foster carers rejecting child due to GD

Foster carers wanting the child to hide their GD

Foster parents feeling particularly anxious

Found GIDS mostly supportive and helpful

Found GIDS suportive

Found it difficult working with the parents

Found majority of parents to be unhelpful

Found other clinician’s views challenging

Found psychoanalytic theory can pathologise GD rather than try to understand

Found some articles about GD to be rigid and a misunderstanding

Found the interview space really interesting

Found working with GIDS confusing

Frustration

Frustration around GIDS waiting lists

Frustration of waiting for GIDS

Frustration that pressure is being put on young people to go down a route that they may not be ready for

FTM more supported than MTF in local schools

G

Gaining understanding can’t be rushed

GD a gateway into CAMHS

GD as aggressive attack on mother

GD as an attack on parents/objects

GD as a group

GD as an option for expressing their distress

GD and sexuality often mixed up

GD a new concept

GD because they know they can

GD being the person’s perception of themselves

GD causes a huge amount of distress

GD causes all kinds of complications, issues and anxieties

GD causes a lot of disagreement in society

GD causes immense sadness

GD causes significant impact daily

GD causes unhappiness

GD causing bullying

GD causing patient debilitating trouble impacting daily life

GD covering up another issue

GD defensive structure to protect against fear of male potency

GD difficult to think about in isolation

GD due to sexual abuse

GD due to struggling with identity in adolescence

GD due to trauma

GD emerges due to a feeling of being at odds with their development

GD expression of gender incongruence

GD gives them a sense of identity

GD group identity different to other conditions

GD has more language to describe it now resulting in it being used more

GD impacted by peer identity and confusion in adolescence?

GD is a difficult journey

GD is becoming clearer as time goes on

GD is difficult to define
GD is an uncomfortableness with their biological gender
GD is a way of letting it be known they are struggling or there is a difficulty
GD is people have different thoughts around their gender to the gender assigned at birth
GD less shameful
GD less taboo
GD linked to family difficulty
GD may be mask for not feeling heard or validated
GD never occurs on it’s own
GD not always main concern
GD not always the biggest issue
GD not previously acceptable
GD often causes parents a lot of distress
GD only part of the person and the stuff going on for them
GD origins are very hard to think about
GD part of wider difficulties
GD previously caused a lot of persecution
GD is quite complex
GD reflecting another difficulty
GD seen as an aspect of wider state or issue
GD scares a lot of clinicians
GD stirs up a lot of anxiety in adults, the world and society
GD stirs up stronger opinions than other mental health difficulties
GD sufferers known pretty much all their lives
GD tearing family apart
GD used as an attack on parents
Gender as a continuum
Gender as an identity
Gender as an identity perception
Gender as a preference
Gender as identity rather than physical body parts
Gender as outlet for other difficulties
Gender assigned at birth has been so rigid for a long time
Gender as something fluid

Gender being more fluid
Gender change/reassignment feels too heavy for young children
Gender concerns versus GD
Gender contains multiple things
Gender dysphoria more acceptable than homosexuality in schools
Gender not connected to physical sex
Gender preferences ingrained in own culture
Gender really individual
Generalising rather than focusing on GD
Genuine dissatisfaction with body
Get a sense of the agony for the patient
Getting caught up in a fixed way of thinking about gender rather than something fluid and explorative
Getting it wrong feels really dangerous
Getting rid of what makes them uncomfortable about their body
Get to experience pain patient has been through

GIDS didn't link up with other cases
GIDS often pushing for psychotherapy input for young people
GIDS often recommend local psychotherapy
GIDS pushing for exploration of sexual abuse to be explored before being allowed to transition
GIDS pushing for psychotherapy as a way of coping with their limited resources?
GIDS recommending work with local CAMHS clinicians
GIDS services less clear
GIDS specialism not ours
GIDS taking young people out of the context they've grown up in
GIDS trying hard to do a good job despite overwhelming number of cases
GIDs used to have more presence
GIDS well organised
Giving a name/reason to their difficulties
Giving families the sense that GIDS

has the magic answer

Giving self permission to be curious

Giving time to explore dysphoria is really important

Going against what families want

Good communication with GIDS

Good outcome with parents has been when they are able to think more psychologically about their child and why they are going through this

Grateful that have the chance to work with them

Greater amount of knowledge and information around GD now

Grey area

Grief

Grieving for child

Group culture

H

Had some discussions with GIDS

Had strong personal views

Had to seek out parts of training that thought about GD

Had very little training around GD

Hard when exploration not possible

Hard to be in touch with and aware of unconscious bias

Hard to be the only one they talk to about their GD

Hard to describe gender

Hard to know where to gain facts about GD

Hard to sit with anxiety around them

Hard to understand for parents

Hard to understand when not own experience

Hard to even name what is going on

Hard when won't explore what you want

Harder to work with when rigid

Harder when they want more guidance

Has GD always been around but not validated?

Hasn’t previously felt safe to express GD

Have they really had GD?

Haven’t seen the same rate of

increase as GIDS

Having a patient with GD sparked their interest

Having no contact with the GIDS team

Having specialist in London undermines and takes away from the thinking that can be done locally

Having specialist service pathologises GD

Having to do GIDS work while on waiting list

Having to seek better understanding and knowledge themselves

Heading into the unknown

Hearing parents perspective was useful

Heightened awareness of getting it wrong

Helping parents hold the frustration

Helping parents to be more supportive and sensitive

Helping parents to think psychologically about their child

Helping patient to broaden their thinking

Helping patient to find their real self

Helping them manage the transition from hiding to being open with parents

Helping the young person to have confidence to speak to their families

Helping to find congruence

Helpful to get a wider understanding of family’s situation

Helpful to have positive and negative experiences with parents

Helpful to pick out prejudices against GD within CAMHS

Helplessness following sessions

Hesitant about the language they use

High level of concern around patient’s expression of GD

Historical abuse

Historically some really shit theory around GD

History of trauma

Holding

Holding anxiety so young person can develop in the way they want at the pace they want

Hopeful that provided good enough service
Hopelessness following sessions
Hope that there aren’t many people later regretting decisions
Hormone imbalance possible reason for GD
How does the patient consider gender
How do they understand their gender
How hard to push them
How to define gender?

I

Idealisation of GIDS from patients
Idea that changing gender will make everything ok
Identification with perpetrator of abuse
Identify as anything less genuine
Identity fluctuations
Identity in young people can change
Identity now more expressed through sexuality, gender and identification
Identity used to be about music or hair
I don’t know what to call it, how to class it
If accepted by the family would they need CAMHS?
If identity disorder need intervention, dysphoria needs space to consider
If lots of distress ethical to provide treatment
If you offer a service more people will come
Ignored by GIDS
Impact on others depends on their own beliefs and expressions
Impact on those around the patient can be very unpredictable
Importance of communication
Importance of exploration
Important not to rush and for time to be given to think, explore and deal with what is going on
Important that grapple with things when working with these patietns
Important they feel heard and validated whilst also asking questions
Important to explore
Important to consider other factors not just GD

Important to try and understand why they might be using GD in a specific way to get their needs met
Important to understand their lived experience
In a battle with the parents
Increased acceptability of sexuality made people feel more comofortable to come out
Increased knowledge causes increased vigilance
Increased knowledge results in more attention paid
Increased sense of gender fluidity
Increasing confidence
incongruence
Incongruence between internal and external states
Incongruence works exploring more than clinicians do
Incorporating families into the work more than might with other patients
Individual curiosity
Information changing fast and wanting to keep up to speed

Initial increase in cases/referrals
Initially believed GD had been provoked by difficult experiences or was an attempt to avoid things
Initially felt unequipped
Initially provoked strong feelings in them when had cases of GD
Initially was closed off, shocked and limited in their thinking around GD
Inner feeling that somethings not quite right
In the wrong body
Insecurity about the topic
Insecurity in explaining view of GD
Interest in GD came when started working
Interesting discussions as a professional cohort
Interesting working with parents
Internal feelings or external assignment that problem?
Internal versus external conversation different
Intolerable feelings

Irreversible changes
It is all very challenging work around GD
It feels driven by a political agenda rather than an understanding of young people’s struggles
Is it easier to focus on sexuality?
Is GD a defence?
Is GD a motivation?
Is it a mental illness?
Is it an internally painful expression of psychic pain about incongruence?
Is it dysphoria?
Is it even a condition in it’s own right or is it part of something sider?
Is it possible for the service to have a shared starting point for working with these patients?
Is the motivation to move towards something or away from something?
It was considered irrelevant during training
J
Judgement

K
Keeping the exploration within teams may be easier than service wide
Kept involved with GIDS
Knowledge increasing
L
Labels provide understanding
Lack of capacity to manage/accept their child
Lack of confidence with GD
Lack of clarity around language that is use
Lack of connection with GIDS
Lack of curiosity in our CAMHS
Lack of exploration around gender in GIDS training
Lack of exploration frustrating
Lack of focus in training
Lack of joined up thinking within teams
Lack of parental containment
Lack of paternal role resulted in maleness being terrifying
Lack of willingness to explore
Language changes regularly

Learning about right language from social media
Learning alone
Learning from experience
Learning from personal experiences, conversations with other professionals and patients about GD
Learnt about GD from experience with patients
Learnt from reflection about what have read
Leaving the responsibility around medical treatment with GIDS
Leaving to the specialist
Left feeling lost
Left feeling low following sessions
Left individual to learn about it themselves
Left not knowing
Left questioning assumptions and understanding by meeting patients
Left to feel like assume will be discriminatory
Left very moved following sessions

Left with a massive range of emotions
Left with confusion
Left with lots of questions
Left with tension when parents aren’t accepting
Less cases recently
Less cases versus less novelty
Less of a conversation around GD than previously
Less patients with GD than expected
Less societal stigma
Letting the patient take the lead
Life is very fluid but with GD time isn’t given
Likeable bunch of kids
Limited knowledge initially
Little contact with GIDS
Loneliness and isolation of the patients
Long term intensive therapy for patient
Long waiting lists
Looking for answers in what’s been written around it
Looking for a quick cure

Looking for guidance from GIDS
Looking for guidance from specialists
Loss of accepting person
Loss of their child
Lots of anxiety around young person
Lots of anxiety in the adults around them
Lots of concern often stirred up in the external worl
Lots of different ways of describing GD
Lots of pressure on these young people to transition which don’t agree with
Lots of silence
Lots of speculation around origin of GD
Lots of structural barriers for young people who want to transition
Lots of things we don’t know yet and need to be careful
Lots of ups and downs
Lots of variation and change in the language used around GD
Lots of worry and concern about GD

Love the patients
Loved working with GD patients
Lumped under mental health
M
Majority have been older adolescents
Make assumptions based on previous patients
Making reference to other disorders
Managing anxiety in parents
Managing own anxiety
Many aspects contribute towards a person
Many aspects of who a person is
Many different issues coming up for different patients
Many different possibilities
Many levels to gender
Many more people having discussions around gender
Many other things going on for these young people
Many people previously hid GD and were very very unhappy or killed themselves

Many personal reactions within each clinicians
Many ways to describe and label that young people give themselves
Many young people struggle with identity during adolescence and childhood
Massive variation in language used
May be easier to refer to GIDS than manage themselves as CAMHS services
May be easier to use the label of GD than look at other things going for that person
May be helpful for the service to offer more space to explore GD but also very complicated
May seem to be functioning well but may still be things to be addressed
Media allowing for lots of people identifying in different ways
Media making conversations more mainstream
Mediating the parent child relationship
Mental illness versus expression
Mind and body complimenting
Mind and body not complimenting
Minimising differences compared to other patients or families
Minimising difference to other work
Mixed experiences of working in a multi-disciplinary way with GIDS
Mixed experiences with GIDS
Mixture of responses from parents
More able to talk about GD now
More acceptable to have a different perception of your gender
More acceptable to have more fluidity around gender
More acceptable to talk about GD
More acceptance in society
More awareness results in increased ability to talk about GD
More broadly about identity?
More conversations around GD happening now
More experimentation with gender
More exploration around dissatisfaction with body

More freedom to be open about feelings and mental health

More genders now

More ok to be an individual

More open conversations around gender

More prevalent a few years ago

More space needing to be given for parents

Most cases came from GIDS recommendations

Most cases felt GIDS wasn’t interested in what they were doing

Most parents been supportive and thoughtful

Mother initially shocked, hurt and retreated

Mother needing own therapy to understand and shift her enjoyment of her child

Mother’s disgust in son as a boy

Mother’s fear of son being like his father or other male family members

Mother’s perception of maleness resulting in abuse and danger

Mother’s preference of girls

Move towards gender being more fluid

Move towards other gender as an attack of the maternal object

Moving away from their biological gender rather than towards perceived gender

Moving to description of patient rather than experience

Much better experience when work closely with GIDS

Much more acceptable to have GD now

Much more complicated situation for patient than just GD

Multi agency liaison important

Multi agency liaison missing

Multitude of factors

N

Needing equal attention to other conditions

Needing more conceptualisation with CAMHS around GD

Needing time means ruining child’s life

Needing to be careful when explaining thoughts

Needing to decide on an approach

Needing to stand their ground that doing what they feel is in the child’s best interest rather than just what they want

Needing to think more about parents

Need more discussions as a service

Need more integrated and joined up thinking as a service

Need more resources for families around these patients

Needs patience to work with this patient group

Need to be able to consider the defences at play more to understand

Need to be held and supported by local services

Need to consider psychosocial changes going on for each person before intervene

Need to learn understanding GD from experience

Need to question treatment more

Need to think more about how we see gender and where it sits and the assumptions we make

Need to think particularly about how support parents

Need to treat whole patient rather than just GD part

Needing a joined way of thinking as a service about GD

Needed very careful supervision to understand presentation

Needing to contain the anxiety in the network

Needing to see the whole spectrum of expressions in the patient to understand them as a whole

Needs more consideration within the service

Negative impact of long waiting lists

Neglect

Network needing more help than the young person to manage their anxieties around what is helpful

Never been the only thing they’ve presented with

Never came across it till the last few years

No contact with GIDS

No difference in approach to other patients

No difference in referrals to CAMHS for GD

No different to working with other young people or families

No formal training

No joined up thinking within psychotherapy team in CAMHS

No mention of GD at all boy’s school

No mention of gender in their description of gender dysphoria

None of their cases been seen by GIDS

No ongoing contact with GIDS once referred

No room given to sit back and understand what is trying to be said rather than catergorising

No space at all boy’s school for gender exploration

No training during professional training

Not a choice for them

Not allowing fluctuations in their identity

Not a lot included in training on GD

Not a set way of approaching things within CAMHS for GD

Not about treating patient for wanting to be other gender

Not averse to working with GD

Not comfortable in the gender assigned to you

Not easy to describe gender

Not easy to talk about gender

Not enough space to think about these cases as openly as possible

Not feeling able to say what think and feel

Not feeling happy in the body they were born in

Not feeling happy with the gender society has assigned to them

Not feeling happy with your gender assignment

Not feeling like the service has come together around these patients

Not given much thought to the dysphoria part
Not giving opinions
Not having the answers
Not helpful if too scared to share view
Not helpful to just agree with everything
Not impressed by GIDS training
Not knowing
Not knowing allowing space for curiosity
Not knowing being a common experience for clinicians
Not knowing much, or having pre-conceptions allows to ask the young person questions about it/to show curiosity?
Not knowing what is going on with GIDS treatment
Not met a young person where they could be referred to GIDS and not needed any further work from CAMHS
Not rushing
Not seen as mental illness
Not set up for GD within CAMHS
Not sitting with the uncertainty
Not something to rush into
Not a straight forward process or experience emotionally
Not sure it is understanding GD is something you can be taught
Not sure where GD starts
Not the body they wanted to be in
Not wanting their work or parents to be controlled and limited by GD
Not wanting to be seen as negative
Not wanting to blame families
Not wanting to collude with the idea their biological gender doesn’t exist
Not wanting to make rash decisions
Not wanting to push them one way or another
Not well explained in literature
Not willing to refer patients unless willing to talk
Not working closely with GIDS can cause issues in the therapeutic relationship
Noticing similarities in families

O

Often have other co-morbidities

Often other issues besides GD

Once start working with the anxiety and uncertainty disappears and begin to understand them and like them

Only practical contact with GIDS

Only see if comorbidity

One size doesn’t fit all in the treatment of GD

Only factual contact with GIDS in providing a report

Only made referrals to GIDS

On the backfoot

Open minded in personal life

Other clincians views more shocking than other patient groups

Other clinicians holding strong assumptions and beliefs

Other clinicians not being compassionate or understanding

Other diversities covered in professional training but not in relation to gender identities

Others who have strong views left them thoughtful about their own

Our role versus the Tavistock

Out of their control

Outward expression that is trying to influence how they are seen?

Outward expression versus internal painful experience

Own attitudes have changed over time

Overlap with other diagnoses

P

Pain and distress for parents

Parental acceptance

Parental fears of doing the wrong thing

Parent abandoning their young person due to GD

Parent’s dislike for child’s biological gender impacting on presentation

Parent’s drive for their child to change gender

Parent’s feelings and perceptions of gender having a massive impact

Parents concerns of whether they

should be letting young people transitions

Parents dealing with grief, anger, frustration and anxiety

Parents fearing encouraging something that is unacceptable

Parents feeling conflict about whether to support their child

Parents feeling heart broken

Parents feeling they have to be stoic

Parents finding it difficult

Parents in a terrible state about it

Parents needing time

Parents needing time to explore too

Parents not accepting

Parents not wanting to look at psychosocial factors

Parents really struggling with GD

Parents refusing to facilitate transitions

Parent’s sense of gain from GD

Parent’s sense of loss from GD

Parents struggling

Parents trying to physically stamp GD out of a child

Parent’s unhappiness with child’s biological gender

Parents want to look like they are absorbed from blame

Parents wanting to project difficulties onto a diagnostic label

Parent’s wish for child to change gender

Parental unacceptance challenging

Parent unacceptance makes it harder for patient

Parallel processes

Patient assumed clinician couldn’t tolerate their GD

Patient coming well informed about GD from using the internet

Patient engagement

Patient being under GIDS but not needing specialist service

Patient felt them asking about their biological question was completely intolerable and couldn’t return

Patient gaining from conflict of GD as pushed Mother away

Patient having to give up education

due to bullying
Patient holding onto things till therapy sessions
Patient not feeling safe in the world
Patient not pursuing transition
Patient presenting difficult of the family.
Patient slowly letting go of new gender
Patient unsure whether could trust them with telling them about their GD
Patients able to talk about things with clinician that they've not talked about with anyone else
Patient's coming with other clinical presentations and uncovering GD as got to know them
Patient's fear of aggression towards them due to GD
Patient's fear of clinician's maleness
Patient's fear of discrimination
Patients expected to be rejected by clinician for having GD
Patients feeling highly judged

Patients feeling uncomfortable with being transgender
Patients have felt authentic
Patients having varying experiences at school about how GD was approached
Patients knowing who they are
Patients not knowing who they are
Patients not pursuing transition
Patients not wanting to explore
Patient passing on understanding to clinician
Patients projecting helplessness
Patients respond well to approach
Patients struggling with identity
People didn't previously feel able to talk about GD
People having male and female personas within their identity
People feel more comfortable using language to describe their difficult
People want to push GD away and given interventions and treatment
People are much more likely to talk

about GD now

People with GD often being enormously misunderstood

Personal and professional opinions very different

Personal fear of rushing things

Personal observation of family impact

Personal view of blaming parents

Personal view of disagreement with transition

Personal view of it being a reflection of another difficult in the family

Person belief that people will be unkind to young people with GD

Person views on GIDS kept private?

Physical abuse

Picking up on anxiety of being seen, heard or validated

Poor experience of training around GD

Polarised responses from each parents

Polarised views on GD

Politics getting in the way of freedom and flexibility for these young people

Politics results in young people being pushed into something

Position of the expert

Positive experiences

Positive experience with GIDS

Positive societal changes

Possible that make more assumptions about GD than other patients

Powerful parents

Pressure on parents and professionals to provide medical treatment to young people

Pressure on parents to comply

Previously GD has had to be kept hidden

Previously GD wouldn’t have been expressed till later in life

Previous had to keep GD hidden

Previously people would have suffered in silence for longer

Previously very few cases of GD

Previously very few people spoke of their GD

Previously very little discussion

around GD

Previously very open and believed it is definitely a thing

Previously wouldn’t have admitted to their GD

Previous supervisor wanting clinician to help patient to change back

Private theory of normality

Private theory of ridigity

Proactive parents

Process of transitioning takes excitement out of job

Projecting confusion

Projections from patients can impact how people respond to GD

Psychoanalysis considers incongruence more

Psychotherapists considering the complexities more than other professions

Psychoanalysis pathologizing GD

Psychoanalysis used to control people’s sexuality and gender

Putting themselves in the parent's shoes

Q

Questioning ethics of own practise

Questioning ethics of treatment for GD

Questions from clinicians can be unwanted

Questioning gender impacting mental health

Questioning how genuine some people are

Questioning whether colluded with something shouldn’t have

Questioning whether stupid for sticking with these patients

Quirky individuals

R

Radical shifts in family structure and experiences

Realising others may not know an awful lot about GD

Really challenging for everyone

Really difficult to describe GD

Really disliked patient at times

Really hard to have patient expecting

you to reject them

Really hard working with parents

Really important and helpful to be able to work closely with GIDS

Really shocked and surprised by other clinician’s attitudes, prejudices and beliefs

Really surprised by the range of views and surprised held within the clinician group

Really struck by the variety of patients

Really warmed to the patients

Reasons for lengthy processes

Recorder as the third

refer to general rather than personal

Referral form to GIDS helped conversations with the patient

Referral for psychotherapy caused great difficulty and more waiting

Referral for psychotherapy delayed their transition

Referral processes aren’t straight forward

Referral to GIDS considered serious process

Referrals have now decreased

Referrals to Tavistock feel a bit too heavy

Referring less to GIDS

Regular contact with GIDS

Rejected by foster family due to GD

Relief for patient when they spoke about their GD

Relief of being listened to within CAMHS versus reactions outside

Relief of young person reverting back to biological gender

Reverting back to biological gender

Ride the rollercoaster with them

Risk to patients when parents are unaccepting

Roles of CAMHS and GIDS difficult to know

Role unclear when Tavistock involved

Rooted in sense of who we are and how we fit in the world

S

Sadness at the end of sessions

Sadness that transitioning is

normalised for young people
Scary to be in the idealised position
School considering GD as an attempt to gain attention
Schools are much more aware of the number of people presenting with gender issues
School’s concerns around wearing clothes of opposite gender
See it as young people playing with an idea of being the opposite sex
Seen a huge progression in people’s interest, knowledge and capacity to explore issues around gender
Seen a massive change through career in this area
Seen an increase in referrals and patients with GD
Seen a societal change
Seen a steady increase in referrals
Seeing past gender to the person
Seen an increase in cases
Seeking training themselves
Seen how cruel world can be

Sense of being born in the wrong body from an early age
Sense of chronic emptiness
Sense of entitlement in patients
Sense of narcissism in patients
Sense of reluctance to refer to GIDS
Sense that many more people are exploring their gender in a way wouldn’t have been possible before
Sense that others consider it a treatable presentation
Sense that there could be a solution
Sessions with patients have been helpful for them
Sexual abuse
Sexual abuse of patient
Sexuality versus gender
Shame and contempt around GD
Shared responsibility with GIDS
Sharing information and changes feels important
Sharing resources between clinicians
Sharing what’s been helpful and unhelpful within the service

Shift to presentation that expresses spectrum of male and female aspects

Shock

Shocked by gay being considered a treatable condition

Shocked by underlying prejudice still being present

Shocking for current generation to know that gay was considered pathological

Shouldn’t be allowed to play with changing gender at school

Shouldn’t be an automatic pathway

Shouldn’t be focusing on gender but identity more widely

Should the focus be on the external body?

Significant changes over the last few years

Single mothers needing to provide maternal and maternal functioning

Silence painful

Sitting on anger

Sitting with not knowing

Sitting with the frustration

Sitting with the uncertainty

Slight increase in how many people see but not sure

Slowing things down can cause some frustration

Slow shift in society of freedom to speak about identity

Slow to engage as a test of whether going to be accepting or derogatory

Social constructed role of gender

Social constructs of gender

Social constructs around gender versus their body image

Social care difficulties

Social contagion

Social media allows for a testing of presentations

Social media allows testing of reality and recognition

Social media allows for instant recognition of a state of being at any time

Social media allows us to portray identity different to what people may normally see

Social media contributing to the increase in GD

Social media giving a voice to people who might feel isolated in their experience

Social media helping young people not to feel alone with their GD

Social media discussions around GD

Social media helps gain understanding

Societal changes in perceptions of gender

Societal influences

Society moving away from binary constructs

Societal norms

Societal shift in acceptability of GD

Societal tolerance has increased around gender

Society becoming more open to talk about things

Society giving message that GD is just another way of being that doesn't need to be thought about

Society more accepting of difference

than used to be

Society moved to it being acceptable

Society puts pressure on that doesn't allow time for consideration

Society wanting binary constructs

Softer approach to GD in CAMHS than adult services

Stigmatisation of GD

Some cases work is more with parent that child

Some clinicians see it as fashionable to work with GD

Some contact with GIDS

Some feel so strongly about emerging sexuality in their bodies that causes them so much distress

Some parents fighting their child's corner for a referral

Some parents have had a negative reaction

Some parents like that they don't instantly agree

Some parents really supportive of their child

Some parents refusing to acknowledge

what their child is saying
Some parents wanting you to “sort out this nonsense”
Some patients not wanting to talk about it
Some people are more accepting of it now
Something else underlying GD
Sometimes a shock for parents
Sometimes getting it wrong
Sometimes unclear whether transition is what they really want
So much online about GD that people can explore
Some young people may be exploring gender, sexuality and identity rather than being fixed
Something has slowly developed that has allowed people to be able to express themselves in this way
Sometimes psychotherapy feels appropriate and sometimes it doesn’t
Space to explore
Space to explore GD within the service would need to be open and explorative

rather than standardised and avoidant
Specialist services leaves clinicians not feeling confident or specialist enough
Specialist versus knowing nothing
splitting
Staying with case descriptions rather than personal experiences
Striving for congruence
Strong feelings about specialist GIDS service being in London
Structure helps know what doing
Stuck between patient and parents
Struggle with using personal pronouns
Struggling is ordinary and important when working with GD
Struggling with their place in the world
Suffering with mental health
Suicidality and GD interlinked
Supervision is really important
Supervision is vital with these patients
Surface level acceptance in society with underlying prejudice
Surprised by how carers have been

able to be supportive, understanding and committed despite feeling unsure, wary and out of their depth

Sympathetic towards parents

T

Taboo

Taboo subject

Taken a long time to understand the language being used

Taking responsibility

Technical, medical language being used to describe ordinary things which can cause confusion

Technology has allowed more access to information

Temporary versus long term incongruence

Tension in families

Terminology used as a barrier to reaching them

Testing reality through social media versus only getting a tailored response from a specific audience

The bullying patients receives feels awful

The damage done by psychoanalytic theory around GD

The fear of being misgendered

The fear of real identity being uncovered

The media facilitating many more discussions around gender

The pain the families experiences

The person’s way of being doesn’t fit with what is physically on the outside

The recorder being the third

The help offered isn’t always where the young person is and can feel too much

The sense of the world not being right for people with GD

Their body causing them distress

Their body turning into something that they are not identifying with

Therapy previously offered to get rid of uncomfortable sexual feelings or gender confusion

There’s a label and a treatment pathway that can now be used therefore increasing people identifying this way

There to help them make sense of things around the decision to transition

Things that upset young people can be dealt with if they're given enough time

Think could do with a lot more training around GD

Think it is crazy to say that a six or seven year old has the capacity to make a decision about their future gender

Thinks it's right to ask questions about whether they are sure and whether it is linked to their sexual abuse

Think that having a specialist clinic is political

Think we can get to know GD better

Thought needed to know how to define

Through patient's own research come to conclusion that GD

Time is a very good healer but society doesn't give us time

To have an honest conversation would need to be small groups with people you know

Took years to understand and digest what was going on for patient

To speak honestly about opinions around GD needs to feel safe

Training and supervision has been a source of support with these cases

Training focused on sexuality more than gender

Training included gender but only feminism/being a feminist

Training since qualification has felt very inadequate

Training when treatment was still offered for gay people

Transference experience with patient was very unpleasant

Transitioning feels unethical

Trapped in the wrong body

Treading very carefully when addressing parent's part to play

Treating GD versus helping to become more congruent with their identity

Trendy way of expressing their distress

Try hard not to put any labels on what

a young person is experiencing

Trying manage own anger about the way the patient was treated

Try not to assume one person is going to be the same as the next

Trying not to feed frustration

Trying not to force parents into acceptance

Trying not to let thinking become too fixed

Trying not to make assumptions

Trying not to stigmatise patients

Trying to acknowledge when get it wrong

Trying to be careful not to make assumptions based on previous patients

Trying to be curious

Trying to be neutral

Trying to figure out what CAMHS do versus what GIDS do

Trying to find discrepancies

Trying to focus on the young person rather than the theory around GD

Trying to gain more insight

Trying to get alongside young people and explore with them

Trying to get it right

Trying to give them space to make decisions for themselves

Trying to hold back pre-conceived ideas but it leaving you confused

Trying to keep own views separate

Trying to minimise difference

Trying to remain person centred

Trying to re-find identity with GD

Trying to see people as equal

Trying to stay grounded in the person and what they bring

Trying to stay with what they bring

Trying to understand

Try to be really broadly open minded

Try to encourage patients to explore

Try to follow the young person’s lead around language

Try to keep the conversation open and explorative rather than narrow

Try to sit on the fence and understand

why they have this sense of not being complete

U

Unacceptable

Unaccepting

Unaccepting parents versus accepting parents

Uncertain territory

Uncertain whether always need to be referred to specialist

Uncertain why GD happens

Uncertainty about what GD is and where it comes from

Uncertainty around reason for rise in referrals

uncertainty around questioning things

Uncertainty of expressing observations

Uncertainty of future for patients

Uncertainty of the difference between what CAMHS offers and GIDS

Uncertainty of what the Tavistock/GIDS do

Uncertainty whether cantered around society or their body

Uncertainty whether got it righ

Unclear what their personal views are

Unclear whether they think it should be medically addressed

Uncomfortable

Uncomfortable feeling between actual gender and preferred gender

Uncomfortable position

Uncomfortableness that GIDS is in London

Uncomfortableness with defining gender

Uncomfortable with the idea of conversion therapy

Uncomfortable with using term dysphoria

Unconscious bias really painful

Unconscious efforts to quash GD, treat it and hide it away

Understanding and not understanding

Understanding of GD from people have met

Understanding parents conflicted

feelings
Understanding the defence that motivates it can help understand unconscious processes at play
Under umbrella of identity
Unethical to give medical treatment until adults
Unhappiness with their body appearance
Unsure about being definitive in opinions
Unsure about how other disciplines approach the conversation within their professions
Unsure how we have conversation as a service
Unsure if been presented with GD
Unsure if being helpful
Unsure if CAMHS feel able to do more
Unsure if can help
Unsure if gender is really patient’s main concern
Unsure if right or wrong
Unsure know what doing

Unsure what dysphoria is
Unsure what is the correct management of GD
Unsure what's helpful
Unsure what the right way is
Unsure what they are doing
Unsure what trying to do within CAMHS for GD
Unsure whether been helpful
Unsure whether have seen an increase
Unusual conversation for the patient
Unusual experience for parents
Used as umbrella for other difficulties
Used to be a sense of disapproval, contempt, them being beyond repair which stopped people being able to talk about their GD
Useful to have a debate and share different positions
Use of binary explanations
Use of jargon unhelpful
Use of medicalised language to describe things

Using blunt instruments for diagnosis and treatment of GD
Using medicalised language turns something ordinary into a disorder
Using professional narrative
Using resources to boost confidence
Using the “right” terms
Using young people’s words rather than own
Usually focus on other aspects apart from gender in assessments
V
Variety results in it not feeling clear or straightforward
Very aware of society even though may not agree
Very careful about sharing personal views
Very careful answer to what GD is
Very close relationship with GIDS for one case
Very different experience externally and internally
Very different responses from clinicians on a personal level

Very difficult to really understand patient’s experience
Very extreme reactions from parents
Very little contact GIDS
Very painful work
W
Waiting lists too long CAMHS and GIDS
waiting lists felt to be unhelpful
Want more research to be done
Want to be able to discuss thoughts and ideas with the team and in supervision
Want to be able to have space to explore and give it time
Want to be able to think about it more without thoughts becoming polarised
Want to be different
Want to have permission from the service to have freedom to be authentic, curious and ask questions in sessions
Want to put the brakes on, take a step back and see what comes up
Want treatment to be routed in

research
Wanted to be seen to be taking patient’s experience seriously
Wanting a better understanding
Wanting a better understanding of how as a service we think about young people with GD
Wanting access to peer group supervision
Wanting a reflective time and space to think with other clinicians
Wanting a safe space where can have a rich debate about GD
Wanting a space to explore GD within the service that is different to what other clinicians may want
Wanting a unbias space to consider GD
Wanting clearer guidelines within CAMHS for GD
Wanting closer working with GIDS
Wanting guidance on where to start
Wanting clarity on GIDS service procedures
Wanting GD to be kept on people’s

radar
Wanting GIDS to share and update more
Wanting help with keeping in touch with the language young people use
Wanting more guidance
Wanting more guidance from GIDS
Wanting more guidance on what should be doing
Wanting more practical help around the process
Wanting more space to explore GD as a service
Wanting more team training around GD
Wanting more training
Wanting permission to think, reflect and be curious rather than just having to accept something and follow a certain path
Wanting security to explore
Wanting supportive open discussions as a service
Wanting to be able to discuss with patient

Wanting to be able to have the conversations outside of GIDS

Wanting to be reflective rather than reactive

Wanting to come together more as a team around GD

Wanting to consider patient as a whole rather than just GD

Wanting to consider the impact of treatment

Wanting to consider the spectrum of gender rather than pathologise it.

Wanting to consider within the service the feelings that are evoked in us working with these patients

wanting to explore

Wanting to explore more as a service about people’s positions around GD

Wanting to explore things

Wanting to get it right

Wanting to help them think in a broader way

Wanting to know

Wanting to know it’s ok to explore GD more

Wanting to leave the responsibility with the specialists

Wanting to share experiences (practically and emotionally) with other clinicians

Wanting to think very carefully about everything with patients

Wanting to undertstand before referring

Wanting to understand the diversity of people’s lives

Wanting to understand what is going on

Want to try and explore and understand what is going on for a young person before making a referral to GIDS

Wanting to work closer with GIDS

Want more work to be done with the parents and families

Want someone within the service who has up to date knowledge that can speak to

Want support when asking some very difficult questions when exploring GD

Want the patients to stay in our service as a priority before going to GIDS
Wary of interventions with some cases despite the distress
Way see themselves doesn’t match with their body
Ways of expressing identity now feel really powerful
We all experience incongruence in our identity
What constitutes gender?
What is the dissatisfaction?
What is their narrative?
What they see in the mirror isn’t conducive to what they feel on the inside
When had first case felt really uncomfortable and found it really challenging
When how feel and biology clash
When work closely with GIDS kept informed about their treatment
Whether struggle is validated impacts how express that
Who are people aside from their gender?
Who the patient wanted the clinician to be as a therapist
Why GD happens feels really big question
Wish for family and network for patient to be cured
Wish had better training
Wish had had more time
Wish more involved in training
Women can give birth, men can’t
Working alongside GIDS not experienced as joined up
Working jointly on cases with GIDS the links haven’t been strong
Working more with parents than child to help them understand what is going on for their child
Working with families on acceptance
Working with families on grief of their child
Working with GD can feel isolating
Working with the parents
Working with the individual

Worried about people considering GD attention seeking or fashionable
Worried about saying the wrong thing
Worries about being offensive
Worries about getting it wrong
Worries about how do people perceive them
Worries about prejudice and bullying patients may receive
Worries about reactions of others
Worries around surgery
Worries about young people later regretting their transitions
Worries of being bullied or teased
Worries that too much pressure can be put on these young people
Worry about getting it wrong
Worry about people's political motivation in relation to GD
Worry about sounding harsh
Worry about whether they would recognise them in the waiting room
Worry of how views have been perceived
Worry of what people might think or say preventing people from expressing GD
Worry not felt to be genuine
Worrying about the patients
Worrying telling family
Wrong body or wrong gender?

Y

Young people's belief that they can be either gender
Young people expecting judgements
Young people finding where they fit
Young people not making a choice
Young people often have to share their GIDS process with the clinician themselves
Young people using GD to get a reaction from parents
Young person abandoned due to their GD
Young person had responsibility on updating clinician on GIDS journey

Appendix 10 – Examples of data relevant to codes

Participant	Line Number	Quote	Code
1	62	I think it’s moved away from it being related to mental illness but I don’t know whether it was related to mental illness in the beginning	Is it a mental illness?
1	128	they bring their own stuff and I just go with what they bring rather than a pre-conceived idea of what you should do with them sometimes it leads you to get a bit lost	Letting the patient take the lead
2	87	I would think about it as people who generally who I’ve met and the way they’ve talked about it is there being quite an intense feeling of dissatisfaction of the body that they are in erm and so much so that they want to alter that because it’s so distressing for them to see their body in the state that it’s in. erm and it is perhaps those associated feelings that are the things that case the most difficulty and the things that we want to look at and	Dissatisfaction with the body

		explore. Erm, is that ok?	
2	340	it's the same as working with any other family really, it's not different. It's just they are different issues and different emotions that we associate with different issues and different questions to ask. But it's not that different. I don't, my treatment is no different to how I treat anyone else.	Minimising differences compared to other patients or families
3	128	they might have a different difficulty and it comes out as gender difficulties so I'm thinking of a particular young person that I worked with in my previous role which was meant to be a brief interventions role and I don't think exploring identity in any way would be brief work but anyway they found themselves with me and they thought they had gender difficulties but actually it was sexuality difficulties and I'm not sure how overlapped the two may be. But because sexuality was so a taboo subject in their family it was actually more acceptable to have gender difficulties so it came out, it presented	Easier to be transgender than gay

		like that but the more explored it they knew they were male but they were a homosexual male so they felt they had to female because then they could go out with a male in their family so then that's where I think actually what had the family constructed to make them feel like they can't express themselves.	
3	350	When you ask what I think or, how would I define gender dysphoria, I've never had to really think about defining it so maybe having some more like boundaried understanding like a structure of understanding if someone comes in with this you treat it or not treat it, you work with it with X Y and Z so yeah I'd hope for some training in the service given because I don't feel like I'm the only one that thinks that gender is the rabbit hole expression yeah. And everyone's got different experiences haven't they.	Wanting more training
4	87	I think as a service we've seen more people presenting here within the	Seen an increase in referrals and

		CAMHS service. I also work for a charity and I'm aware that I see a number of people who are presenting with gender dysphoria in that setting as well and so I do think that there has been an increase over the recent years. Yeah.	patients with GD
4	123	Someone else I have worked with has come with lots of understanding so helping me to understand some of the terminology, some of the contradictions like using pronouns and how there's a lot of mismatch between people's social identity and not using the correct pronouns when they are meeting people and come really well informed from and I think some of that knowledge base that they have had is not just about their direct experience but also being able to do social media searches and using the right language and that's, that's, therefore come into the meeting with myself really well informed about gender dysphoria yeah.	Social media helps gain understanding
5	18	So dysphoria, the first question I'm	Is GD a defence?

		always thinking about is it part of a defence? Is it a motivation? If it is a motivation the first questions I'm always asking or considering is the motivation towards something or away from something? Is this patient moving towards an alternative experience or a moving away from a position that they don't like and is that part of a defence because I think it can often be, I feel they are two different things and it's within that intention that we may be able to get to see some of the relevance and meaning on an unconscious level for patients.	
5	142	How much that was related to his Mum's fear of males, experiences of males and that this was a boy you know after all the work it really came down to his parents separating and him feeling massive pressures to be the male in the house and him trying to work with it in a maternal state of mind and gaze upon him who was a little bit disgusted in him as a boy and the fear of him being like	Parent's feelings and perceptions of gender having a massive impact

		his Father and the fear within a Mum who had experienced sexual abuse at the hands of family males and he was able to say to me very near the end that it was that it felt safer to be a girl because in his mother's mind that was a very dangerous thing to be was to be a boy.	
7	101	I think you need local conversations at local levels with parents and children about it it shouldn't all be going to specialist centre somewhere else who makes exclusive decision. I don't think that's particularly helpful but I think it's a hot potato so it may be easier as a CAMHS service to go oh I'll refer you to a specialist centre because we don't want to deal with the politics of it.	May be easier to refer to GIDS than manage themselves as CAMHS services
7	342	I think they've most of have been referred I mean usually there's usually other things alongside to get into CAMHS so usual there's other stuff too. A lot of them there's been self harm, depression, anxiety, family issues so a lot of them have come in that.	Often have other co-morbidites

8	99	because I would say that they can now talk about it, it was always hidden before. I suppose that’s the difference, the five that I saw years ago had to keep it hidden and I was probably the only person they could tell apart from maybe if a parent was aware.	More acceptable to talk about GD
8	144	whenever I’ve met them initially you’ve really been able to experience the pain that they’ve been through with them, really get a sense of the agony to be in that situation.	Get to experience pain patient has been through
9	229	well I think I suppose what I’m talking about which I think is reduced over the years considerably is that sense of oh my god what am I going to do, will I understand? Will I feel uncomfortable? I think one of the anxieties that continues that I certainly felt earlier when we were talking oh my god will I say the wrong thing? Will I talk about something that is clearly no longer an acceptable way of talking	Fear of saying the wrong thing
9	276	I think I think mostly apart from at times a sense of what am I doing? Do I know	Unsure what they are doing

		what I’m doing? Am I out of my depth? But that isn’t such an unusual experience for me to have with other people that I meet with and I know you are specifically saying well what specific feelings for those young people.	
10	173	I think with the person I was talking about I genuinely felt really angry. I felt angry for them, on their behalf you know. These aren’t their words, these are my words that it was kind of like a double deprivation you know you go through all this really shit stuff that happens to you when you’re a young person you’re subject to abuse, you’ve end up being a young carer, you manage to achieve at school despite all of that because school is your haven, you know from the age of four and half that you’re in the wrong body and you have to not only fight to get that recognised by other people you have a double fight on your hand because you have to to prove that it isn’t because some idiot abused you on top of that.	Feeling very angry for them

10	300	I remember one time when someone was really upset because the decision to start hormone had been delayed and they had been told it was because they were waiting for a letter from me to say that I didn't think that there were any barriers and no one had communicated with me that there should have been a letter so then I've got an angry young person in front of me saying why haven't you written a letter, you're screwing up my life basically. You know, you're a really not you know not being a great therapist. I didn't know that was expected of me.	Not working closely with GIDS can cause issues in the therapeutic relationship
11	11	I would describe it as I suppose an uncomfortable sort of sense of being that a person might have between their actual gender and their preferred gender. Just sort of incongruence or yeah an uncomfortable way of being between the two, between a yeah. Sorry that's a bit muddily.	Feeling muddled about GD is
11	341	my sense was a lack of connection and you know a few of them that the	Lack of connection with

		families have come back and said have the Tavistock been in touch? Have they been in touch yet? They said they would get in touch and they haven't been in touch so no no.	GIDS
12	106	yeah I must say I've been working here for about eleven years now and I would say over the years there's been a steady increase in numbers of referrals for identity disorders gender identity disorders or dysphoria. Yes I think there has been a steady increase. Not that I have any measure.	Seen a steady increase in referrals
12	396	I think they need the local services, the local psychiatric, mental health services. It's very very vital. Life is life and we all express stress in life whatever the gender issues you still need that you know.	Feel they need support from local services, not just GIDS
13	58	to be honest it wasn't really formally it didn't seem to be formally part of training and certainly not at medical school I don't remember it ever being mentioned at medical school.	No training during professional training
13	493	I guess if I guess if it could be included	Wanting more

		on any kind of wider team training and things like that. I know sometimes we have slots on team away days or there was a little academic programme out of one of the clinic in the afternoons so I guess if it was kind of kept on people's radars and I guess like I say one of the things I found most useful so was that presentation from the lady from mermaids followed by the debate and hearing people with these different positions on it so I guess it kind of keeps it on people's radar a little bit	team training around GD