

Written evidence submitted by Polly Carmichael to the Transgender Equality Inquiry

NHS services for trans youth

The Gender Identity Development Service for Children and Adolescents

Description of the Service

The Gender Identity Development Service for children and adolescents (GIDS) is a highly specialist interdisciplinary service. We see children and young people up to the age of 18 years, and their families, who are experiencing difficulties in the development of their gender identity. Typically, these young people are unhappy about their biological sex and wish to belong to the other one. The onset of puberty is commonly associated with an escalation of distress and an increased risk of self-harming behaviours. We also offer counselling to children of parents with a trans parent or carer or other gender identity problems.

The service was established twenty five years ago in response to an unmet need in publicly-funded child mental health services. Knowledge and experience of how to support these unconventional children and adolescents built up slowly in partnership with families.

The GIDS interdisciplinary team comprises professionals with specialist child and adolescent training from a range of disciplines including psychiatry, clinical psychology, family therapy, social work, psychotherapy and adolescent endocrinology. Clinicians in the service accept that gender non-conformity cannot be explained adequately within any monolithic theoretical model, and that explanations are probably multi-factorial.

The Service has seen large increase in the number of referrals received, by an average of 50% per annum since April 2009. In 2014/2015 the service received 697 referrals.

Along with the increase in referrals, the number of complex cases has increased. Many of the young people referred to the service have significant associated difficulties, features of ASD and challenging social circumstances. Self-harm is not unusual in adolescent service users and local CAMHS can be difficult to engage to manage this risk.

Improving access to the service

The GIDS is committed to increasing equity of access to the service. To this end we have a hub and spoke model and when and where possible respond to demand with the provision of outreach clinics.

The Service operates from two main bases, London and Leeds, with regular outreach clinics held in Exeter, Barnstable, Bath, Bristol and Brighton.

Model of care

The appropriate care of Gender Dysphoria in children and adolescents is contentious and debated in the absence of an adequate evidence base. It is not possible with any certainty to predict the outcome of gender identity development and the evidence available suggests that for the majority of pre-pubertal children their gender dysphoria does not persist into adult hood. Young people are increasingly exploring gender, as reflected in our referral rate, and gender expressions and identities are diversifying. In this context it is all the more important to follow established national and international guidelines, which offer a staged approach to care.

The GIDS offers comprehensive and interdisciplinary assessment and on-going care of children and adolescents with gender dysphoria (GD). The Service recognises that GD can be an extremely distressing condition, for those who present with it and their families/carers. The service aims to ameliorate the potential negative impact of gender dysphoria on general developmental processes. We endeavour to help young people and their families manage the uncertainties inherent in the outcome of gender dysphoria and provide on-going opportunities for exploration of gender identity and support.

In GIDS we recognise that it is important to have an awareness of the history of social and moral oppression of the trans community, and their struggle for self-determination that still continues. The service espouses affirmative aims and practices, attempting to nurture the confident development of the young people's unconventional gender identification, while acknowledging the impact of living in a social world where poorly-informed and negative attitudes towards gender variance are widespread. Only recently in the UK have gender variant people become protected by law, with substantial rights enshrined in the Equality Act of 2010. The empirical data on the mental health of gender variant young people demonstrate plenty of evidence of social suffering: fear, anger, self-doubt (Wallien et al., 2008). It seems that the normative criteria for judging one's worth do not remain as judgments from outside, but rather they may be internalised (Russell & Bohan, 2007).

The GIDS has a well-established network model and regularly convenes local network meetings in CAMHS or schools to ensure that roles are agreed and any associated difficulties are well supported locally. Liaison with other agencies often involves us the demonstrating the emancipatory element of our work: for example, making it clear where we feel that discriminatory language and practices are operating to disempower our clients at their school or workplace, or in their contact with health or social care, and raising our voices with those agencies to improve their practice in what may be for them an unfamiliar domain of work.

Physical interventions

The GIDS team in London and Leeds work closely with Paediatric Endocrine colleagues at University College London Hospital (UCLH) and Leeds General Infirmary (LGI) and these services are commissioned by us through a Service Level Agreement. Following a detailed assessment a referral may be considered, in collaboration with service users and their families, to the Paediatric Endocrinology Liaison Clinic. GIDS clinicians attend the endocrinology liaison clinics with the young people in their care.

We provide two types of endocrine liaison clinic: The Early Intervention Clinic is available for carefully selected young adolescents in at least Tanner stage 2 of puberty and up to age 15; and Standard clinics for adolescents aged 15 – 18 years.

After a series of physical tests young people may be prescribed hormone blockers to produce a state of hormonal neutrality. This intervention is putatively completely reversible. The pausing of physical development associated with puberty aims to reduce distress associated with this and so facilitates reflection and further exploration of the young person's gender identity. Such interventions are considered as part of an overall treatment plan offered by the GIDS and other therapeutic treatment/consultation and psychological monitoring remain ongoing.

It is important to establish the competence of any of the young people for whom physical intervention is recommended. This evaluation must be done with special care for those under the age of 16. 'Competence' requires young people to understand fully what is proposed, retain an understanding, appreciate the importance of information and see how it applies to themselves, and weigh the information in the balance. The level of understanding that is sufficient will vary with the complexity and gravity of the decision. *Greater understanding is expected if the burdens are heavy, the risks high, or the benefits uncertain.*

We offer assessment and treatment not just to those young people who are identifiably resilient and for whom there is an evidence base for a likely 'successful' outcome. We have carefully extended our programme to offer physical intervention to those who have a range of psychosocial and psychiatric difficulties, including young people with autism and learning disabilities, and young people who are looked after. We have felt that these young people have a right to be considered for these potentially life-enhancing treatments. This has involved careful liaison with local service mental health providers and Social Care, who may know these young people well and who have particular responsibilities for their well-being. Indeed, the service has no record of refusing anyone who continues to ask for physical intervention after the assessment period. Some young people back off from physical treatment at an early stage, but the majority who choose to undertake physical interventions stay on the programme and continue through to adult gender services where surgery becomes an option.

Transition to adult gender services

Adult services continue to have long waiting lists, which creates problems for some older service users who are keen to move to adult services to pursue surgical interventions. The GIDS and adult services are working together to put into practice a jointly developed transition protocol.

Research and development

We are committed to raising awareness of gender dysphoria and provide regular CPD events, conferences and consultation. We actively engage with the media to promote understanding of the complexity of gender development and the diversity of gender expressions and outcomes.

The GIDS follows and contributes to international and national guidelines on the management of GID in children and adolescents. These include the Royal College of Psychiatrists Guidelines on the Management of GID (1998) and the Statement of Management of Children and Adolescents with GID issues by the British Society of Paediatric Endocrinology and Diabetes (BSPED, 2010). The GIDS is actively engaged in research in collaboration with well-established specialist centres in Europe.

Advocacy and support groups

As a service we are in regular dialogue with advocacy and support groups to receive feedback on our clinical approach, and to discuss the meaning and implications of research findings and of initiatives for new approaches to treatment. Previous and current users of our service usually present their perspectives at conferences we organise, and clinicians speak at events run by support organisations. Such an exchange of perspectives has, over the years, shaped professional perceptions, understandings and language, as well as our intervention protocols. For example, changes have been made in the provision of outreach clinics in the UK, in the availability of early intervention at the start of puberty, and in the regular offer of family days.

We are aware of the risks of talking *for* and *about*, rather than *with*, the young people who are at the heart of our service. We try to establish effective alliances with the community of young people and families attending the service. This needs to be a process over time where trust is built up and topics debated, with the acknowledgement of genuine differences. Problems only occur in such partnerships when a small group seizes the agenda forcefully and proves unable to grasp the drivers for, and constraints on, action for other groups.

The service has an active young people's Stakeholders group, which meets three times a year. Members of this group have received training and sit on interview panels for new staff.

The service protocol is regularly reviewed in relation to ongoing discussions between professionals, parents and young people, where innovative and cost-effective ways of providing the service are considered. For example, we have expanded the provision of family days, groups for young people and their parents/carers, and education days at UCLH to provide information about physical treatments.

Evaluations and outcomes

We encourage young people and parents/carers to complete the Experience of Service Questionnaire (ESQ) - always anonymously - so that the trust can gain regular feedback on how service-users view their relationships with GIDS staff and their contact with the service. The 2014/15 ESQ data are shown below:

GIDS ESQ Summary 2014-15

I feel that the people who have seen my child/me listened to me

	Frequency	Percentage
certainly true	62	91.18%
partly true	6	8.82%
not true	0	0.00%

not known	0	0.00%
Total	68	100.00%

It was easy to talk to the people who have seen my child/who saw me

	Frequency	Percentage
certainly true	52	76.47%
partly true	16	23.53%
not true	0	0.00%
not known	0	0.00%
Total	68	100.00%

I was treated well by the people who have seen my child/who saw me

	Frequency	Percentage
certainly true	64	94.12%
partly true	4	5.88%
not true	0	0.00%
not known	0	0.00%
Total	68	100.00%

My views and worries were taken seriously

	Frequency	Percentage
certainly true	60	88.24%
partly true	7	10.29%
not true	1	1.47%
not known	0	0.00%
Total	68	100.00%

I feel the people here know how to help with the problem I came for

	Frequency	Percentage
certainly true	53	77.94%
partly true	13	19.12%
not true	1	1.47%
not known	1	1.47%
Total	68	100.00%

I have been given enough explanation about the help available here

	Frequency	Percentage
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certainly true	51	75.00%
partly true	15	22.06%
not true	1	1.47%
don't know	1	1.47%
Total	68	100.00%

I feel that the people who have seen my child/me are working together to help with the problems

	Frequency	Percentage
certainly true	54	79.41%
partly true	12	17.65%
not true	0	0.00%
don't know	1	1.47%
Total	68	100.00%

The facilities here are comfortable

	Frequency	Percentage
certainly true	50	73.53%
partly true	18	26.47%
not true	0	0.00%
don't know	0	0.00%
Total	68	100.00%

The appointments are usually at a convenient time

	Frequency	Percentage
certainly true	30	44.12%
partly true	26	38.24%
not true	12	17.65%
don't know	0	0.00%
Total	68	100.00%

It is quite easy to get to the place where the appointments are

	Frequency	Percentage
certainly true	23	33.82%
partly true	31	45.59%
not true	14	20.59%
don't know	0	0.00%
Total	68	100.00%

If a friend needed similar help I would that he or she come here

	Frequency	Percentage
certainly true	60	88.24%
partly true	7	10.29%
not true	0	0.00%
don't know	1	1.47%
Total	68	100.00%

Overall, the help I have received here is good

	Frequency	Percentage
certainly true	61	91.04%
partly true	6	8.96%
not true	0	0.00%
don't know	0	0.00%
Total	67	100.00%

We recently reviewed our data on rates of self-harm for 2014/5 at different time points before and after engaging with the service.

Analysis of Self Harm Outcome Measures

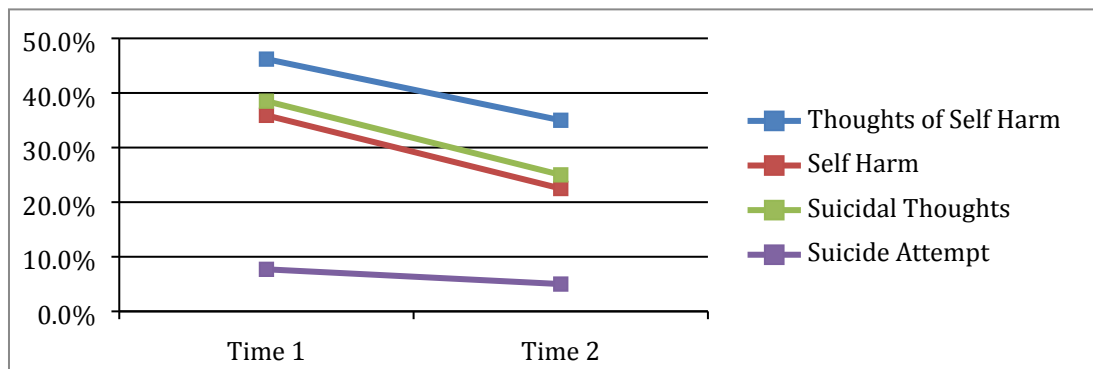
Self-Harm and Suicidal Thoughts Questionnaire Q1-Q4 2014-15 (repeated 6 monthly)

Across all four measures on the clinician rated Self Harm and Injurious Thoughts Questionnaire (**Thoughts of Self Harm, Self-Harm Attempt, Thoughts of Suicide,**

(n=40)	Time 1			Time 2			Improvement
	Yes	No		Yes	No		
Thoughts of Self Harm	46.2%	53.8%		35.0%	65.0%		+11%
Self-Harm	35.9%	64.1%		22.5%	77.5%		+13%
Suicidal Thoughts	38.5%	61.5%		25.0%	75.0%		+14%
Suicide Attempt	7.7%	92.3%		5.0%	95.0%		+2.7%

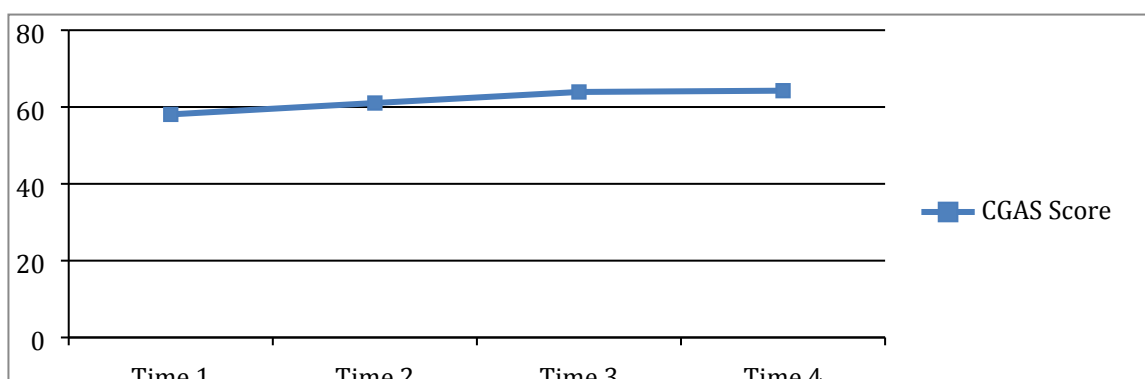
Suicide Attempt), there was a decrease after six months, from the initial date this was filled in; typically the second assessment appointment. Self-harm rates across the general population vary, but typically range between 8-18%

<http://www.capmh.com/content/6/1/10>



Children’s Global Assessment Scale (CGAS) data for 2014/5 show a significant improvement in the young people’s well-being after both psychological and physical interventions

Children’s Global Assessment Scale Time 1-4 (6 monthly)



N=76	Time 1	Time 2	Time 3	Time 4
	58.08	61.04	63.92	64.25

Across all four time points, there was a mean increase in functioning, as marked by clinicians, at each 6 month time period, from the second

Across all four time points there was a mean increase in functioning, as rated by clinicians, at each 6 month time period, from the second assessment appointment. Patients therefore on average moved from the defined category '*Variable functioning with sporadic difficulties or symptoms in several social areas*' to '*Some difficulty in a single area but generally functioning pretty well*' within just over two years of first being seen in GIDS.

Gender Dysphoria in children and adolescence: an update of the evidence

Gender Dysphoria (GD) is a potentially distressing condition, particularly in adolescence. There is no established psychological causation for GD and it does not yield to change through psychotherapy; evidence for a biomedical causal model also remains limited (Drescher & Byne, 2012; Bao and Swaab 2011).

Epidemiology

Formal epidemiological studies on gender dysphoria among adolescents of 15 years or older and adults are usually based on the number of people who were treated at gender identity clinics. The numbers vary widely across studies, probably reflecting differences in methodology and differences between countries in treatment availability and criteria for treatment eligibility. Estimates of the prevalence of gender dysphoria range from a lower estimate of 1:2000 (or about 0.05%) in the Netherlands and Belgium (Conway 2008) to 1.2% in New Zealand (Clark et al 2014). These numbers are based on those who identify as transgender.

The number of adolescents referred to specialized gender identity clinics for gender dysphoria clinics appears to be increasing. GIDS data has shown an increase in referrals each year:

Referrals to the service have increased year on year as follows:

- 2009/10 – 97 referrals
- 2010/11 – 139 referrals
- 2011/12 – 208 referrals
- 2012/13 – 314 referrals
- 2013/14 – 468 referrals
- 2014/15 – 697 referrals
- 2015: at least 100 new referrals per month are coming in.

There also appears to be a corresponding shift in the sex ratio, from one favouring natal males to one favouring natal females. In a study at clinics in Toronto and Amsterdam there was a significant change in the sex ratio of referred adolescents between the two cohort periods: between 2006 and 2013, more natal females were referred, but in the prior years here were more natal males. (In Toronto there was no corresponding change in the sex ratio of 6,592 adolescents referred for other clinical problems.) Sociological and sociocultural explanations are offered to account for this recent inversion in the sex ratio of adolescents with gender dysphoria (Aitken et al 2015).

Published guidelines for the treatment of adolescents with gender dysphoria (GD)

The Endocrine Society (2009) and the World Professional Association for Transgender Health (2012) have published guidelines for the treatment of adolescents with gender dysphoria. Provided they fulfill eligibility and readiness criteria during the diagnostic phase, the guidelines recommend the use of gonadotropin-releasing hormone agonists in adolescence to suppress puberty, later followed by cross-sex hormone treatment from age 16 (sex steroids of the experienced sex). If they fulfill additional criteria, they may have various types of gender affirming surgery from the age of 18.

There has been some debate about the minimum age at which puberty suppression and cross-sex hormone treatment could start. At first, an age of 12 years was recommended for puberty suppression. However, boys and girls enter puberty at different stages; also psychological maturity, competence and decision making authority differs between adolescents. Therefore, not age but the stage of onset of puberty is now mentioned in the Standards of Care. It is up to the clinicians to assess for treatment, even in older adolescents who already reached Tanner stage 5. The recommendation remains internationally that cross-sex hormone treatment should not commence before the age of 16 – although in some clinics in the US there are reports of physical treatments being offered at younger ages (Spack et al 2012; Rosenthal 2014). Thus far these are descriptions of clinical practice rather than reports of

outcomes.

Persistence / Desistence

Many children experience incongruence between their experienced and their assigned gender early in life. They may identify with the other gender, show behaviours and preferences, typical for the gender they were not assigned to at birth, and sometimes strongly dislike their physical sex characteristics. Children who show gender variant behaviour only do not fulfill the criteria for a GD diagnosis. If the distress resulting from this incongruence reaches clinical levels, the diagnosis of Gender Dysphoria according to the DSM-5 is applicable.

In most children, gender dysphoria will disappear before, or early in, puberty. However, in some children these feelings will intensify and body aversion will develop or increase as they become adolescents and their secondary sex characteristics develop. The period of adolescence, with its changing social environment and the onset of physical puberty, seems to be crucial for the development of a persisting non-normative gender identity.

A GIDS review of cases closed between April 2013 and December 2014 indicated that of 262 closed cases 17% did not attend, 17.8% attended but dropped out, 5.9% declined further treatment and 51.4 % were referred to adult services. 2.8%, were referred to another agency, 2% were referred to private therapy. In about 20% of cases the clinician noted that gender dysphoria had decreased. There was a 20% 'desistence' rate.

Prospective studies on the development of children fulfilling diagnostic criteria for gender identity disorder have indicated that the most common psychosexual outcome is homosexuality, or heterosexuality without gender dysphoria. Across all studies, the persistence rate of GD has been approximately 16% (Steensma & Cohen-Kettenis 2015). It should be emphasised that most studies did not use the fairly strict criteria of *DSM-5*, and children might previously have received a diagnosis based only on gender-variant behaviour.

Although both 'persisters' and 'desisters' can be quite similar in their gender atypical interests, preferences and behaviours, there is also a noticeable difference. Steensma et al. (2013) followed up in adolescence 127 adolescents who were referred for GD in childhood (<12 years of age). Persisters attributed their GD primarily to the discrepancy between body and gender identity and a true longing for having a different body. The desisters, however, indicated that their desire to have the body of the other sex (if present at all) or the desire to be the other sex, was more related to the opportunity to fulfill the preferred gender role, than to a true aversion against their bodies per se. Nevertheless, it remains the case that *'predicting individual persistence at a young age will always remain difficult'* (De Vries et al 2015).

There is some evidence that persistence or desistence of childhood GD may be related to three factors, looking at the period between 10-13 years of age.

1) Changing social environment: between 10-13y the social distance between boys and girls was considered to gradually increase. 2) Their change in feelings to the anticipation of, and actual body changes during, puberty: this created severe distress and concerns about future. 3) The experience of falling in love and sexual attraction: for the persisters, who were all attracted to same sex partners in this study, this functioned as a confirmation of their cross-gender identification, as they viewed this as typically heterosexual (Steensma et. al., 2013).

Social transition

The age at which adolescents transition socially has decreased in the last decade. Many young people socially transition before any treatment has started, although some more anxious youngsters often prefer to wait until cross-sex hormone treatment actually starts (Kaltiala-Heino et al. 2015).

Steensma & Cohen-Kettenis (2011) report that between 2000 and 2004, out of 121 pre-pubertal children, 3.3% had completely transitioned (clothing, hairstyle, change of name, and use of pronouns) when they were referred, and 19% were living in the preferred gender role in clothing style and hairstyle, but did not announce that they wanted a name and pronoun. Between 2005 and 2009, these percentages increased to 8.9% and 33.3% respectively. This study strongly suggests that early social transition does not equate to an adult transgender identity. In a qualitative follow up study it was reported that two girls, who had transitioned when they were in elementary school, had been struggling with the desire to return to their original gender role. Fear of teasing and shame to admit this wish resulted in a prolonged period of distress (Steensma, 2011).

In their writings the Dutch team does not encourage early social transition and explicitly advise parents to proceed with great caution, to seek to keep a balance between the acceptance of cross-gender play and preferences and encouraging activities that are associated with the child's natal gender (Steensma & Cohen-Kettenis 2011). In the Amsterdam clinic pre-pubertal children may be assessed, but generally will not be seen again until they enter puberty.

Associated difficulties

Various studies show that transgender young people may present with psychosocial difficulties. Yet it is also true that many youngsters who present to gender services are not acutely distressed. This may be particularly true for adolescents who live in an accepting environment, are aware of the possibility of gender transition, and who can have access to puberty suppressing treatments until they are able to take a decision to transition physiologically (Drescher et. al. 2012). Some empirical studies of the mental health of gender variant young people, mostly from the US, show that adolescents are at high risk of self-harm and suicidal ideation (e.g. Grossman &

D'Augelli, 2006). However, it is not helpful to generalise across the whole population of gender variant young people: data from the Netherlands (de Vries 2015) show that there is a group of well-supported, mentally stable young people who cope well with their significant gender incongruence.

In the UK the experience of GD can correlate with severe distress (Holt, Skagerberg & Dunsford 2014). Within GIDS the three most common associated difficulties were bullying (47%), low mood/depression (42%) and self-harming (39%) (Holt et al, 2014). In their service the Dutch team found that 67% of referred young people had no additional psychiatric disorders (de Vries et al 2010). For Dutch adolescents with gender dysphoria, it was more common to have coexisting internalizing disorders such as anxiety and depression, than an externalizing disorder such as oppositional defiant disorder (de Vries et al., 2010).

Self-harming thoughts or behaviours are common in adolescents referred to GIDS. In an early study, the incidence of suicide attempts e.g. overdoses, was seen in 23% of cases prior to referral to the service; contact with GIDS reduced this risk to between 1% and 2% (Di Ceglie et al 2002). In a more recent study, 24% of the young people being referred self-harmed, 14% of the young people had thoughts of self-harming, and suicide attempts were indicated in 10% of the young people prior to attending the GIDS (Skagerberg et. al., 2013). Looking separately at the data for the natal females and natal males it was found that thoughts of self-harm were more common in the natal males than in the natal females prior to attendance at the GIDS, whereas actual self-harm was more common in the natal females. These figures for associated difficulties appear to be increasing in line with the rise in the general population; self-harm rates in the general population tripled between 2002 and 2012 (HBSC Report, 2014).

In Finland more than three quarters of the adolescent sex reassignment applicants had needed/or currently needed specialist level child and adolescent psychiatric services due to psychiatric problems other than gender dysphoria (Kaltiala-Heino et al. 2015). These researchers identified five distinctive groups of young people and adolescents amongst 49 adolescents presenting at their service: Group A: Early onset with no significant psychopathology; Group B: Early onset with considerable psychopathological difficulties; Group C: Adolescent onset with no, or very few psychopathological or developmental difficulties; Group D: Adolescent onset with severe psychopathological and developmental difficulties; and Group E: Adolescent onset with identity confused development. This last group was the largest, consisting of young people who were bullied, isolated with few friends, not attending school or leaving the house, and frequently self-harming; they had a strong conviction that gender reassignment would solve their psychosocial difficulties.

In some settings, it appears that social exclusion may be a key causal pathway for the relationship between gender identity and disadvantageous health outcomes

(Hendricks & Testa 2012). This can take the form of prejudice; stigma; transphobia; individual, institutional, and societal discrimination and violence.

When young people do communicate a strong sense of despair this can lead to extreme pressure being placed on clinicians to act and provide immediate solutions through physical interventions that may not be clinically appropriate at the time of the request. It is recommended that services provide a staged approach (Di Ceglie, 2014) to reduce the risk of self-harming behaviour and to try and prevent rash decisions being made during a time of severe distress.

Autistic Spectrum Conditions

There seems to be a higher prevalence of autistic spectrum conditions in clinically referred, gender dysphoric adolescents than in the general adolescent population. For example Holt, Skagerberg & Dunsford (2014) found that 13.3% of referrals to GIDS in 2012 mentioned comorbid ASD (although this is likely to be an underestimate). This compares with 9.4% in the Dutch service; in the Finland service 26% of adolescents were diagnosed to be on the autism spectrum (Kaltiala-Heino et al. 2015).

Intervention

The research evidence for the effectiveness of any particular treatment offered is still limited. In adolescents with GD, psychological support and puberty suppression have both been shown to be associated with an improved global psychosocial functioning. Both interventions may be considered effective in the clinical management of psychosocial functioning difficulties in adolescents with GD (Costa et al: in press).

Engagement in social action with other transgender people has been shown to help build resilience: Testa, Jimenez & Rankin (2014) demonstrated this effect empirically.

In the Dutch long-term evaluation study, it has been found that the psychological functioning of selected transgender adolescents tends to improve after a staged programme of puberty suppression, cross-sex hormones and gender reassignment surgery (de Vries et al, 2014). In this series of studies, 55 adolescents with GD have been followed up three times: at intake, before start of puberty suppression (mean age 13.6); when cross-sex hormones were introduced (mean age 16.7); and at least 1y after gender reassignment surgery (mean age 20.7). No adolescent withdrew from puberty suppression, and all started cross-sex hormone treatment. Their psychological functioning improved steadily over time, resulting in rates of clinical problems that were indistinguishable from general population samples (e.g. numbers in the 'clinical' range dropped from 30% to 7% on some CBCL measures). Quality of life, satisfaction with life, and subjective happiness were comparable to same-age peers. Transwomen showed more improvement in body image satisfaction and in psychological functioning than transmen, who showed continuing high rates of anger and anxiety. The researchers note that in the context of the Netherlands, transgender

youth tend not to experience the gender-related abuse and victimization that young trans people in other setting may undergo.

This Dutch research programme indicates that a treatment protocol including puberty suppression followed by cross-sex hormones and gender reassignment surgery, leads to improved psychological functioning of a comprehensively evaluated and selected group of transgender adolescents. The authors conclude: *'Clinicians should realize that it is not only early medical intervention that determines this success, but also a comprehensive multidisciplinary approach that attends to the adolescents' GD as well as their further well-being and a supportive environment'* (de Vries et al 2014).

It is important to underline that in this Dutch follow-up cohort study young people were only eligible for the puberty suppression if they (a) had persistent GD from childhood, (b) lived in a supportive environment and (c) had no serious co-morbidities. These were called the *'immediately eligible'* group (de Vries et al 2011). (This is not the profile of a high proportion of GIDS clients.) In other words, those young people who achieve good outcomes are more likely to be those who have experienced lifelong gender non-conformity and who start off with significant social advantages: chiefly, the absence of any serious psychological difficulties and the presence of strong family support. Young people were started on puberty suppression only after a *'comprehensive psychosocial evaluation with many sessions over a longer period of time'* (de Vries et al 2014. For the *'immediately eligible'* group, the time from starting assessment to starting on the blocker was up to 18months, with a mean of 9 months.

If the young people did not show persistent GD from childhood, live in a supportive environment or if they had serious co-morbidities, assessment was prolonged to up to almost 2 years (1.86 months). Such young people were in the *'delayed eligible'* group. This delay in starting the blocker was to ensure they had adequate mental health treatment prior to medical intervention.

It is worth noting that in Spack et al (2011), all the young people seen in the Boston service are reported to be in counselling, and the authors reference studies to show that *'those who do not receive counselling have a higher risk of behavioural and emotional problems and psychiatric diagnoses'*.

With physical interventions there are still some concerns about safety aspects. Although pubertal suppression, cross-sex hormones and gender reassignment are generally considered safe in the short term, the long-term effects regarding bone health and cardiovascular risks are still unknown (Cohen-Kettenis & Klink, 2015). Therefore, vigilance is warranted during and long after completion of the last gender affirming surgeries. Tragically, we have recently been reminded (de Vries, 2014) that the risks of surgery remain very real: one young person from the original Dutch treatment cohort died after her vaginoplasty owing to a postsurgical necrotising

fasciitis.

The Dutch team emphasises that at each stage, it is important that the adolescents are able to give informed consent. This means being informed about the possibilities and limitations of gender reassignment and other types of treatment, including psychological interventions. As gender dysphoria may exist in many forms and intensities, gender reassignment is not the only treatment option to help resolve GD. The broader impact of gender reassignment on many aspects of their lives has to be discussed, such as fertility.

Concluding note

Gender dysphoric young people do not form a monolithic group in terms of how they experience their gender and their bodies, in their relationship to distress and disempowerment, or in their demands for support and treatment. The process of gender identity development is likely to be rich and layered, and the pathways to gender non-conformity are surely legion. For many, the incongruence between gender identity and body creates a form of psychological distress in the deep relationship between the self and the body. We are not in a position to say how far this distress might be experienced even in a more accepting social context.

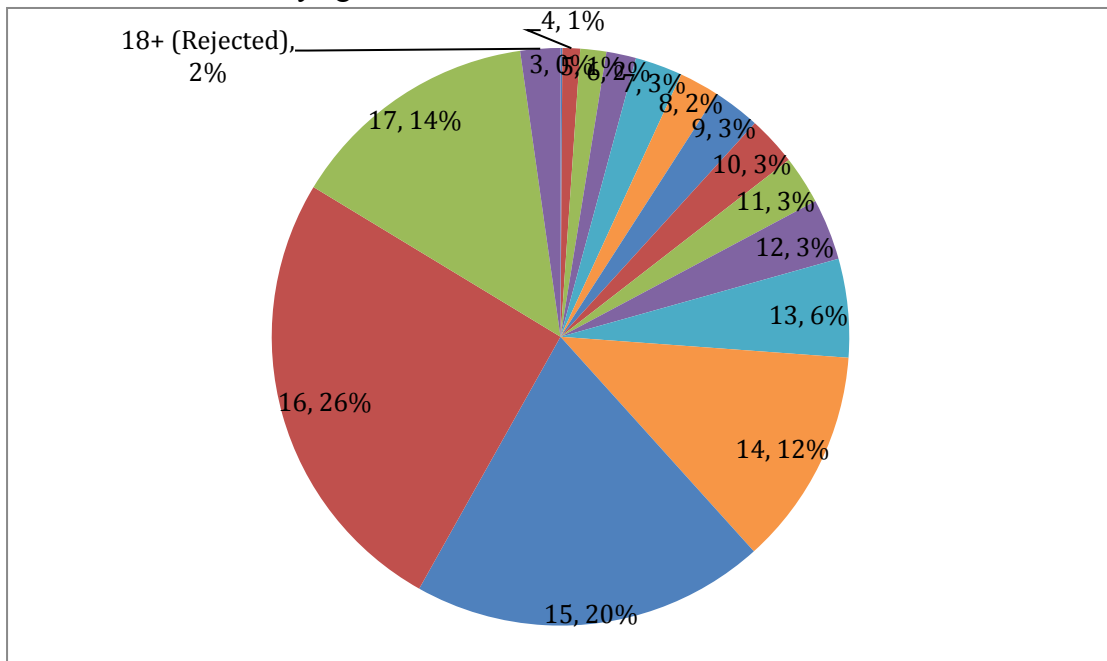
There is always a risk that the work of GIDS in offering physical intervention itself represents a potentially oppressive acceptance of a version of gender that many - not just gender non-conforming people - experience as limiting, precisely because it demands conformity of body and mind to a narrow binary discourse. Add in a concern, within a society that widely promotes body dissatisfaction, that young people may be led to idealise the transformation of the body, with the limitations of physical intervention poorly understood. A non-essentialist view of gender offers conceptions of gender as to a large degree multi-layered and evolving over time. From such a perspective we are surely bound to interpret the urgent requests of some young people for hormonal and surgical sex reassignment as *sometimes* demanding too much coherence and clarity. At the least, we should be promoting a grasp of the possibilities of varied trans identities, in order to encourage thinking critically about conventional notions of masculinity and femininity, and to challenge a passive relationship to diagnosis and classification.

Dr Polly Carmichael
Clinical Director GIDS

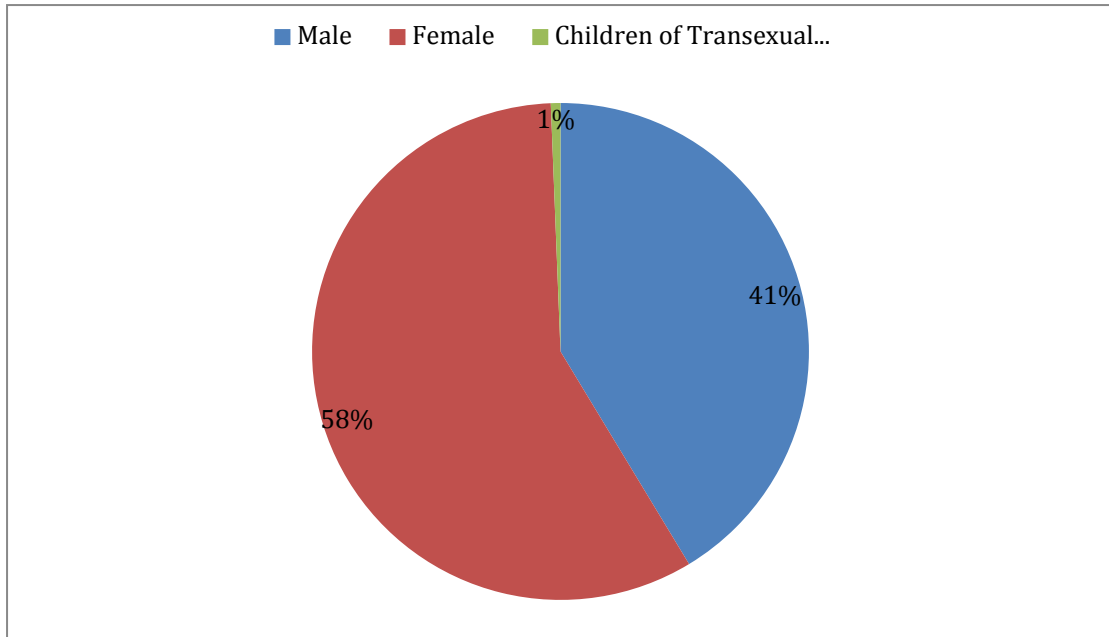
Dr Bernadette Wren
Associate Director of GIDS

Referral by age, gender and location.

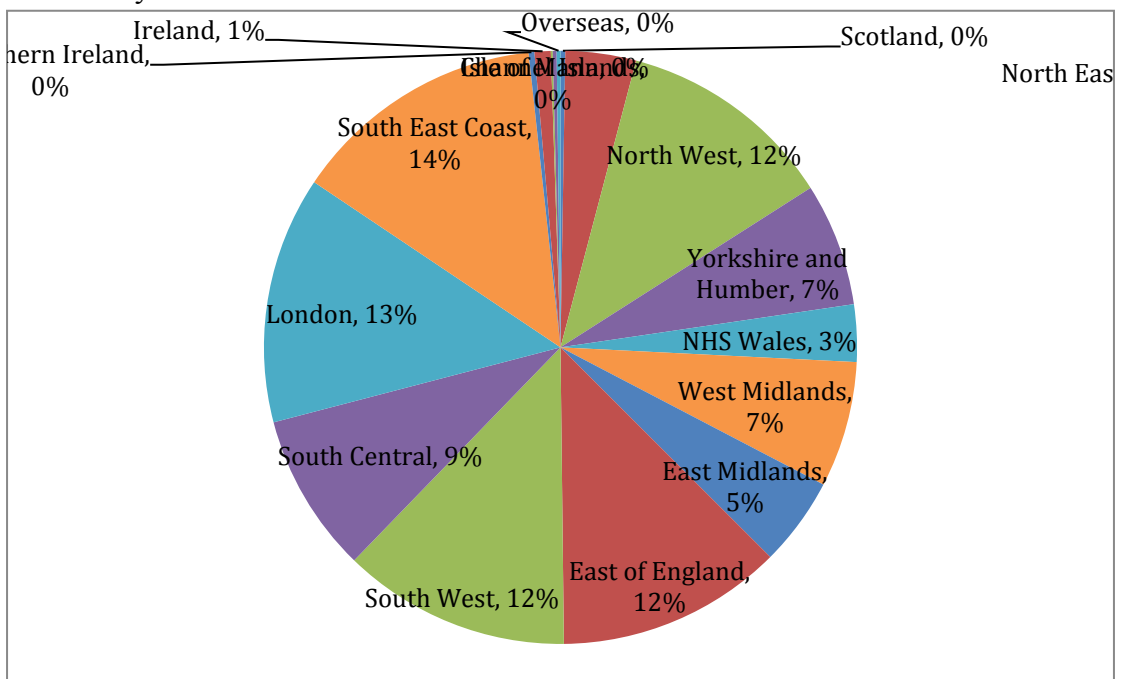
Referral to the GIDS by age 2009 -2015



Referral by natal sex 2009-2015



Referral by location 2009-2015



21 August 2015