

# (Im)possible childhoods: contesting healthcare for gender and sex diverse youth

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*(Im)possible Childhoods: contesting health provision for gender and sex diverse youth*

- is the result of my own work and includes nothing which is the outcome of work done in collaboration except as declared in the Preface and specified in the text.
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## Abstract

This study explores health provision for gender and sex diverse (GSD) children and young people in National Health Service (NHS) settings in England, Wales and Scotland. Recent years have been a time of profound challenge to traditional ideas about gender and identity. Young people have been developing increasingly diverse ways of thinking about and expressing gender. At the same time there has been a proliferation in the number of young people experiencing issues with gender seeking out health services. These dynamics have incited intense public, policy and clinical controversy, particularly over how best to support children and adolescents in specialist NHS clinics.

In this interdisciplinary, mixed-methods study I analyse data from 86 qualitative interviews with (40) GSD children and young people, (31) caregivers and (15) key experts; as well as a quantitative survey with (1,776) youth ages 14-24 years. I argue that young people's experiences and wellbeing are hampered by a system of care which assumes gender and sex typicality to be healthy, permanent, 'natural' and 'real', while forms of gender and sex variance are framed as pathological, deviant, artificial and 'curable'.

These presuppositions are rooted in naturalised accounts of sex, gender and sexual desire, which posit these categories as inextricably aligned and defined through unequivocal, binary, biological 'truths'. Meanwhile, underpinning and regulating these ideas is a developmentalist discourse of 'childhood', which has depicted children as fundamentally naïve to matters of sex(uality), gender and the body, and defined gender and sex diverse knowledge, experience and expression as harmful to children's development.

I show how this matrix of beliefs functions to limit the possibilities of viable childhoods through ordering medical practices. GSD children may be either *denied* services or *obligated* to undergo interventions (both physical and psychological), without respect for their individual autonomy and informed consent.

The wellbeing of GSD youth may be improved through an alternative system of care: one, which better recognises the complex heterogeneity of sexed and gendered experiences and welcomes and accommodates the creativity and agency of children.

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## Chapter 1 Introduction: ‘we are losing the innocence of childhood’

Gender and sex diversity, especially amongst children and young people, has emerged in Britain as a topic of increasing public policy concern and debate. Recent years have borne witness to a heightened awareness and visibility of variant sex and gender identities, including in mainstream media (Pang *et al.*, 2020). Simultaneously, there has been a proliferation in the number of young people experiencing issues with their gender identity seeking out information and support. Over the last decade, the NHS Gender Identity Development Clinic for children based in England has seen a 25 fold increase in referrals from just 138 in 2010-11 to 3,585 in 2021-22.<sup>1</sup> Adult Gender Identity Clinics (GICs) across England, Scotland and Wales have also seen marked increases in referrals, leading to the recent opening of the Wales Gender Identity Clinic in 2017 (Royal College of General Practitioners, 2019).

Transgender children, in particular, have featured prominently in the public discourse: including TV, radio, and print and digital news. Headlines on the subject from prominent newspapers across the political spectrum have included: *‘Politicismised trans groups put children at risk’* (The Guardian, 2019), *‘Calls to end transgender ‘experiment on children’* (The Times, 2019) and *‘By indulging the whims of transgender children, we are losing the innocence of childhood’* (The Telegraph, 2016). Such articles are framed by concern about a novel and ever-growing type of ‘danger’ posed to the nation’s children, inflicting new forms of ‘harm’ on the ‘vulnerable’, ‘confused’ and ‘innocent’.

Public anxieties over the welfare of children in the context of social and cultural change are endemic to contemporary constructs of ‘childhood’, which convey notions of immaturity, passivity and innocence (Garlen, 2019). These ideas, influenced by developmental and psychological accounts of the ‘naturalness’ and ‘universality’ of childhood, posit children as reflexive receptacles of a social order that is to be reproduced through the appropriate protection and nurture of future generations (Prout and James, 1997). Indeed, the current debate concerning gender diverse children, is strikingly reminiscent of the 1980s, when an upsurge in lesbian and gay activism incited a wave of moral outrage, arousing ‘discourses of childhood innocence’ (Robinson, 2008). Concerns about the nation’s children culminated in the passing of ‘Section 28’ of the Local

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<sup>1</sup> The Tavistock and Portman NHS Foundation Trust. Gender Identity Development Service Referrals, <https://gids.nhs.uk/about-us/number-of-referrals/> Access February 2023.

Government Act (1988) prohibiting the ‘promotion of homosexuality...as a pretended family relationship’ by local authorities and in schools. Thirty years after the law was created, Baroness Knight (one of the key individuals involved) apologised for her part, insisting that “*the intention was the wellbeing of children.*” (BBC, 2018).

Whereas in the 1980s the assertion of new sexual subjectivities was threatening to subvert the social landscape of Britain, the late 2010s have borne witness to an advancing cultural siege on binary gender. This in turn has incited a growing mass of journalists, politicians, academics and members of the public united in their concern about the exposure of children to new forms of gendered knowledge and expression. Over the last couple of years, an emerging academic and clinical literature has been accruing around the novel concept of ‘Rapid Onset Gender Dysphoria’ (first coined by Littman, 2018) which posits that increasing numbers of adolescents (particularly birth-registered females) are identifying as transgender, and seeking out invasive medical interventions, after learning about new identity categories propagated by their peers and on online social networking forums. Activists have established new campaigning organisations, such as *Transgender Trend*, *the Safe Schools Alliance* and the *LGB Alliance*, whose stated purpose is to preserve the pre-eminence of ‘sex’ as a classification based on binary biological difference, and to protect and ‘safeguard’ children from being exposed to dangerous new ‘ideologies’ of gender, and setting off down a harmful pathway of diagnosis and medicalisation.<sup>2</sup>

Yet, far from being ‘innocent’ of gender, children’s lives are profoundly shaped by it. A growing body of ethnographic research in Britain has documented the ways in which children’s lives and identities are strictly organised around categories of ‘sex’ and ‘gender’ (e.g. Renold, 2005; Renold, Ringrose and Egan, 2015; Atkinson, 2021). These studies have explored how binary, hierarchical notions of sexual difference, regulated through a normative regime of compulsory heterosexuality, are deployed within childhood cultures to reward particular expressions of masculinity and femininity, and punish forms of deviance. Meanwhile, notwithstanding the constraints of children’s social worlds, research indicates that young people may be developing increasingly diverse ways of thinking about and ‘doing’ gender. For example, a 2018 study conducted by Bragg et al., found that their sample of young adolescents (ages 12-14 years) used as many as 23 different terms to describe a myriad of different ‘genders’, and was engaged in critical reflexivity about gendered norms, categories and inequalities.

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<sup>2</sup> See: <https://www.transgendertrend.com/>; <https://safeschoolsallianceuk.net/>; <https://lgballiance.org.uk/>, accessed March 2020.



Although these studies investigate the ways that children's social relations are regulated by, as well as productive of, different gendered and sexual identities, detailed exploration of the personal experiences and subjectivities of transgender and sex variant children is not the key focus of these literatures. Despite the attention afforded to the issue, there is a dearth of empirical research, that has sought to examine, explore and understand the lives gender and sex diverse (GSD) children and youth. There is a pressing need for more evidence: the issue is rapidly becoming a key source of controversy and uncertainty for policy makers and front-line service staff working with young people across a variety of sectors, as well as a matter of litigation (e.g. *Tavistock v Bell*, *Webberly v GMC*).

A growing body of evidence, particularly from the US, and with older GSD individuals, suggests that the consequences of gender and sex atypicality may be punishing and severe. Gender and sex variance has been associated with a broad range of negative outcomes, including: poor mental and physical health (Warren, Smalley and Barefoot, 2016), social isolation (Budge, Adelson and Howard, 2013; Jones, 2022), alcohol and drug use (Reisner *et al.*, 2015), homelessness (Whittle, Turner and Al-almi, 2007) and suicidality (Holt, Skagerberg and Dunsford, 2016).<sup>3</sup> The evidence suggests that the relationship between gender diversity and poor outcomes may be mediated by experiences of discrimination, victimisation and prejudice (e.g. Toomey *et al.*, 2010). GSD groups are at particular risk of becoming victim to (extreme) forms of physical and sexual violence, often motivated by attempts to 'correct' their gender presentation and force them to conform to normalised understandings of sex, gender and sexuality (Grant *et al.*, 2011; Winter *et al.*, 2016). Concerns about high rates of self-harm and suicide amongst transgender youth are of particular concern, and have been widely reported. One of the rare empirical studies that captured data on trans adolescents' experiences in the UK, conducted by LGBT charity Stonewall, found that more than four out of five trans youth self-harmed, and that two out of five had previously attempted suicide (Bradlow *et al.*, 2017).

On the other hand, outcomes may be improved for those GSD individuals who are provided appropriate and early support and permitted to exercise agency and self-determination over their gender identity during childhood, including through the ability to select a pronoun and name of their choosing, as well as hairstyles, clothing and toys to reflect their own preferences (Hidalgo *et*

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<sup>3</sup> Specific percentages and effect sizes vary from study to study.

*al.*, 2013; Olson, Key and Eaton, 2015). The data, however, are limited and mostly based on research conducted in the US. Whilst studies are few, research subjects have largely constituted transgender children (to the exclusion of other GSD groups), those registered male at birth, and very young children; less is known and understood about what happens to these children during adolescence (Olson, Key and Eaton, 2015).

In the UK, much of the literature that has historically purported to include information about transgender and (to a lesser extent) other gender and sex variant experience, has discursively subsumed these groups within an overarching ‘LGBT(+)’ umbrella. This approach problematically bundles a vast diversity of gender and sexual differences into one grouping; trans, sex variant, non-binary, and other GSD perspectives have generally been side-lined and lost in discussions, which in practice have almost exclusively focused on the experiences and struggles of *sexual* (LGB) minority youth (e.g. Kneale *et al.*, 2021). A 2016 review of evidence conducted by the National Institute of Economic and Social Research concluded that the evidence base required to inform policies for removing barriers to LGBT equality is ‘deficient and has major gaps’, in part due to a failure of research to disaggregate disadvantage into individual LGBT groups; the report noted a particular lack of evidence on gender minority experience (Hudson-sharp & Metcalf, 2016: 1).

Furthermore, children have been particularly neglected within the limited body of research that has focused on GSD groups, as these have tended to concentrate either primarily or exclusively on adults (Ellis, Bailey and McNeil, 2015; Nodin *et al.*, 2015; Vincent, 2016; Monro, Crocetti and Yeadon-lee, 2019). Studies that have considered children’s experiences tend to be methodologically limited, having sought to exclusively gather data through interviews with parents, carers, clinicians and other adults, speaking on behalf of young people (e.g. Elizabeth A. Riley *et al.*, 2013; Horton, 2022). Proxy reports are not without value, but they are based on the secondary and partial perspectives of adults, who do not possess the situated knowledge necessary to be truly expert in the day-to-day spaces of childhood and adolescence (Balén *et al.*, 2006; Carter, 2009). Aitken (1994) writes: “*it is one of the great ironies of human development that by the time we are old enough to reflect on what is it like to be a child, we are so far removed from the experience that it is difficult to empathise*” (p.30).

Only rarely has empirical research in Britain focused specifically on gender and sex variance as a field of subjectivity in childhood, through primary research with children themselves. Where

studies exist, their samples tend to be small and specialist: for example, in 2013 Le Roux conducted research into the developmental experiences of 10 London-based young people with gender dysphoria, focusing on those who were not wishing to pursue medical interventions for gender reassignment, and in 2016 O'Flynn reported on the school experiences of two trans boys aged 15-16 years in London.

Within gender theory and research, intersex and transgender studies are increasingly emerging as subjects of significant social-scientific interest, drawing attention to the existence of persons whose bodies and identities continue to confound, in complex ways, varied attempts to locate and theorise notions of 'sex', 'gender' and 'sexuality', as well as the relationships between these three constructs (Bettcher, 2016; Elliot, 2016). Meanwhile children and young people's bodies have increasingly become a key site of political, intellectual and legal contest over sex and gender variance and transness. I suggest that the complex questions that have arisen out of these disputes (and the shifting cultural conditions within which they have emerged) are most usefully unpacked and explored through returning to a contextual, empirical investigation of the lived realities of those individuals who have come to be the key subjects (/objects) of such debates.

My study was designed with this goal in mind: I conducted a large body of mixed methods primary research with GSD children and youth, their caregivers, and other key informants and experts. I focused my inquiry in particular, on young people's experiences in health care settings in England, Scotland and Wales. I was interested in exploring how particular conceptions of sex and gender and childhood were embedded within the logics and practices of health services, as well as investigating the broader implications of these dynamics for those young people whose bodies and identities fail to conform to dominant, institutionalised understandings of gender and sexual difference.

Although this study was primarily oriented towards improving policy and practice to better protect the rights and welfare of GSD youth, it is my hope that learning from this project might have implications beyond this group, to the benefit of people of all genders. As Stryker (2006) writes:

Transgender studies, far from being an inconsequentially narrow specialisation dealing only with a rarefied population of individuals... represents a significant and ongoing critical engagement with some of the most trenchant issues in contemporary humanities, social sciences and biomedical research (p.3-4).

Broadly, I hope my work may offer some contribution to broader field of work that seeks to examine, understand and address forms of gender-based oppression, as well as presenting new possibilities for transformation and change, towards a position where all individuals are free to define and pursue their identities free from coercion, discrimination, de-humanisation, and violence.

### *Chapter 1 outline*

In the succeeding sections of this chapter, I explore evolutions in theorisations of categories of ‘sex’, ‘gender’ and ‘childhood’, drawing on insights from the existing literature (sections 1.1.1 and 1.1.2). I discuss the importance of these theorisations for understanding the social positions of GSD children and youth (section 1.1.3), thus informing my methodological approach to this research (taken up in 0). Building on these insights, in Section 1.2, I provide an account of how I will use different terminologies in the context of this thesis.

In the final sections of the chapter, I set out my research objectives and questions (Section 1.3), and further justify the selection of young people’s experiences in health settings as a particular area of focus, drawing on insights from the current literature (Section 1.4). In section 1.5, I explain my inclusion of both sex variant (SV) and gender diverse (GD) youth in the same study. Finally, I provide a summary of the succeeding chapters, which seek to explore and respond to these lines of investigation and inquiry (Section 1.6).

## 1.1. ‘Queer’-ying Innocence, ‘the heterosexual matrix’ and the social construction of childhood

### 1.1.1. Theorising sex and gender

*“Gender is not what culture created out of my body’s sex. Sex is what culture makes when it genders my body”* – Transgender activist, quoted in Monro (2010, p.30)

Many individuals experience their bodies and identities in ways that do not fit within a male-female binary. To make sense of the challenge that the existence of such persons presented to dominant social and scientific understandings of sexual difference, a group of scientists in the 1950/60s first advanced the English language distinction between ‘sex’ – the biological characteristics of male and female bodies, and ‘gender’ – the social and psychological aspects of being a man or woman (Moi, 2005).

Developed during debates in the North American medical community about whether or not to perform sexual reassignment surgeries on transgender and intersex patients, the distinction between the two terms was initially used to justify interventions into physical bodies, to enable the transformation of a person's 'biological sex' to align with their 'social' or 'psychological gender' (Hines, 2007). The utility of the concept of gender, and its differentiation from sex, lay in its potential to elucidate the purpose of sexual reassignment surgeries, at the same time making sense of the transsexual experience (Meyerowitz, 2004; Friedman, 2006). Later, in the 1960s and early 1970s, a 'second wave' feminist movement adopted and reformulated the distinction but for entirely different purposes (Friedman, 2006). These feminists were preoccupied with the metamorphic potentials of 'gender', concerned, not with the transformation of individual bodies, but with the social gender norms and roles, rooted in notions of biological essentialism, that positioned women as subservient to men (Fausto-Sterling, 2000; Friedman, 2006). Thus, while the original sex/gender distinction was rooted in the idea that sex was entirely alterable - indeed, more easily changed than a person's gender - this formulation was subsequently abandoned in favour of a new, more influential, construction: whereby 'sex' became to be understood as a fixed matter of biology, and 'gender', a fluid and capricious set of culturally defined characteristics (Moi, 2005).

Whilst, conceptualisations of 'gender' became increasingly complex, sophisticated and expansive, sociological analyses of *sex* received much less attention (Friedman, 2006). An implicit binary 'sex/gender', 'nature/culture', 'fixed/mutable' system of analysis prevailed. This dyadic formulation has been widely adopted by institutions and continues to dominate the public and political discourse (as well as a substantial part of the social scientific and medical research) concerning sex and gender diversity today.

And yet, in the field of bioscience understandings and definitions of sex were far from settled; research was rapidly expanding the range of variables that were understood to 'produce' biological sex. Chromosomes, gonads, hormones, and internal and external genital morphology were all considered to play a role, with complex variations observed across all these axes of development. Sex came to be understood as a dynamic developmental process rather than a fixed unitary measure. Particularly fascinating developments in genetics pointed to a complex process of sex determination, through which primary sex characteristics emerge from a finely balanced 'competition' between two opposing networks of gene activity; scientists identified more than 25

genes, each with their own mutations, which may result in variations in sex development in humans` (Ainsworth, 2015). Recent data indicate that the global prevalence of children born with intersex variations may even be increasing, due to the impact of changing environmental factors on reproductive organ differentiation and development in utero (Rich *et al.*, 2016).

Meanwhile, in the 1980s/90s, a subset of feminist scholarship, particularly influenced by queer and intersex perspectives, further theorised the relationships between gender and sex. Gender was (arguably) better conceptualised as the system of knowledge that gives meaning to bodily difference (Scott, 1999), as opposed to the reflection or construction of a body's fixed, objective and immutable sex. Constructs of binary, biological sex were reconceived as the body's performance of gender: the product of the continuous and iterative performance of gendered bodily practices, which over time generates a naturalised image of 'male' and 'female' bodies (Butler, 1990). In this way, what appeared to be the origin of gender came to be seen as its *effect*: an effect which, in turn, imposes discursive meanings on bodies, demanding their conformity to closed categories of being and restricting possibilities for other forms of gendered bodily expression. Gender performance theory (which finds its most systematic exposition in the work of Judith Butler (see also Moore, 1994; Morris, 1995) thus demonstrated how holding on to the notion of a male-female *sex* binary reproduces and entrenches a (naturalised) *gender* binary, and vice-versa, even when diversity of gender and sexuality is recognised (Butler, 1990).

In addition, (hetero-) 'sexuality' was identified as a key organising category in gendered performance and the production of 'sex', such that all three categories ('sex', 'gender' and 'sexuality') are constitutive of each other (Butler, 1990; Wittig, 1982). This is because gendered categories are posited in terms of a binary difference relation, organised and structured around a regime of normative heterosexuality: the 'heterosexual matrix' (Butler, 1990). Butler writes:

'The internal coherence or unity of either gender, man or woman, requires both a stable and oppositional heterosexuality.... The institution of a compulsory and naturalised heterosexuality requires and regulates gender as a binary relation, in which the masculine term is differentiated from a feminine term, and this differentiation is accomplished through the practices of heterosexual desire.' (p.30)

These claims are persuasive. Whilst many queer theorists and activists have called for an analytic distinction to be drawn between gender and sexuality – rightly pointing out that heteronormative ideas *ought* not to order discourse about gender – the conceptual assimilation of these constructs is so entrenched it permeates the structure of (English) language. Whilst the word 'sex' refers both

to the practice or expression of sexual desire, and to an individual's status as male or female (Green, 2005), the language used to describe and categorise sexual orientation – straight, gay, heterosexual, homosexual, same-sex, different-sex desire – defines a person's sexuality *in terms of* their gender as it stands in relation to that of their partner. This means that to gender transition within the conventional binary of gender, is also to transition from gay to straight, or vice versa, even though a person's sexual preferences may in fact remain stable.

The effects of the assimilation of sex, gender, and sexuality are more than linguistic; there are numerous examples of its material and practical consequences. Popular nineteenth century scientific theories of 'same-sex' desire, which attributed such orientations to a variety of gender 'disorder' were influential in informing harmful treatment programs directed at 'curing' homosexuality through reinforcing normative gender identities and roles (Mottier, 2008). Further, there has been a long history of questions of sexuality influencing or structuring the provision of and access to health services for gender variant individuals, with providers (often quite erroneously) viewing the potential for heterosexual orientation after transition as evidence of an authentic 'transgender' identity (e.g. Hastings, 1978). Meanwhile, GSD groups have faced particular challenges with heteronormative legal rules governing sexuality and marriage, including having their marriages unintentionally annulled as a consequence of gender transition (Fausto-Sterling, 2000).

Understanding the instability and independency of constructions of 'sex', 'gender', and 'sexuality' is crucial for unpacking the social positions and experiences of gender minority youth. Meanwhile, there is an additional category of being, which simultaneously interacts with, produces and subverts ideas of sex, gender and sexuality to structure young lives: namely, 'childhood'.

#### 1.1.2. Sexuality and the social construction of childhood innocence

*LGBTQ identities are particularly taboo [amongst children]...where the hyper-sexualisation of gay and lesbian sexualities clashes strongly with [the] widespread myth...of the asexual and naïve child'. (Payne and Smith, 2014: 402)*

A body of research within childhood studies has drawn attention to the idealised image of the ('western') 'child' as an essentially innocent and passive being (e.g. Duschinsky, 2016; Jackson, 1982; Robinson, 2013). Prout and James (1997) contend that an 'evolutionary' perspective on childhood has obtained cultural pre-eminence in contemporary Western thought: a schema where children are conceived as embryonic beings 'awaiting temporal passage through the acquisition of

cognitive skill' into a world governed by adults (p. 11). This frame for understanding 'childhood' has resulted in a body of work, particularly in the fields of psychology and education, that has set out the define the parameters by which children are expected to develop - physically, cognitively, emotionally and socially - through a series of progressive, predefined stages of maturation into adulthood (Robinson, 2013b). According to such a perspective, children are defined by their biological immaturity. Childhood, a natural and universal feature of human groups, is the sanctuary of the prototypical human: pure, uncorrupted, and immaculate, on the one hand; passive, incompetent and naïve, on the other.

Meanwhile, (a)sexuality has been particularly constitutive of constructions of childhood passivity and 'innocence'; discourses of developmentalism have defined access to sexual knowledge as harmful to children's normal and healthy development (Robinson, 2013a). In fact, according to Jackson (1982), the social taboo that 'children and sex should be kept apart' is so powerful that lack of sexual knowledge and experience is part of what is thought to distinguish children from adults as separate and distinct categories of person.

These dynamics have resulted, amongst other effects, in a distinct lack of research into children's (gendered) sexual embodiment (Tolman, Bowman and Fahs, 2014). Yet, an emergent body of ethnographic work exploring children's gendered sexual relations, has begun to document the many ways in which children's lives and identities are, in fact, profoundly shaped by, and structured around, categories of 'sex', 'gender' and 'sexuality'.

The work of E.J. Renold has been particularly influential in this field. Their research has explored how binary, hierarchical and oppositional constructs of masculinity and femininity, signified through compulsory expressions of heterosexuality, are continuously performed, enacted and instilled within British primary school environments; whilst hegemonic masculinities are deeply aligned with power and dominance, sexism, homophobia, and sexualised forms of violence and bullying are routinely deployed in order to maintain a patriarchal (hetero-)gendered order (Renold, 2005; Renold, Ringrose and Egan, 2015). Other authors have highlighted the pervasive celebration of heterosexuality and notions of (hyper) masculinity and femininity within children's cultures, including from the earliest years, pointing to common childhood play practices such as 'mummy and daddy' role play, pretend weddings, dress-up games, and the celebration of princess culture, amongst many others (Payne and Smith, 2014; Ryan, 2016; Depalma and Jennett, 2017).



Research with older children, adolescents and youth has yielded very similar results. Whilst there has been relatively more gender and sexuality research with adolescents, studies tend to be conducted within a framework which problematises youth sexuality: conceiving it primarily in terms of ‘risk’, danger and wrong (hence a particular focus in the literature on issues such as sexual violence, unwanted teenage pregnancy and sexually transmitted infections (Wellings *et al.*, 2001; Tripp and Viner, 2005)). Meanwhile, institutional and policy responses are often directed towards prohibiting and punishing young people’s sexual expression,<sup>4</sup> in part based on fears associated with ‘encouraging’ or ‘inciting’ the release of a dangerous youth sexuality and a desire to ‘protect’ young minds from the corrupting influence of ‘adult’ knowledge (Green, 2005; Robinson, 2013a).

Lorraine Green’s (2005) ethnographic work with older adolescents, undertaken in residential care institutions, explored how staff members’ silence on subjects of sex, sexuality and gender (despite the fact that most young residents were sexually active and many had past histories of sexual abuse) resulted in institutional collusion with a sexist and homophobic culture. This entailed both the systematic, sexist diminution and objectification of girls, and the ridicule and punishment of gender non-conforming boys. Similarly, Pascoe’s (2007) study, which explored the construction of youth sexuality within American High Schools, illustrated how gendered institutional practices, interactions, and school rituals, carried out by students, teachers and school administrators alike, all contributed to the construction of dominant and violent masculinities, reinforced through *‘repudiating and mocking weakness...represented by femininity or the fag’* (p.168). In more recent work, Pascoe argues that whilst dominant constructions of masculinity may be evolving, the same systems of power, dominance, exclusion and inequality prevail (Bridges and Pascoe, 2018).

These studies form part of a wide body of literature that provides compelling evidence of how the structural conditions of childhood, which persist throughout early childhood and adolescence, underpin hegemonic categories of sex, gender, and sexuality. They reveal how the notion of childhood innocence is constitutive of the strategy that conceals the possibilities for sex and gender configurations ‘outside the restricting frames of masculinist domination and compulsory heterosexuality’ (Butler, 1990: 192-3). Under a cloak of passivity and naivety, images of the hyper-(hetero)sexual, masculinized male, and the sexually hetero-passive, feminized female covertly circulate within institutional spaces, to construct young gendered sexualities; as Duschinsky (2016)

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<sup>4</sup> Examples being the expulsion of children from school for having sex, or abstinence-only sexual education campaigns.

writes, ‘innocence...appears as blankness, but is in fact a powerfully unmarked training in heteronormativity’ (p.2).

### 1.1.3. Being young and gender variant

*“The best thing about being a girl is now I don’t have to pretend that I’m a boy.”* – Transgender girl, aged 9, quoted in *National Geographic* magazine.<sup>5</sup>

Within the studies explored above, explicit discussion of transgender, sex variant and non-binary children and youth is largely missing; however, the findings and analysis of this body of research have clear implications for the experiences and wellbeing of such groups. Gender is a particularly threatening field of childhood subjectivity as it sits at the intersection of bodies and sexuality. Through adherence to unmarked and invisible (default) norms, gender-conforming children and young people are afforded (a degree of) invisibility within these complex systems of social control that are produced by the intersection of social norms governing childhood and those governing sex, gender and sexuality. GD children, on the other hand, are dangerously exposed. As their bodies and identities eschew the terms of the ‘heterosexual matrix’, their very presence and existence as gendered and sexual beings becomes jarringly manifest.

Such dynamics contribute to the gendered sexual objectification of LGBT+ cultures (most particularly transwomen and sex variant persons) in general (Erickson-Schroth, 2014; David A. Rubin, 2017). However, for young people, the consequences of becoming ‘visible’ as sexual and gendered beings can be particularly punishing. If as Butler argues: ‘normative conceptions of gender... exclude particular forms of embodiment and personhood from the domain of the intelligibly human’ (Rubin, 2017: 61), this is particularly true of LGBT+ children. Violating boundaries between the sexual and gendered ‘adult’ and the (presumed) a-sexual, gender-neutral ‘child’, and transgressing norms delineating the appropriate knowledge and behaviour of children, GSD youth find themselves in confrontation with social (and legal) constructions of childhood, in addition to those of sex, gender and sexuality: they are ‘illegible’, not only as gendered subjects, but also as children. Existing outside of dominant social norms, their lives may be vulnerable and precarious.

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<sup>5</sup> National Geographic, Special Issue, Gender Revolution, January 2017.  
<http://www.nationalgeographic.com/magazine/2017/01/> Accessed May 2017.

The contradictions these dynamics cause for gender diverse children are evident in dominant narratives within the public, policy and legal discourse concerning transgender children, which often draw on claims that children are ‘too young’ to possess a gender identity, only to insist that a child’s gender aligns with that of their given sex. For example, in a recent family law case (a custody battle between two parents which centred on a disagreement over whether their child, assigned male at birth, should be raised as a boy or a girl) the Judge found that the mother had been forcing her son to live as a girl. Paradoxically, in reaching his conclusions the judge repeatedly emphasised the child’s young age as evidence of the wrong of imposing a fixed notion of ‘his’ gender upon ‘him’.<sup>6</sup>

Meanwhile, when a child with ambiguous sex characteristics is born, the imperative to provide the child with a stable (binary) gender-marker is considered so essential it is rendered a social and medical emergency (Hester, 2004; Karkazis, 2006; Cannoot, 2020; Crocetti *et al.*, 2020). In her 2006 study, which drew on extensive interviews with adults with sex variations, parents and physicians, Karkazis writes:

Raising a child with.. gender ambiguity.. is almost universally seen as untenable.. anguished parents and physicians have considered it essential to assign the infant definitively as male or female and to minimize any discordance between somatic traits and gender assignment. (p.7)

Whilst fears around transness during childhood often revolve around the potential harm of exposing young bodies to painful and irreversible surgeries and hormonal therapies before they are old enough to have a stable sense of their identity, these very same treatments have been routinely imposed on SV infants to normalise and correct their sexually ambiguous bodies on the grounds that assigning gender is necessary to protect a child’s ‘normal’ and healthy gendered development (Bettcher, 2016). Comparing the treatment of GD and SV children and youth is revealing of the unexamined assumptions and concerns that lie beneath institutional responses to gender and sex variance in childhood, including naturalised understandings of gender and sex, and the desire to preserve the ideological notion of binary sexual difference, underwritten by ‘biological’ sex as an unambiguous fact (Fausto-Sterling, 2000). These dynamics are, in turn, enabled and supported by the mythology of the innocent, asexual and a-gendered child.

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<sup>6</sup> Re J (a minor) [2016] EWHC 2430 (Fam)

Constructions of sex, gender and sexuality, therefore, are at once ubiquitous and fundamental organising features of children's lives, and simultaneously fields of subjectivity that threaten to destabilise the foundations of childhood. The normative conditions of these intersecting identities organise the policing of young lives, from the earliest years of human socialisation and identity formation, well into late adolescence, and long after young people's gendered and sexual identities have been developed, explored and confirmed (Lou, 2013).

## 1.2. Key definitions

### 1.2.1. Towards a working definition of 'sex' and 'gender'

The above analysis provides an account of how constructs of 'sex', 'gender', 'sexuality' and 'childhood' might be conceptualised, drawing most particularly on insights from poststructuralist and queer theory (e.g. J. Butler, 1990; Renold, 2005). As can be seen from the above analysis, these theoretical approaches are particularly useful in their exposition of the *co*-constitution of these categories, thus elucidating the vulnerable social positions of gender and sex diverse children and youth.

On the other hand, a central limitation of such theories is their tendency to (re)collapse the distinction between 'gender' and 'sex'; only, whilst once there was only sex now all is gender. When Butler famously wrote 'sex by definition will be shown to have been gender all along' (Butler, 1997: 281) she eclipsed the very distinction that conceptually elucidated those embodied experiences in which sex and gender fail to 'align' in socially normative ways.

The strength of poststructuralist and queer theory is the attention that it draws to the social and cultural aspects of sex. Deconstructing 'sex' has been indispensable in disentangling both sex and gender from the exclusionary functions of biological determinism: exposing the unstable nature of hegemonic categories of sex, gender and sexuality, and opening up new possibilities for the recognition of diverse identity configurations outside of a naturalised, reproductive binary. Yet in viewing the body as the 'material' construction of gender discourse, such theory has arguably lost sight of the significance of the body, as an active co-contributor to the construction of gender. In the words of Hester (2004):

What medical research into intersexed people shows us...is that bodies are hardly passive at all. They force certain consequences, they confront culture, they upset and undermine cherished beliefs. They are active participants in the environment of sex–gender. (p.220)

In recent years, there has been a renewed interest in a (so-called) ‘corporeal’ feminism, exploring the physical, material and biological features of gender (albeit in ways that are mindful of avoiding the pitfalls of a regressive descent into essentialism and determinism) (Grosz, 1994; Kim and Lee, 2020). Rather than viewing the body as the passive recipient of cultural forces enacted upon it, these perspectives turn their attention to the material body as an active participant in the production of gendered meanings, subjectivities and experiences, such that social processes and physical (‘natural’) bodies are inextricably inseparable. Crawley *et al.* (2008) write:

There is no physical body separate from social practices. There is no social experience separable from physical bodies.. In essence, the social world and the physical world work together to co-construct gendered bodies. (p.16)

Thus, the idea that gender can be differentiated from sex through reference to a simple ‘nature/culture’ divide has been progressively dismantled. There is a pressing need to develop a new account of the gendering and sexing of bodies, without relegating sex to biology, or viewing gender as wholly social. And yet, although, the terms are deeply interconnected, a distinction between the two is important for understanding the varied experiences of different GSD groups.

With this in mind, in this study, the words ‘sex’ and ‘gender’ often appear together but are not used interchangeably. Each are recognised as distinct, but deeply interrelated (coconstituted) constructs, and both are understood as outcomes of biological, psychological and social processes in interaction.

*Sex* is used to refer to the (gendered) system of scientific and cultural knowledge that gives meaning to anatomical differences concerning the sexual and reproductive functions of bodies. This may include descriptions of a person’s chromosomes, gonads, hormones, reproductive organs and genitalia.

*Gender*, on the other hand, refers to the social, psychological and biological mechanisms through which persons know, understand and express themselves, as well as recognise (and relate to) others, as men, women, non-binary, or otherwise (sexually) embodied persons.

Whilst a powerful and oppositional binary underwrites biological processes as well as social and cultural understandings associated with both terms, a simple dyadic formulation of either term cannot fully account for the complex lived diversity of human histories of sex and gender.

### 1.2.2. Conceptualisations beyond the binary: defining forms of sex and gender diversity

The words ‘gender and sex variant/diverse/atypical’ (and the abbreviation ‘GSD’) are used as umbrella terms to describe a variety of experiences of sex and gender that fall outside majority definitions of ‘male’ and ‘female’, which posit these categories as binary, and determined by anatomical sex. Children within these groups include transgender (‘trans’), nonbinary and gender non-conforming children, and children living with a variation in sex development: sometimes referred to as being ‘intersex’.

*Trans(gender)* children have a gender identity that is different to their sex registered at birth. Occasionally, the language of *transsexual* is used to refer to a narrower group of trans individuals who had undergone, or who were seeking to undergo, a change of ‘sex’ through medical transition. The word *transsexual* is considered outdated and offensive by many trans individuals and groups; it is nonetheless occasionally used in this thesis, where the context specifically requires the reader to understand that what is being discussed is a (desire for) change of ‘biological sex’ through medical transition.

*Non-binary* children are a subset of *trans(gender)* children who identify outside of a traditional ‘masculine/feminine’ binary as something other than or in-between ‘male’ and ‘female’.

*Gender non-conforming* children are those whose gender role expression persistently and significantly deviates from the expectations associated with their birth-registered sex: for example, birth-registered males who consistently ‘present’ as female, including wearing the girls’ uniform and using girls’ facilities at school.

*Sex diverse* children are born with variations in congenital sex anatomy that are considered atypical for ‘female’ or ‘male’ bodies, including children with differences in development of their chromosomes, gonads, sex hormones or genitals. Such persons may use the term ‘intersex’ to describe themselves, to reflect the fact that their bodies may have both ‘male’ and ‘female’ attributes. The medical terminology for such variations is ‘disorders of sex development’ (DSD), an umbrella term covering a broad range of specific typologies and conditions. On the one hand, the language of ‘DSD’ is apparently pathologizing, and is rejected by many communities due to its role in reinforcing stigma. On the other hand, this terminology has been explicitly adopted by some individuals and groups, who favour it to the language of ‘intersex’ because it avoids any commitment to the view that people with variations in sex characteristics are in some way ‘in-

between' male and female. Indeed, many sex diverse youth have a binary gender identification. In this study, when describing *people*, I use the language of 'sex variant (SV)/ diverse' or people with a 'variation in sex characteristics' ('VSC'), to avoid the problematic associations of both the 'intersex' and 'DSD' terminologies. I sometimes use the language of DSD to describe an *event* of medical diagnosis.

The umbrella terminology 'sex and gender typical' ('SGT') is used to describe children who are neither gender nor sex diverse. Sometimes I use the word 'cisgender' to describe an overlapping but slightly different category of children and young people whose gender identity is the same as their sex registered at birth.

The term 'gender incongruence' is used to describe experience of a mismatch between an individual's gender identity and their sex registered at birth; and 'dysphoria' refers to the distress that is often associated with such an experience. Some young people who experience gender incongruence may undergo various aspects of 'social' or 'medical' 'transition'. 'Social transition' is an umbrella term used to describe a variety of changes that a child or young person may make to their gender presentation, including changes to: names and pronouns, appearance and dress, use of gender segregated facilities, and participation in gender segregated activities, to better reflect their gender identity (when different to their natal sex classification) (Olson, Key and Eaton, 2015; Davy and Cordoba, 2020). 'Medical transition' describes the use of a range of interventions designed to bring a young person's physical sex characteristics into better alignment with their gender identity. Examples of treatment and procedures involved in medical transition include: feminizing or masculinizing surgeries to the genitals, chest or face; feminizing or masculinizing hormonal therapies (sometimes referred to as 'cross sex hormones' or 'hormone replacement therapies') which involve taking testosterone or oestrogens in the form of injections, tablets, patches or gels; and the use of gonadotropin releasing hormone (GnRH) analogues to suppress or delay puberty (commonly referred to as 'puberty blockers').

Often the terminology of gender- 'affirming/confirming' medical interventions is preferred to the terminology of 'transition'; this is because many trans people do not consider themselves to be changing their biological sex, so much as confirming their 'natural' gender (Serano, 2007). Referring to 'gender-affirming' interventions (rather than medical transition) is also useful in that this terminology can be inclusive of medical care for (cisgender) sex variant youth, reflecting the fact that the very same medical treatments (hormonal therapies, surgeries etc) are often used to

‘treat’ VSCs, to bring young people’s bodies more in line with binary male and female sex categories. For the same reasons, I have chosen to use the language of ‘hormone replacement therapies’ (HRT) rather than ‘cross sex hormones’.

### 1.2.3. Defining age-related terminologies

As with language concerning gender and sex diversity, age-related terminologies can be diffuse, overlapping and value-laden. Several different terms are used throughout the thesis, in different ways and in different contexts.

Given the legal significance of the category ‘child’ – which is used to designate a range of important rights and protections – this terminology is used precisely to refer to any person who has not yet reached their 18<sup>th</sup> birthday, in accordance with English law. (An ‘adult’ - including ‘young adult’ – conversely, refers to a person who has reached their 18<sup>th</sup> birthday or beyond). ‘Childhood’, on the other hand, is a more diffuse term, which conveys a set of social meanings, norms, practices and relationships, which constitute the lives of children (up until the age of 18).

The terms ‘adolescent/adolescence’, ‘young person’ and ‘teenager’ refer to a period of human development during which a person is undergoing a process of transition from ‘childhood’ to ‘adulthood’; this transition is generally understood to span from the stage at which a person enters puberty, until they have passed through the first (few) year(s) of full legal personhood.<sup>7</sup> Although not definitively age-bound, ‘adolescent’ is generally understood in policy discourse to refer to any person around the ages of 10-19 years (while those aged 10-14 may be considered ‘young adolescents’); ‘teenager’ is a slightly narrower bracket, spanning ages 13-19, and ‘young person’ or ‘youth’ may be used to describe any person from around the age of 15 up until their 25<sup>th</sup> birthday.<sup>8</sup>

## 1.3. Research questions

With these working definitions in mind, the key questions central to this research project were as follows:

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<sup>7</sup> Secretary-General’s Report to the General Assembly, A/36/215, 1981

<sup>8</sup> Secretary-General’s Report to the General Assembly, A/40/256, 1985



- 1 a) How do GSD children and young people experience health services in the UK?  
b) How do these experiences influence aspects of their wellbeing?
- 2 (How) are young people's experiences and wellbeing influenced by the particular conceptions of 'sex', 'gender' and 'childhood' embedded within the logics and practices of health institutions?

A more detailed articulation of the methods used to respond to these questions is set out in Chapter 2 below.

#### 1.4. Focus on health

I chose to focus on experiences in health services a number of related reasons. Firstly, with the development of modern medicine medical institutions have played a particularly powerful role in shaping the genealogy of categories of sex, gender and sexuality (Dreger, 1998; Fausto-Sterling, 2000). Secondly, GSD groups are highly reliant on health care services, for reasons both directly and indirectly related to their gender and sex variance (Ellis, Bailey and McNeil, 2015); in particular, the use of diagnostic labels to classify forms of gender and sex variance brings GSD groups into specific relations with health professionals which have significant implications for care (Johnson and Browne, 2012). Third, despite these dynamics, very little empirical research has been conducted in the UK exploring experiences of health care amongst GSD groups, and most particularly amongst children and adolescents (who have been under-represented in health care research more broadly (Carter, 2009)). Whilst a small number of recent studies, particularly resulting from service audit, have considered the needs and experiences of gender minority children and their families in specialist gender clinics (Riley, Sitharthan, Clemson, & Diamond, 2013), there is a particular gap in information about GSD experience within primary care.<sup>9</sup>

Since the beginning of the nineteenth century, the medical profession has been heavily involved in the 'sexing' and 'gendering' of bodies through a range of diagnostic, surgical and medical interventions. The scientific schema which has dominated the medical management of gender variance has been widely critiqued within (trans)gender, intersex and feminist literature for being grounded in the normative and simplistic assumptions of the 'two-sex system', and its concomitant 'one body, one sex' imperative (Dreger, 1998; Fausto-Sterling, 2000; Karkazis, 2006). There are

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<sup>9</sup> Referred to in the UK as 'general practice'.

shared experiences, as well as important differences, in how individual GSD groups (e.g. transgender, sex variant) have been treated within health systems. However, a common thread that has historically underwritten medical responses to different types of gender and sex variance has been the desire to preserve and protect the stability and fixity of notions of binary categories of ‘biological sex’, particularly in the wake of new scientific discoveries that were, in fact, complicating understandings of the body (Fausto-Sterling, 2000).

In the last decades, negotiations between gender minority activists, human rights groups, scientists, scholars, and health professionals have given rise to some important changes in medical responses to gender and sex variance. There is increasing recognition of some of the harm caused by past practices and the need for new medical models more centred on patients’ care (Wiesemann *et al.*, 2010). In 2006, new standards of treatment for VSCs were set out in a ‘Consensus Statement on the Management of Intersex Disorders’ containing a number of important recommendations for reform, including that genital surgery should no longer be performed on SV infants without careful thought and planning, and should prioritise preserving fertility, sexual function and sensation, rather than cosmetic appearance (Hughes *et al.*, 2006). Meanwhile, in May 2013, ‘Gender Identity Disorder’ was renamed ‘Gender Dysphoria’ in the 5<sup>th</sup> edition of the American Psychological Association’s Diagnostic Statistical Manual (DSM-5), in recognition of the stigmatising effect of the word ‘disorder’. Further, the diagnosis was reconceived: ‘dysphoria’ refers to the discomfort and distress that may result as a consequence of transgender identity, such that transgender identity itself is no longer defined as mental illness. Alongside these policy developments, there are numerous examples of new initiatives within health services in the UK aimed at promoting awareness and understanding of gender diversity amongst health professionals.<sup>10</sup>

On the other hand, some advocates have argued that in many respects there has been little change in medical attitudes, and the changes that have occurred are largely symbolic (Johnson, 2015). In particular, analysts have pointed out that the continued presence of a mental health diagnosis for transgender identity does little to combat the stigmatising effects of the general understanding of transness as a medical condition, specifically a psychiatric illness, notwithstanding the new ‘non-stigmatising’ terminology (Johnson, 2015). VSCs are still regarded as physical impairments or ‘syndromes’, diagnosable under the umbrella nomenclature of ‘Disorders of Sex Development’ (DSD). Davis (2015) has characterised the invention of this terminology as ‘a linguistic move

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<sup>10</sup> For an example of one of these see <http://www.nhsemployers.org/your-workforce/plan/building-a-diverse-workforce/get-involved/celebrating-diversity/transgender-awareness-2016>. Accessed May 2017.

designed to reclaim [medical] authority and jurisdiction over the intersex body’ (p.2).<sup>11</sup> Meanwhile, in the new DSM-5, ‘DSD’ has curiously been included as a specifier of ‘Gender Dysphoria’, bringing intersex conditions within the purview of psychiatric diagnosis, which Kraus (2015) has argued contradicts the purported aims of the new terminologies, specifically to alleviate stigma and reduce the risk of misdiagnosis, and to provide healthcare that caters to the particular and varied needs of individuals. At the level of practice, irreversible pharmacological treatments and aesthetic surgeries continue to be administered and performed (Balocchi, 2014), with the ability to engage in ‘heterosexual’ intercourse, and the importance of having ‘appropriately’ sized genitalia continuing to guide decisions about sex assignment and re-constructive surgeries on infants (Hughes *et al.*, 2006; Davis, Dewey and Murphy, 2016).

The expectation that gender minority groups enact specific, ‘ideal’ gendered positionings in order to access healthcare services is an issue of ongoing concern (Johnson & Browne, 2012). Advocates have expressed concern that binary and essentialised conceptions of gender continue to dominate medicalised constructions of the ‘authentically’ (trans-)gendered subject, impacting on referral to specialist services, as well as the provision of services and care within such services, with particular consequences for non-binary groups. Meanwhile, within universal services significant difficulties can arise when a patient’s identity contradicts gendered understandings of embodied health needs (e.g. when trans men need smear tests, or when trans women require prostate checks). Whilst research on gender minority experiences within universal health services is particularly limited, a study undertaken in Brighton and Hove in 2008 found access to GP services to be a significant problem for transgender people. Many respondents reported being subject to prejudicial and abusive treatment by providers whilst seeking treatment for a broad range of ailments (including those entirely unrelated to their gender identity) which they considered to be a direct result of their transgender status and embodied gender presentation (Browne and Lim, 2008).

#### 1.4.1. Developments in health provision for transgender children

In recent years, controversies and debate surrounding GSD health provision have intensified particularly on the subject of how best to support transgender children and youth. Whilst youth advocacy groups such as Mermaids and Stonewall have campaigned for improved access to medical interventions such as puberty blockers for trans adolescents, others have condemned such

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<sup>11</sup> In 2022, DSM-5 was updated to note ‘differences in sex development’ as an alternate term for ‘disorders of sex development’. See <https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/DSM-5-TR/APA-DSM5TR-GenderDysphoria.pdf> last accessed January 2023.

treatment practices as harmful, ‘experimental’ and dangerous. As a result of these debates, the clinical practice of the NHS Gender Identity Development Service (GIDS), which provides support and treatment for children up to 17 years experiencing issues with their gender (a formerly fringe and rarely heard of entity, catering for just a few thousand children across England, Wales and Scotland) has come under increasingly intense visibility, scrutiny and criticism.

In August 2018, an internal report based on conversations with an anonymous group of staff was presented to the board of the Tavistock and Portman NHS Trust, in which GIDS’s Headquarters resides (Wren, 2021). The report, which was widely covered in the media, expressed concern that children were being ‘fast-tracked’ into life-altering decisions, without a proper and full assessment of their psychological needs, social issues and personal histories. Later, in October 2020, the Care Quality Commission rated the service ‘inadequate’ after inspectors identified ‘serious concerns’, including: that GIDS was ‘difficult to access’; that record keeping was poor, and that there was insufficient management of risk for the growing numbers of children languishing on increasingly lengthy waiting lists. Particular concerns were raised about the documentation of children’s competency, capacity and consent on referral for medical treatments.<sup>12</sup>

Meanwhile, in the same month a claim for judicial review was brought before the High Court seeking a declaration that aspects of GIDS’s practices were illegal (*Bell v Tavistock*). The claimants alleged that persons under 18 were not capable in law of giving valid consent to the administration of puberty blocking medications, and that the information provided to children by GIDS was inadequate to form the basis of proper consent. In its judgement, published in January 2021, the Court rejected both claims, but, on qualified terms, concluding that, in practice, it was *highly unlikely* that a child aged 13 or under would ever be competent to give consent to hormone blockers, and *very doubtful* that a 14 to 15 year old would possess such competency. The judges proceeded to give expansive guidance on policy and practice, including that a court order should be sought before referring any child under 16 for puberty blockers, and suggesting that the same action may be appropriate for those aged 16 and 17. In reaching its judgement the Court found that ‘[t]he administration of [puberty blockers] to people going through puberty [was] a very unusual treatment’ and was ‘properly described as experimental’ because there was ‘real uncertainty over

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<sup>12</sup> <https://api.cqc.org.uk/public/v1/reports/7ecf93b7-2b14-45ea-a317-53b6f4804c24?20210120085141>; <https://www.bbc.co.uk/news/health-55723250> ; <https://www.theguardian.com/society/2018/nov/03/tavistock-centre-gender-identity-clinic-accused-fast-tracking-young-adults>

the short and long-term consequences of the treatment with very limited evidence as to its efficacy, or indeed quite what it [was] seeking to achieve’.

The judgement had immediate and drastic effect on adolescents’ access to treatment for gender dysphoria. GIDS ceased all new referrals to the endocrinology service for under 16s seeking puberty blockers, as well as conducting a review of all existing cases (including for those ages 16 and 17). Furthermore, ‘best interests’ court applications were to be made for all children under 16 already receiving hormone blocking medications, as well as ‘considered’ for those aged 16 and over.<sup>13</sup>

Subsequently, in March 2021, in *ab vs cd & ors*, the Family Division of the High Court ruled that no application to the courts was necessary in circumstances where the child, their legal caregivers and their clinician were all in agreement concerning puberty blocking treatment. Following this judgement, GIDS referrals for puberty blockers resumed; however, the requirement that every case is reviewed by an independent Multi-Professional Review Group (MPRG) remained.

In October 2021 the Court of Appeal overturned *Bell v Tavistock*. Relying on the Supreme Court’s 1985 *Gillick* judgement, they held that it was ‘for doctors, not judges, to decide the capacity of under-16s to consent to medical treatment’, on a case by case basis. They criticised the Divisional Court for providing extensive declaration and guidance on matters of clinical practice that it ‘was not equipped to make’, and for making factual findings on the basis of ‘impression’ and ‘disputed evidence’, assuming scientific consensus in areas where there is none (CoA, 2021: 32) .

There is now a considerable backlog in cases of children seeking referral for hormone blockers, leading to significant delays in access to treatment. Meanwhile the future of health services for GD children in Britain is uncertain. In March 2022, the initial findings of an independent review of GIDS services commissioned by NHS England and the NHS Improvement Quality and Innovation Committee (The Cass Review) published its interim findings. The review concluded that’s the current clinical model of a single national provider was no longer sustainable and a fundamentally different model of service provision is required. The interim findings declined to come to a conclusion on the use of hormonal treatment due to lack of evidence. In July 2022 it

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<sup>13</sup> Amendments to service specification for gender identity development services for children and adolescents. E13/S(HSS)/e. Effective 1st December 2020.

was announced that GIDS would be closing its service in the spring of 2023, to be replaced by more localised services.<sup>14</sup>

Overall, there remains considerable and urgent need for more evidence on this area of medicine as well as empirical and social research on the experiences of gender and sex diverse children within health systems to complement the clinical literature. Whilst there is an increasing literature on the medical management of gender variance during childhood and adolescence in the US (for example, in March 2012 the *Journal of Homosexuality* published an entire ‘special issue’ on this subject, which contained a range of articles and perspectives from clinicians, sociologists, lawyers, and other analysts with expertise on the topic), very little has been written about the health needs and experiences of gender minority children in the UK. For example, in 2012, Ellis et al. (2015) conducted the first comprehensive study specifically focused on trans people’s experiences of health care and mental health needs in the UK; whilst a number of under 18s filled out and returned the survey, these scripts were discounted and removed from the analysis.

### 1.5. Inclusion of both *gender* and *sex* diverse children and youth

Although in the analysis below, gender and sex diversity are often included under the same umbrella – ‘GSD’ - it is recognised that gender diversity and sex variance are two distinct phenomena which have the potential to lead to different experiences and challenges, including in health settings. Furthermore, it is necessary to acknowledge from the outset that the majority of the discussion and analysis in this thesis focuses on childhood experiences of gender incongruence, with trans youth and their caregivers constituting the overwhelming majority of my sample. A small number of sex diverse youth filled out the survey (31) and participated in qualitative interviews (3). Despite these small numbers, I considered that these young people had vital perspectives to share. The retelling of their narrative histories provides insights with significant implications for answering the research questions, as I hope will become increasingly apparent during discussions within the chapters that follow.

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<sup>14</sup> NHS to close Tavistock child gender identity clinic. [https://www.bbc.co.uk/news/uk-62335665?at\\_custom3=BBC+News&at\\_campaign=64&at\\_custom2=facebook\\_page&at\\_custom1=%5Bpost+type%5D&at\\_custom4=2280BBE8-0E70-11ED-A6E5-2C282152A482&at\\_medium=custom7&fbclid=IwAR2n5TCuUYzNmYUYia6SRzHTdyWr\\_cIkdsjwhhEggGLvxF\\_6ZsStn6WTcBA](https://www.bbc.co.uk/news/uk-62335665?at_custom3=BBC+News&at_campaign=64&at_custom2=facebook_page&at_custom1=%5Bpost+type%5D&at_custom4=2280BBE8-0E70-11ED-A6E5-2C282152A482&at_medium=custom7&fbclid=IwAR2n5TCuUYzNmYUYia6SRzHTdyWr_cIkdsjwhhEggGLvxF_6ZsStn6WTcBA). July 2022. Last accessed January 2023.

Certainly, there are some significant shared experiences between gender and sex diverse groups that justifies their inclusion both within the same study, as well as under one, broad “GSD” umbrella. Firstly both groups are positioned problematically with respect to hegemonic, binary, categories of man/woman and male/female, and face discrimination and exclusion as a result (Bettcher, 2016). Secondly, both groups are subject to medicalisation, and may require medical treatment related to their hormones, genitals or reproductive organs. Third, both GD and SV children and youth face similar barriers in access to care, often experiencing a loss of decision-making authority over their own bodies, an inability to provide informed consent to medical treatments, and difficulties in asserting individual and bodily autonomy.

On the other hand, there are key differences in the ways that institutions have responded to forms of gender variance in childhood, compared to sex diversity. Drawing attention to the different ways these two groups of children have been considered and treated, within health policy in particular, reveals some of the inconsistencies, contradictions and core assumptions that underlie institutionally constituted knowledges about sex and gender. Discussion and analysis of these contradictions has the potential to advance understandings of institutional practices affecting both communities, as well as to challenge dominant constructions and theories of embodiment, sex, and gender, beyond the parameters of existing gender theory.

A final point of note is that there is substantial empirical overlap in these two categories of diversity, with many young people with differences in sex development also identifying under a ‘trans’ or otherwise gender variant umbrella. Although the sample is small and cannot be considered representative, as many as two thirds of the sex diverse children included in this study said that they were suffering from some degree of gender dysphoria, and around half identified with a gender other than that assigned to them at birth when non-binary genders are also considered.

## 1.6. Outline of dissertation

Chapter 2 details my methodological approach to conducting this study. I discuss the metatheoretical framework (critical realism) that informed how I designed and implemented this study, and why I found it particularly valuable for research on this topic. I explain and justify my interdisciplinary and mixed-methods approach to gathering and analysing data (including qualitative interviews and a quantitative survey). I provide a brief descriptive summary of the

sample on which my evidence is based, and discuss its limitations, as well as the broader methodological and substantive limitations of the project. Finally, I outline the ethical considerations and procedures that I implemented in order to protect the rights, privacy and wellbeing of all participants, especially those under 18 years, throughout the research process.

In Chapter 3 I explore gender and sex variance as a developmental experience and field of childhood subjectivity. My data challenge common presumptions about (atypical) childhood gender development which have informed current health policy. Participants' accounts illustrate the deep psychic investment in embodied gender incongruence that children may manifest from the earliest years of childhood. In clinical settings childhood gender variance is often associated with rigid and inflexible ways of thinking about gender and sexuality (Turban and Schalkwyk, 2018); social transition is often discouraged in childhood for fear that it may solidify these rigid cognitions and foreclose opportunities for children to develop more expansive and complex ideas about gender (Churcher Clarke and Spiliadis, 2019; Wren, 2019b). By contrast, I show that gender and sex diverse children may develop particularly nuanced and creative ways of thinking about gender and sexuality. Meanwhile, attempting to limit opportunities for social transition may cause children profound distress, with detrimental consequences for their wellbeing.

The next three chapters (4,5 and 6) focus on children and young people's experiences in health services. Chapter 4 explores participants' experiences in general healthcare settings (i.e. services not specialised in care for gender or sex variance), with a particular focus on GPs. Meanwhile, Chapters 5 and 6 move on to discuss specialist care. Chapter 5 focuses on service provision concerning physical interventions, whereas Chapter 6 explores psychiatric diagnosis and the psychological and therapeutic aspects of support for GSD youth.

In each chapter I explore how healthcare practices are structured through naturalised and binary accounts of gender and sex that preclude GSD embodiments, with negative consequences for young people's wellbeing. In Chapter 4 I show how being gender or sex diverse significantly impacts on children and young people's experiences in healthcare broadly, as all aspects of medical interactions are shaped by the assumption of two binary sexes, within which all individuals can be easily classified. This singular and immutable classification is then used as a proxy for determining health screening, diagnosis and treatments.



In Chapter 5 I show how health provision for trans youth comprises a (so-called) ‘cautious’, delayed and staged approach to physical intervention into bodies, while care of SV children has favoured early treatment, including in young childhood and adolescence. I argue that these practices function to preserve and protect medical authority over the stability and fixity of (binary) categories ‘gender’ and ‘sex’. Regardless of young people’s own views, physical interventions are sanctioned when they appear to reinforce a young person’s sex and gender as medically and scientifically assigned, and denied when they threaten to contradict this purpose.

In Chapter 6, I discuss the intersections between young people’s mental health experiences and the restrictive framework through which medical understandings of ‘healthy’ gendered and sexed bodies are constructed. While sex variations are construed as disorders of the body, gender dysphoria is conceived as a psychiatric illness. This has resulted in a system of care that may neglect the mental health needs of SV children and youth, while subjecting GD children to coercive and harmful psycho-therapeutic interventions, with profoundly negative impacts on their wellbeing.

Bringing the learning from different chapters together, in Chapter 7 I argue that the health experiences of GSD youth are shaped by a system of care that is routed in a particular set of intersecting assumptions about sex, gender and childhood. First, there is the foundational belief in the natural alignment of sex and gender (also informed by normative accounts of heterosexual desire); second, and inextricably linked to this, there is an absolutist view of sex as binary, and rooted in biological ‘fact’. And third, underpinning and regulating both suppositions, lies an evolutionary perspective on childhood: one that views children as naïve to matters of gender and bodies, primitive in their cognitions, and governed by a universal and biologically determined pathway of natural growth. Together this matrix of beliefs functions to limit the possibilities of viable childhoods, with harmful consequences for the wellbeing of GSD youth.

## Chapter 2 Methodology: ‘we haven’t got enough data’

### 2.1. Metatheoretical foundations

Upon embarking on this study, I set out to explore and theorize relationships between health institutions and the construction of gendered categories in childhood. I was interested in learning more about how knowledges about sex and gender were institutionally structured through the provision of medical care within the National Health Service (NHS, the publicly funded healthcare systems of the United Kingdom) (research question 2), and with what consequences for young people’s wellbeing (research question 1b). I proposed to explore this through enquiry into the subjected knowledges and lived experiences of those children who embody non-normative sex and gender subject positions, in their encounters with medical institutions (research question 1a).

In this sense, I was influenced by a post-structuralist and queer epistemic stance and methodological design (Butler, 1990). As outlined in Section 1.1 above, poststructuralist and queer theoretical approaches have been indispensable in exposing the unstable nature of hegemonic categories of sex, gender and sexuality, and opening up new possibilities for the recognition of diverse identity configurations outside a naturalised, reproductive binary. They are particularly useful in their exposition of the co-constitution of notions of sex, gender, sexuality and childhood, thus (in the manner described above) elucidating the vulnerable social positions of GSD children and youth.

And yet there have been substantial and compelling critiques levelled against these methodologies, including from gender and sex diverse communities. Whilst the learning that has been gleaned from gender and sex minority communities has been indispensable to the development poststructuralist and queer gender theories, such theories have (ironically) often had a difficult time encompassing the experiences of GSD (particularly sex variant and transsexual) people. These approaches have been criticised for their failure to capture or understand the material lives and struggles of actual, living, human subjects (Richards *et al.*, 2014). Queer theory has been criticised for failing to understand ‘the social and political importance to many individuals of establishing stable, coherent identities’ (McQueen, 2016: 73) as well as the material bases that organise the conditions within which these identities are formed (Edwards, 1998). ‘Gender performance’ theory (a particularly influential variety of queer theory), with its focus on linguistics and discourse, has been criticised for its failure to direct enough attention to the physicality of the body, and to

consider the ways in which material differences between bodies inform how bodies are experienced, known, and recognised (Grosz, 1994; Tolman, Bowman and Fahs, 2014).

Despite its poststructuralist influences, therefore, my study was decidedly empirical in design, as opposed to textual or theoretical: I was interested in exploring GSD childhoods, as they exist in the material world, as both objects and subjects of knowledge. I set out to gather a substantial body of primary data. It was my firm belief that empirical work is deeply desirable and necessary in these times of profound challenge to traditional understandings of sex and gender.

My research was also designed to be interdisciplinary. Although drawing most heavily on qualitative approaches, I also gathered and analysed a substantial body of quantitative evidence. Further, throughout the research process, I sought to engage with multiple, diverse literatures, perspectives and theories of gender, sex and the body, including gender and embodiment theory, clinical approaches, psychology, public/health policy literatures, the life-sciences and biomedicine (albeit from a critical standpoint). I aimed, in particular, to afford attention to those formulations seeking to move beyond the rigid and reductive terms of the ‘culture vs nature’ duality and ‘constructivism vs essentialism’ debate and pushing forward in complex and innovative ways to theorise the body, gender, sex, sexuality, and identity formation (e.g. Fausto-Sterling, 2000; Roberts, 2007).

In adopting an empirical and interdisciplinary approach, the study, although influenced by poststructuralism, also borrows from a critical realist paradigm. Unlike poststructuralism, critical realism maintains focus on exploring questions of ontology, as well as those of epistemology and a commitment to the value of empirical enquiry. Nevertheless, a critical realist lens refuses the naïve assumption that reality can be reduced to observation, recognising that reality is mediated through perception and interpretation, requiring critical reflection on the representational practices associated with its construction (Lawson *et al.*, 2013).

Danermark *et al.* (2001) characterise critical realism as an approach to social science which favours a ‘both-and’ methodological approach to resolving the key ‘either-or’ questions – positivism or hermeneutics, universalism or particularism – that have polarised much of social scientific scholarship. These disputes, they argue, have resulted in either empirical descriptions devoid of analytical depth, or the development of abstract theoretic models lacking empirical foundation. They have also led to clashes between proponents of quantitative and qualitative research

methodologies, with some advocates of the former viewing social reality as exclusively empirical and objective, with no room for subjective attitude and judgement, and the latter sometimes rejecting the notion of an existential reality outside of socially constructed and situated 'knowledges' and interpretations. Since, as Danermark *et al.*, (2001) write, according to a critical realist perspective 'there exists both an external world independently of human consciousness, and at the same time a dimension which includes our socially determined knowledge about reality' (p.6), such an approach opens possibilities for developing a more pluralist and interdisciplinary research practice, one which recognises the values and limitations of multiple strands of enquiry. This is the approach adopted in this study.

Applying a critical realist frame, I endeavoured throughout the research process to reflect on my own situated positionality in relation to the research participants, as both a 'researcher' and a cisgender woman. I did not assume that I would be able to adopt the role of a neutral and objective observer. Rather, I viewed myself as an active participant in the research process, with my own interests, assumptions, biases and subjectivities, that have inevitably influenced both the data collection process and the results of my analysis. Throughout the chapters that follow I have sought to foreground participants' own words and reflections, recognising the value of their situated and embodied knowledge as they are positioned as experiencing subjects within discourses of gender and childhood. My own voice is nevertheless implicated throughout the analysis as I represent and interpret their accounts, supplementing quotes from interviews with my own observations and reflections, in conversation with existing literatures.

## 2.2. Approach to addressing the research questions

The research questions (set out in Section 1.3) focused on identifying, exploring and understanding the relationships between 1) GSD young people's experiences, 2) their wellbeing, and 3) gendered institutional healthcare practices. A two-staged approach was taken to responding to the research questions.

**Step 1** constituted an enquiry into young people's experiences and wellbeing at *an individual level*, in relation to different encounters with health services. This entailed gathering information on young people's experiences, as well as detail on the contexts within which these experiences occurred. The attention to young people's wellbeing was aimed at capturing evidence on the implications of gender and sex variance for youth with particular regard to their encounters with health services.

I considered that this evidence would provide important insight into how health institutions function as sites for regulating gender and with what social consequences.

There is a broad and diverse body of literature that has engaged with the concept of “wellbeing”: a popular term within youth-oriented research, as well as public policy (Tisdall, 2015), which expansively refers to an individual’s ‘quality of life’, encompassing physical, social, psychological, emotional and material dimensions (Wright and McLeod, 2015). Criticism of the concept has drawn attention to its diffuse and ambiguous meaning (McLeod and Wright, 2017). However, it is precisely the broad and elastic nature of the construct that rendered it particularly useful for this project, which was primarily inductive and exploratory in its design. It is also well aligned with my focus on healthcare experiences, given the expansive definition of health advanced by the World Health Organisation as ‘a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity’ (WHO, 1948).

The question of what constitutes ‘experience’ and ‘wellbeing’ was framed broadly in order to foreground young people’s own accounts of the concrete aspects of their care, recognising the value of young people’s situated knowledge within discourses of sex, gender and childhood. Notwithstanding this broad framing, the research tools were developed to gather data in relation to the following areas of interest:

*Experience of services:* access and accessibility, inclusivity, interactions with providers, areas of unmet need, experiences of discrimination and harassment.

*Wellbeing:* distress, dysphoria, mood and anxiety, self-esteem, relationships, coping and efficacy.

**Step 2** involved an analysis of the relationships and linkages between young people’s individual experiences and wellbeing, and the *systemic* features and logics of health institutions that comprise their organisational norms and practices. I was interested in exploring what ‘truths’ about sex and gender were embedded within, and produced by, health systems (and those that were conversely foreclosed) and the consequences of these dynamics for GSD children and youth.

### 2.3. Data collection methods

I combined mixed methods to draw on insights provided by both qualitative and quantitative approaches. Following a critical realist approach, my aim was to gather a body of data that was simultaneously measurable, in-depth, interpretative and explanatory: to empirically elucidate responses to the research questions in as much detail and as thoroughly as possible. Gathering quantitative data and conducting statistical analyses enabled me to draw some general conclusions about my sample; meanwhile the use of qualitative data and analysis enabled me to interpret, illustrate and explain issues, and explore them in complexity and depth. With this in mind, the below methods were used to collect information and data relevant to the research questions.

### 2.3.1. Literature review

The project began with a thorough narrative review and analytical synthesis of the existing literature relevant to the research questions, including both academic and grey literature and a legal and policy review. Given the interdisciplinary frame of the research, and the dearth of empirical studies focusing on GSD childhoods, there is no one, systematic literature upon which my thesis is grounded. Rather it draws on multiple literatures spanning the fields of sociology, psychology, public/health policy and biomedicine. I have taken an integrated approach to engaging with these disparate literatures across the thesis, enabling me to present my results and analysis in conversation with existing theories and evidence: highlighting areas of convergence and divergence, and more readily enabling an understanding of how my research is situated within, and contributes to, key debates within multiple and diverse literatures.

#### *Academic literature*

This included:

- feminist, queer, (trans-)gender and intersex theory and philosophy exploring constructions of “sex”, “gender”, “sexuality” and the body;
- feminist science research in the fields of biomedicine and public health (e.g. Fausto-Sterling, 2000; Roberts, 2007);
- ethnographies of youth experience focused on aspects of young people’s gendered and sexual embodiment;
- empirical studies (both qualitative and quantitative) containing evidence on the experiences and wellbeing of gender minority youth within health systems (focused on evidence from the UK and other comparable contexts);

- psychological literatures exploring gender identity development within both GSD and SGT groups;
- bioscientific, medical and other clinical literatures exploring diagnosis and health provision for children diagnosed with gender dysphoria and disorders of sexual development.

### *Grey literature*

In addition to academic literature, I conducted a grey literature review of published evidence and testimony from third sector organisations and online media platforms that provide evidence on health practices, the experiences of GSD groups, and the discursive constructions of these. The purpose of this review was to fill gaps in evidence that could not be obtained from the academic literature, which (as discussed) is limited in the UK. Findings from this review were integrated into the analysis.

### *Legal and policy review*

Prior to starting the fieldwork, I conducted a comprehensive review and analysis of publicly available legislation, policy and guidance pertaining to the treatment and care of GSD children and youth (e.g. guidance for the prescription of hormonal therapies; safeguarding procedures for children seeking support for issues related to gender, etc.). This review informed the development of the data collection tools for primary research, and findings from the review were also integrated into the analysis of my data to provide information on the legal and policy contexts which frame institutional practices. This evidence was particularly useful in responding to research question 2.

#### 2.3.2. In-depth interviews

I conducted a series of semi-structured, narrative interviews with GSD youth ages 14-24 years, as well as caregivers with gender diverse children ages 5 years and over. Most interviews were conducted in person, however some were conducted over the telephone according to interviewee preferences. Several interviews were conducted over more than one meeting. Most interviews were conducted one on one, however, a few participants chose to be interviewed together with their caregivers or partners. Interviews allowed participants to discuss their experiences and perspectives in a confidential setting. I drew on a life-histories approach (Bertaux, 1981; Goldman *et al.*, 2003) to conducting the interviews. This is a method of qualitative data collection where participants are asked to provide an account of their life over a period of time, covering key events and timelines of personal significance.

Conversations explored children's histories of gender and sex variance, their experiences of health care (e.g. accessibility of services, interactions with staff and peers, experiences of discrimination, areas of unmet need etc.) and the impacts of these on their wellbeing. Interview guides were developed to frame discussions, but these were applied flexibly to ensure interactions were participant-led and focused on the elements of participants' experiences which they considered most relevant, meaningful and important, within the broader frame of the research topic.

Following a life history approach had two core benefits. Firstly, it enabled me to build a stronger rapport with research participants: affording them a level of control over the narrative structure of the interview and the process of generating meaning from their experiences. Secondly it enabled me to collect more in-depth, contextual and complex evidence about participants' experiences, and how these developed and changed over time. The aim was to achieve a holistic picture of the trajectories of young people's experiences within health services, to enable me to identify any systematic patterns and themes that threaded participants accounts and explore how these related to gender and sex (as well as other aspects of participants' identity and background circumstances).

#### 2.3.3. Key informant interviews

Qualitative data was supplemented by a small number (15) of 'key stakeholder' interviews with healthcare professionals, and other frontline providers working directly with gender and sex diverse children and youth. These were recruited through voluntary sector, academic, and education institutions. The purpose of these interviews was to gain expert perspectives in relation to the issues explored in the research, as well as to provide more insight into professional and institutional practice. In particular, these interviews provided important insights for filling gaps and contextualising information from the policy and grey literature reviews; I was able to speak with a number of practitioners who were key leaders in the development and delivery of healthcare policy and practice concerning GSD children and youth.

#### 2.3.4. Structured survey

Finally, a structured survey was distributed in schools, further education colleges, and online forums to youth ages 14-24 years (Annex 1). The survey was designed to be independently filled out by participants on a strictly anonymous and voluntary basis. The survey primarily consisted



of questions that required respondents to select an answer out of a set of predefined options, and had four major sections.

The first component of the survey gathered general demographic information about the respondent, such as age, ethnicity, disability status and others.<sup>15</sup> The second section of the survey was designed to measure a respondent's position on a gender variance scale ('GVS Scale'). The GVS is an original scale which measures an individual's level of variance from a prevailing 'cisgendered' norm: on a scale from 0 (minimum possible variance) to 80 (maximum possible variance). The tool has the potential to capture diversity amongst both trans and non-trans youth. I was inspired by reflections that whilst 'trans' and 'cis' is a binary, gender variance may exist on a spectrum within both populations (Hansbury, 2017). More details of the development and testing of this scale are attached as Annex 2 to this thesis.

Section Three looked at experiences in health care, including general and specialist services, and the extent to which young people felt that services were addressing their needs, as well as the level of trust, confidence and comfortability that young people experienced when visiting health providers.

The final section of the survey focused on questions about young people's wellbeing. I used a well-established, validated tool from the literature, the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS): a 14 item Likert scale covering aspects of subjective well-being and psychological functioning (Tennant *et al.*, 2007). The WEMWBS is scored by summing the score for each of the 14 items; the scoring range for each item is from 1-5, and the total score is from 14-70. As well as the WEMWBS, the survey asked an additional 5 questions related to stress, self-esteem, self-harm, suicidal ideation, and disordered eating, as these aspects have been identified in the literature as particularly relevant to the wellbeing experiences of GSD youth (Kaltiala-heino *et al.*, 2015; Vicky Holt, Skagerberg and Dunsford, 2016).

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<sup>15</sup> Three simple questions were asked to provide basic information about young people's socio-economic background: 1) "does your household receive income support?"; 2) "is your household eligible for free school meals?"; and 3) "did either of your parents complete a degree course or equivalent?". Young people received a point for answering "yes" to either of the first two questions, and for answering "no" to the final question. These scores were aggregated to form a simple Scale ("SEC Scale") ranging from 0 (least deprived) to 3 (most deprived).

### *Piloting of the survey*

The survey tool was piloted with two groups (each around 15 students) of A-level students accessed through a London-based further education college. Young people were asked to fill out the survey independently. After completing the survey young people were divided into groups of 2-3 students and asked to discuss their experiences of filling out the survey. They were asked to consider the interest, relevance, and accessibility of the survey, with a particular mind to identifying: any questions that they found difficult to answer, questions that they found repetitive and questions that they felt were missing. Subsequently, I brought the whole group together to provide feedback on what they had discussed. Final revisions to the survey tool were made on the basis of the outcomes of the pilot, in particular the tool was shortened significantly as some questions were considered repetitive or inaccessible, questions about disability were modified to include further differentiation, and some modifications were made to the GVS (Annex 2).

## 2.4. Sampling and recruitment

### 2.4.1. Qualitative sample

Interview participants (including young people, caregivers and key informants) were recruited through a 'snowball' sampling approach. Contact was initially established with voluntary sector organisations, providing services and support to GSD youth, who were asked to share recruitment materials with their network. Those who volunteered to participate in the research were then asked to further share details of the study with their contacts.

Additional recruitment of young people was achieved through the use of the survey. Sex and gender diverse respondents who had filled out the survey, were invited to leave their email at the end if they were interested in taking part in a qualitative interview. This enabled the recruitment of a wider diversity of young people who were not necessarily in direct receipt of gender-related services or gatekeeper support.

### *Description of qualitative sample*

Overall, 86 participants were included in the qualitative sample: 40 youth, 31 caregivers and 15 key informants. Young people and caregivers came from a total of 50 separate families.

Youth interviewees included 40 children and young people: 23 of these were teenagers ages 14-19 years, and 17 were young adults ages 20-24 (Table 1). Thirty-three were from white British and/or

Northern Irish backgrounds, three were from other white backgrounds, one was mixed race white and black African, and two were Jewish. All identified as gender or sex diverse at the time of interview. Conversations with young people about their gender identities were in-depth and complex, rendering it hard to draw generalisations across the sample. However, by way of approximation: 11 youth identified as binary-male and 12 as binary-female. Eight identified as (non-binary) transmasculine (mostly male, but partially female); five identified as more ‘centrally’ non-binary or genderqueer. Three identified as ‘gender non-conforming’, and one as ‘bi-gender’. Twenty-six were natal females, 11 were natal males and 3 were born with a variation of sex development and assigned female.

*Table 1: Sample of young people*

Name	Age at interview	Rough age knew was gender/sex diverse	Age ‘came out’	Gender	Sex at birth	Ethnicity	Location	Caregiver also interviewed?
Amalia	17	4	11	Female	Male	White	Cheshire	No
Devan	18	15	16	Non-binary	Female	White	Newcastle	Yes
Isla	15	2-3	2-3	Female	Male	White	London	No
Jacob	14	10	10	Non-conforming	Female	White	West Yorkshire	Yes
Aaron	18	15	15	Transmasculine	Female	White	Suffolk	Yes
Spencer	21	13	15	Transmasculine	Female	White	West Midlands	No
Henry	15	13	13	Transmasculine	Female	White	Durham	Yes
Chris	17	15	16	Male	Female	White	Cumbria	Yes
Alex	16	12-13	15	Male	Female	White	Leicester	Yes
Emily	23	Early childhood		Female	Male	White	Sussex	No
Theo	19	14	15	Transmasculine	Female	White	West Midlands	No
Stevie	19	15	18	Female	Male	White	Oxfordshire	No
Ember	20	13	18	Female	Male	White	Berkshire	Yes
Caiden	19	4	12	Male	Female	White	Gloucestershire	No
Olivia	23	16	N/A	Female	VSC assigned female	White	Dorset	No
Hugh	18	14	18	Male	Female	White	West Midlands	No
Phoenix	24	Puberty	19	Non-binary	Female	White	Kent	No
Finley	21	18	18	Non-binary	VSC assigned female	White	London	No

Blake	23	11	N/A	Female	VSC assigned female	White	Cambridgeshire	No
Daxton	17	puberty	14	Male	Female	White	London	Yes
Layla	23	Early childhood	15	Female	Male	White	West Midlands	Yes
Valerie	23	Early childhood	22	Female	Male	White	West Midlands	No
Justin	14	9	10	Male	Female	White	Lanarkshire	Yes
Jennifer	24	21	12	Female	Male	White	Bristol	No
Ivan	20	14	16	Male	Female	White	Lanarkshire	No
Quinn	22	Early childhood	16	Transmasculine	Female	White	Lanarkshire	No
Kit	17	12	15	Transmasculine	Female	White	Oxfordshire	Yes
Jade	18	14	15	Female	Male	White	West Yorkshire	Yes
Franki	22	16	19	Genderqueer	Female	White	Cambridgeshire	No
Mason	21	Puberty	17	Non-binary	Female	White	Cambridgeshire	No
Rory	16	11	12	Male	Female	White	Lincolnshire	No
Joe	19	17	17	Male	Female	White	East Sussex	No
Nell	18	Puberty	14	Non-binary	Male	White other	Hampshire	No
Clyde	21	12	19	Male	Female	White	Edinburghshire	No
Briar	16	14	15	Transmasculine	Female	White other	Kent	No
Hazel	24	17	17	Non-conforming	Female	White	Lanarkshire	No
Revel	16	13	Not out	Bigender	Female	Jewish	London	No
David	15	12	13	Male	Female	White other	Bristol	Yes
Melanie	15	3	7	Female	Male	Mixed black African and white	Conwy	Yes
Ezra	21	Puberty	16	Transmasculine	Female	Jewish	London	No

Caregiver interviewees included 31 parents and carers of gender diverse children: 23 of these were women and 8 were men. 12 of these caregivers were parents of young people also interviewed for the research. The children of these caregivers ranged from 5 to 23 years at the time of interview (Table 2).

*Table 2: Sample of caregivers*

Name of caregiver	Gender of caregiver	Name of child	Age of child	Rough age knew child was gender/sex diverse	Gender of child	Child sex at birth	Location	Partner also interviewed?	Child also interviewed?
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Kate	Female	Jamie	9	6	Gender expansive	Male	London	Yes	No
Scott	Male	Alex	16	15	Male	Female	Leicester	Yes	Yes
Dorothy	Female	Alex	16	15	Male	Female	Leicester	Yes	Yes
Irene	Female	Raya	9	7	Trans-feminine	Male	Kent	No	No
Camilla	Female	Aaron	18	15	Male	Female	Suffolk	Yes	Yes
Andreas	Male	Aaron	18	15	Male	Female	Suffolk	Yes	Yes
Hannah	Female	Ivy	17	14	Female	Male	Hertfordshire	No	No
Maria	Female	Layla	23	15	Female	Male	West Midlands	No	Yes
Elizabeth	Female	Liam	7	4	Non-conforming	Male	Kent	No	No
Rose	Female	Kit	17	15	Trans-masculine	Female	Oxfordshire	No	Yes
Clare	Female	Jade	18	15	Female	Male	West Yorkshire	Yes	Yes
John	Male	Jade	18	15	Female	Male	West Yorkshire	Yes	Yes
Anne	Female	Tommy	11	9	Male	Female	Manchester	No	No
Daisy	Female	Aria	12	8	Female	Male	Surrey	Yes	No
Keith	Male	Aria	12	8	Female	Male	Surrey	Yes	No
Faye	Female	Josh	12	8	Male	Female	Manchester	No	No
Nicholas	Male	Devan	18	16	Non-binary	Female	Birmingham	No	Yes
Ruth	Female	Henry	15	13	Trans-masculine	Female	Durham	No	Yes
Fiona	Female	Stewart	15	11-12	Trans-masculine	Female	Lancashire	No	No
Chloe	Female	Mia	5	2-3	Female	Male	Berkshire	Yes	No
George	Male	Mia	5	2-3	Female	Male	Berkshire	Yes	No
Lucy	Female	Amber	11	6	Female	Male	Cambridgeshire	No	No
Ashley	Female	Justin	14	11	Male	Female	Lanarkshire	No	Yes
Victoria	Female	Ember	20	19	Female	Male	Berkshire	No	Yes
Maddison	Female	Chris	17	16	Male	Female	Cumbria	No	Yes
Brenda	Female	Daxton	17	15	Male	Female	London	No	Yes
Tessa	Female	David	15	13	Male	Female	Bristol	No	Yes

William	Male	David	15	13	Male	Female	Bristol	No	Yes
Sophie	Female	Isla	15	2-3	Female	Male	London	No	Yes
Janet	Female	Jacob	14	10	Non-conforming	Female	West Yorkshire	No	Yes
Arthur	Male	Melanie	15	7	Female	Male	Conwy	No	Yes

Key informant interviews included 7 interviewees from the health sector (including specialist clinicians and GPs), 5 from the education sector, and 3 from the voluntary sector. All had extensive direct experience working with either gender or sex diverse children and youth (Table 3).

*Table 3: Sample of key informants*

Pseudonym	Area of specialism	Specific role
Jemima	Health	GP
Brian	Health	GP
Dexter	Health	GP
Maria	Health	Psychotherapist
Ana	Health	Family therapist
Roger	Health	Family therapist
Melanie	Health	Psychiatrist
Cheyenne	Education	Pastoral care
Orla	Education	Progress Coach Lead
Henry	Education	Assistant Principle
Danielle	Education	Support worker
Annabelle	Education	Teacher
Charlotte	Voluntary Sector	Senior Manager
Brian	Voluntary Sector	Youth worker
Andrew	Voluntary Sector	Youth worker

To protect participants' anonymity, all interviewee names have been changed. Pronouns are used according to the preferences of participants at the time of the interview (except in the context of direct quotes, which are included verbatim).

#### 2.4.2. Survey sample

The approach to recruiting young people for the survey drew on several strategies, combining probability and purposive techniques; the aim of mixing strategies was to ensure a sufficiently large sample of GSD youth to enable effective analysis. 1,509 respondents were accessed through 10

schools and further education colleges. Six of these schools/colleges (including 1,358 respondents) were selected randomly from an online directory. Schools/colleges were grouped into districts across England, Wales and Scotland; a random number generator was used to select one school in each district to be contacted concerning the study. Those who responded positively were then asked to distribute the survey to all students ages 14 and above, to be filled out on a voluntary basis. An additional 4 schools (including 151 respondents) were accessed through convenience/personal contacts. Finally an additional 267 young people were recruited online, through social media groups/forums specifically for GSD youth, as well as through asking participants who participated in qualitative interviews if they would consider distributing the survey across their networks.

*Table 4: Sample of schools*

Type of institution	Finance	Gender composition	Location	Mode of access
College	Publicly funded	Mixed	London	Personal contact
Secondary School	Independent	Girls only	London	Personal contact
Secondary School	Independent	Boys only	Surrey	Personal contact
Academy	Publicly funded	Mixed	Bristol	Personal contact
College	Publicly funded	Mixed	East Midlands	Online database
College	Publicly funded	Mixed	Staffordshire	Online database
Academy	Publicly funded	Mixed	Kent	Online database
Secondary School	Publicly funded	Mixed	Shropshire	Online database
College	Publicly funded	Mixed	Norfolk	Online database
Secondary School	Publicly funded	Mixed	Midlothian	Online database

#### *Basic description of survey sample*

Overall, a total of 1,776 young people were included in the survey. 293 of these (16.50%) were gender or sex diverse, 1,483 (83.50%) were sex/gender typical (Figure 1). Figure 2 provides a breakdown of the gender and sex diverse sample into different categories of diversity. (Young people were offered the option of selecting multiple categories). 82.30% of the sample were white British and/or Northern Irish; 17.7% were from black or ethnic minority (BAME) backgrounds. 12.16% were from non-white backgrounds, including Black, Asian and Mixed minority groups (Figure 3). 17.94% of young people reported to have a disability. Rates of disability were significantly higher amongst GSD youth compared to sex and gender typical youth (Figure 4).

Figure 1: proportion of sample sex or gender diverse

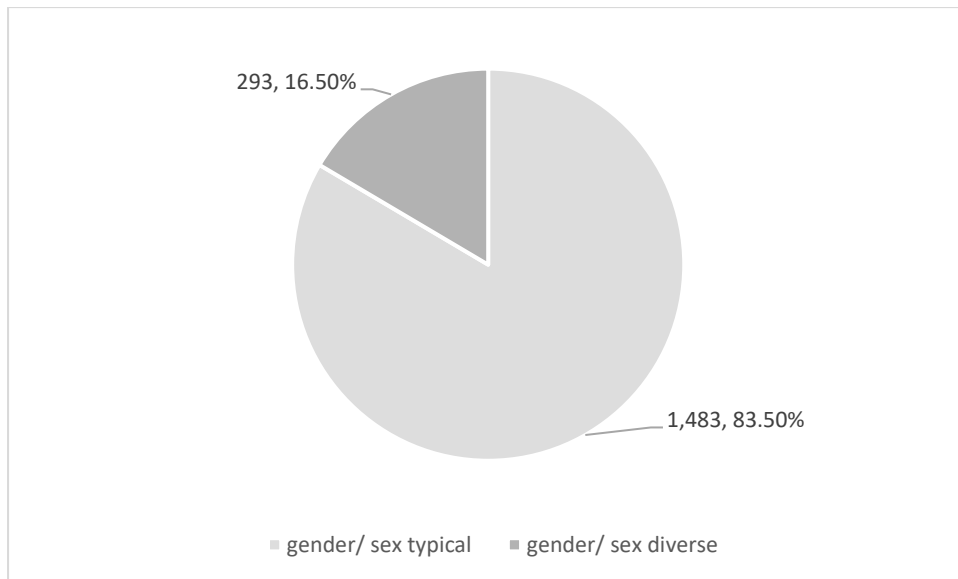


Figure 2: Disaggregation of sex and gender variance



Figure 3: Ethnic composition of sample



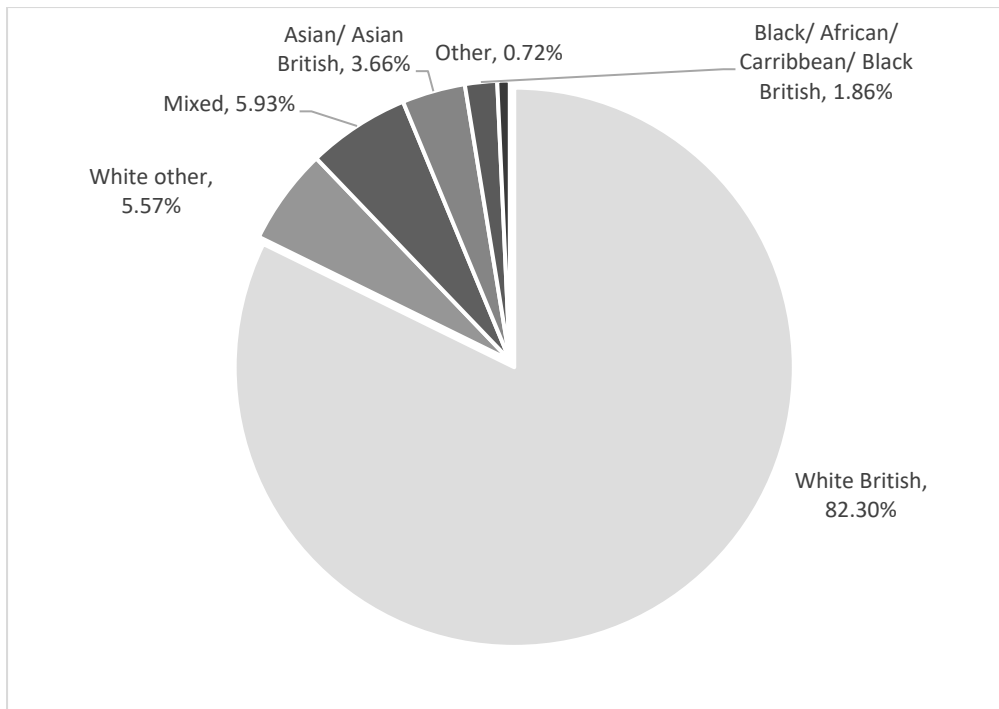
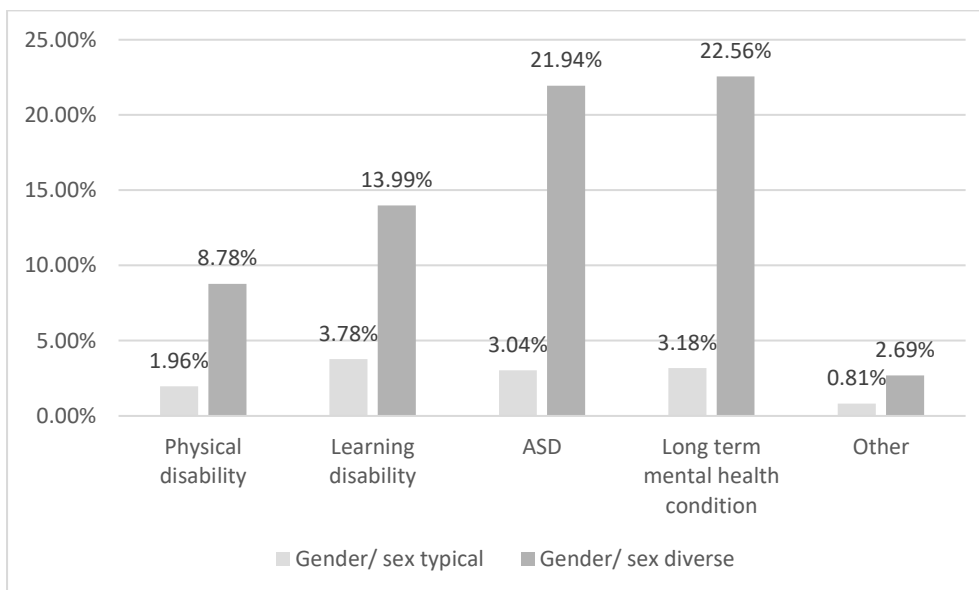


Figure 4: Rates of disability by sex/gender typicality



## 2.4 Analysis

I followed a ‘parallel mixed’ data analysis method: qualitative and quantitative data were analysed concurrently, although separately and through different processes (Teddle and Tashakkori, 2009). Qualitative interviews were recorded and transcribed verbatim. All qualitative data, including literature, were transcribed and uploaded into Nvivo software, where they were organised and coded. Quantitative data from the online survey were sent automatically, or manually entered, into

an Excel sheet. This was uploaded into STATA for statistical analysis using descriptive and inferential techniques.

#### 2.4.1. Qualitative analysis

All qualitative data were coded using abductive analysis (Timmermans and Tavory, 2012). Abductive analysis blends inductive and deductive approaches, recognising that the coding process may be facilitated through the application of existing concepts and theoretical links, yet at the same time should seek to generate new ideas ‘to account for puzzling empirical materials’ (p. 180). Following this process, during the initial analysis, I identified passages where gender and sex diversity became pertinent in different health settings, paying close attention to emergent themes. Relevant passages were then coded line-by-line and grouped into themes and subthemes, drawing attention to discrepant cases and heterogeneity within the sample. Material was divided into two types of coding ‘bins’: ‘theoretical’, codes developed from prior theory and literature, and ‘organisational’ topic codes derived from patterns perceived in the raw data. The coding process was iterative: codes were progressively added, changed, supplemented or deleted; as themes emerged throughout the coding process, I revisited previously coded passages in light of new themes.

I applied a narrative analysis approach to interpreting qualitative data from interviews, focusing on the way that people make, use, and tell stories to generate sense and meaning within the social world. The value of narrative analysis (and its affinity with poststructuralist and critical realist perspectives) is the attention this approach affords to the contingent social, cultural and political contexts within which human lives are both lived and recounted, and the relationships between ‘truth-telling’, subjectivity and power. According to a narrative analytical approach, data gathered from qualitative interactions should not be treated as ‘objective’, ‘factual’ information about the world, but rather reconstructive accounts of human experiences that are told within (institutionalised) relations of power (Connelly and Clandinin, 1990).

#### 2.4.2. Quantitative analysis

Quantitative data was analysed using STATA. Initially, the data was analysed to generate a descriptive profile of the sample in terms of basic demographics, gender/sex diversity, experiences within health services (access, inclusion, interactions with staff etc.), and indicators of wellbeing (self-esteem, social integration, efficacy and others). A range of bi-variate and multi-variate

statistical analytical techniques were then used to explore correlates and associations between gender and sex-variance, experiences within services, and aspects of wellbeing, disaggregated by other demographic features (e.g. ethnicity). These tests included the use of the following (amongst others):

*Bi-variate:*

‘Comparison of means’ (T-test): used to determine whether two populations (e.g. ‘cis’ vs ‘trans’) (delineated by a binary, categorical variable) were significantly different from each other in relation to a particular (scalar) outcome (e.g. satisfaction with GP service).

‘Chi-squared test’: used to examine the strength of association between two binary, categorical variables (e.g. whether trans identity is associated with disability).

*Multi-variate:*

‘Linear or non-linear regression’ and ‘logistic regression’ (for binary outcome variables): used to provide estimates of the strength of the relationship(s) between two or more independent or explanatory variables and a dependent or response variable, and the respective contributions of different explanatory variables. When used in conjunction with other information, regression analysis can contribute usefully to an analysis of causality; it can also help in the development of diagnostic signals and ‘predictors’. I used regression analysis to explore, for example, whether being sex or gender diverse helped predict the likelihood that a young person felt comfortable visiting a doctor.

#### 2.4.3. Integrating the analysis

The qualitative and quantitative data findings were interpreted concurrently. Inferences made on the basis of the results from each strand were compared, integrated and synthesized into a coherent whole, to respond to the research questions, and draw final conclusions (Teddlie and Tashakkori, 2009).

In general, the material presented in the chapters below draws most heavily on qualitative data and analysis. The post-critical influences of the study and the focus on examining and deconstructing institutionally constituted knowledges about sex and gender have a natural affinity and compatibility with qualitative methods, which are useful for illuminating and exploring the

instability and multiplicity of social categories, as well as the social and discursive construction of meaning and processes of meaning-making. The presentation of conclusions drawn from quantitative data is used to triangulate points of analysis, and provide further evidence of the generalisability of particular conclusions.

Despite the epistemological compromises that have inevitably been made in the collection and analysis of quantitative data, such as the use of deductive assumptions and the imposition of inflexible ontologies, following a critical realist paradigm, I remained of the view that there was value to be gained in (partially) responding to the research questions through the production of some evidence with generative, measurable and generalisable potentialities. At the very least, I considered that there were practical and strategic gains to be made for the project through the incorporation of quantitative methods which would enable the study to speak to a wider body of literature focused on evaluating and informing health provision for GSD children and youth.

## 2.5 Ethics

An ethics protocol was developed to guide the research which established procedures for safeguarding the physical, psychological and emotional wellbeing, rights, interests and privacy of research participants at all stages of the research process.

In particular, a detailed, staged procedure was developed to guide the process for including adolescents aged 14-17 years in the research. For adolescents under the age of 16, written consent was required from their legal guardian, in addition to obtaining consent from the child. Prior to obtaining consent, participants were provided clear and accessible information about the purposes of the research, the scope and boundaries of their participation and the use and storage of data. (A written information sheet was developed to assist with this process). All participants were provided with the opportunity to be interviewed either one-or-one, or in the presence of a trusted carer (e.g. parents or support worker) or peer, depending on their preference. Strict procedures were developed for managing any distress that should occur during interviews, as well as any concerns regarding a young person's safety.

All materials and tools that formed part of the research instrument, including the methodology, data collection tools, consent forms, research briefings, capacity assessment materials and the

distress management chart were developed in consultation, and reviewed by a group of experts<sup>16</sup> who agreed to act as advisors to the research.

Strict maintenance of the privacy and anonymity of research participants was ensured at all times. No identifiable personal information was used in the study, or recorded on any output or written information. Data was stored on a secure, password locked computer.

The ethics protocol, along with the research methodology and tools, was subject to full review and ethical approval by the Ethics Committee for the School of the Humanities and Social Sciences, University of Cambridge.

## 2.6 Limitations

The methodology for this study was limited in several respects which have implications for the results and how they should be interpreted.

The survey sample cannot be considered ‘representative’ of the general population in a statistical probabilistic sense due to the mixing of recruitment strategies. Nonetheless, it comprises a large and diverse sample of adolescents and young people, which may provide some indication of the generalizability of its results. Interestingly, the survey sample appears to broadly reflect population level statistics with regards to key demographic variables such as ethnicity and disability.<sup>17</sup>

The sample of caregivers and young people who participated in qualitative interviews was less diverse in some significant respects. Firstly, almost all participants were white British; despite attempts to reach BAME communities, only a few young people interviewed were from minority

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<sup>16</sup> These included clinical psychologists and other professionals with direct experience working with vulnerable children. All individuals had a wealth of experience conducting research with children and the associated issues, including concerns related to vulnerability and consent.

<sup>17</sup> Overall 17.70% of young people self-defined as having a disability, the government 2021 census for England and Wales found reported a disability prevalence of 17.8%.

[https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/disabilityenglandandwales/census2021#:~:text=does%20it%20matter%3F-.Disability%20in%20England%20and%20Wales,19.5%25%20\(10.0%20million\)](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/disabilityenglandandwales/census2021#:~:text=does%20it%20matter%3F-.Disability%20in%20England%20and%20Wales,19.5%25%20(10.0%20million)) accessed February 2023. 82.30% of young

people in my sample were white British, compared to a prevalence of 81.7% observed in the recent census <https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/population-of-england-and-wales/latest> accessed February 2023.

backgrounds. Further research should explore the histories and perspectives of BAME children and youth, whose (gendered) experience is likely to intersect with their position as racialised subjects, and the various additional forms of discrimination and exclusion this entails.

Since my recruitment strategy began with contacting gatekeeper organisations, my sample includes an overrepresentation of families well integrated into social support networks and receiving help from formal services. Notably, as I moved through the recruitment process and began to interview young people who volunteered through the online survey, I noticed a shift: young people contacted through the survey tended to come from more deprived and vulnerable backgrounds, relative to those accessed through support organisations.

The sample of caregivers is particularly biased in that it almost exclusively captures the perspectives of caregivers who were in contact with support organisations, and who, at least at the time of interview, were broadly accepting of their children's identities (although many caregivers reported taking some time to reach this position of acceptance). The sample of younger people reflected more diversity, including young people with varied experiences of caregiver support, ranging from full acceptance to rejection and estrangement. Further research could consider exploring the experiences of caregivers who hold different perspectives on their children's gendered development.

A major limitation of the research is that, despite my best efforts, I was unable to recruit more sex diverse youth. While communities of trans youth are becoming increasingly cohesive and vocal, sex variance remains a profoundly 'hidden' and isolating form of difference. 'Sex variance' captures a wide heterogeneity of physical variances, as well as personal identities; many people with VSCs reject advocacy narratives and terminologies (e.g., 'intersex') and do not identify as part of a broader LGBT+ community. Given such contexts, my 'snowball' approach to recruitment was ineffective in reaching more respondents, because none of the SV youth included in this study had connections to other sex diverse individuals or groups. There is an urgent need for further research with this highly vulnerable and marginalised population; the few SV youth included in this study were found to have particularly negative experiences in healthcare, and especially poor wellbeing outcomes.

As with all studies involving 'reports' from human subjects (through interviews or survey questionnaires) my research is inevitably limited by the partial and mediated nature of what

participants chose to share with me, as well as my own ability to comprehend and ‘represent’ their accounts. These dynamics, in turn, will have been informed by the complex set of values, beliefs, experiences and interpretations that each of us brought into the research process, and the meanings that were (re)created through the process of shared participation. Throughout the research process I attempted to be both mindful and interrogative of these dynamics, especially the extent to which participants’ may have been affected by their perceptions of me as both a ‘researcher’ and an ‘outsider’ (neither gender nor sex diverse myself, nor the parent of a GSD child). In particular, I noticed that caregivers sometimes appeared initially suspicious of my intentions and felt ambivalent about participating in the study: on the one hand, they wanted to share their stories, on the other they felt guarded and protective over their children. I sought to mitigate their concerns by being clear and open about the goals of the research, as well as my own personal background and motivations for conducting the study. I explained what actions would be taken to protect their (/their children’s) anonymity. During interviews I strove to express empathy, attunement and active listening, and to ensure that participants understood that all responses to my questions were equally acceptable, valid and welcomed.

Finally, despite my original aim to include pre-teen children in the study, this was ultimately not possible due to institutional barriers to obtaining ethics approval. This means that descriptions of early childhood experiences are dependent on adolescents’ and young peoples’ memories of the past, and therefore subject to recall bias, or, alternatively, mediated through the accounts of caregivers. Whilst participants’ stories, particularly contemporaneous accounts provided by caregivers, contain rich and detailed insights into early childhood experiences of gender incongruity, there is need for future research which includes younger children as direct participants. As Carter (2009) argues, direct participation of children in research is of paramount importance, since the structural conditions of (early) childhood are distinct, and cannot be recreated.

### Chapter 3 “I want to go back inside and be born again”: gender and embodiment in early childhood

This chapter explores sex and gender variance as a developmental experience, and field of childhood subjectivity. Discovering how children develop and embody trans, non-binary and sex diverse subject positions is integral to understanding their experiences in health services, and consequent implications for their wellbeing.

In this chapter I show that children may express trans or gender diverse identities from early childhood. I suggest that participants’ accounts dispel common representations of trans children and their caregivers, often advanced in clinical settings. For example, there is a tendency to associate gender incongruence in childhood with developmentally abnormal gender cognitions (Turban and Schalkwyk, 2018), and to perceive early social transition as driven by caregivers (Patterson, 2018; Wren, 2019b; Griffin *et al.*, 2021). This has led to a practice of discouraging or delaying social transition in childhood, for fear that it prematurely forecloses scope for more expansive ‘exploration’ and modes of identification (Churcher Clarke and Spiliadis, 2019; Wren, 2019b: 238). I argue that this perspective reflects an unconscious bias that assumes a shared norm of gender-typicality.

The presentation of data and analysis is divided into three parts. The first two parts draw on in-depth qualitative interviews with young people and their caregivers. Section 3.1 explores children’s experiences of embodied gender incongruence, as recalled by young people and their caregivers. Young people and caregiver accounts illustrate the deep psychic investment in gender (variance) that children may manifest from the earliest years of childhood. They highlight the distress that children may experience when their need to claim themselves as authentically gendered subjects is contradicted by requirements to accommodate gender as externally assigned. Section 3.2 explores negotiations between children and caregivers over aspects of social transition. Participants’ accounts suggest that (even the youngest) children may be active participants in the creation and negotiation of diverse gendered subject positions, and may tenaciously pursue recognition of their identities, despite refusal or delay from their caregivers. Whilst parents of GD children are often depicted as hasty to facilitate social transition (Davy and Cordoba, 2020), almost all the caregivers



in this study recalled moving through a protracted period of resistance, devastation and loss, before reconciling to support their children's transness.<sup>18</sup>

Integrating findings from the survey, Section 3.3 shifts focus to considering what the data collected in this study might contribute towards understandings of gender (variant) development. In clinical settings, gender incongruence in childhood is often associated with children's acquisition of (developmentally abnormal) rigid and simplistic ways of thinking about gender and sexuality (Wattel, Walsh and Krabbendam, 2022). Yet gender diverse children and youth in this study typically expressed complex and sophisticated ideas about sex, gender and sexuality, and incorporated these into their self-concepts. Survey data suggests that GD children may exhibit *less* rigid gender typing than their cisgender peers. Furthermore, social transition may be associated with a relaxation in children's performance of stereotypes roles.

The themes explored in each section of this chapter challenge normalised expectations of gender typicality, as well as notions of childhood passivity and innocence. From the earliest years of life, children may be active participants in developing and adopting complex and deeply felt gendered subject positions, sometimes generating unanticipated forms of diversity. Furthermore, far from exhibiting developmentally abnormal gender cognitions, trans children may follow broadly the same processes of gender cognition development as those attributed to cisgender children in the clinical literature (e.g. Martin and Ruble, 2004; Ruble *et al.*, 2007; Zmyj and Bischof-Köhler, 2015).

### 3.1. Experiences of gender incongruence in childhood

*"The shoe isn't mine. The shoe doesn't fit. And never will"*<sup>19</sup>

#### 3.1.1. Emerging differences

According to participants' accounts, for many children experiences of gender incongruence began in early childhood, well before the onset of puberty. Of the young people interviewed, the majority said they had remained 'closeted' about their feelings as young children. Young people described lacking the cognitive, linguistic and cultural frameworks to make sense of their feelings: *"I didn't have the words or explanations at the time."* (Amalia) Rather they described nebulous feelings of discomfort, unfamiliarity and dissociation from 'self': *"I didn't even know what to call it. [But] I always felt that wasn't me"* (Ember); *"I always felt something was off. Something just didn't feel right. I didn't know*

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<sup>18</sup> These findings are consistent with the few previous studies that have explored parents' experiences of early social transition (e.g. Pearlman, 2006; Rahilly, 2020; Lorusso and Albanesi, 2021; Horton, 2022).

<sup>19</sup> A poem written by a child, hanging in the Tavistock and Portman Trust Gender Identity Development Service in London.

*what it was, but like – I’m not me” (Chris); “I kind of thought it was only me in the world – I was different to everyone else. I wasn’t aware of the concept of dysphoria, but I always felt like the outsider.” (Emily)*

On the other hand, young people remembered feeling compelled to remain quiet about certain feelings, sensing the censure and disapproval of adults: *“I grew up in this very traditional background. There wasn’t really any openness. I didn’t realise [being trans] was an option.”* Amalia recalled a memory from her first year of school, where she was reprimanded for trying to use the girls’ bathroom at school: *“that was confusing for me. I was at the age where the teacher is the moral authority, so I just thought that what I was feeling was wrong.”* She added: *“because it was coming from all people, I always felt that’s [a boy] what I had to be. I couldn’t be who I was inside, I had to be who everyone else wanted me to be”.*

For some young people, hiding their feelings and desires felt particularly urgent; a matter of avoiding the violent punishments associated with failing to fulfil normalised gendered expectations:

*I used to get bullied for what other people called different. So I was like, I wanna be myself, but I also wanna fit in and be normal. I didn’t want to be beaten for it, like mum always said that were wrong. When she weren’t in the house, I’d be myself. (Hugh)*

And yet, children’s incongruity was often making itself apparent in other ways: *“I thought I was giving away different clues! I think my mum from early on was like, ‘why are you always wearing girls’ clothes?’ But she just let it happen”* (Amalia). For some children this started as early as toddlerhood. According to participants accounts, with the development of language and ability to assert preferences about toys and clothes, some children started expressing strong and consistent ‘cross-gender’ predilections and behaviours. Mia’s parents described how she would refuse to get dressed and leave the house if she was required to wear any clothing that in her view was intended for boys: *“every day was a nightmare trying to get her dressed to go to nursery. Just going out was difficult. This very active and physical child was saying ‘I don’t want to go outside”* (George). Anne relayed how Tommy would insist on only ever wearing boys’ underpants, a preference that was deemed curious enough that it had been recorded in his medical notes by his General Practitioner. Arthur joked how Melanie would always have to be the female character during pretend play, requiring her younger sister, Beth, to play the male: *“I remember they played Titanic. [Beth] had to be Jack because Melanie wanted to be Rose!”*

Whilst for many children, indirect signifiers regarding their experience of gender included choices about clothes, games and playmates, other children, like Isla, were more direct and explicit about

their feelings: *“as soon as she could start to talk and express herself, she would say: ‘I’m a girl. I’m a girl. I’m a girl! Say it relentlessly to anyone who would listen. [She] was very small – 2 – literally as soon as [she] started talking”* (Sophie). Isla’s mother, Sophie, remembered that she was initially unfazed by Isla’s assertions, as well as her insistence on wearing girls’ clothes, assuming it was “just a phase”. Sophie remembered the health visitor – curious that Isla was often dressed in a gold, lace skirt – asking her one morning whether Isla called herself a girl. Sophie recalled dismissing the question as somewhat absurd: *“I said ‘well yeh, but if you asked [Eli’s brother] if he was a train he’d say yes!’ So at the time... I assumed she grow out of it!”*

Like Sophie, the majority of caregivers remembered initially supposing that their children’s behaviours were temporary; or, perhaps, they were simply expressing their own unique characters and personalities. This aligns with common wisdom and research evidence that suggests that amongst younger children ‘cross-gender’ performance and the expression of gender-atypical preferences is not unusual, regardless of future gender identity or sexuality (Yogman et al., 2018). Over time, however, caregivers reported a gradual shift in thinking, away from assuming their children’s gender non-conformity was just part of typical childhood exploration and play, and towards the idea that they might expressing a more unusual form of difference; a change in perspective that was often driven by the intense expressions of sadness and distress that were increasingly accompanying their children’s growing awareness of gender: *“Jamie was talking more and more about his unhappiness”* (Kate); *“he was just getting so depressed in himself.. It was torture”* (Lucy); *“she got very, very sad, very, very, unhappy at school. We watched her deteriorate. And that was when I started saying to my husband: ‘we have to step up now or we are going to lose her’.”* (Lucy)

### 3.1.1. Expressions of distress

*“I just want to go back inside and be born again”*

Though not universal, distress was a very common feature of participants’ accounts of childhood gender and sex variance. Blake recalled: *“I just remember feeling very, very different, in a way I didn’t want to be. I felt like I was living a lie. It just became quite extreme really; my emotions, how I felt, was so negative.”* Jennifer described: *“I didn’t know what was wrong with my brain. I just sat through it, and was sad for a while. I just sort of learned to cope with the rubbishness of background noise.”* Mia’s parents remembered going through a nightly cycle of negotiation and tears as their toddler begged them to recognise her as a girl. They recounted how her “happiness” and “joy” disappeared, replaced by a deep and “strange” sadness, and daily bouts of crying:

*A two year old... she started saying, 'I'm not a boy, I'm a girl', more and more vocally to the extent where by age three and a half it was nightly – really upset and sad... No matter what we said we couldn't persuade her out of this... Every bed time all she'd want to talk about was being a girl, and, on the drive home from nursery first, and then pre-school, she'd just start crying in the car... So we kind of realised it was a problem that wasn't going away and we had a really sad little kid.*

Lucy explained how, over a number of years, from nursery school to the first years of primary, she witnessed Amber becoming gradually more withdrawn and depressed: *"once she got into year 1, from a very happy child we ended up with a really sad child, and it was very clear to us that something was really wrong."* According to Lucy, Amber's explanations started vaguely: *"for a year or so it was 'mummy there's something wrong, I don't feel right... It's in my tummy'".* Over time Amber became increasingly more descriptive: *"she'd say: 'I feel like I'm in a prison mum, and there are black bars all around me. I've got this heavy man on my back'".* As Amber's distress intensified, getting her to school became increasingly challenging: *"she used to say, 'I'm lying to my friends, mum'. She didn't feel like she was being honest with who she was. Her anxiety, OCD behaviour, went through the roof. The school started noticing she had changed."*

Similarly, Daisy described watching Aria's *"light going out"*. She recalled Aria becoming increasingly reclusive and distant: isolating herself from everyone, including her previously close group of friends at school. Daisy recalled one day in particular, when Aria's grandparents picked her up from school:

*She came in and ran straight upstairs. I just thought she was going to get changed, but the next thing I could hear crying, she was crying on her bed. I asked her why, and she said: 'because my life is so awful'. So, it was a 'what would make you happy?' type conversation. And it was – 'I want to be me. I just want to be me'.*

Daisy remembered vividly the day she first realised that Aria might be trans: Daisy had just parked the car at a local garden centre when Aria, suddenly burst into violent tears. Daisy begged her to share what was wrong; eventually Aria respondent: *"I have to ask you a question, is there an operation that can make me a girl? Because I'm not really a boy. I'm a girl"*. Daisy recalled:

*I'll never forget it. I'm never lost for words, but I was lost for words. Initially she couldn't say anything because she was crying so hard. I was so scared of what was she going to tell me, because she was so upset. I just wanted to take away her pain. She told me she was scared we wouldn't love her anymore, and that's why she held it in for so long, because she thought that we would reject her.*

Not long after this conversation, Daisy received a call from one of Aria's teachers asking for a meeting to discuss some of Aria's work: *"I went in [to school] after work. She showed us [Aria's] homework.*

*I've kept it – it's somewhere upstairs". Each child in Aria's class had been asked to draw two pictures: one representing how they saw themselves in the present, and the second representing their future self. Daisy described the pictures Aria had drawn: the first was of a sad, lonely boy, with no friends. The second was a happy, adult woman, with long hair and female features. Daisy said this was the first conversation she had with the school about Aira's gender: "I remember I said: 'it doesn't surprise me. I can see my child's pain coming off the page, but none of that surprises me given the conversations we are having at home'."*

Jamie was even younger than Aria, just four and a half, when Kate remembered their first detailed conversations about his gender. One morning, watching *The Sound of Music*, Jamie started to sob. When Kate asked what was wrong, he explained he was crying because he would never be able to be a nun. Kate described:

*'[It was] the first time he expressed really clearly his distress that he wasn't a girl, and he said that it made him sad every day. He became incredibly upset and tearful. There is something, I suppose, that is uniquely female about nuns, I suppose that was what he was responding to. And [he said] that he wished he was a girl, and he always wished he was a girl. And he was so upset.'*

Over the next couple of years Kate kept a written diary of the conversations that she was having with Jamie. Kate found these conversations so confounding and extraordinary, that she wanted to keep an exact of Jamie's words, to keep hold of them, and return to them later to try to make sense of their meaning. She retrieved this diary during interview and read some passages:

*'Even when I'm happy, there's a little bit of me that's sad every day because I'm not a girl.' 'I wish I was a girl?' Why? 'I don't know, I just feel it in my body and my bones and my heart.'*  
*'I wish I was a girl – that's the reason I'm so sad. Inside that reason there are a 100 reasons, or maybe 99. That's why it's so hard for me to get a smile on my face. Once it's there it feels comfortable, but I can lose it again so easily. Whenever you are not looking at me I feel so sad.'*  
*Why do you wish you were a girl? 'Oh we'd be here all through the night and half of the day if I told you!'*

Jamie's words are arresting: it seems remarkable that such a young child would be able to express himself so articulately, and in a manner that conveys such emotional depth. Comparing Jamie to her other (gender-typical) child, Kate acknowledged that he was precocious. She attributed this to his experience of gender incongruence. She surmised that, because Jamie's experience of his gendered-self was so at odds with the recognition he was receiving from the external world, he *"had to delve really deeply into trying to understand his feelings"*.

### 3.1.2. Experiences of the body

Jamie's words are also startling in the manner in which they convey his experience of female gender as embodied: *"my body feels it"; "I feel it in my body, my bones."* Research addressing the lived body is rare in the context of childhood: the physical body is typically rendered either implicit – an 'absent presence' – or an object of containment, control and risk (Coffey and Watson, 2015). Consistent with this approach, gender identity development research has traditionally focused on children's acquisition of (fixed and immutable) 'knowledge' about their sexed body, reducing children's bodies to objects of knowledge. Yet the testimonies of young people and their caregivers in this study highlight the different and changeable ways that children may come to 'know' and inhabit their bodies, as active, living subjects of experience. Daisy recalled one day in Year 5 when Aria was asked to draw an outline of herself in biology class: *"they have to write your eyes, write your nose - so it's about your body. Aria had drawn in breasts and written the word 'vagina' with an arrow to where the genital area would be"*.

Indeed, in the field of sociology, a wealth of gender and embodiment research has explored how the sexed body is not a fixed, natural object, but a mutating and mutable force (Lane, 2009), (inter)acting with a variable social world which itself plays role in forming and informing how bodies are experienced, identified and recognised (Tolman *et al.*, 2014). On the one hand, over the course of the last century, collective understandings of the sexed body have been transformed by the invention of new technologies which have complicated scientific understandings of sexual differences (Fausto-Sterling, 2000) (as well as enabling the medical modification of both primary and secondary sex characteristics). On the other hand, at an individual level, a person's embodied experience may evolve over time, in response to physical, environmental and social changes.

For many children in this study, children's (gendered) knowledge, feelings and experiences of, and within, their bodies appeared to evolve over time. For many children this was a gradual change, influenced by a developing association of their body with social categories of gender, illustrating how the cultural 'gendering' of bodies may influence children's embodied knowledge and gendered experiences within their own bodies:

*I always imagined myself as a girl if that makes sense? I never thought of myself as a boy. Like – I knew I'd have to be a boy in school and stuff like that. But I was like, 'no I'm a girl' and that's what I would think in my head. When I was younger I didn't think about [my body]. The older I got the more I thought, nah, things just aren't right, but before that I wouldn't have thought [about it], I just thought I'll be a girl when I'm older. Whereas [later] it became more the reality that I had to do something. (Melanie)*

Other children, like Finley and Blake, were subject to more sudden, seismic shifts in their experience of gender and dysphoria, typically occasioned by medical encounters defined by dimorphic understandings of sex. Finley remembered learning for the first time that they had a VSC that meant they would never menstruate:

*It was the first time anyone had said to me your body deviates from 'healthy' in a way that won't heal. So it was very distressing. I just shut down. It did make me feel a lot more dysphoric, this idea that I have a disorder. It made me feel a lot panic at my body.*

Blake, raised female, described how during a doctor's appointment, aged 11, she was informed for the first time that her karyotype was XY and she had no uterus. This in turn led to what she described as 'identity death', and a radical reformulating of her conception of 'self' as a gendered subject:

*I was really shocked, completely reeling on the inside. It felt like a bad dream because it happened so suddenly in my memory. It instantly felt like – identity death. Like there had been this person who I thought I was, and suddenly that just changed and the future. I'd always envisioned, just felt suddenly very, very different. I just kind of lost who I was. It's not necessarily how I feel now, but [at the time] for me, that meant I was not a woman, and somehow it very quickly became – loneliness. I thought it meant I would always be alone.*

By age 11, Blake had already developed such a deep sense of an embodied female 'self', that this discovery about her body constituted a moment of profound loss: a loss of both 'who she thought she was' in the present moment, and of all that she had imagined for her future

Whilst children typically develop objective body self-awareness somewhere between 18-24 months of age (Brownell *et al.*, 2007), it was often not until the onset of puberty that gender incongruent children in this study began to experience the physical manifestation of their bodies as discordant with their sense of a gendered self: "puberty is when you go – my body's all wrong. It shouldn't be like this, it should be the other way" (Emily); "I recognised that there was something not right about my body since puberty – things like wanting to bind, feelings of strong dysphoria against the chest" (Phoenix). With the development of secondary sex characteristics, young people described how feelings of gender dysphoria often intensified around aspects of the body, resulting in distress so acute that participants were driven to coping strategies such as disassociation and self-harm:

*When puberty was starting it was incredibly traumatic and stressful and nobody seemed to understand. There were lots of instances of self-harming. One time I basically kind of severed down there. It didn't do any lasting damage, but I had to go to hospital for a bit. (Emily)*

Emily described how her experiences of disaffection from her body, and her attempts to remain closeted about these feelings, eventually culminated in an acute psychotic episode, for which she was eventually sectioned under the Mental Health Act (1983):

*I would mainly try and dissociate - the coping mechanism I had for it [dysphoria]. Basically my mental health was deteriorating really badly, and I wasn't able to keep up that façade of functioning. I wasn't eating, I wasn't sleeping, I was hallucinating things. I was delusional. So it was just very strong, very serious dysphoria. It was just this total disconnect between the idea of self, and the physical embodiment of self. Everything felt wrong, it didn't feel like me, so it was just a constant feeling of a passenger. And I ran out of ways to deal with it by myself.*

Blake described a similar experience of disconnection, and separation of 'self' from 'body': *"I felt female, but there was this big piece of evidence that I wasn't female. I felt like I was living a lie – like I wasn't being truthful with people – that I was, I suppose, a fake?"* Blake's words convey a sense of 'self-objectification' prompted by the gendered values imposed upon her body by her DSD diagnosis: *"my body became something that revolted and confused me"*. Like Emily, she resorted to self-harm as release for her emotional pain: *"I didn't speak about it at all, but I was very, very upset about it. I self-harmed a lot – that was a big part of the coping mechanism"*.

These passages highlight the pain that may be caused to children whose sense of personhood is contradicted by normative and naturalised assumptions about gender, sex and the body. Emily and Blake's accounts evoke the impossible subject position of living in a state where one's subjective experience of an (embodied) gendered self is at odds with acquired 'knowledges' about one's sexed body. For many years Emily lived in this state of contradiction – of impossibility of being – through dissociation from self, which eventually culminated in a more pervasive psychic rupture from reality. Emily's recovery included a process of social and medical transition, through which she was able to restore, reconcile and make whole her embodied self.

Similarly, Phoenix described their social and medical transition as a process through which they were able to leave behind the pain, disaffection and disconnection from their body, towards a creative reconstitution of themselves, through a process of "coming into" a body that, for the first time, felt comfortable, familiar and distinctively their own: *"it felt like coming into a space that was safe. I feel like my body is unique and mine. The body I've longed for – come into – through bindings, surgery, testosterone"*.

Phoenix's experience resonates with some of the writings of Ashley and Ells (2018) who have theorised the different ways that trans people may relate to their bodies through transition: on the



one hand the process may feel like an unearthing of a pre-constituted image of the self, on the other, there is a sense of actively creating the self through ‘transfiguration’; they write: ‘creative transfiguration...is one of the manifold ways in which we may assert ownership over our bodies, transforming them into an art piece that is truly ours out of previously alienating flesh’. (p. 24)

### 3.2. Parental resistance and child ‘persistence’: negotiations between children and caregivers over ‘social transition’

For parents and caregivers, the levels of distress that were increasingly accompanying their children’s articulations of gender incongruency were disturbing and disorienting; many parents described cycling through feelings of fear, confusion, denial and loss: “*we were really in panic mode, not knowing what to do and feeling terrified, and very alone. Jamie was talking more and more about his unhappiness...it was a very scary time*” (Kate); “*this can’t be happening; this can’t be true. Not my child!*” (Daisy). These concerns were exacerbated by the fact that most parents had little or no understanding of gender diversity or dysphoria prior to being confronted with their own child’s experience: “*I’ve never met anyone who was transgender before our daughter! So it was a steep learning curve for us. We were very ignorant to start with*” (Chloe). Kate explained:

*It’s not something I’d ever had first-hand experience of, and certainly the idea of a child expressing that just wasn’t on my radar at all... I didn’t know what to do with this information, you know, in terms of what it meant and how best to react to it, I was so ignorant – because this was nearly 5 years ago – and it just wasn’t in the media. I had nothing to draw on – it was just totally outside of my life experience, so I just didn’t know what the possibilities were.*

Several parents broke down in tears as they remembered different events and feelings. Keith expressed the grief he felt in “losing his son”, and he described his ongoing struggle adjusting to Aria’s transition:

*It’s a process. It’s something that you don’t wake up one morning and say – ‘I accept this’. You accept it because you can see what’s happened, day, by day, by day, by week, by month. There’s no shining light at the end of it. It’s just getting used to the idea subconsciously. It’s not the easiest journey. It’s easier now than five years ago. To lose your son it’s difficult...[I] lost a son and gained a daughter – still, lost a son. [through tears] I don’t want to cry. She’s a beautiful person – boy or girl.*

Scott described a very similar sense of grief and loss concerning Alex’s transition: “*I think the initial perception is – I’m losing a daughter.*”. He explained how Alex’s transition had radically disrupted his image of his child, his memories of their past, and imaginings for their future:

*That [my daughter] is how I remember Alex: that picture, those clothes, learning to walk. And plus we named [birth name] after my nan, so that was a blow as well. For 15 and a half years that's been my daughter. I taught Alex to walk and talk and eat, changed his nappy. I was there when he opened his eyes. All that stuff is still for me a memory of him being a girl. It's just how I am in my mind. I don't know whether I understand what Alex wants now. Like my sister – she wanted to get married like my mum, and she wanted to have kids. And you think that's going to happen for your daughter and when it changes you think hang on a minute.. I have no prejudices and never will, but when it's your own child you don't see many positives at first.*

Camilla remembered worrying that her child, Aaron, was becoming a “different person”, one she didn't know and wouldn't recognise: *“there's a fear that somehow it's not the child you know. You love that child, and you don't want them to be different”*. She explained how she and Aaron shared a talent for art and creative activities together: *“I thought that was going to go! Which is quite distressing isn't it? You think, this is a different person, somebody who likes different things.”* Most of all Camilla recalled her intense feelings of concern for her child, her “terrific fear” for her child's wellbeing and safety, in a “world where's there's so much discrimination”. She described her most overwhelming concern: *“the fear that he was throwing himself in front of a train. And I had to encourage him to do it. That was a very powerful feeling, that stayed longer than the others. I'm still frightened sometimes”*.

Camilla's words “and I had to encourage him to do it” illustrate the ways in which caregivers were often self-reflective about their roles as potential ‘enablers’ of their children's transgressions. Daisy described the struggle she went through trying to work out how best to support Aria without influencing her further towards transition: *“I didn't want to lead her in anyway. I didn't want to make assumptions and judgements. I wanted stuff to come from Aria. I wanted her to know that there are so many different paths you can follow to be who you are.”* Like Daisy and Camilla the majority of caregivers expressed concerns about the consequences of both social and medical transition and felt wary of their potential role in facilitating their children to set shift down a harmful pathway of development: *“we weren't supporting her if that then made a trans outcome more likely.. if that might reinforce that identity or solidify it in some way.”* (George). Kate described undergoing a painstaking and difficult process of self-reflection and interrogation as she attempted to balance support for Jamie's developing autonomy, with her desire to protect him from the potential dangers of transition:

*I found the whole process really difficult. There's so much fear that you are going to make the wrong decision, and either expose your child to ridicule and bullying, negative reactions, on the one hand, or - you're repressing them and giving them the message that who they are and how they want to be, is not ok. And it's incredibly hard: to what extent are you encouraging something or to what extent are you holding something back? There's no absolute.*

Confronted by their children's distress, and feeling unable to fully comprehend what their children were expressing, parents would often describe attempting to dissuade their children out of their cross-gender identification, bargaining with them over toys and clothes, and seeking to reassure them that they could live and be happy in their natal gender: "*we were like 'do you want a different toy or something?'*" Arthur recalled his reaction when Melanie first told him she was transgender:

*I didn't— couldn't — take all that on board. I just said: 'you are who you are, and this is your body. You can be whoever you are. You can be girly, and do what you want, but — this is you!' It scared me a bit, I didn't really engage with it at that point.*

Kate described trying to discuss with Jamie the different ways that he could express himself as a boy: reassuring him that he could have long hair and wear dresses without needing to change his gender. According to Kate, these assurances only served to deepen Jamie's pain and distress. In interview, she read the record of one of these conversations from her diary:

*He was focusing on the very external things: hair, clothes, dresses. So I was saying, well you can have long hair — in your view — like a girl, and you can wear dresses! You can do those things, you don't have to be a girl to do those things. [Kate reads Jamie's response] I don't want you to say that — even kindly like you do. I don't want you to talk about it anymore because it makes me a 1000 sad and normally I'm just a 100 sad.'*

In retrospect, Kate reflected that perhaps Jamie was trying to tell her she was "missing the point".

Similarly, Daisy remembered repeatedly asking Aria: "*is it that you want to dress like a girl? But still be a boy?*" Daisy tried to highlight different role models for cross-dressing and gender non-conforming men: "*look at Grayson Perry — there are successful people - Eddie Izzard! He's a comedian, he's male, but frequently he's beautifully made up, and that's fine! And there's this successful artist.*" Daisy wondered if Aria might be struggling with her sexuality, seeking also to reassure her: "*It's ok to be gay*". Despite her efforts, according to Daisy, Aria just kept insisting "*no, no, no. I'm a girl. I'm not gay. I'm a girl who likes guys.*" According to Daisy: "*Aria was just consistently clear with us that that was what was going on.*"

Similarly, Mia's parents explained that they had been unwilling to accept Mia as a girl, fearing that in doing so they would be leading her down a path where a transgender outcome might be more likely: "*we told her we loved her, but we couldn't take that step*". Instead, they focused on assuring her that being a 'boy' was consistent with whoever she might want to be, and whatever she might want to do:

*We were like 'you're not a girl, there's all sorts of ways you can be a boy and that's fine. What can't you do that you want to do, that being a girl would allow you to do?' I mean, in simpler language for a 2 year old.*

Yet, according to George no matter what they said, they couldn't "*persuade Mia out of this.*" Instead, these conversations led to daily arguments and tears and Mia becoming "*deeply upset and depressed*". Meanwhile, unable to persuade her parents to recognise her as a girl, Mia turned her attention to her peers, seeking to obtain recognition from other children, first in her nursery, and then in her pre-school. George described how each day, Mia would return home and report on which children she had successfully convinced: "*it would be a small victory. Like – yes! I persuaded so and so today! Before we'd ever called her a girl – she had half the class [doing it]!*"

Similarly, Anne recalled that Tommy's classmates were the first to accept him as a boy. Anne remembered Tommy trying to tell her he was trans: "*one day she asked me about why she hadn't got a wrinkle. I explained to her because she was a girl – and she said to me, 'But I'm not a girl. I'm a boy'".* There were other signs, the way Tommy dressed and looked: "*if you was ever to meet her, straight away you'd think – that's a boy*". Yet, Anne explained that she hadn't engaged: "*I left it. I just put it to the back of my head*". Meanwhile, age 6-7, Tommy had chosen a male name for himself at school. One afternoon, the school called Anne to inform her that 'Tommy' had stopped responding to his birth name: he would only react when addressed as 'Tommy' (a recommendation that had been made to the teacher by Tommy's classmates who had allegedly been calling him 'Tommy' for some time). Anne recalled: "*little did I know! The other children just sort of accepted [it].*"

Whilst some children began their transition at school, in other cases, caregivers took active steps to try to confine children's nonconformity to the home. This was particularly the case for transfeminine children. Kate recalled how Jamie slowly transitioned to wearing girls' clothes at home, firstly as a form of dress up, and later as a matter of routine, but Kate always insisted he took off his skirts and dresses when leaving the home, afraid of people's judgements: "*it's a very, very uncomfortable place to be when you have a male child who is exhibiting very strongly feminine traits and behaviours – people don't react well.*" Kate recalled a period of two years during which she agonised over trying to buy Jamie clothes that expressed more femininity without being obviously intended for girls: "*I was thinking I'd try and meet this need, by getting Jamie nicer clothes, fun clothes, brighter clothes... But obviously it wasn't meeting the need at all. Particularly for someone like Jamie, where the feelings are so deep..*" Over time, Kate felt her position becoming increasingly untenable: Jamie was becoming more and

more insistent on wearing his skirts and dresses outside the house, and she found herself running out of justifications as to why he couldn't:

*I just got to that point where the only reason is - other people won't like it. And what kind of a reason is that? What sort of message is that to give to your child: you can't be who you want to be because other people won't like it? So, about a week before the summer holidays a conversation happened. I think Jamie needed to get changed because we were going out somewhere. And I think I just said: 'do you want to keep wearing your dress?' And he went [gasps] 'Abh yes!' And we went out for a picnic. We've got these photos of him just wearing a little t-shirt dress. Just so happy. So, so, so happy. And I think we both knew at that point that there was no turning back.*

Daisy felt a similar discomfort about allowing Aria to wear girls' clothes in public; she explained how unprepared she felt for the challenging conversations she would have to have with family and friends, and the inevitability of encountering people who wouldn't understand or accept it: "*not everyone is supportive. I felt I [wasn't] resilient enough.*" In interview, through tears, Daisy recalled the moment when she bought Aria, aged 9, her first dress, at the same time telling her she could only wear it at home.

*I will never forget the look of joy on her face. [We] were out shopping with my mum, and I saw Aria looking over at clothes. And I said, 'is there anything you really like?' And she pointed at a dress. I said: 'do you want me to buy it for you?' [Daisy starts to cry:] it was like I had just shown her the world, it really was. I will never forget that feeling, and that expression on her face. But even when I was buying her the dress, I said, 'I don't think you'll be able to wear this outside [home]'. So even as I was doing that, I was still holding her back.*

Later, at a family wedding, Daisy and her partner Keith were still insisting that Aria present as male in public. Daisy remembered the morning of the wedding; she looked over at Aria watching her older sister getting her hair curled. Silent tears were rolling down Aria's face. Daisy asked Aria what was wrong: "*she said to me, [Sister] looks so beautiful getting her long hair done, and that's never going to be me. I'm never going to have that.*" Daisy remembered deciding in that moment that she was never going to make Aria present as male again: "*I think I really understood the depths of her sadness and misery then. And I thought - wow - I'm doing this to you. Your dad and I are doing this to you. And we have to stop.*"

Like Daisy and Kate, Faye explained that she had tried to confine foster child Josh's 'transition' to home. She described how Josh, who had been expressing gender incongruent behaviour since he was three, reached crisis point aged eight, insisting he had to live as male. Faye explained that she initially negotiated a compromise: Josh could change his name at home and she would buy him some new 'boy' clothes and redecorate his room. Meanwhile, he was to continue with his birth

name and female identity at school. Faye explained she was nervous about her position as a foster carer to a gender transgressive child, and she was worried about Josh's welfare, characterising him as a "shy" and "underconfident" child. Just a few weeks later, however, Josh took matters into his own hands, and 'outed' himself at school: *"I had a phone call from one of the [school] staff saying, [Birth name] has just informed everybody he's now called Josh and he's a boy. What should we do?"*

Similarly, Elizabeth remembered trying to persuade Liam to conform at school. Liam had been wearing skirts and dresses at home since toddlerhood. However, when it came time to start school Elizabeth insisted on the boys' uniform and a male haircut: *"he was a big boy starting school. We thought it [the "cross dressing"] would stop. It would be knocked out of him, or he would realise this isn't what everyone else is doing"*. Just a few months later Liam started to insist that he wanted to wear the girls' uniform instead. Elizabeth tried to stall. She told Liam to wait; if he still felt the same by his fifth birthday, she promised to talk to the school. Months went by, and Elizabeth assumed that Liam had moved on. Then, a week before his fifth birthday, they were out shopping for new school clothes, Liam suddenly reminded his mother of her promise. According to Elizabeth: *"he said 'don't forget it's my birthday next week, so why are you buying me more trousers?' So, he hadn't forgotten! He'd just kept it in his head. He said, 'you've got to keep your promises'."*

Honouring her promise, Elizabeth set up a meeting with the school. Elizabeth recalled the headmistress being "uncomfortable" and reluctant to grant Liam's request, suspicious of Elizabeth's role in encouraging him. The headmistress asked to meet with Liam without his mother present, and also requested an independent consultation with Liam's clinician.<sup>20</sup> Elizabeth was happy to facilitate these meetings, although she found the headmistress's concerns absurd: *"as if I would be the one wanting [this]! I'm supportive, but I worry about bullying and what the future holds. It's not something I would choose!"* Ultimately the school agreed. At interview, Liam (age 7) had been wearing the girls' uniform ever since. Elizabeth explained that she was continuing to buy both sets of uniform in case Liam should ever change his mind: *"every now and then I'll say to him – do you want to put the boys' uniform on? He never says yes, but he knows it's there. So, he's got a choice. It costs me a fortune."*

Sophie faced similar suspicions from Isla's school. Sophie had been allowing Isla to 'live' as female since she was 6, after seeking advice from CAMHS. (Isla was known to CAMHS having been previously assessed and diagnosed with ASD). Sophie wanted to know whether Isla's gender

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<sup>20</sup> By this stage Liam was having appointments with GIDS, who offered the school advice.

nonconforming was “just another obsession”. Sophie recalled the clinician telling her “no”, that Isla’s female gender expression was “too pervasive”. The advice Sophie was given left a strong and lasting impression: *“you won’t change the outcome. Isla will be whoever Isla is going to be. All you can do is make him or her happy or unhappy along the way”*. At that moment Sophie made up her mind to support Isla to live as a girl: *“I said – ok you can be who you want to be”*. She added: *“up to a point. And the point was – school.”*

Sophie explained that the school refused to allow Isla to wear the girls uniform. Moreover, according to Sophie, the headmistress accused her of ‘forcing’ Isla to live as a girl: having heard rumours from that Sophie (who had an older son) had been hoping her second child, Isla, would be a girl. Sometime later, Sophie received a call from social services, notifying her that they were opening a child protection investigation: *“she said I understand your son dresses as a girl”*.<sup>21</sup> A formal meeting was set up at Isla’s school to discuss her case: *“there was the head teacher, the head tutor, social worker – can’t remember who else. There was about a half a dozen people who were in there, and me and [husband].”* Sophie remembered the headmistress repeating her allegations: *“it all came out – me making Isla be like this - forcing Isla to be a girl, act like a girl, dress like a girl!”* Sophie recalled her outrage and distress as she tried to defend herself:

*I might have said once ‘oh I’ve [already] got a boy, I’d quite like a girl’. But then we had the scan, and we found out it was a boy, and I was perfectly happy! And I said, ‘you know [Isla’s brother], can you imagine me telling him to wear a dress? Would he do it? Of course he wouldn’t! There’s no way I’m doing this. No way I’m forcing this. Forcing Isla! Really?’*

As reflected in Elizabeth and Sophie’s accounts, dominant representations of parents of openly transgender children often depict caregivers as directing children’s behaviour. Parents may be viewed, at best, recklessly permissive, or, at worst, coercing their children into assuming (trans)-gender roles and identities they would otherwise not readily adopt (Davy and Cordoba, 2020). And yet, in this study, all but one of the caregivers interviewed, recounted going through an extended period of resistance to the idea that there was anything particularly different about their child’s gender. Parents recalled cycling through feelings of shock, fear, devastation and loss, and working through a profoundly painful process of and introspection, before eventually reconciling themselves towards acceptance of their child as trans. Meanwhile these accounts are revealing of the persistence, constancy and determination with which gender variant children may apparently pursue social transition, including when faced with refusal or resistance from their caregivers.

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<sup>21</sup> Social services had received a report from a member of staff at Eli’s local ballet class, where Elli had been wearing a dress and changing in the girls facilities for some time.

### 3.3. Gender diversity and stereotyping in childhood

Suspensions concerning the role of parents in facilitating social transition in young children often centre around fears that gender stereotyping is so endemic that children who exhibit atypical (yet superficial) preferences and interests may be erroneously labelled ‘transgender’ and led down a harmful path of medical transition (Patterson, 2018). Such fears are so pervasive that they were often expressed by caregivers of trans children themselves. Arthur was critical of some of the other parents he had encountered at a support group for families with trans children: *“there was this toddler running around. Their mum thought they were transgender because they like My Little Pony!”* Hannah, whose child “came out” as a teenager, expressed scepticism about the actions of caregivers who were facilitating social transition in early childhood:

*Our child showed cross gender preferences [under 5], but we didn’t immediately start putting ponytails in, and dresses with pink tights! Because of course there are children who are gender questioning, that’s only natural. And there are lots of children who will not persist in that gender curiosity, they will eventually think – ‘actually you know, I’m a gay female, or a gay male, or I’m neither’.*

Linked to such concerns, it is often suggested that children’s experience of gender incongruence may be a consequence of their exposure to crude and limiting stereotypes about gender and sexuality (Griffin *et al.*, 2021). According to this theory, children, who are not cognitively mature enough to understand the differences between gender expression, sexual attraction and biological sex, might mistakenly perceive themselves to be the opposite gender, simply because they want to have a certain hairstyle, play with a particular toy, or form romantic attachments to particular others.<sup>22</sup> It is thought that such ideas may be especially persuasive to younger children, as well as some neurodivergent children, who may have reduced capacity to critically reflect on the basic messages about gender that they receive from their external environment (Ceglie *et al.*, 2014; Vicky Holt, Skagerberg and Dunsford, 2016). Indeed, this is one of the theories that has been frequently offered to explain the high co-occurrence of autism spectrum condition (ASC) and transness in childhood (see Wattel, Walsh and Krabbendam, 2022) (a powerful empirical trend also observed in this study, see Figure 4).

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<sup>22</sup> This was an opinion expressed by clinicians interviewed for this study.



As well as children with neurodevelopmental differences, concerns have been raised about the situations of lesbian and gay children whose gender non-conformity may be an early expression of their developing sexuality. There are fears that growing visibility and acceptance of transness in childhood may be driven by homophobia (Patterson, 2018; Griffin *et al.*, 2021). This is a view that is prominent in the public discourse surrounding social transition, and one that is shared by some clinicians, including within GIDS (Cass, 2022).<sup>23</sup> Elizabeth explained that Liam’s clinician told her there was a “95 per cent chance” Liam would realise he was gay once he started puberty: “[she] said...that’s what’s driving this feminine side of him – he just doesn’t know how to express [his sexuality]. I can well believe it’s likely.”

It follows from these concerns, that one ‘solution’ to the distress caused by gender variance may be to work with individual gender incongruent children to expand their definitions and understandings of both gender and sexuality, whilst advocating at a societal level to eliminate the harmful social stereotypes that have led to children’s confusion. This philosophy is at the heart of GIDS’s approach to providing assessment and support for GD children, particularly their practice of psychotherapeutic ‘exploration’ (discussed in depth in Chapter 6), where emphasis is placed on encouraging young people to embrace more ‘curiosity’, ‘complexity’ and ‘ambiguity’ in exploring their gender identity. Wren (2014) writes:

In the individual and family psychotherapy offered at the clinic, a very open exploration of possibilities is advocated, promoting the idea of tolerating and living with conflict and contradiction. However, working with these gender dysphoric children and young people, the non-trans clinician may sometimes struggle to fully grasp the *determination of otherwise rational and reflective young people to define themselves irreversibly*. (p.272) (Emphasis added)

Yet, despite their popularity, there is a lack of empirical evidence underpinning theorisations that link gender incongruence to inflexible cognition and gender stereotyping; in fact, the very few studies that have sought to investigate a link (most particularly in context of ASC diagnosis) have typically found no association (Wattel, Walsh and Krabbendam, 2022). In contrast to these ideas, one of the most striking aspects of the data gathered in this study (both through the survey and through interviews), was the complexity and sophistication with which GSD children and youth appeared to incorporate ideas about gender, sex and sexuality into their self-concepts, and the diversity of different identifications expressed by children and young people within my sample.

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<sup>23</sup> This was a view often raised by clinicians interviewed in this study.

### 3.3.1. Gender categories and self-concept: evidence from interviews and the survey

In general, there was widespread consensus amongst young people and caregivers on the pivotal importance of challenging gender stereotypes and creating space for diversity. Sentiments about the desire to complicate, or even eliminate, fixed gender categories were often reflected in interviews with young people and their caregivers. This was especially important for young people who expressed a gender neutral or genderless identity, who often asserted their desire not be defined by gendered categories:

*I've basically just stopped thinking about my gender, and I just don't really consider myself as having a gender really. (Aaron)*

*I just want them to see me as a person instead of a label. I don't really like that. (Jacob)*

*I don't see myself in binary terms. I like to think of myself as 'post-genderist'. I don't want to be in the binary, and that's why I don't identify as a trans man. (Finley)*

*I like the word queer because it's deliberately vague, and although I have tried out using different labels on myself- like non-binary, or gender fluid – ultimately, I feel like those haven't quite felt right, whereas, queer has space for being unsure, and being not quite confident, which I think is often how I feel about my gender. (Franki)*

Amongst the younger cohort, there were several children who were expressing fluid and complex gender configurations; these children didn't appear to fully embrace or identify with either sex: “some days he's one, and some days he the other. Not that he hasn't got a gender, but he's got two genders – or anything in-between. I can't seem to get it right sometimes!” (Elizabeth) Parents of children, such as these described how they found themselves navigating a complex and unpredictable middle ground, where the need to ‘de-gender’ objects, events and activities felt particularly paramount. Kate explained:

*It feels quite important to let Jamie be the kind of gender expansive person that he is. I suppose that's what I've learnt over these last couple of years – not to replace one set of stereotypes with another. The ideal for [Jamie] is just not to be made to choose. It's not helpful for him to have to align himself with either gender. It doesn't seem helpful to have this polarised situation. Having gender neutral everything – that would be the ideal.*

For other children and young people, however, (binary) gendered categories remained foundational and salient aspects of self-concept. Indeed, the majority of children and young people included in the study identified mostly, or completely, as either male or female. In the youth survey, around two thirds (65.07%) of trans youth identified as primarily male or female,

and roughly half (48.91%) identified exclusively within these terms. Melanie expressed her frustration about some of the questions she was asked at GIDS, which she felt were geared towards persuading her that she might, or could, be gender fluid or non-binary rather than a transgender girl:

*It annoyed me because I'm trans. I want to be a girl. I didn't think I could be gender fluid or something. Like – you know when you're trans! It wasn't just the one time it was every other time [you go] they'd ask you. It gave me the impression that they didn't think I was trans or something. I felt [annoyed] because I knew myself.*

Joe dismissed the view that he was confused about his gender and lacked self-understanding and knowledge because of his ASC diagnosis:

*I think doctors like to diagnose so they want to know the reasons – they want it [transness] to be caused by something - you struggle with identity or you don't have a good sense of self. For me I have a great sense of self: I know who I am and I know that I'm a man.*

Yet, contrary to portrayals of gender variant youth as deterministic and resolute in their conceptions of gender and identity, young people typically expressed sophisticated, multifaceted and complex ideas about gender, sex and sexuality. Whilst maintaining a strong sense of their own identities, young people shared a variety of different perspectives on gender; they were keen to emphasise the differences between gender identity, social roles and modes of expression (as well as their intersections), and reflect on the various biological, social, cultural and relational aspects of gender:

*People say gender is a spectrum. I think it's more complicated than that - more like a constellation of stars or like a galaxy or something. Like certain gender identities can be linked together, but there is just so many different ways to feel gender or to see gender. We don't know why we feel gender. (Nell)*

*I mean it depends on what you pin down as femininity.. People think it's like 'oh yeh, makeup and dresses', except that's not really a requirement for being a woman is it? I mean tomboys exist and they're still women. (Jennifer)*

*I feel like I understand my gender in terms of community and in terms of people who get me in ways that other people don't. I like the word queer because it has a lot of ambiguity and it has a lot room for manoeuvre, which is often how I feel about my gender. (Franki)*

*The language around 'I feel born in the wrong body' seems to me to be like a common lay man's understanding, like this is the book, you get it, we can go from here. But that actually doesn't capture what I feel to be the nuance of my gender. In a way, I sort of want to forget the body, and lose the trappings of my body and just see the body as a tool for expressing what I feel to be my gender. I just feel this desperation for people to just see me as I am. And it's just really hard to*

*communicate that to people. And it makes me feel incredibly safe when I feel people do see me that way. (Finley)*

*I do feel like I fit [as female] although what's going on inside [my body] doesn't quite match-up. That's ok with me. It just seems so black and white in text-books, doesn't it? It's either this or it's that and there's no middle area but in real life that's just not the case. (Olivia)*

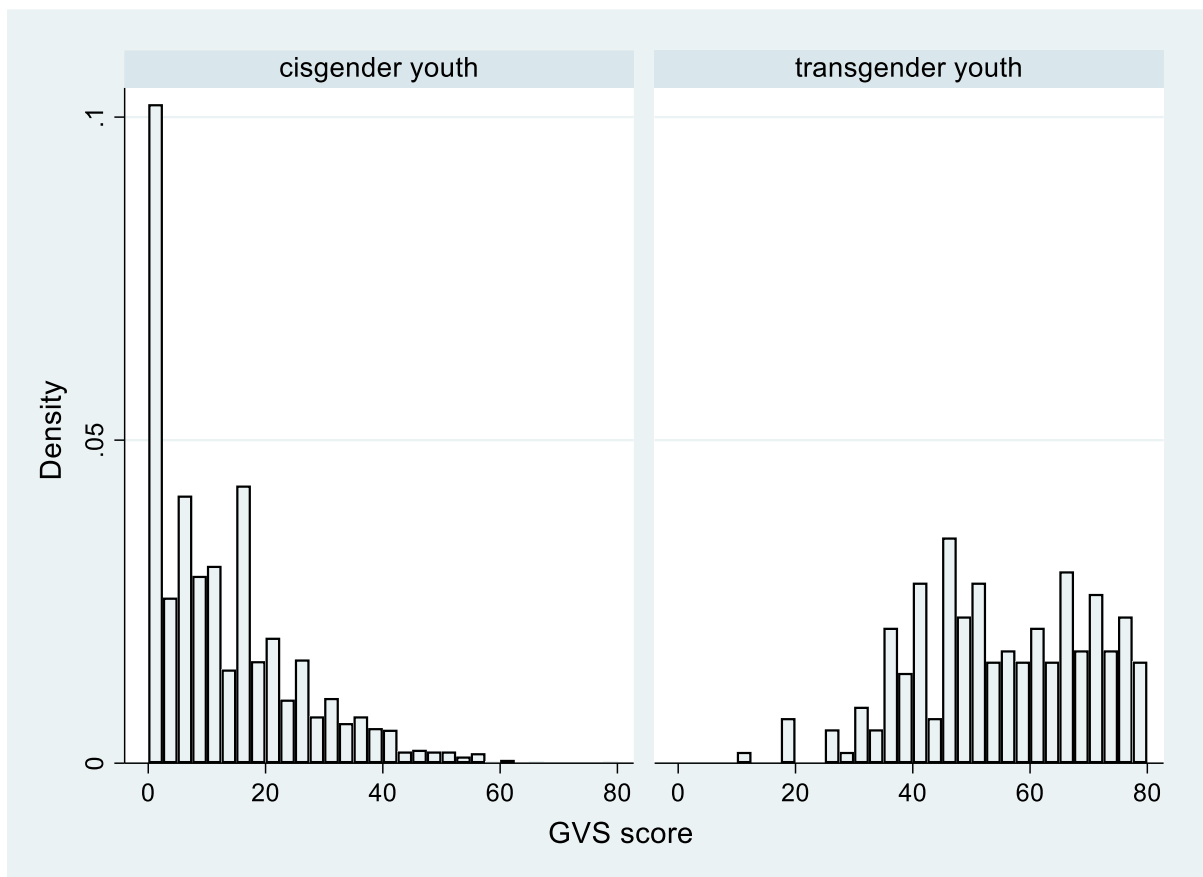
In fact, evidence from the survey indicates that trans youth, may be *less* likely to incorporate same-gender stereotypes and generalisations into their self-concept, when compared to their gender typical peers (especially cisgender boys). Two of the subcomponents of the GVS asked young people to rate the extent to which their ‘interests’ aligned with those of a typical ‘man/boy’ or ‘women/ girl’; and the extent to which they would say they ‘do’ things in the manner of a ‘typical’ ‘man/boy’ or ‘women/girl’. Cis- boys were significantly more likely than trans boys to identify their interests ( $t(734)=4.35, p<0.00001$ ) and behaviour ( $t(735)=6.64, p<.00001$ ) as normatively aligning with those of a ‘typical man or boy’, and significantly more likely to differentiate their interests ( $t(735)=-2.68, p<.01$ ) and behaviour ( $t(738)=-6.29, p<.00001$ ) with what is ‘typical’ for women and girls (Table 5). Less difference was observed between trans and cis- girls in terms of how they viewed their interests; however, cis- girls were significantly more likely than trans girls to identify their behaviour as conforming to what is ‘typical’ for a woman/ girl ( $t(946)=2.85, p<.005$ ). Overall, cisgender youth were found to have more ‘polarised’ GVS scores, with 17.35% of cisgender youth having an ‘absolute’ gender typical/ conforming score of ‘0’, compared to just 2.62% of trans youth having an ‘ideal’ transness score of ‘80’ (Figure 5).

*Table 5: Self-perception of gender-typical interests and behaviour: gender typical vs transgender youth*

	Sample	Mean	Difference among means	P value
On a <b>scale</b> of 1-9 where 1 means “not at all” and 9 means “completely”, to what extent are your interests those of a typical boy/ man?				
Gender typical boys	631	7.48	1.07	<.00001
Trans boys	103	6.41		
Gender typical girls	895	3.94	0.12	0.76
Trans girls	51	3.82		
On a scale of 1-9 where 1 means “not at all” and 9 means “completely”, to what extent are your interests those of a typical girl/ woman?				
Gender typical boys	632	2.44	-.67	<0.01
Trans boys	103	3.12		
Gender typical girls	896	6.27	0.58	0.12
Trans girls	51	5.69		
On a scale of 1-9 where 1 means “not at all” and 9 means “completely”, to what extent would you say you “do” things in the manner of a typical boy/ man				

Gender typical boys	632	8.10	1.10	<.00001
Trans boys	103	7.00		
Gender typical girls	894	2.70	-.38	0.19
Trans girls	51	3.08		
<i>On a scale of 1-9 where 1 means “not at all” and 9 means “completely”, to what extent would you say you “do” things in the manner of a typical girl/ woman</i>				
Gender typical boys	632	1.77	-1.06	<.00001
Trans boys	103	2.83		
Gender typical girls	895	7.17	0.80	<.005
Trans girls	51	6.37		

Figure 5: GVS distribution for cisgender compared to trans children



According to caregivers, even the youngest children – despite often exhibiting hyper-gendered interests and modalities of behaviour – expressed sophistication and depth in their contemplation and navigation of the complex social meanings of gender:

*We were surprised how, aged 5, our daughter had a very nuanced understanding of gender. Because she'd had to navigate these different environments and persuade other people to accept her gender, she was very aware of pronoun usage and how people regard any sort of division of gender, however small. She was hyper aware of that.* (Chloe)

This was also reflected in the imaginative ways that younger children tried to account for their gender incongruence, which conveyed conceptions of gender as contingent, non-linear, layered and unstable. At age five, Liam reportedly declared to his mother, Elizabeth, that while he was “in [her] tummy”, a witch had cast a spell to change him into a boy. When Elizabeth asked what he meant by this, he allegedly replied this must have happened because: *“his head was a girl’s head, but his body was a boy’s body”*. Elizabeth reflected: *“He’s obviously trying to rationalise it somehow, because at other times he says to me ‘why am I like this? Why is it? Why me? Why am I...? Why can’t I...?’ So – I think he tries to find a reason for it, and at [age] five – that [witch] was the reason.”* Similarly, Arthur recounted how, age four, Melanie had told him that there had been a *“mistake in mummy’s tummy”*. Melanie told her dad that her sister was meant to be born a boy, and she (Melanie) was meant to be a girl, but there had been a “mix-up” and they had been swapped. Arthur chuckled: *“I didn’t explain to her that they weren’t in there at the same time.”* One afternoon Jamie asked his mother why he was “born one of the humans”. He went on to muse about the various beings he could change into *“I wish I could change into something else. I wish I could be – um - a fish? Oh no, then I’d get caught and eaten. A shark could eat me. I don’t know what I could change into. I just have to say, being me, I know I could change into a girl.”* (Kate)

Caregivers also demonstrated a tendency to thinking critically about and challenging gender stereotypes and norms:

*[Melanie] always wanted to wear dresses, but I don’t think that’s really a sign because they’re just clothes. You’re not born with an innate need to wear a dress if you’re a girl, are you? It’s just a piece of material. People wore dresses in different times, so I didn’t see that as a sign.*

Sometimes caregivers would interrupt their accounts of their children’s gender expression to clarify their position on gender stereotyping:

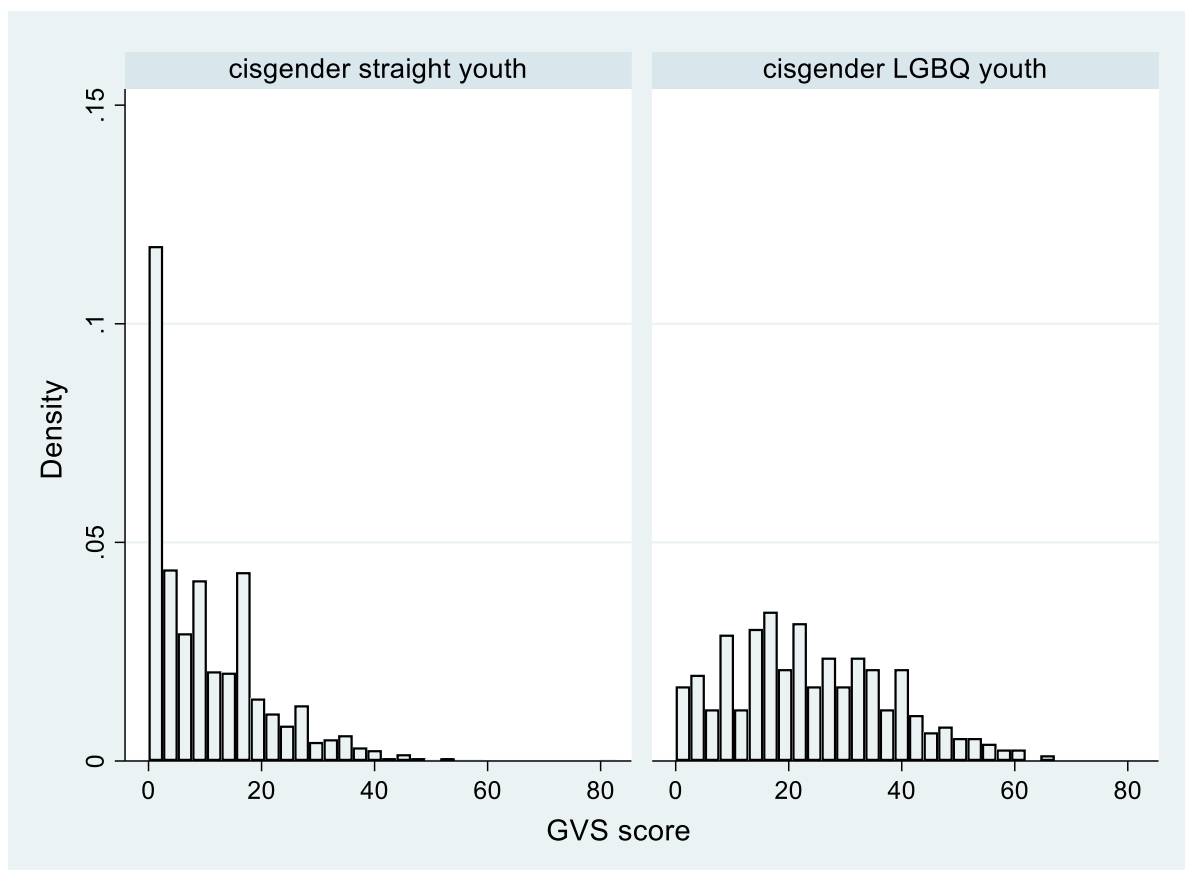
*So, Isla would choose - I always say the ‘girl toys’ – but things people would traditionally associate with girls. This is not my personal belief, but I’m sure you know what I mean.* (Sophie)

*When you have a boy who is expressing - sorry it’s so difficult because you get wrapped up in your own language, because I want to say ‘expressing female traits’ but I don’t think they are female - but, you know, stereotypically.* (Kate)

### 3.3.1. Gender diversity and heteronormativity.

Similarly, cutting against theories which associate transness in childhood with rigid (heteronormative) ideas concerning sexuality, conversations with young people about sexuality were also varied and complex. On the one hand (reflecting clinical perspectives) evidence from the survey and interviews indicates an intersection between sexuality and gender. In interviews, young people sometimes recalled that questions about gender had started with questions about sexuality: *“when I was about 9 or 10 I was questioning my sexuality, and that led on to me questioning my gender”* (Jacob); or, the reverse: *“about a year or two before I came out [as trans] I did come out to my parents as bisexual because I thought, there’s something wrong with me. It’s dysphoria of some sort.”* (Layla). Meanwhile, in the survey data, a powerful association was observed between the GVS and LGB attraction (see Annex 2): with significantly higher levels of gender variance observed in the (non-trans) LGB population compared to the straight cisgender population ( $r=-13.61$ ,  $p<.00001$ ).

*Figure 6: Distribution of GVS amongst ‘straight’ compared to LGB youth*



Nevertheless, cutting against concerns that trans children are gay youth, driven by homophobia, to seek out gender transition in order to ‘become straight’, young people in this study expressed a variety of sexual orientations both before and after transition. Furthermore, according to young people’s narrative accounts, the process of coming out as transgender often led to an ‘opening up’ and complexation of their ideas about sexuality. For example, Alex identified as ‘straight’ prior to his social transition: *“I was attracted to guys”*. Subsequent to ‘coming out’, he decided, that gender mattered much less than he thought it did in terms of who he was attracted to: *“now I try not to label it at all. Labels confuse me. I fall for who I fall for and nothing else comes into it.”* Alex initially came out as lesbian, before transitioning to male. At the time of interview, Alex had a boyfriend. He explained that socially transitioning had given him a newfound confidence in himself and in his sexuality:

*Now I’m just chilled with whoever. Ah man, it’s great, ’cos ever since I’ve come out, I’ve just got so much confidence in every single way. Before I came out, I was like terrifyingly shy, I couldn’t talk to anyone, and now I love talking about myself all the time! [laughs] But, yeh, now I like having relationships with cis and trans people – anybody.*

Valerie and her girlfriend Layla, both transgender women, had both considered themselves bisexual before transitioning to female. Now in a relationship with each other, they discussed how



their own transition, and meeting other trans people, had caused them to disregard the importance of sexed bodies in defining sexual and romantic attraction:

*I've realized that I don't really care what's in your pants, as long as we click, a relationship can form. There's no need to worry about the intricacies. If I get on with somebody that's all you really need to start a spark. (Valerie)*

*I don't think it really matters about putting a label on anything. I don't know why people are so obsessed. There's seven billion people in the world, three and a half billion are men, are you saying, there isn't a single one that you wouldn't consider? There's always an exception to every rule. I don't think that anybody is 100% straight or 100% gay. (Layla)*

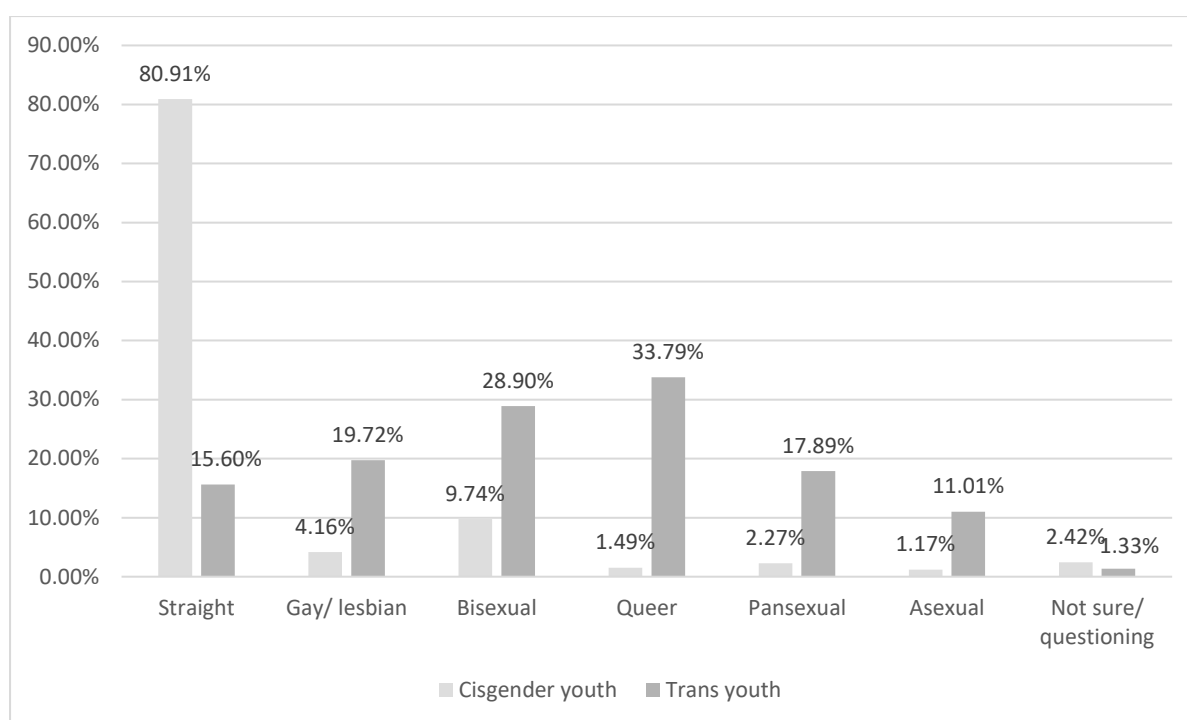
These accounts, with their emphasis on the dissolution of meanings, labels and categories, resonate with the writings of theorists such as Butler (1990) who have explored how (hetero/homo/bi)-sexual practices are produced through the framework of naturalised binary gendered categories, and vice versa.

Indeed, recently concerns have amassed that a rise of trans identities may lead to lesbian and gay erasure, on the basis that, without definitively 'sexed' bodies, there can be no 'same-sex' attraction.<sup>24</sup> On the surface young people's accounts might be perceived as lending weight to such a proposition. And yet arguably, the fallacy of this ideological account of human sexuality, is its insistence on defining minority sexualities exclusively in heteronormative terms. According to such a perspective, gay and lesbian sexuality is necessarily derivational: the binary, oppositional 'other' of a dominant heterosexual norm. Meanwhile, empirically, while the disintegration and diversification of gendered categories may be associated with a similar disintegration and diversification of sexual terms, this process is not seen to be associated with the erasure of LGB identities, but rather an expansion and multiplication of young people who identify with these, along with a variety of other, non-normative identities. For example, in the youth survey, more than 2 out of 5 (43.58%) of trans youth identified under an 'LGB' umbrella, compared to just over 1 in 8 (12.93%) of non-trans youth. Trans youth were 5.7 times more likely to identify as 'gay' or 'lesbian' (OR=5.67, z=8.15, p<0.001); and 3.8 times more likely to identify as 'bi' (OR=3.77, z=7.69, p=0.00) than cisgender youth. Cisgender youth were as much as 23 times more likely to identify as straight (OR=22.94, z=15.85, p<0.001), compared to their transgender peers.

*Figure 7: Young people's descriptions of their sexuality by gender typicality*

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<sup>24</sup> E.g. see written evidence submitted by the *LGB Alliance* for the UK Government's 2022 consultation on proposed reforms to the Gender Recognition Act. <https://committees.parliament.uk/writtenevidence/17828/html/>. Accessed February 2023.



### 3.3.2. Gender typing and identity development in early childhood

Despite these complexities, gender variance may be associated with rigid and deterministic ideas about gender (and sexuality) when GD children express, behave and dress in hyper-stereotypical ways, or when gender incongruence is narrated or explained with reference to stereotypes. Certainly, this was a feature of caregiver accounts. Caregivers, particularly of the youngest trans children often discussed their children's preferences for gender-typed clothes, toys and activities as evidence of their emerging transness. Arthur explained how four-year-old Melanie would love to wear "fairy dresses". Anne described how Tommy was never interested in dolls and prams, and always wanted to dress in jeans and tracksuits: *"when we was going shopping, I'd be the one looking at all the girly dresses and pink-coloured stuff. He wouldn't entertain me whatsoever- it was always jeans and tracksuits"*. Elizabeth described how she was unable to potty train Liam until she bought him a pink potty: *"even from 3 we were struggling with potty training. Nursery said he uses a pink one and we only had a blue one, so I took him shopping for a pink one and then he was fine."* Daisy described how: Aria was only interested in playing with her sister's toys *"like dolls and makeup"*; she liked to "dress up" as *"princesses, or lady birds, or mini mouse"*; for her third birthday she had asked for a "butterfly cake", and during pretend play she would hold a pillow case to her head to emulate having long hair. Similarly, Sophie described how when she took Isla to play groups and nursery, she'd always pick out a dress to wear: *"he'd go for something pink. Isla wouldn't wear trousers."*

Interestingly, however, parents also often commonly described how their growing acceptance of their children's identity and willingness to take steps towards social transition (e.g. changing pronouns, allowing a change of uniform at school etc.) was accompanied by a relaxation in their children's role rigidity. They attributed these changes to their children finally receiving the recognition and acceptance that they were seeking. Lucy explained how Amber, used to insist on wearing pink "lurex dresses", lately she had shifted to more "neutral" clothing: *"it [was] all very pink, and incredibly gendered. She still is girly, but, you know, it's settling down"*. Kate remembered how once she and her partner had started allowing Jamie to wear skirts and dresses, he stopped being so particular about clothing choices: *"so he doesn't mind what he wears as long as they are girls' clothes. [Before] he always wanted to wear pink tutus."* Kate reflected on this change:

*I think was a kind of insistence that he be recognised for who he is and was. Now he has been recognised, it's not important. He's finally been heard, and therefore, the external stuff is external: it's not the core of what he was trying to say, it's just that was his only means of trying to express that.*

According to Sophie, Isla refused to ever wear trousers until her parents accepted her female identity. After being allowed to socially transition, Isla became much less preoccupied with clothes; she also started expressing interest in a broader range of toys and activities:

*[Sophie] You went through a very girly phase, and I think that was just you trying to assert your identity. Once – my feeling is that once we accepted your identity, you kind of relaxed, and went 'ok, they've got it now'.*

*[Isla] Give me the legos!*

*[Sophie] I spent the last 4 years telling them I'm a girl!*

*[Isla] Ok. You get it. Give me all the legos!*

*[Sophie] And the dinosaurs! And Thomas the Tank Engine. And the blue clothes! Because Isla wasn't fighting anybody any more to prove that she was really a girl, that all fell by the wayside basically.*

Neatly illustrating these dynamics, Chloe and George shared an anecdote about a children's party they had taken Mia to, where the girls and boys were given different party bags. They remembered how Mia was overjoyed when she was given the 'girls' party bag. At the same time, Mia was annoyed about its contents, which she considered less fun and interesting than those contained within the boys' bag: *"she realised the flower was the rubbish option. She wanted the sword, but because the girls were given the flower, she was made up – absolutely made up. It was like – acceptance."*

As well as becoming more relaxed in her gender expression, after being allowed to social transition, Mia allegedly became much less 'fixated' on issues related to gender:

*Overnight, from wanting to talk about her gender every day, every night, and being desperately unhappy, she just wasn't anymore. She was just like, 'right fine, let's get on with it!' And then [she] started talking about other stuff. How do turtles swim, and how do rockets do it. Suddenly a normal kid talking about normal stuff.*

George and Chloe described how Mia's shift in focus left them feeling relieved but also "lost". They had become so used to these nightly conversations about gender and anyway they felt they should continue to discuss these issues, to make sure that Mia was still feeling the same about her social transition:

*Once we said 'ok we'll call you a girl', she was just, 'oh I don't want to think about that'. She wasn't interested in talking about it. [We felt] like we needed to continue to bring it up, asking her, 'if you decide that you'd like to be a boy, then, you know...' And she would just tell us that was ridiculous: 'don't talk about that, don't be daft!' And we still check in, you know: 'some people feel like this now, and then when they grow up they decide..' and she's like 'not me!' (George)*

Similarly, Kate explained how Jamie's transition to wearing girls' clothes was associated with a decrease in his interest in discussing his gender: "*we don't really talk about it very often now. [After] having to talk about it every night, it being the only thing he could think about and talk about, he now says 'why does it matter?'*". Interestingly, Kate explained how she had initially assumed that Jamie would want to be slowly moving towards a more complete social transition, including a change in pronouns and name. However, after making the changes Jamie was demanding (including wearing the girls' uniform at school) he had ceased insisting that he wanted to 'be' a girl. At interview, Kate estimated that it had been around two years since Jamie (9) had said that. She explained:

*He now says – so the quote is – 'I don't care whether anybody else is a boy or a girl. Why does it matter what I am? I just want to be me, I just want to be Jamie'. And so – it may be that Jamie is non-binary, it may be that he's going to be gender fluid, it may be that he is gender expansive. Who knows who Jamie is, but I feel very strongly, that he needs to be who he is. So, we are doing this very confusing to other people, sort of grey area. So, he wears whatever he wants to wear, and that is always girls' clothes. But he's never objected to male pronouns.*

As reflected in this passage, Kate was the caregiver who appeared to be most closely modelling GIDS's ideal of tolerating 'contradiction' and relaxing gender roles and expectations. Yet, Kate found herself at odds with the clinician she was seeing to guide and advise her about Jamie's gender development. Kate, who had been seeing this clinician for a number of years, reflected on her viewpoint:

*I suppose from her perspective – Jamie's not saying he's a girl, so why did you bother doing this? You're just going to create problems. She points out – once you take the step to transition, then you come up against [other] things like toilets, like PE at school. That child kind of then aligns*

*with the other gender totally, and there is no research to indicate what impact that will have. I think her fear is that huge numbers of children will grow up to identify as transgender and will undergo surgery and hormone treatment and had they not been allowed to [socially transition] they may not have ended up in that place. She says – wouldn't it be better if it was more possible to be more gender fluid, without feeling that you needed to change your body to identify as another gender, simply in order to be able to express yourself? Because society's expectations of each gender are so narrow and stereotyped. So, if you are a little boy who likes wearing princess dresses and playing with girls and doesn't like doing things that boys are supposed to like, like playing football and playing guns, wouldn't it just be better [if] you could just still be a boy? And you could play with dolls, and you could wear whatever you want, and you could be the person that you want to be, without thinking that the only way you are acceptable is if you actually assert that you are a girl.*

This passage neatly illustrates the key assumptions and logic chains that underwrite criticisms of 'social transition' in early childhood, as well as their central contradictions. On the one hand, it is contended that aspects of social transition are best avoided, because (the logic posits) one element of social transition (wearing female clothes), leads to another (using the female bathrooms), and so forth, gradually producing, solidifying and confirming an (undesirable and otherwise avoidable) binary transgender identification. On the other hand, it is, paradoxically, suggested that a child should be supported to understand that they may express themselves (through dress, play, activities etc.) in ways that challenge and debunk the social and cultural norms and roles associated with their birth-registered gender. How then are these two competing goals to be reconciled?

Ultimately such perspectives are best understood through a lens that simultaneously assumes, yet renders invisible, a shared norm that children's gender identities, roles and modes of expression will always align with their natal or assigned sex. Because gender-typicality in childhood constitutes the 'unmarked norm' – that which goes unnoticed and unseen – demands that a child conform to dominant gender norms are able to be (deceptively) reconstructed as efforts towards 'de-gendering' childhood: towards liberating children from the clutches of oppressive gender norms. This framing is in turn supported by the construction of 'childhood' as a state of gendered innocence, an ideal that sits neatly within the broader phantasm of the passive, asocial and pre-cultured child (Prout and James, 2015).

### 3.4. Conclusions

The accounts shared by young people and caregivers in this chapter offer a rare insight into children's lived experiences of sex and gender variance, which have implications for advancing understandings of gender variant identity development, and sexed embodiment in childhood.

They demonstrate the deep psychic investment in embodied gender (incongruence) that children may acquire from the earliest years of childhood (e.g. Jamie, Blake and Isla), and the distress sometimes caused to children who are unable to express their identities and have them externally validated (for example, Aria and Mia). They challenge widespread presumptions, often reflected in the clinical literature, that ‘naturalise’ gender-typicality in early childhood, and root children’s development of gender identity (/constancy) in their acquisition of objective and fixed knowledge about the physical manifestation of their bodies (e.g. Ruble *et al.*, 2007; Zmyj and Bischof-Köhler, 2015).

Reflecting this literature, clinical measures of gender identity development have typically focused on children’s successful completion of developmental objectives, defined by normative understandings of gender and the body that have been read as singular and universal developmental truths. For example, the *Ages and Stages* questionnaire, used by the NHS to evaluate children’s development at age 36 months, includes the instruction to parents: ‘using these exact words, ask your child “Are you a girl or a boy?”’ Parents are then asked to record whether their child ‘answers correctly – ‘yes’, ‘sometimes’ or ‘not yet’ (ASQ-3, p.5).<sup>25</sup> This question is revealing, not only because it demonstrates that from the earliest years of life children are expected to be able to articulate a gender identification, but also because it poses only one possible form that this may take: an identification which aligns with their given sex; thus seamlessly demonstrating Butler’s (1990) claim: ‘because certain kinds of ‘gender identities’ fail to conform to those norms of cultural intelligibility, they appear only as developmental failures or logical impossibilities from within that domain’ (p.24). Yet the narrative accounts of childhood gender diversity, explored in this chapter, demonstrate how children are not just passive objects of acquired knowledge about gender and the body, but active participants in the creation and negotiation of embodied gender meanings, and the adoption of gendered subject positions, sometimes generating unanticipated forms of diversity.

How and why children come to adopt gender atypical subject positions is not well understood. One dominantly held perspective, that influences clinical practice in the UK, is that children’s ideas and behaviour may be caused by the acquisition of rigid and limited (binary) gender beliefs (also influenced by homophobia) (Patterson, 2018; Griffin *et al.*, 2021). It is further suggested that caregivers may play a dominant role in influencing, validating and reinforcing these ideas through

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<sup>25</sup> See <https://agesandstages.com/products-pricing/asq3/> accessed November 2022.

enabling gender nonconforming children to undergo aspects of social transition (Wren, 2019b). By contrast, in this study, GD children and youth appeared to express particularly complex and sophisticated ideas about gender and sexuality relative to SGT peers. Meanwhile, children were described as persistently and steadfastly pursuing transgender subject positions in the face of protracted refusal or resistance from caregivers.

On the other hand, caregivers did often narrate children's gendered experience with reference to apparently crude stereotypes (e.g. Liam always wanted the pink potty, Melanie always wore fairy dresses, etc.). These narrative descriptions, particularly when mobilised to justify an understanding of a child's gender, may present as troubling; certainly, an extensive body of gender literature has pointed out the arbitrary and culturally contingent nature of gender stereotypes and roles (Lawford-Smith, 2022).

Yet, (hyper)gender-typed behaviour and expression is pervasive amongst (young) children, regardless of gender typically, and, amongst cisgender children, this is understood to be a normal part of how children learn about and explore gender (Martin and Ruble, 2004). For example, a body of psychological research tracking early childhood gender development among gender-typical children has observed that children are motivated to learn about gender concepts and norms, and that, as their awareness and understanding of gender-related information increases, children move through phases of rigidity and flexibility in their adherence to gender related beliefs and stereotypes (Ruble *et al.*, 2007). There is broad scientific consensus that children are able to observe differences based on gender as young as 18 to 24 months of age, and that around this time children start expressing preference for gender-typed toys and activities, with boys typically choosing stereotypical masculine toys and play activities (such as trucks, trains and toy weapons), and girls selecting stereotypically feminine toys and play activities (such as dolls, tea parties and dress up) (Carone *et al.*, 2020). These patterns become more pronounced as children grow and typically reach peak in middle childhood, where children are often most rigid in their ideas about gender stereotypes (Martin and Ruble, 2004). By age six, most children are thought to have a permanent sense of their gender: referred to in the clinical literature as 'gender constancy' (Ruble *et al.*, 2007).<sup>26</sup>

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<sup>26</sup> Whilst the research on gender identity development tends to assume gender typicality, a recent study conducted by Olson, Key and Eaton (2015) found that transgender children show gender preferences mirroring those of cisgender children, such that in early development 'transgender youth are statistically indistinguishable from cisgender children of the same gender identity' (p. 467). Indeed, interviews with caregivers contained illustrations of all the key markers of gender constancy and cognition which have been identified in the clinical literature as pervasive amongst gender typical children. (e.g. preferences for same-gender activities, clothing and peers and gender stereotyped knowledge).

When viewed from this perspective, what is curious is not the gender-role rigidity of gender variant children, but the tendency to pathologize or exceptionalise childhood gender performance only where it confounds the assumption that a child's development of gender cognition markers will be logically determined by their natal sex. Also curious are the different theorisations of the aetiology of gender identity development that have been used to explain the gender development of trans compared to cisgender children in clinical settings. For example, within the psychological literature that has explored gender identity development in gender-typical children, gender 'beliefs' are not generally understood to be causally related to a child's core perception of him or herself as male or female (e.g., 'gender beliefs are not plausible causes of constancy' (Ruble *et al.*, 2007, p.1128); 'a child's gender identity is distinct from the gender stereotypes the child harbours' (Perry, Pauletti and Cooper, 2019)). Instead, gender stereotypes and beliefs are understood to develop alongside a child's growing awareness of the social salience of gender. Similarly, gender-typed behaviours and preferences are not commonly thought to precede children's identification with a given gender category. Rather, it is the acquisition of gender identity and gender labelling that is understood to lead to the adoption of gender-typed attitudes and behaviours, as these attitudes and behaviours become the modes of expression through which children explore, communicate and learn about gender (Martin and Ruble, 2004).

Interestingly, whilst amongst cisgender children, gender-typed play and enactment is understood to increase with children's developing understanding of the social relevance of gender and their acquisition of gender labels, research has also indicated that as children become more confident in their understanding of the 'permanence' and 'stability' of their gender (e.g. 'a boy who puts on a dress and a long-haired wig is still a boy even though he resembles a girl'), gender role rigidity begins to relax (Ruble *et al.*, 2007; Yogman *et al.*, 2018). Indeed, it is this understanding of the trajectory of gender-role rigidity that appears to resonate with the accounts shared by caregivers and young people in this study. According to caregiver's accounts, accepting children's expressed/experienced gender and facilitating social transition preceded a relaxation in children's performance of gender stereotypes roles.

These insights are integral for understanding relationships between clinical practice and GSD children's wellbeing, matters which are taken up further in the chapters that follow. For the children discussed in this chapter, experiences of gender (variance) appeared to be deeply felt and profoundly personal: fundamental to their imaginings of 'self' (both present and future), and experiences of bodily being in the world. According to participants' accounts, these children



experienced profound distress when they were denied external recognition of their internal selves, and were required to conform to extraneous expectations informed by naturalised assumptions about gender and sex.

## Chapter 4 “They have certain expectations about [your] body”: encountering gender and sex diversity in general health services

This chapter explores the experiences of GSD children and youth and their caregivers in general healthcare settings in Britain, with special regard to the role of General Practitioner (GP) surgeries. Whilst GSD youth may require health services for reasons related to their sex/gender variance, like any young person they will also need support for routine reasons (standard screening, check-ups, vaccinations, etc.) as well as treatment for acute conditions or chronic illness unrelated to gender/sex diversity. Indeed, the intersecting health vulnerabilities of GSD youth observed in the youth survey (i.e. high reported rates of disability and mental health needs) highlight the particular dependency of these young people on a broad range of services. GPs provide a particularly pivotal role as expert generalists who are tasked with taking a broad and holistic view of young people’s health needs across a diversity of axes, incorporating aspects of physical, mental and social wellbeing, and making referrals, where required, for specialist care (RCGP, 2019). GPs also have an important role in facilitating specialist care, through making referrals into services such as gender identity clinics, paediatric endocrinologists and adolescent gynaecologists, as well as for providing joint care (including administering prescriptions and monitoring any side effects) for patients under Shared Care arrangements set up between specialist clinics and GP practices care (RCGP, 2019).

Evidence on GSD experience in general healthcare settings in Britain is sparse. Only a few studies have considered broad experiences of health services, including within primary care (Vincent, 2016; Rickett *et al.*, 2021). Meanwhile, research in other contexts, has identified a number of challenges faced by GSD populations in general healthcare settings, including experiences of discrimination, harassment and a rejection or denial of care, which may lead to barriers in access to and underutilization of health services (e.g. Cruz, 2014; Shires and Jaffee, 2015; Chisolm-Straker *et al.*, 2017).

This chapter is divided into three major sections. The first two sections draw on evidence from the qualitative research. Section 4.1 explores participants’ experiences in general areas of medical care (e.g. those not directly related to gender or sex diversity). Section 4.2 moves on to discussing experiences at the GP when young people/caregivers’ were seeking referrals or shared care agreements for reasons directly related to gender or sex variance. The third part of the chapter,

Section 4.3, analyses data from the youth survey; the data reveal a number of broad trends which complement and underscore key themes identified in the qualitative research. Participants' accounts indicate that GSD youth may have reduced trust and comfort in general health services (compared to SGT youth) with negative implications for their wellbeing.

#### 4.1. Experiences in general areas of medical care

##### 4.1.1. Health systems bureaucracy and administrative procedures

One of the first issues that typically arose during conversations with participants about their general healthcare experience was anxiety around chronic 'misnaming' and 'misgendering' caused by health systems bureaucracy. This was a major concern for trans youth undergoing (or wishing to undergo) social and medical transition and seeking to change the details on their medical records. Changing their name on official health records was of considerable importance for trans youth, given the frequency with which they were confronted with circumstances where their official name would be used and sometimes displayed publicly. A number of young people described experiencing health communications and sign in procedures distressing. Others recalled feeling humiliated and unsafe when, sat in a health centre or hospital waiting room, their birth name had been suddenly announced and/or displayed on a digital screen to call them in for an appointment, effectively outing them to everyone present: *"you can see the slightly shocked people in the waiting room going, 'wow what's going on here'"* (Irene). According to Dorothy, her son Alex (15), who needed to regularly see a GP for his eczema, had started to refuse to attend his appointments for this reason: *"he's not willing to go to the doctors anymore. He says – if I go for an appointment, my birth name will come up on the screen"*. Dorothy had called the practice and asked if they could use Alex's preferred name when calling him for appointments, and was allegedly refused: *"they said it's like identity fraud or something."*

According to official guidance patients have the right to change their personal details, including names, titles, and gender markers, direct with their local GP practice, without needing to go through any gender reassignment treatment. Patients may also change the name and gender on their official NHS registration documents without obtaining a Gender Recognition Certificate.<sup>27</sup> Local practices are free to set their own procedures for facilitating name changes on records, and to determine what, if any evidence, they require. However, NHS England considers it 'best

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<sup>27</sup> <https://pcse.england.nhs.uk/help/patient-registrations/adoption-and-gender-re-assignment-processes/> accessed February 2023.

practice’ to require some evidence of official name change, e.g. through the presentation of a legal deed poll,<sup>28</sup> which can create difficulties for many children and young people.

Reflecting the intentions of this guidance, in some cases young people reported being able to change their records easily, and with little perturbation or fuss: *“I haven’t had any issues. I just took my deed poll and nobody blinked an eye- just switched over. It’s all been quite positive”* (Clyde). Meanwhile, others described facing significant barriers to modifying their records, including being subject to dismissive or confrontational treatment: *“they said, ‘we go by what’s on your legal documents, so to us you’ll always be – that name’. I told them I was transgender, but they didn’t care. They just told me to go away.”* (Hugh)

Requiring an official change of name through deed poll can create particular difficulties for children under the age of 16, as the law provides that everyone with parental responsibility must agree to the change. Melanie (15) and Josh (12) had been unable to change their records for this reason: despite living with primary caregivers who were supportive of a change, they had little contact with birth parents who still retained legal responsibility. Irene was unsuccessful in changing medical records for her daughter, Raya (7), as her ex-partner, whilst reconciled to using Raya at home, refused his consent to any change on her official documents. According to Irene, this had caused a major rupture in Raya’s relationship with her GP: *“[the doctor] kept calling her [Birth Name]. The whole thing was absolutely obstructive.”* Raya, a seven-year-old with multiple developmental and behavioural difficulties, would allegedly respond by *“trying to trash the office”* out of frustration and anger: *“she doesn’t say anything, because of her autism, she just starts to dismantle the furniture.”* Irene had become so angry by what she perceived as their doctor’s intentional insistence on repeatedly misnaming and misgendering Raya, that she had resorted to attending all medical appointments with an advocate from a local trans support group, as well as audio recording all of their interactions.

Although GMC guidance emphasises that providers should ‘take care to address patients by their preferred name and title’ as a basic matter of respect,<sup>29</sup> this guidance may not always be followed in practice. Obtaining an official change to records can protect young people and their caregivers from the need to engage in potentially difficult negotiations with individual providers, as well as

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<sup>28</sup> <https://pcse.england.nhs.uk/help/patient-registrations/adoption-and-gender-re-assignment-processes/> accessed February 2023.

<sup>29</sup> <https://www.gmc-uk.org/ethical-guidance/ethical-hub/trans-healthcare> accessed February 2023.

being exposed to individual prejudice and discriminatory treatment. Irene was convinced that the attitude of Raya's doctors was a consequence of prejudice and transphobia, pointing out that they were happy to call Raya by her (previous) male nickname: *"they say they can't possibly call her anything other than what's legally her name. But then they seemed happy enough using [Nickname]."* Similarly, Ruth expressed her view that her local GP surgery were reluctant to call her son 'Henry', because of their attitudes concerning gender transition: *"It's like they cannot get their head around the fact – not the name change – but that it's a boy's name, not a girl's name."* Ruth described how exhausting she found it to constantly have to explain their situation and remind professionals to address her child as Henry:

*It just feels like unnecessary labour to have to explain things to people and ask them to do things a certain way. They just stare at you like you are crazy. And especially if it's in a public place and there's people around who can hear. Even as a parent you have to be quite thick-skinned; god knows what it's like for the kids.*

Ruth's account resonates with themes explored in broader literatures that have analysed the heavy 'emotional labour' burden placed on minority groups when they are required to navigate and negotiate normatively-coded institutional spaces, resisting everyday micro-aggressions that deny and invalidate their realities and experiences (Evans and Moore, 2015).

The complexity of NHS administration systems and the multiple different systems that store details about patients also pose a significant challenge. Each NHS system is different and able to hold different information about titles, gender markers and names; some of these may be automatically updated when a young person's changes their details at their local surgery, and others may not. Joe expressed his frustration with the situation:

*I don't think I'm ever going to feel okay. There seems to be a weird thing that not all the systems are linked up. If I went into an A&E now, it's very possible that that old name would come up. I could have had surgery and been living as male for like 20 years, but if I'm in Wales for the weekend and go to an A&E, it will come up as I'm a woman!*

Furthermore, in some systems, while young people can change their name, their options for 'titles' are limited, or required to be in-line with official gender markers. Chris explained that he had started avoiding doctor's appointments, even though he had successfully changed his name: *"but it still comes up as "Miss" when they call you in!"* Spencer was reportedly told it was simply not possible to be called 'Mr.', as he was logged 'female' on his medical records: *"they were like, 'we don't understand, we don't have that option'"*. Young people's accounts are illustrative not only of how entrenched the use of binary sex classifications are in healthcare contexts (and the forms of exclusion this creates),

but also of the bureaucratic rigidity of medical institutions, which can be structurally maladapted to making adjustments to accommodate the experiences of minority and diverse groups.

#### 4.1.2. Sex-segregated services

Reflecting this rigidity, Joe made a complaint to PALS after his local GP practice had allegedly stated that he would *“have to have a full gender change”* before they would be willing to alter his records. According to Joe, the practice explained that if he were to change his records he wouldn’t receive appropriate medical care, such as being invited to routine screenings for cervical cancer. Similarly Ezra described how the receptionist at his local surgery had tried to dissuade him from changing his gender marker on the grounds that that the practice wouldn’t be able to contact Ezra for smear tests and that he wouldn’t be able to access gynaecological exams. According to Ezra, the receptionist also added: *“people will be confused if you come in for [that]”*.

Given the current systems in place, it is indeed a matter of significant concern that trans youth may be left out of important screening and disease prevention procedures related to sexed aspects of the body: *“once they’ve changed a person’s gender on the system, they’re going to assume that they have all the body parts, as though they were assigned that gender at birth”* (Irene). In their recent ‘Position Statement: the role of the GP in caring for gender-questioning and transgender patients’ the RCGP acknowledge:

‘GPs also face difficulties with current IT systems which do not accommodate for transgender and non-binary patients in relation to referrals and screening. For example, a trans male cannot be referred for a cervical smear or to a gynaecology clinic if they are recorded as male in the practice database, despite still having female reproductive organs.’ (2019)

This is despite the fact that several pieces of guidance assert that disease prevention screening should be organ-specific and not gender-specific and that changes to a patients records should be managed in a way that facilitates screening for health risks appropriate to a patient’s physiology (e.g. GICs England, 2012; Royal College of Psychiatrists, 2013).

As well as impacting on physical health, these practices have implications for young people’s wellbeing. Young people’s accounts are revealing of how health care providers’ gendered assumptions about patients’ embodied health needs may play a dual role in either affirming or negating their embodied experiences, either alleviating or triggering experiences of discomfort and dysphoria. K explained how he no longer went for cervical screenings because of the stress caused

by providers' tendency to draw assumptions about his identity based on his body parts: *"even if they had some sort of awareness that I don't identify as the general population who usually goes in for the exam that would help. I've been and they say 'oh hi Miss..' and I'm like, 'oh – bello'..."* Furthermore, he explained that he had started avoiding medical appointments more generally due to fear that they would trigger his dysphoria: *"even probably quite essential appointments – I've not gone because of that"*. Ezra expressed a similar fear of being 'misrecognised' by medical providers, which he characterised as "dehumanising":

*Doctors still have such a reductive understanding of gender. If you are a M you must have testes etc. I just want them to call me by the right thing so that they know it's me. But when you have an F marker on your record, they have expectations about what kind of body they are going to be dealing with.*

Jennifer, who was growing breast tissue after starting her cross sex hormone therapy, said that she had been advised by her doctor that she should start getting regular checks for lumps: *"I haven't done that, because I think it's kind of awkward going in with a boy name on the register and going in for that. I just get a lot of social anxiety around that."*

As reflected in these accounts, participants described clinical encounters concerning intimate matters such as sexual activity and fertility as particularly distressing, because of the gendered nature of the scientific and medical language used, and the lack of sensitivity to GSD experiences. Daisy explained how a conversation with the GP about options for gamete freezing had been difficult and unwelcome for Aria, because it had involved using gendered language to describe male body parts and "sperm" production: *"she said, I can't touch that part of my body because [it] actually shouldn't be on me. I'm female. If I'm going to be a parent, I want to be a mum, not a dad"*. Phoenix explained how at a sexual health clinic check-up they had been asked to take a vaginal swab; Phoenix suggested it would have been more sensitive to ask them for a urine sample instead to avoid triggering their dysphoria. Andrew described how he had sought medical care after being subject to a violent sexual assault: he explained that his trauma was compounded by the terminology that was used to describe his body parts and the way he was asked to narrate the incident.

Young people's concerns about the gendering services of medical services were not limited to areas of medicine distinctly concerning the 'sexed' aspects of the body. The sorting of bodies into dimorphic sex categories in health services also appears to affect young people's experience in other areas of care, in ways that lead to exclusion. For example, Finley (non-binary and sex diverse) described how they had approached their GP for support with her eating disorder. Services in the

area were divided by registered sex: having initially been referred to male services, Finley was later told they didn't fulfil the criteria: *"it was very frustrating, especially because there isn't space for a non-binary group, right? I mean, where do I go?"* Finley explained that they wouldn't feel comfortable or safe to attend a female-only service. They felt that their issues with disordered eating would not be well understood or accepted in a support group for gender-typical girls:

*Imagine if I went to female services and said 'I see a way to be more androgenous through being thinner because I'm non-binary?' Imagine - in that setting - where it's all women talking about the pressures of the media on young girls. I don't know how well that would go down.*

Several parents raised concerns about the administration of the HPV vaccination in schools, which (at the time interviews for this study were conducted) was routinely offered in all English schools to girls (only).<sup>30</sup> Irene discussed her concerns about whether her trans daughter, Raya, would be included: *"she should be getting [it]. Whether she gets invited or not, I don't know, because she's down in the records as a boy"*. Irene pointed out that the sex-segregated policy excluded trans youth who might, in fact, be in particular need of the vaccine:

*[Trans girls] are at far higher risk of those all the other more obscure cancers, and potentially the same risk profile as gay men in terms of sexual activity when they are older. It completely makes sense to vaccinate trans girls against HPV. And I can't imagine trying to pull in your average trans boy for a smear test - it's going to be quite difficult for them to access screening.. but [they] are still at risk of HPV infection - so high risk of cervical cancers that are just not going to get caught. They should all be getting vaccinated. The healthcare system's completely unaware of this - they're like, 'all the girls over here, we're going to do this vaccine.' That's then difficult for trans [kids].*

Fiona described how Stewart had become really distressed when one day in class all the girls were called out of the lesson to get their HPV vaccine: Stewart's name was read out, despite being socially transitioned and presenting as male at school. Fiona described:

*Somebody came into the classroom and called all the girls out for the vaccination. He sat there and murmured 'I'm not a girl so I'm not going'. Unfortunately they had a temp admin person who came back into the classroom and said 'no you have to come out. You need to go and do this.'*

Fiona described how Stewart, devastated from this humiliation, had left the classroom and spent the rest of the day hiding in the loos, until he was eventually found, and Fiona was called in to pick him up.

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<sup>30</sup> The policy has now been amended. In England, girls and boys aged 12 to 13 years are routinely offered the 1st HPV vaccination when they're in school Year 8. The 2nd dose is offered 6 to 24 months after the 1st dose.



Lucy explained that her trans daughter, Amber, had anxiously asked her one day whether she would be included in the HPV vaccination programme, after hearing some girls talking about it at school. Lucy told Amber that she didn't think she would be eligible; however, she reassured Amber that she could stay home and *"take a sick day"* to avoid drawing unwanted attention: *"she'd feel a bit visible – you know – if all the girls were queuing up"*. At interview Lucy reflected that she should raise the issue with the school, knowing how important it was to Amber to be included in all activities for girls, whatever those might be: *"she would really love to have the injection, it would really validate her even more."* The idea that Amber would be 'validated' by receiving the vaccine also illustrates how medical encounters can play a role in shaping young people's self-narratives and embodied constitution of a gendered self (Paine, 2018).

Sex-segregated in-patient services were also a concern for young people. Joe described how distressed he had become after an incident where he had been admitted to a female-only ward, after presenting at A&E for crisis support due to feeling suicidal. He explained how this experience had intensified his feelings of dysphoria: *"all the nurses would say 'ladies' and all that stuff. It was a constant reminder."* Joe had initially refused admission (after realising that his only option was placement on a female ward), however, he was placed under Section<sup>31</sup>, and admitted against his wishes. Joe interpreted the decision to section him as a "punishment" for being gender transgressive, and attempting to assert his 'rights': *"I was sectioned for being trans. It's because I was being difficult – I was arguing about my rights.. This guy [the Dr] – I think he was on an ego trip – he said 'I'm done being Mr. Nice Guy'."* Joe explained that he was so terrified by this encounter that he had started avoiding health services altogether; meanwhile, his fears had also begun to extend to other authorities and services:

*I would never go back to A&E. I won't access a dentist if I need to. I'm not going to go to a sexual health clinic if I need to because I'm like – none of these places I feel safe. I think I would have to be stabbed to call someone. I'll maybe call the fire brigade if the house is on fire, but even then – there's zero repercussions for them if they are awful and transphobic.*

Joe's fear of accessing care derived from his perception of medical services as institutions capable of acting with unbridled, arbitrary power to police adherence to normative sex/gender categories, through the punishment of those who occupy trans embodiments: *"they think that they can do it for the sake of it...there's nothing to stop them... There's a lot of transphobia."*

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<sup>31</sup> A legal process where a person can be detained and treated without their consent under the Mental Health Act (1983). See <https://www.nhs.uk/mental-health/social-care-and-your-rights/mental-health-and-the-law/mental-health-act/#:~:text=If%20the%20police%20find%20you,you%20there%20under%20Section%20136>. Accessed February 2023.

Indeed, feeling wary, fearful and unsafe during health encounters was a common theme in participant accounts. Andrew explained that it was important for trans youth to adopt a subservient and submissive manner when interacting with medical professionals. Failing to do so, he argued, could cause a patient to come across as “*an uppity trans*”, which could “*backfire*” and cause “*providers to become defensive and respond aggressively*”, resulting in abusive treatment, and/ or refusal of care. According to Irene, the family local GP practice had started refusing to make referrals and provide care for Raya because: “*they don’t like her being trans and they are not willing to deal with it*”. Ezra explained that he now avoided accessing any services related to the sexed aspects of the body (e.g. SRH services) as health providers, in his words, “*can be nasty if you go in for those services and you don’t look right.*”

#### 4.1.3. Diagnostic overshadowing

Other participants, whilst not having experienced overt, hostile and aggressive treatment, described how accessing health services often came with insensitive and intrusive questioning about their bodies and identities: “*I’ve had problems in that, I would get routine blood tests, or I would go to a GP about something else, and they would ask me inappropriate questions about transition.*” In the literature, a phenomenon known as ‘diagnostic overshadowing’ has been identified as common in healthcare settings amongst patients with long term conditions or disabilities, whereby health providers automatically assume that a patients’ symptoms are a consequence of their underlying diagnosis, without exploring other potential causes or factors (e.g. Shefer *et al.*, 2014). Reflecting this, participants’ accounts contained numerous stories of medical encounters which had become derailed after providers had become distracted by their gender/sex diversity, which then became the focus of the interaction, regardless of the reason for which they were seeking care. Ezra laughed: “*when you’re trans it’s like the doctor’s don’t know how to deal with you. The response is: I’m not a [gender] specialist!*” But really all that’s wrong is I have a cough!” Similarly, Eli quipped: “*why does being trans cause me to have swollen knees or pain?*” Theo described his frustration that he’d been for several mental health assessments, all of which had ended up focusing entirely on his gender (dysphoria) when there were a range of issues he felt he needed to discuss: “*every time I go for [an assessment], I list off symptoms and explain how I’m feeling, and then as soon as I say ‘I’m trans’, they seem to jump on that and just assume that everything is because I’m trans*”.

Emily explained how every time she would go see a doctor they would raise the issue of her hormone therapy, and suggest ceasing her treatment as the first solution: “*they say, ‘let’s try stopping*

*that, and see if that fixes things first'. And then I go 'abb, no, I can't really stop that'".* Similarly, Ezra recalled visiting the doctor for a vaginal infection and being told it must have been caused by his testosterone therapy: *"they told me I had to stop taking my hormones but I didn't want to do that."* Unwilling to cease his treatment, Ezra lived with the infection for six months, before his doctor eventually suggested removing his intrauterine device<sup>32</sup>. Ezra pointed out that he had suffered a relatively common complication, which should have been straightforward to diagnose: *"my issue was simple. Getting an infection from an IUD is common.. But because I was trans, they just didn't know how to deal with me."* Ezra and Emily's experiences highlight how, whilst disproportionately preoccupied with a young person's gender diversity, providers may also be dismissive of it: quick to assume that young people can and should just stop gender-affirming treatments, and careless about acknowledging and respecting their identities. As well as potentially detrimental to physical health, these encounters can be upsetting for young people; for example, Ezra expressed his distress when his doctor reportedly kept "misgendering" him: *"even though I asked them to stop, they kept referring to me as female, because of my vaginal infection"*.

According to participants' accounts, medical providers preoccupation with sex/gender variance often manifested in a particular interest in their genitals, without any of the usual discretion which would normally accompany such discussion. Joe remembered once visiting his GP for a routine blood test and being asked by the nurse if he was going to have genital surgery. He felt angry about the encounter, which he experienced as intrusive and humiliating:

*I was 17, so I'm thinking - you're asking a child about their genitals? When I told her that's really not relevant and inappropriate, she was like, 'okay, I'm sorry you don't want to talk about it.' That's abusive. You don't get to ask that. Doctors are really entitled and they feel like they're allowed to ask these questions, but they're not.*

Chloe and George remembered one encounter which took place during a trip to hospital for an ear operation for Mia. Mia, aged 5, was already presenting as female, and Chloe felt she should mention that Mia was transgender:

*The head nurse on the children's ward said, in front of lots of other people, very loudly. 'so when did she have the operation?' A five-year-old! I didn't even know how to react. It was like "no, no – she hasn't.. It's like – what are you talking about?! We've just changed a pronoun and that's it.*

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<sup>32</sup> A small plastic and copper device that is inserted into the womb to prevent pregnancy.  
<https://www.nhs.uk/conditions/contraception/iud-coil/> accessed February 2023.

#### 4.1.4. The need to ‘come out’ to providers

Although Mia’s trip to the hospital had nothing to do with her transgender status, her parents had felt the need to mention it to staff, to avoid any potential misunderstandings and awkwardness that might arise as a result of Mia’s female presentation, and the automatic assumptions that this would give rise to. This need to ‘come out’ to doctors (and the inevitable curiosity that this would generate) was another commonly reported concern and source of distress for respondents: *“I feel like I have to come out to my doctor every time I see a new one”*. Spencer explained:

*It’s just awkward because if I’m talking about an issue that I have, I don’t know whether I should say it or not. It’s like – eurgh - I’ve got to go through this conversation again. Because me being trans doesn’t really affect my daily life anymore. I don’t really think about it until I have to. So I’d rather not have to worry about it when I go to the doctors.*

Kate confessed that she had been putting off making an appointment to see the GP about Jamie’s asthma, because of the discomfort and stress of having to constantly explain and justify Jamie’s female presentation:

*Each time he goes to the GP, I don’t know what comes up on their screen. Do they see that he’s had a referral to the Tavistock? Do they have any information about it? Am I starting from scratch here? And I’m aware I’m putting off that appointment. I think there’s a real danger that you could avoid accessing healthcare altogether.*

Blake described how she was constantly having to reexplain her sex variation to every new provider she encountered; she described the intrigue her variation would inevitably generate, and the emotional toll of having to go into details, irrespective of the relevance to the particular medical appointment:

*It’s a difficult thing to talk about – them wanting to know the very details of it, and having to spell it out to them every time. Like, I’ve never met this doctor before and they’ve just met me, and they want to know all about what this is – why am I taking these hormones? And they’ve never heard of it [AIS] before, and they go [mock gossip tone] ‘ooh what’s that?’ kind of thing. Yeh it’s not great.*

## 4.2. Experiences of GPs in their role as facilitating specialist care

In addition to experiences in general areas of care, participants also shared their experiences of visiting their GPs for reasons directly related to sex/gender variance. For the majority of participants, their local GP was usually the first point of contact with the health system for these reasons. Participants often recalled these encounters vividly: their stories were evocative of highly

emotional events, sometimes painful and exasperating, sometimes funny, often heart-warming, touching and affirming.

Two factors stood out in participants' accounts. First, was the highly emotional and emotive language that participants used to describe their GPs, such as: "gorgeous", "marvellous", "lovely", "high-handed", "hateful", "jerk". Second, was the wide polarisation in recounted experiences. Ember recalled how her GP was the first person she had ever confided in about being trans; she remembered how she broke down in tears as all the thoughts she had been keeping inside for so long finally came tumbling out.

*I was like – I just need to go speak to someone. I'd never seen her before, the Doctor. I just sat down, and she was like – what's up? I remember crying loads because I had never just put it all out on the table. And I just told her everything.*

Ember remembered the Doctor being kind and understanding, and making her feel instantly at ease: *"she was really sweet. She was like a young girl too, so I think she could just like get it. She just made me feel comfortable"*.

Like Ember, many other participants described being received by their GPs, with respect, care and support. Clare, whose family had been in contact with multiple services (including GIDS, a GIC and CAMHS) described their local GP as the most helpful and accepting of all the services they had encountered: *"he was brilliant! Really helpful, because - the kind of person he is - he's really caring and you could tell he was accepting. He didn't say anything that was negative or anything. He's been very supportive."* Camilla described taking her teenager, Aaron, to their family doctor, to let him know about Aaron's transition. She was anxious about how he would receive the news. She laughed as she recalled the GP's initial surprise, followed by his warmth and earnest desire to help:

*I sat Aaron down in the wee chair to speak to the doctor, and I said – er – 'this is the person that you know as my daughter, and is now my son!' And he just looked [pulls stunned face]. Eventually, he looked at Aaron and said [open arms enthusiastically] 'welcome!' [Laughs]. Well you've got to hand it to him haven't you? So we ambushed him! If only they were all like that. He's such a lovely man. As we were leaving, he said: 'if you want anything, anything, either of you, don't hesitate to come and see me.' That's been his attitude throughout.*

In contrast, a number of other participants described their GPs as obstructive, dismissive, and sometimes apparently alarmed by their requests. George described the reaction from the family GP when he went to discuss Mia (aged 3): *"just – I don't know anything about this. This is ridiculous. Why do you think this is some [issue]."* Lucy recalled similar when she approached their GP with

Amber, aged 6: *“the GP didn’t know what they were doing. [He] looked at me like I was a big weirdo when I first said [it].”*

Finley, whose sex variation was undiscovered until adulthood, remembered being brushed off when they first approached their GP with concerns about their sexual development: *“I went to him and said I haven’t started my periods and I’m kind of worried about my body”*. Finley described the doctor as cold, insensitive and dismissive: they recalled the brusque response: *“nothing to worry about. You’re not 18 yet, wait until you’re 18”*. Finley, 17 years at the time, remembered finding this “ridiculous”; they were a very early developer (a side effect of their VSC) and knew something wasn’t right: *“I’ve had boobs since – what feels to me - like I was 5. If I would have [periods] I should have had them.”*

Olivia described a similar dismissive reaction when she first approached her doctor, age 16, with the same anxieties: *“it was just, you know, [it’s] nothing, [your period] should come eventually”*. At a later appointment, Olivia recalled her Doctor’s emerging panic as he started to realise something might, in fact, be wrong: *“he rushed out the room, he didn’t want to – nobody wanted to tell me. Just ‘oh we need to order another [test] can you come back on the day and another day’.”*

Ruth recalled a similar sense of alarm when she took Henry (15) to the GP to discuss his social transition: *“there’s this big look of panic on his face. You could see his mind was working at a million miles an hour and he didn’t have a clue what to say”*. Ruth added that they had been to the GP a few times now, each time being met with: *“that same ‘rabbit-in-the-headlights’ look”*.

According to participants’ accounts a combination of young age and transness was liable to arouse particular alarm and suspicion amongst primary care providers. Alex, 15, recalled her doctor telling her that she had seen trans patients in the past, but that: *“she’s never had someone young go to her about that kind of thing.”* Lucy recalled the doctor staring at her ‘blankly’, when she asked that Amber be referred to GIDS: *“he looked at me, you know – blank, blank. Completely blank. And I said: ‘surely you know what transgender is?’ And he said ‘oh yes, erm.. but I’ve only ever come across it in adults.’”*

At worst, a few participants concerned their GP’s reception of them to be “dehumanising”, “transphobic” and “abusive”. Hannah characterised their family GP as “a dinosaur”; she explained how he had responded aggressively for their request for a GIDS referral and suggested that Ivy had a mental health disorder or behavioural problem: *“he said [to Ivy] ‘we need to know whether this is just you being a little shit, or whether or not you need some time in hospital’”*. Hannah recalled her dismay:

*“it’s like - oh my god! Immediately you recognise as a parent, I’ve got to protect my child, from way more than I realised...from doctors, teachers, social workers, pretty much everybody we come into contact with that doesn’t understand.”*

Joe described approaching his GP, age 17, for a referral to a gender clinic. Joe went alone as his parents were not supportive of his transition. Joe experienced his GP as hostile and obstructive. He explained that she refused to refer him to a GIC, instead insisting on CAMHS. Joe felt stigmatised by her attitude and approach, which he also felt had reinforced some of the difficulties he was experiencing at home:

*I was horrified because my parents were already abusive I was like they don’t need permission from doctors to carry on being abusive, which was sort of [the message] what was given [in that appointment]. The GP just looked like [pulls a sour face] she was like, “you need to go to CAMHS, somewhere.” She was very much dismissive. She was quite stubborn. She was like, “I don’t believe you.”*

#### 4.2.1. Access to referral

Given these mixed experiences, it is unsurprising that young people characterised the idea of approaching their GP for a referral to a specialist clinic as an intimidating prospect. Briar worried that he wouldn’t be able to articulate himself properly: *“I can’t word things very well. I would be sitting there not knowing how to start, what to say”*. David was afraid that if he misspoke it might ruin his chances of obtaining a referral, cutting off his access to any care: *“if your GP says no, you’re completely barred from anything and any range of service.”* Chris expressed his fear that he would not be well understood or accepted by health providers: *“I would hope that they wouldn’t say anything transphobic but that’s always a possibility.”* Davie wondered whether he might be subject to intrusive questioning *“they [doctors] question about random things, from what I’ve heard [from others] it’s just made them feel like they’d done something wrong or something like that.”* Quinn explained that he *“couldn’t face the idea”* of going to speak with his local GP, he explained that he was still working on feeling comfortable in himself and the thought of opening up to someone who might be judgemental or lack understanding was, in his words, a *“horrific prospect”*.

These accounts illustrate the sense of vulnerability that many GSD young people felt in relation to the authority of medical providers. For these reasons, according to participants’ accounts, the majority of young people in this research who had sought a GP referral prior to the age of 18 years had attended the appointment with their caregivers. Sometimes this was also the case for older youth; Layla was 19 when she decided she wanted a referral to a gender clinic, according to her mother, Maria: *“she said I really want to go to the doctors, and I want you to come with me”*.

### *Role of caregivers*

It was also apparent from participants accounts that caregivers typically assumed the dominant role in interactions with providers, even those involving older teenagers, including organising appointments, explaining the situation, and negotiating referrals.<sup>33</sup> Dorothy described her experience taking Alex, 15, to see their GP.

*I set up a joint appointment. On the Internet I found a link, to another link, to another link, and there is a page out there that tells you transgender-friendly GP's. When we went for that appointment, we sat down, and, [Dr said] 'What can I do for you?' I said it as it is: 'Alex has come out and we want to see what the next steps are. I've done lots of research. I know about blockers.' Then I started talking to her about, 'I know about this, this, and this.' She said, 'Okay. I've got to be honest: you've done research, and that's understandable as a mum. I think at this stage, you know more than me. I'm a GP, I'm not a specialist. I can listen. I can signpost you, but I think you already know where to go.*

Dorothy's account reflects the amount of strategic and administrative work that caregivers often described undertaking to negotiate a GP referral to a specialist gender clinic. Like Dorothy, a number of caregivers spoke of doing extensive research prior to their appointment, including informing themselves of the details of NHS referral and treatment guidelines, researching potentially sympathetic GPs, phoning surgeries in advance to advise them of the purposes of the appointment, and compiling supporting 'documentation' and 'evidence' to facilitate referral. George explained that their local GP had refused to help the first time he went asking for a GIDS referral for three-year-old Mia. George returned a few weeks later better prepared and determined to succeed:

*I looked up the NHS guidance on referrals, I pre-filled out the form, I took the kits, I took the letter that we'd sent out to other parents [at school] which touches on some of the gender dysphoria issues. I took all that and said 'I'm not going to leave until you do the referral'. I can be quite persuasive.*

Kate explained that she was nervous about approaching her surgery to ask for a referral for Jamie: "we're part of quite a big practice, so I don't know any of the GP's particularly well." She decided the best strategy was to book an appointment for herself regarding an unrelated issue and use it as an opportunity to "suss out" the doctor to see if they were likely to be someone she could comfortably talk to. After determining the doctor appeared to be "nice" and "helpful", Kate confided in her about the real reason she had come: "I said, I would like to make an appointment to talk to you about my

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<sup>33</sup> This fits with previous research on children's agency in healthcare settings that has found that children tend to occupy a marginal position in consultations, with consultations largely carried out between parents and health professionals (Coyne, 2008).



*child, because... I would like a referral to the gender identity clinic. She went – slightly panicked – ‘ok. Yep. Fine. Let’s book a double appointment’.* Jamie’s appointment was booked for two weeks later. Kate decided to take the written diary that she had been keeping to document her conversations with Jamie; she hoped that reading Jamie’s direct words would be more persuasive than trying to provide a secondary account of his struggles. According to Kate, this strategy was indeed effective:

*I said ‘can I just read to you how he is feeling?’ So I read half a dozen of these things – I picked out the most heart-wrenching ones. And [Dr] said, ‘yep, where where’s the form – where do you want me to refer?’ And she said: ‘when you said to me that you wanted to talk about this, I was thinking, what’s the big deal, why does it matter? Let him wear girls’ clothes at home, whatever. It’s only when hearing what you’ve just read to me that makes me understand the level of unhappiness’.*

These accounts illustrate the pivotal role that caregivers may play in successfully negotiating referrals to clinics, particularly GIDS, through careful preparation and advocacy, raising important questions about access to specialist care for children and young people from more disadvantaged backgrounds, especially those under 18, whose parents may be unable or unwilling to support.

#### 4.2.2. Shared care arrangements

The need for extensive advocacy and negotiation with GPs to obtain access to care was also reflected in discussions concerning shared care arrangements: whereby GPs take responsibility for prescribing and monitoring hormone treatments under advice and supervision of specialist clinics.<sup>34</sup> As with referrals, the data reflected a wide variety of different attitudes and approaches taken by GP surgeries, with some willing to cooperate and others refusing to take any responsibility: *“we’ve been really lucky. The GPs been perfectly happy to prescribe”* (Sophie) *“a shared care agreement was just completely rejected by our GP – no I’m not willing to do shared care, because this is too important”* (Hannah).

Given that there are few specialist services and they are widely geographically dispersed (especially for adolescents) the willingness of the local GP to participate in care has a significant impact on the accessibility of treatment for young people. Daisy explained how she was in the process of negotiating with the local GP over their refusal to administer Aria prescribed PBs. According to Daisy, the surgery had said they would support Aria “emotionally”, but wouldn’t be participating “clinically” until she was an adult. Daisy explained that she was writing to the surgery to ask them

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<sup>34</sup> NHS England. "Service Specification: Gender Identity Services for Adults (Non-Surgical Interventions)." 2019; NHS England. NHS Standard Contract for Gender Identity Development Services for Children and Adolescents. NHS England, 2015.

to “*formally document their concerns*”, before taking the matter further. Daisy expressed her concerns about how it would affect Aria’s schooling if she had to travel to GIDS every month for her medication:

*It just seems very unfair, very unjust and just pointless. We know that children who miss school they’re likely to get that [lower] grade. Most of the time, she’s having a blocker on a school day. That’s at least 12 days of schooling that she’s missing a year. Then there’s days that she’ll miss [because of] her therapy. Then there’s days she might miss if there’s other checks that they need to do.*

The challenges many families face in obtaining shared care agreements for treatment for gender dysphoria reflect the highly contentious and rapidly evolving dynamics of trans healthcare.<sup>35</sup> Representing the views of many GPs, the Royal College of General Practitioners (RCGP) has expressed concern that GPs are under increasing pressure to compensate for systemic capacity failures of specialist gender clinics to meet increasing demand, raising significant medicolegal and ethical concerns. These problems are exacerbated by the fact that GPs are often being asked to prescribe medications, outside of their competency, that are not actually licensed for treatment for gender dysphoria, but rather for conditions such as precocious puberty, prostate cancer or endometriosis. Meanwhile, overstretched and under resourced specialist services are hard to reach or inaccessible in practice, and not readily available to respond to GP’s questions. For example, Emily explained how her GP had repeatedly written to her GIC explaining that Emily was allergic to some of the medication they had prescribed her, and asking for advice on alternatives, and received no reply for “months and months”: “*because the clinics are so full up, she’d write and write, and there’d be nothing.*”<sup>36</sup>

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<sup>35</sup> In addition, there are broader structural issues: in general, funding and commissioning arrangements make negotiating shared care agreements between primary and tertiary services (the latter being commissioned by NHS England) challenging: there are no standardised provisions or template guidance, and each agreement has been negotiated on an ad hoc basis through the local Clinical Commissioning Group, and typically without any funding in place.

<sup>36</sup> Even more contentious are ‘bridging prescriptions’ where GPs are asked to prescribe hormones for patients with gender incongruence before specialist input, as part of a harm reduction strategy, while the patient awaits specialist assessment and advice. There are disagreements over whether such treatments can safely be prescribed in a primary care setting, and whether GPs can be considered clinically competent to prescribe such medicines. The Royal College of Psychiatrists (2013) have previously recommended this approach, particularly in cases where patients are already self-prescribing from an unregulated source. Furthermore, in 2016 the General Medical Council published advice on treating transgender patients which included a section of advice to prescribe hormones for patients with gender incongruence, awaiting specialist involvement, in circumstances where it may be necessary to mitigate harm. This guidance, however, along with a subsequent letter written to the BMA confirming the same principles, has since been removed from the GMC website. Meanwhile, since 2015, the General Medical Council has been pursuing an investigation against a GP practitioner for prescribing puberty blockers and testosterone to adolescents without GIDS oversight. Currently a Tribunal is being heard about the case, raising debates about whether such treatments can safely be prescribed in a primary care setting, and whether GPs can be considered clinically competent to prescribe such medicines. See <https://www.mpts-uk.org/hearings-and-decisions/medical-practitioners-tribunals/dr-helen-webberley-jul-21>. Last accessed September 2021. This research did not reveal any cases where GPs were willing to prescribe bridging prescriptions for young people awaiting specialist support, which appears to be a rare (and increasingly censored) practice. There was, however, one case, that of Emily, where a GP had been willing to monitor the effects of drugs that a young person was purchasing through an irregular source online, including through ordering and reviewing blood tests and other investigations.

#### 4.2.3. Knowledge of primary care providers

The difficulties participants often described in securing referrals and shared care agreements may be exacerbated by a lack of specific guidance and training for GPs on this area of care. Whilst it is not the role of GPs to be expert in specialised areas of medicine, there is arguably a particular lack of professional training opportunities, as well as guidance, on issues concerning GSD healthcare. While the current GP curriculum broadly references the need for GPs to adapt their clinical approach to respect the rights and equality of gay, lesbian and transgender people, gender dysphoria and gender identity issues are not part of the GP curriculum or GP Speciality training, and there are limited Continued Profession Development (CPD) programmes available for trans health issues. In general, there is no nationally recognised training programme for gender identity healthcare and no comprehensive Guidelines produced by The National Institute for Health and Care Excellence (NICE) on treating gender incongruence.<sup>37</sup> A similar lack of clarity and standardisation exists around the provision of care for SV children and young people. According to a recent review by the Equalities Office, models of clinical practice vary considerably across the country, and there is no standardised pathway of care for children and young people affected by VSCs (although NHS England are in the early stages of scoping the feasibility of commissioning one).

At the time that participants in this study were seeking referrals, specialist gender clinics, particularly GIDS, were rarely known services, and GPs may have been unaware of their role in facilitating care: “[the doctor] didn't really know properly what transgender was. I don't think they knew about the Tavistock” (Amalia). Participants accounts were peppered with accounts of refused, delayed and misdirected referrals. Hannah described how her GP had twice made a referral to the wrong service, delaying Ivy's access to care by over three years. Devan said his GP had refused to refer him to GIDS, claiming it was not something their surgery was able to provide.

Primary health provider's lack of knowledge and understanding of forms of sex diversity may be particularly acute<sup>38</sup>: “it's amazing the number of people who don't know about [AIS] – doctors, counsellors, therapists who you talk to – they have no idea. It's quite shocking. In general knowledge about intersex issues, it's

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<sup>37</sup> Although there are apprenticeship training models in several specialist GICs and guidelines are available from various organisations, such as the British Association of Gender Identity Specialists (BAGIS), the European Professional Association for Transgender Health (EPATH) and the World Professional Association for Transgender Health (WPATH).

<sup>38</sup> This was also reflected in the survey data, where SV young people were particularly likely to say their doctor's lacked knowledge of the issues that were affecting them, as explored in section 4.3.

*terrible. Really bad.*” (Blake) Olivia described how her local GP had so little understanding of her condition that he had recently referred her to a support group for young women diagnosed with an entirely different DSD. Olivia had been excited by the prospect of meeting other young women who shared her experience: *“I was invited to this open day. It’s amazing! There’s going to be 30 other people with the same thing as me. It’s absolutely brilliant.”* Instead, she found herself in a room full of women discussing fertility options not available to Olivia because she had no uterus: *“they’re saying, ‘you’re so lucky that you can still have IVF.’ I was thinking ‘but I don’t think I can?’”* This encounter only reinforced Olivia’s feelings of disconnection and loneliness: *“I didn’t belong in that room. Quite a big error. I was so upset.”* Reflecting Blake and Olivia’s feelings, a recent publication by the government identified lack of awareness amongst GPs and nurses about forms of sex variance, and a lack of knowledge about their own patients’ diagnoses, as one of the central concerns amongst the sex variant community regarding their experiences in healthcare (Government Equalities Office, 2019).

As well as compromising quality of care, when providers rely on GSD patients to serve as ‘educators’ about their condition, it may be harmful for provider/ patient interactions (Farrell, 2018). Sophie pointed out: *“it’s not our job to educate them, but that’s what you have to do”*. Nells recalled finding her doctors ignorance unnerving: *“I found it very intimidating... he said that I was the first trans person he’s had and so he had to do research on it. The way he talked about it made me very nervous.”* Phoenix pointed out that when doctor’s lack knowledge about gender/sex variations, they are liable to ask insensitive and intrusive questions. Joe remembered the first time he went to see his GP for referral, she asked him a series of questions which he found “triggering” and tactless; he wondered if the doctor might be trying to satisfy her own personal “curiosity” rather than helping him access the services he needed:

*The way she spoke about it – wasn’t nice. Instead of being like ‘do you need any support or anything’, she went straight into ‘how do you feel about getting pregnant’. I was just like, ‘No. I’m 16. Why are you asking me about this anyway?’ Just because I said I was trans, that’s where her mind went. It was unrelated and inappropriate. The rest of the appointment was just irrelevant. She went on for quite a while. I remember being very uncomfortable. I think it was her own curiosity of what trans people are, and then maybe trying to prove me right or wrong in it.*

Ezra described similar; he felt that his GP lacked any understanding of “*what trans is*”, and was curious about “*what happened to make [me] that way*”. He experienced the encounter as disrespectful and stigmatising:

*She didn't know anything about being trans. After I tried to explain it to her, she wanted to know what kind of horrible trauma had happened to me to make me trans. That's what she was focused on, rather than supporting me to get the referrals I needed.*

Andrew explained, how, on the one hand GSD patients are forced into a position of having to instruct providers about their condition. On the other hand, if young people come across as too well informed, they may be viewed as challenging the authority of their medical provider in a way that might compromise relationships: “so you have to educate them – doctors, but you have to dumb down your knowledge, otherwise they will be threatened”.

This view was not shared by all participants, however. A number of participants felt that GP's specific knowledge of GSD healthcare was much less important than a willingness to listen and adopt an open and non-judgemental approach to offering support. Phoenix explained their GP had openly admitted that he “*didn't know anything about non-binary stuff*”, but that he “*was really good at just listening*”. Jennifer even described her GP as “*the most helpful person on the route*”, precisely because of her self-awareness about lacking experience and knowledge concerning trans issues. Jennifer explained:

*Everyone at the gender clinic was convinced they were correct about everything, despite not being correct about anything. Whereas my GP was aware that she didn't know much about trans people, and thus started looking things up and did research and actually understood me.*

#### 4.3. Experiences in primary care: findings from the survey

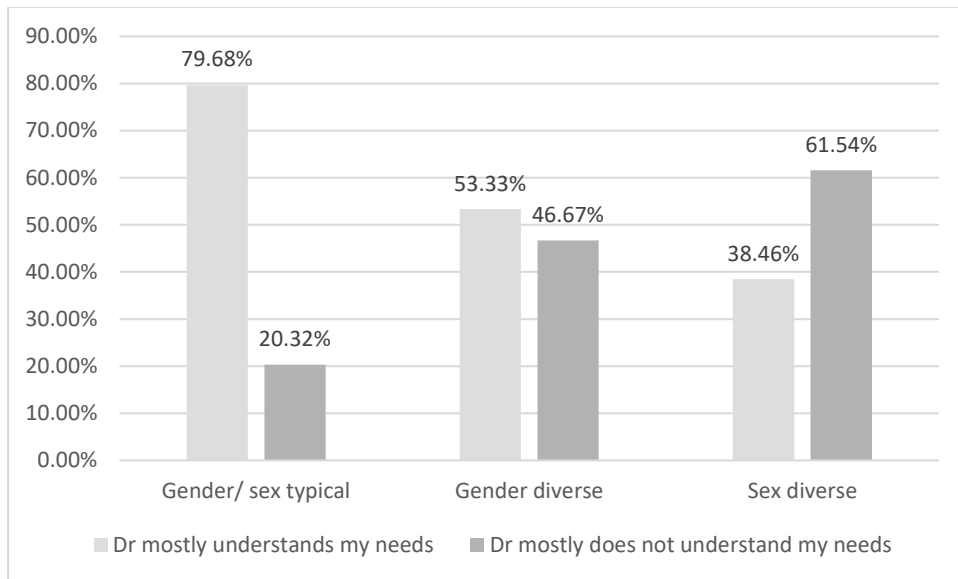
Data from the youth survey complements information participants shared in qualitative interviews. The survey asked young people a series of questions including: how comfortable they felt going to see a doctor; whether they felt able to talk openly to their doctor about their physical and mental health needs; how knowledgeable they felt their doctors were about the issues that were affecting them; whether they felt their doctor addressed their health needs appropriately, and whether they trusted their doctor to support them to access the services they needed. Respondents were asked to rate their responses to these questions on a scale of 1 ‘not at all’ to 9 ‘completely’. *T*-tests were performed to ascertain any differences in mean scores for these questions amongst the sample of GSD youth, compared to SGT youth (Table 6). GSD youth had significantly lower mean scores across all six questions.

*Table 6: t tests comparing GSD youth compared to SGT youth*

	Sample	Mean	Difference among means	p Value (two-tailed probability)
When I have a health problem I feel comfortable going to see a doctor				
SGT youth	1,454	6.45		
GSD youth	280	5.09	1.36	<0.00001
I feel able to talk to my doctor about my physical health needs				
SGT youth	1,453	6.66		
GSD youth	291	5.67	0.98	<0.00001
I feel able to talk to my doctor about my mental health needs				
SGT youth	1,439	5.90		
GSD youth	289	4.92	0.99	<0.00001
I feel that my doctor is knowledgeable and understand the health problems that are affecting me				
SGT youth	1,436	6.54		
GSD youth	287	5.04	1.50	<0.00001
My doctor addresses my health needs appropriately				
SGT youth	1,439	6.81		
GSD youth	286	5.55	1.26	<0.00001
I trust my doctor to support me to access the health care and services I need				
SGT youth	1,443	6.98		
GSD youth	288	5.41	1.57	<0.00001

Young people with a VSC were particularly likely to have negative feelings towards their doctors. Overall, 42.23 percent of GD youth, and over half, 51.72 percent, of SV youth said that they felt (mostly) uncomfortable going to see a doctor when they had a health problem, compared to just 19.60 percent of sex/gender typical youth. Additionally, more than half (55.17%) of young people with a VSC said that they felt that their doctor mostly didn't understand, and was mostly not knowledgeable, about the medical issues that were affecting them. This compares to a reduced, but still high, 40.7% of GD youth, and just 20.32% of sex/gender typical youth.

*Figure 8: responses "I feel my Dr is knowledgeable and understands my health needs"*

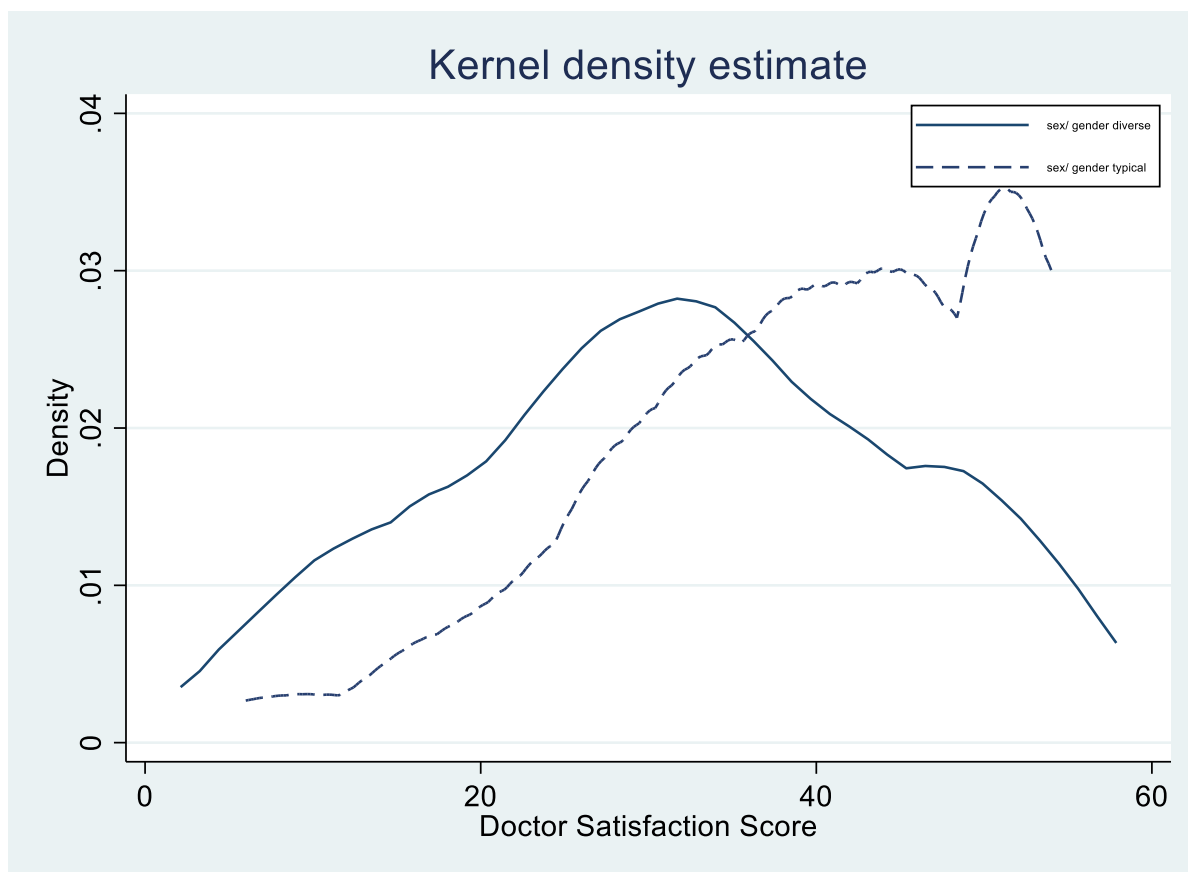


There was a particularly large discrepancy in responses to the question ‘I trust my doctor to support me to access the healthcare and services I need’ based on gender/sex diversity, with GSD youth four times more likely to give a mostly negative response to this question, compared to gender/sex typical youth (OR=4.07,  $p<0.0001$ ).

#### 4.3.1. Doctor Satisfaction Score (DSS)

Responses to each of the six questions (Table 6) were then aggregated to create an overall Doctor Satisfaction Score (‘DSS’) ranging from a minimum 9 to a maximum 54. Figure 9 visualises the distribution of the DSS over the GSD, compared to SGT, youth populations.

*Figure 9: Density plot of Doctor Satisfaction Score, comparing GSD and SGT youth*



Regression analysis was used to explore the relationship between this score and other demographic variables (Table 7). Independent variables comprised five binary variables to measure whether: a respondent was sex or gender diverse; had a self-reported disability<sup>39</sup>; was black or ethnic minority (BME); identified as LGBTQ; and was assigned female sex at birth. Two scalar variables were also included describing a respondents age in years, and information about their socio-economic background.<sup>40</sup> The model was adjusted to account for the clustered sampling design using cluster robust standard errors; the non-normal distribution of the DSS was accounted for using a bootstrap approach.

The results indicate that being gender or sex diverse is associated with a significantly lower levels of trust and confidence in doctors, even when controlling for a range of other demographic variables. Additional variables that were associated with significantly lower Doctor Satisfaction

<sup>39</sup> Including a physical disability, learning disability, Autism Spectrum Disorder, Long term mental health condition or other disability.

<sup>40</sup> Young people in the survey were asked three simple questions to measure their socio-economic status: “does you household receive income support”, “is your household eligible for free school meals”, and “did either of your parents complete a degree course or equivalent”. Young people received a point for answering “yes” to either of the first two questions, and for answering “no” to the final question. These responses were aggregated to form a simple scale (SEC) ranging from 0 (least deprived) to 3 (most deprived).



Scores included having a disability, being LGBQ, being female, and being from a more deprived background. Age and ethnicity were not associated with the DSS.

*Table 7: regression model: demographic factors associated with lower levels of trust, confidence and comfortability visiting a doctor (measured by the DSS)*

N=1,498	Coef.	Confidence interval	p value
GVS	-3.86	-7.38 - -0.33	0.03
Has disability	-2.37	-3.22 - -1.51	<0.0001
Female sex assignment	-4.08	-5.50 - -2.65	<0.0001
LGBQ	-4.36	-6.23 - -2.48	<0.0001
BME	0.25	-1.55 – 2.05	0.79
Age	0.15	-1.55 – 2.05	0.76
SEC score	-1.21	-2.38 - -0.37	0.04

There was also a significant inverse correlation observed between the GVS and the DSS, with higher levels of gender variance associated with lower trust and confidence in doctors ( $r = -0.31$ ,  $p < 0.001$ ). Indeed, even considering the gender/sex *typical* population alone, higher levels of gender variance as measured by the GVS remained significantly associated with lower Doctor Satisfaction Scores ( $\beta = -.24$ ,  $p < 0.0001$ ), when controlling for the same key demographics included in Table 7, indicating that there is a relationship between gender non-conformity and discomfort in medical settings even amongst cisgender and sex-typical youth.

*Table 8: regression model: the relationship between the gender non-conformity and doctor satisfaction amongst gender/ sex typical youth*

N=1,298	Coef.	Confidence interval	p value
GVS	-0.24	-0.28 - -0.33	<0.0001
Has disability	-1.13	-2.72 – 0.46	0.17
Female sex assignment	-3.02	-3.96 - -2.01	<0.0001
LGBQ	-1.92	-3.44 - -0.39	<0.05
BME	0.38	-1.47 – 2.22	0.79
Age	0.22	-0.48 – 0.91	0.54
SEC score	-0.80	-1.92 – 0.33	0.17

Meanwhile, amongst GSD youth, those who felt more comfortable in their gender presentation<sup>41</sup> had significantly higher Doctor Satisfaction Scores ( $\beta=1.74$ ,  $p<0.0001$ ). Mediation analysis indicates that comfort with current gender presentation may mediate as much as 70% of the effect of being gender/sex diverse on the DSS, indicating that concern over how they may ‘present’ or ‘appear’ to doctors as gendered subjects is a major factor affecting GSD young people’s levels of trust in doctors, and ease seeking healthcare services.

SV youth were found to have the lowest mean Doctor Satisfaction Scores, with a mean score of 27.19, compared to a mean score of 32.22 for the (sex-typical) GD sample, and a mean of 39.31 for the SGT sample. The relationship between sex variance and decreased doctor satisfaction was found to hold even when controlling for respondents’ GVS score ( $\beta=-5.65$ ,  $p<0.0001$ ), indicating that having a VSC may affect young people’s experiences of healthcare regardless of *gender* variance/non-conformity.

Finally, a significant correlation was observed between GSD youth’s doctor satisfaction scores and their wellbeing scores. Young people with higher doctor satisfaction scores expressed significantly higher levels of wellbeing ( $\beta=.33$ ,  $p<0.001$ ), even when controlling for disability, age, ethnicity, assigned sex, sexuality and socio-economic score.<sup>42</sup> The direction, ‘causality’ of this relationship, however, cannot be determined. For instance, it may be that young people with higher levels of wellbeing are more inclined to express more positive feelings about their doctors.

#### 4.4. Conclusions

This chapter has explored the experiences of sex and gender diverse youth in general healthcare settings in Britain with particular regard to primary care and the role of GPs. The findings concur with the few empirical studies that have explored general healthcare experiences of GSD groups in the UK (Vincent, 2016; Rickett *et al.*, 2021) as well as in other contexts (Cruz, 2014; Shires and Jaffee, 2015; Chisolm-Straker *et al.*, 2017). Participants’ accounts indicate that within healthcare settings significant complications often arise because medical systems rely on schemas of gender

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<sup>41</sup> Young people were asked to rate how comfortable they felt with their current gender presentation on a scale of 1 “not at all comfortable” to 9 “completely comfortable”.

<sup>42</sup> Using the same variables, as included in tables 8 and 7.

and sex that ‘other’, exclude or render invisible GSD embodiments, with negative implications for young people’s wellbeing.

Evidence from qualitative interviews and the survey suggests that being gender or sex diverse may substantially affect children and young people’s experiences in healthcare broadly (even when not accessing services for reasons directly related to gender/ sex variance). Young people’s experiences highlight how the gendering and sexing of bodies permeates all aspects of medical interactions, from administrative procedures (e.g. the names and gender markers used on medical records, screening forms, sign-in procedures etc.), to doctor/ patient interactions, diagnosis of medical conditions and provision of care. Healthcare related to the sexual and reproductive functions of the body (e.g. sexual and reproductive health screening, gynaecology, urology, fertility and obstetrics, etc.), becomes particularly problematic, in cases where a young person’s body or identity fails to conform to medicalised constructs of binary sex. However, the challenges young people face often extend to more general areas of care.

Participants’ accounts of their interactions with health providers are indicative of the ways in which medical practice is heavily routed in the assumption that there are two binary sexes, within which all individuals can be easily classified, and that this, singular and immutable, classification should be used as a proxy for determining health screening, diagnosis and treatments. This led to a number of challenges for GSD youth, including persistent misnaming and misgendering during systems bureaucracy and paperwork; being excluded from important health screening and diagnostic services and feeling ‘unsafe’ and liable to be ‘outed’ (or needing to out themselves) during their encounters with health providers. Being subject to inappropriate or insensitive care due to providers’ fixation on issues concerning sex and gender diversity to the exclusion of other health needs or concerns, also leading to intrusive and irrelevant lines of questioning, were also matters of concern. Together, these dynamics may have a significant impact on young people’s wellbeing in health settings: exacerbating feelings of body dysphoria and low self-esteem. This in turn appears to impact on health seeking behaviour, with young people (as well as their caregivers) tending to avoid medical services (especially, but not only, concerning the sexed aspects of the body) due to negative experiences and fear of discrimination. This avoidance is likely to exacerbate the forms of exclusion and health inequalities experienced by GSD children and youth.

Importantly, findings from the survey indicate that gender and sex diversity affects young people’s experiences in health settings irrespective of other aspects of identity, and that gender

nonconformity is associated with lower levels of comfortability and trust in doctors even amongst SGT youth. These findings lend weight to a conclusion that gender non-conformity is a significant predictor of negative experiences within general healthcare settings.

Participants' experiences of GPs in their capacity of their role in supporting health needs directed related to sex/gender variance (e.g. through referrals and shared care arrangements with specialist services) were found to be diverse and polarised. Whilst some participants found their GPs overwhelmingly helpful and supportive, others reported hostile, obstructive care. Young people and their caregivers often experienced difficulties negotiating referrals to specialist clinics and persuading GPs to participate in care arrangements. The diversity in participants' experiences may reflect a lack of training and awareness amongst primary care providers; it may also reflect a lack of consensus of the appropriate role of GPs in the context of a system which lacks sufficient capacity to manage such increased demand, in a highly specialised, rapidly evolving and controversial area of medicine (Royal College of General Practitioners, 2019).

Together the material in this chapter indicates a need to rethink the use of current gender and sex categories in medical contexts, to better reflect the complexity and heterogeneity of young people's bodies and identities. It also indicates the need for more training and guidance on issues concerning gender and sex diversity, particularly amongst primary health care providers. Moving away from binary male/female categories, to considering sex relevant properties of bodies may be one way of achieving change, to promote the health, inclusion and wellbeing of GSD children and youth.

## Chapter 5 “Just wait, keep waiting and see what happens”: specialist care and access to ‘gender affirming’ interventions

This chapter explores the experiences of young people and their caregivers in specialist health care services for treating forms of gender and sex variance. The particular focus on this chapter is *physical* healthcare interventions - ‘gender affirming’ treatments and procedures - for altering individuals primary and secondary sex characteristics. (Chapter 6 moves on to discuss clinical practice related to psychiatric diagnosis and psychosocial assessment and support).

Much of the clinical literature on access to physical interventions for transgender youth, which also informs healthcare policy, emphasises the importance of a delayed and staged approach to provision of hormonal and surgical interventions, sensitive the needs of children in the context of the ‘shifting developmental dynamics of childhood’ (Di Ceglie, 2009; Drescher and Byne, 2012; Edwards-Leeper, 2018; Wren, 2019b; Cass, 2022). Meanwhile, health provision for sex variance has favoured a model of early intervention, including offering surgeries and hormonal therapies in childhood (Ahmed *et al.*, 2016; Bettcher, 2016; Naezer *et al.*, 2021). Exploring these dynamics, I argue that health provision for GSD children and youth reflects a series of contradictions concerning the risks and benefits of different procedures at different ages and stages of development. What remains consistent is a lack of regard for young people’s own views on their treatment and a scepticism concerning the capacity of children and young people to provide informed consent to gender-affirming interventions.

The chapter is divided into three major sections. Section 5.1. focuses on healthcare for children and young people diagnosed with gender dysphoria. Section 5.2. moves on to discuss health provision for children diagnosed with DSD. Section 5.3. further elaborates on links between (desires for) physical interventions and wellbeing (as observed in my sample). I conclude the chapter by arguing that NHS healthcare practices are best understood as shaped by conceptions of ‘gender’, ‘sex’ and ‘childhood’, routed in biological essentialism. Medical discourses that inform current policy privilege a framing whereby gender-typicality, binary sexual difference and heterosexual attraction are all presumed to be intrinsic aspects of ‘healthy’ childhood development and growth.

## 5.1. Healthcare provision for gender dysphoria

Healthcare for treatment of gender dysphoria in Britain is network based, primarily coordinated and delivered by specialist ‘gender identity clinics’ (‘GICs’) located across England, Wales and Scotland. These multidisciplinary teams, typically staffed by psychologists, psychiatrists, social workers, (family) therapists, endocrinologists, nurses and others, aim to offer ‘holistic gender care, focusing on the biological/medical, psychological and social aspects of gender’.<sup>43</sup>

In England, there are seven NHS Gender Identity Clinics (GICs) catering exclusively for adults (although these clinics will see young people for assessment at 17 years). These clinics offer assessments for gender dysphoria, prescription of feminizing or masculinizing hormonal therapies, and referrals for ‘gender affirming’ surgeries (in England there are currently three providers of adult genital reconstruction surgery). Meanwhile, there is one designated provider of services for children, adolescents and young people up to 19 years: the Tavistock and Portman NHS Foundation Trust Gender Identity Development Service (GIDS), colloquially known as ‘the Tavi’ or ‘Tavistock’.<sup>44</sup> GIDS are based in London, with a satellite service in Leeds. They offer assessment and support for children experiencing issues with gender, and, in some cases make referrals for physical interventions. For adolescents requiring physical interventions, GIDS work with paediatric endocrinologists at two NHS Trusts (University College London Hospitals and Leeds Teaching Hospitals) who are responsible for prescribing and administering hormonal medications.

GIDS follow a ‘staged model of care’: stage 1 consists of ‘assessment and exploration’ and is available to children of all ages referred to the service. Stage 2 (reversible physical interventions) consists of a referral for PBs and may be available to adolescents with a diagnosis of gender dysphoria, once they have started (Tanner stage 2) puberty. Finally, Stage 3 (partially reversible interventions), entails referral for (oestrogens or testosterone) HRTs, and is only available once an adolescent has reached the age of ‘around 16 years’ and has spent a period of time (usually around 12 months) on hormone blockers. Stage 4 (irreversible interventions), including breast/ chest and genital surgeries, are only available through adult services, once a young person has reached the age of 18 years. Regardless of their age or pubertal development at referral, all children must move

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<sup>43</sup> From the website of the Gender Identity Clinic (often referred to as ‘Charring Cross’) About Us: <https://gic.nhs.uk/about-us/> accessed September 2022.

<sup>44</sup> The Tavistock and Portman NHS Foundation Trust also offers services to adults and to patients from Scotland and Wales.

through each stage of treatment before progressing to the next. According to GIDS' 2016 protocol:

‘A staged process is recommended to keep options open through the fully reversible intervention of the use of hormone blockers to suppress oestrogen or testosterone production; and the partially reversible intervention of hormone therapy to masculinise or feminise the body. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions.’ (NHS England, 2016: 20)

As reflected in this protocol the goal of this staged process is to ensure that young people have sufficient time and space to reflect on their desire to pursue medical interventions in relation to gender ‘transition’. It is considered that a staged process provides the best opportunity to maximise informed consent to treatment, particularly those that have (partly) irreversible effects. The impact of this staging in practice, and the perspectives and experiences of young people and their caregivers are explored in the sections below.

In Scotland, there are four GICs; three of these clinics only offer services to patients ages 17 and over, but Sandyford Clinic in Glasgow provides services for children, adolescents and young people up to the age of 18, providing a similar model of care to the Tavistock, although in Sandyford it is possible for an adolescent to obtain a referral directly for HRT without first starting on PBs.

Wales has just one Gender Identity Clinic that will see patients 17 years and above. There is currently no gender identity service in Wales for people under the age of 17; adolescents in Wales requiring services are referred to GIDS in London, via Child & Adolescent Mental Health Service (CAMHS).

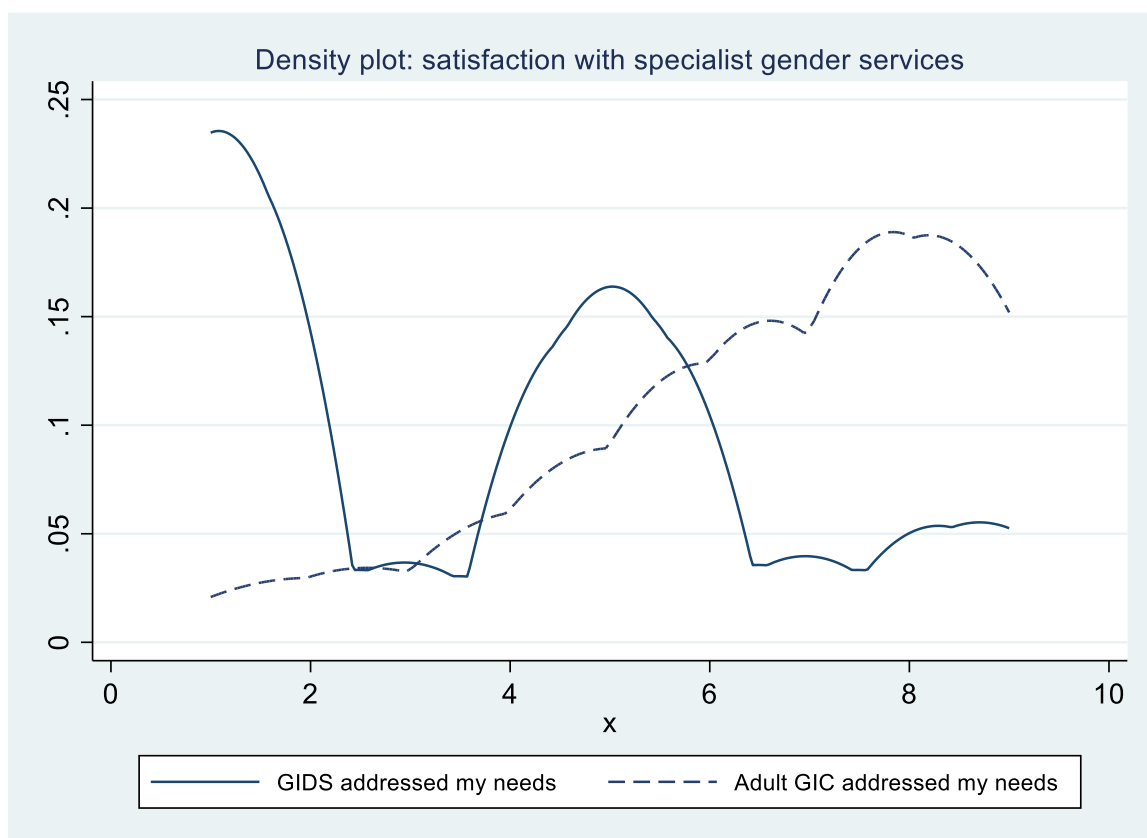
#### 5.1.1. Satisfaction with care

As with experiences in primary healthcare, young people and caregivers’ experiences of specialist care were found to be diverse, particularly within children’s services. The survey asked young people whether they had ever been referred to a (child or adult) specialist clinic for reasons relating to gender, and, if so, to rate how well the clinic had addressed their needs (scale from 1 ‘not at all’ to 9 ‘completely’). Roughly equal numbers of participants who had attended an under 19s services, gave a low rating of 1-3 (36%), compared to a high rating of 7-9 (40%). Ratings were significantly improved for adult services, with just 10% giving a low rating, compared to 62% giving a high rating (Table 9).

Table 9: gender diverse youth rating of specialist services

Rating	Service for under 19s		Service for over 18s	
	Frequency	Percentage	Frequency	Percentage
1	6	12%	2	4%
2	7	14%	1	2%
3	5	10%	2	4%
4	2	4%	2	4%
5	5	10%	6	12%
6	5	10%	6	12%
7	5	10%	9	18%
8	6	12%	7	14%
9	9	18%	15	30%
Total	50	100%	50	100%

Figure 10: density plot, gender diverse youth rating of specialist services



In qualitative interviews, although rarely effusive (as many participants were when discussing GPs), some young people as well as caregivers' expressed broad satisfaction with the treatment and



services that they had received: *It was all right. My dad came with me to one of the appointment. That was quite nice, just to talk to him about it and see his views. I got through system quite quick*"; (Alistair) *"[My GIC] has a reputation for being one of the friendliest clinics. It was a nice place, I had a good experience with them, I just wish I'd seen them sooner"* (Emily). On the other hand, many participants shared profoundly negative perceptions and accounts: *"I mean if we are going to get on to NHS gender clinics I have nothing good to say about them"* (Jennifer) *"I just feel like it was a shambles. Like, nobody knows what they are doing. Like I genuinely tried to kill myself. It's so messed up"* (Ember).

For those who viewed their experiences positively, being listened too, 'taken seriously', and provided prompt access to the treatments they were seeking were key points of focus. This may also explain the divergence in satisfaction with adult compared to child services, since there are significantly fewer barriers to access to physical interventions on the NHS after a young person has turned 18: *"the under and over 18s are very different. Under [18] it's very much a development service, if you're confused that system helps. The adult system is more a transition thing"*; (Rory); *"the fact that [adult GIC] were willing to listen to what I'd said and accept my feelings, and then be willing to refer me for things like hormones, that was quite pleasing"* (Theo); *"the Tavistock take too long. In the end we moved to Nottingham. They were really fast and quick and efficient, and they were nice people"* (Jade). Sophie and Isla were one of the families most satisfied with GIDS care; Isla was one of the few children who had received PBs at 12 and HRT just prior to turning 16 under the 'Early intervention Study' (Carmichael *et al.*, 2021).<sup>45</sup> Sophie explained how pleasantly surprised they had been with Isla's care:

*A lot of people are very unhappy, and I always have to pop up and say – we've had nothing but excellent care. It's all been positive. everything we'd hope[d] for. We were both a bit shell shocked, because we thought we'd have a battle... But they completely took us seriously".*

On the other hand, frustrations and negative perceptions of health services typically centred around the significant barriers that exist in obtaining timely access to medical interventions, especially PBs and HRTs, as explored below.

### 5.1.2. Capacity and resource constraints

In particular, negative accounts focused on deficiencies in the quality and capacity of NHS services linked to resourcing and administrative inefficiencies and long wait lists for specialist services. In recent years, the dramatic increase in referrals of transgender and non-binary youth to specialist

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<sup>45</sup> From 2011, early administration of puberty blockers was started in England under a research protocol; 'the Early Intervention Study'. From 2014, this protocol was adopted by GIDS as routine clinical practice

clinics across England, Scotland and Wales (most especially to child and adolescent services<sup>46</sup>) has drastically outstripped capacity and resourcing, leading to severe bottlenecks in the system. As of September 2021, the average wait time for GIDS was between 22 and 24 months for a first appointment, and around 12 months for Sandyford Clinic in Scotland, with similar wait times for adult services. Whilst considered unreasonable for any patient,<sup>47</sup> such lengthy wait times are particularly challenging for children and young people moving through a life stage constituting relatively rapid and significant biological, emotional and social changes and development. Valerie (21) recalled the moment she learned of how long the wait for her first appointment would be: *“that was a really devastating moment. When you come out, you’re in a rush. You want to become the person you are now. Two years, just to see someone. That’s before they give you any pills, any injections, anything”*.

According to participants’ accounts, frustrations around long wait lists to access services were also compounded by frequent administrative and clerical inefficiencies and errors, including misplaced or misdirected referrals, communication mishaps, and mix-ups in the dissemination of documentation and medications. Ember described how he waited 3 years to finally obtain access to oestrogen therapy, only to realise he had been sent the wrong prescription: *“like – what a piss take. I waited that long and you can’t even send me the right prescription! An– the booklet – it was the female to male one! So it wasn’t even the right booklet! So yeh – a shambles”*. Grayson explained how, due to a clerical error, he had ended up waiting six months for a referral that had never been made: *“the explanation I was given was that my paperwork had somehow been misplaced, or someone else had taken it, and it hadn’t been put through the system, but basically I waiting for a referral that wasn’t going to come.”*

Young people described how being subject to an inaccessible and untransparent system, riddled with bureaucratic inefficiencies, undermined their coping and left them with a sense of powerlessness and a loss of control over their lives, with many young people and families resorting to accessing private and unregulated care: *“this is like your whole world - and you put it into the hands of people who are supposed to know what they are doing but nobody really cares, and it’s on their own watch. There’s just no urgency”* (Ember). Chris described a similar feeling of putting his “life” in the “control of others”, who then failed to take any action to support him; he described feeling like his life was being “put on hold”: *“it’s really hard; a year and a half before you can even have an appointment, then four or*

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<sup>46</sup> Referrals to child and adolescent services have seen a particularly sharp increase: with referrals to the Tavistock GIDS increasing almost 20 fold over the last decade, from 138 in 3585 to 2748 in 2021/22. See <https://gids.nhs.uk/about-us/number-of-referrals/>. Accessed February 2023

<sup>47</sup> according to guidance wait listing for specialist services should not exceed 18 weeks in England and Scotland, and 26 weeks in Wales

*five appointments before they can do anything. It's like you're losing control of your own life, that's what it feels like". Phoenix described feeling like their GIC had "pulled the rug out from underneath" them, leading to an escalation in their self-harming behaviour: "when someone has kind of taken your trust away a little bit – I wasn't stable already, then it was being made worse by not being given that help I was promised". Jennifer described how two years of delays had left her so dysphoric and suicidal that she had resorted to buying hormones from an online website, despite being aware of the risks: "after like two and a bit years of wrestling with the gender clinic, I was like ok, so I'm either going to kill myself, or self-medicate, so I started self-medicating".*

Delays in access to hormonal treatments were felt particularly acutely by children and young people suffering with significant dysphoria. Young people who described their dysphoria as relatively mild and manageable, were relatively relaxed about their long wait for hormonal treatments: "[my dysphoria] was never that bad. I guess it's a discomfort, but not something that I hate. [My body] feels wrong, but it doesn't feel terrible. The Tavistock – not something I wanted. I'll just wait until I'm 18." (Aaron); "I honestly don't mind it really... I'm not really finding it that stressful waiting. I'm just happy that I'm going to get there eventually" (Henry). Henry was taking the progestogen-only pill<sup>48</sup> to help alleviate some of the dysphoria he was experiencing around his period. He felt somewhat ambivalent about accessing further hormonal treatments, and he was unsure how much of his body he wanted to change.

*I wouldn't say I'm excited or not about the puberty blockers – I know they will help. I don't exactly have a big chest, but to stop it from getting any bigger. And I think it stops your periods? So that's good - without having to take a pill every day. I'm probably going to go onto testosterone. I'm not entirely sure, but I think I would like to? I guess I've just heard some rumours about how it can be bad for your body. I might want a deeper voice, but I don't necessarily want other changes, facial hair, I guess I could just shave? I guess when the time comes I could hear from an expert about what's good and what's bad about it.*

Henry and Aaron's experience contrasts to that of other young people, for whom delays in treatment were experienced as acutely painful and distressing. Chris described his dysphoria as agonising and relentless: "right now it's awful and it's not me". The only relief Chris foresaw was through access to HRT: "when they got back to me, it was 18 months [wait] for one appointment. When you hear that, it's heart breaking." Ember described how delays in access to treatment had lead her into a period of crisis, self-harm and ultimately an attempt at taking her life: "I was so dysphoric.. The negativity in my brain was just too much. I just thought – I can't do this. I waited so long." Ember described her experience of NHS care as "traumatising": viewing the treatment she had received as having

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<sup>48</sup> An oral contraceptive that contains no oestrogen and lower levels of progestogen.

exacerbated, rather than relieved, her suffering: *“it’s so sad to think how things could have been. I feel like everyone deserves to be who they are, and they shouldn’t have to deal with hardship from it, you know? I’ve been so traumatised by the whole thing.”*

The impact of delayed treatment on young people’s wellbeing was also evidenced by data from the Youth Survey. Whilst the majority of trans youth in the survey (83.10%) said that they experienced dysphoria, this was not the case for all: a substantial minority (16.90%) did not. Amongst young people who said that they were suffering from gender dysphoria, 41.51% of those waiting for an appointment at a gender clinic said that they had experienced thoughts of self-harm every day or most days, and 27.12% said they had thoughts suicide. Thoughts of self-harm and suicide were significantly reduced amongst young people who had had at least one appointment, amongst whom 15.38% said they thought of harming themselves every or most days, and 16.93% said that they frequently thought of suicide (Table 10).

*Table 10: thoughts of self-harm and suicide amongst young people with dysphoria*

	Thoughts of self-harm		Thoughts of suicide	
	Waitlist	At least one appointment	Waitlist	At least one appointment
Every/ most day(s)	22	10	17	11
	41.51	15.38	32.07	16.93
Some days	22	30	22	22
	41.51	46.15	41.51	33.84
Never	9	25	14	32
	16.98	38.46	26.42	49.23
<b>Total</b>	<b>53</b>	<b>65</b>	<b>53</b>	<b>65</b>

### 5.1.3. ‘One size fits all’ protocol

The impact of long wait times and bureaucratic inefficiencies is exacerbated by two additional factors. First, the fact that the provision of care for trans youth provides no system for triaging of referrals based on clinical urgency. Second (as set out above) GIDS operates a standardised model of care, which requires that all children progress through the same staggered treatment protocol, irrespective of their stage of (pubertal) development, the severity of their dysphoric distress and

their individual circumstances more broadly, notwithstanding the huge diversity in need amongst children and young people referred to specialist services.<sup>49</sup>

*A 13-year-old who's on the way into puberty and is desperate and suicidal – they don't prioritize them any faster than a 5-year-old who's perfectly happy! No system of identifying which kids need to be seen urgently and which don't. (Jemima)*

The lack of flexibility in relation to individual differences in development is particularly curious given that GIDS brands itself a 'gender identity *development* service', based on a model of care which considers gender in the context of broader developmental processes (NHS England, 2019; Wren, 2019b). By contrast, one of the most striking themes identified in participants' accounts was a shared sense that the service was ill-equipped to meeting children's age-appropriate and development needs.

In fact, irrespective of the age at which children had started at GIDS, a majority of caregivers and young people seemed to feel that they arrived at the wrong time. Caregivers of primary aged children like Amber, Mia and Jamie, all complained that GIDS' service was tailored to adolescents, and not effective at catering for the youngest cohort of clients (who form only a small fraction of GIDS's admissions). Kate recalled the discomfort of her family's first appointment at GIDS. Kate had received a letter stating that Jamie should attend the appointment with both his parents. Upon arrival, she described the clinicians as unprepared to manage a conversation with Kate and her partner in front of six-year-old Jamie:

*It was really hard for us to talk about our anxieties, our concerns, Jamie's distress, with Jamie right there. But [the appointment] also wasn't focused on Jamie either! I think they gave him some colouring pens, and paper, so he just sat on the floor drawing the whole time, but he was listening to every word which is always what he does - absolutely listens to everything. And so it was really unsatisfactory for everybody involved, and it wasn't a great experience for Jamie.*

Kate reflected that whilst a joint appointment might be appropriate when attending with an adolescent, it was less suitable for a family with a gender incongruent six-year-old. She speculated that it was probably rather unusual for GIDS to see a child as young as Jamie: *"they seemed surprised... I think they hadn't worked out quite how they wanted to play it yet"*.

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<sup>49</sup> As one clinician shared: *"I think that's what people never understand when they're criticizing from outside, or they're criticizing from the stance of knowing their child maybe is the range, the diversity. I don't just mean in gender diversity, but diversity in every way developmentally. I think that's what people are most struck by when they come to work here is how different these children are."*

Lucy, whose daughter Amber was a similar age to Jamie on referral, recalled the same: *“it was excruciatingly difficult for us, and for Amber, to talk like this [as a group]”*. Further, Lucy expressed frustration at the bureaucratic forms that she was asked to fill out when entering the service, which she felt were tailored towards issues affecting adolescents and largely irrelevant to a child as young as Amber: *“we filled out some really stupid forms – assuming one-size-fits-all. Tick boxes; how you feel about anxiety. Ridiculous questions that didn’t feel relatable. They talked about suicide and harming yourself.”*

Additionally, both Kate and Lucy expressed concerns that the communication style and use of language by clinicians was not age-appropriate, and beyond the comprehension of younger children: *“they aren’t very child centred. Half the time Amber doesn’t understand their questions, or what the hell they are banging on about. They don’t use very kid-friendly language, so she tends to zone out quite a lot.”*

On the other hand, Theo, who was 16 years when he first entered the service, felt patronised by the conversations he had with his clinicians: *“I think a lot of the language they were using was quite young and obviously aimed at younger people”*. Theo recalled feeling like he had to resort to oversimplifications in order to articulate his experience in a way that would be more ‘accessible’ for clinicians and fit within the bureaucratic requirements of the service:

*Sometimes when I was explaining something I would then have to think to reword it in a way that made more sense to what they [clinicians] were used to hearing. If they tried to make me re-explain something, it would be me trying to think of it in an easier way for them to understand, to tick into their boxes, to make it simpler, to make it more accessible to what they were looking at writing down.*

Theo’s view that he was too mature for GIDS service was echoed by the majority of teenagers interviewed in the study. These adolescents expressed frustration that they had outgrown GIDS protocol, which, in their view was primarily oriented towards catering to prepubescent children: *“umm, I think [GIDS] makes more sense if you are a little bit younger”* (Amalia); *“I was kind of realising I was too old for that [GIDS’s] system.”* (Daxton). Rory, 14 years at his first GIDS appointment, explained that at the end of his assessment he was told that the services couldn’t “do much” for him. According to Rory, he was told he was too old for PBs. At the same time, being unable to start on PBs would mean a longer wait for access to testosterone:

*When you turn 16, 17, theoretically you can go on testosterone. [But] if you haven’t already been on blockers for at least a year, they won’t let you. Which is even more frustrating for me because now I’ll have to wait until 18, 19 to do it, and that’s even longer. It’s like, I’m too old for blockers, but until I get that blocker, testosterone’s completely off the table.*

Rory added: “*this is why you have to [start] when you are much younger*”. This view was echoed by many others. Keith reflected that they had waited too long to pursue a referral for 12 year old Ashley: “*we’re behind where we should [be]*.” Arthur said he wished he had approached their GP when Melanie first ‘came out’ (instead of waiting until she was 9 and asking for PBs): “*I wish I’d listened to you when you were seven and gone then. If I had to go back in time, I’d have done it then.*”

Keith and Arthur’s concerns stemmed from the lack of triage within the system for children entering the initial stages of puberty, for priority access to hormone blockers. Meanwhile, Rory’s concern was the requirement that older adolescents are required to spend a period of time, usually at least a year, on blockers before being eligible for HRT, regardless of their progress through the developmental stages of puberty (Tanner stages). The impact of such policies is discussed in sections (5.1.4 and 5.1.5) below.

#### 5.1.4. Access to puberty blockers at Tanner stage 2

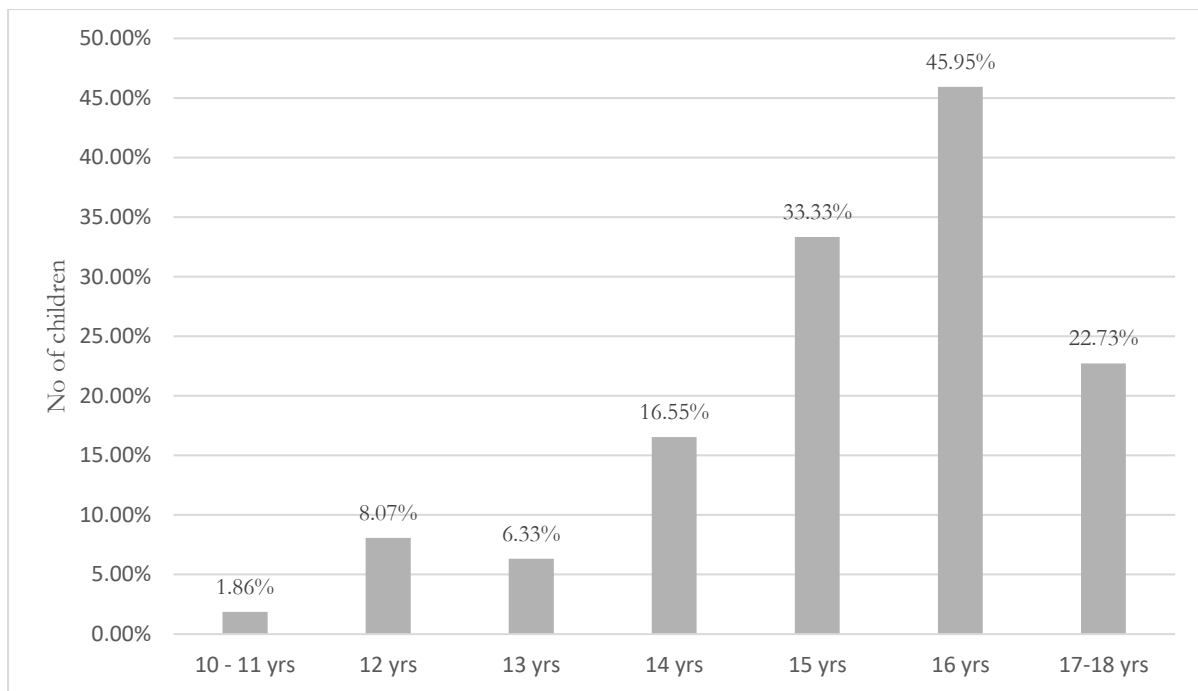
Although GIDS’ protocol recognises that it may be clinically appropriate to administer puberty blockers to children once they have reached Tanner stage 2 puberty, very few children receive treatment at this early stage on the NHS (Figure 13). The age at which a child reaches Tanner stage 2 varies considerably between individuals, however, 10-11 years is about average for natal females<sup>50</sup>, and 11-12 years for natal males.<sup>51</sup> Yet, between 2019-20, for example, just three children (less than 2% of the total pool of adolescents referred for blockers by Tavistock) were ages 10 or 11 years on referral; a further thirteen children (8%) were aged 12, ten (6%) were aged 13, twenty four (17%) were aged 14, forty five (33%) were aged 15, fifty one (46%) were aged 16, and fifteen (23%) were aged 17 or 18 (*Tavistock v Bell*). These statistics are notable in two respects: first they highlight the very small total numbers of children being referred for PBs by GIDS, highlighting the exceptional rarity of this treatment practice. Second, they demonstrate that the overwhelming majority of adolescents referred for PBs are aged 15-18 years, and likely to have already passed through as substantial part, if not the majority, of their puberty.

*Figure 11: Age of referral for puberty blockers by GIDS 2019-20*

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<sup>50</sup> Often earlier for those of African origin.

<sup>51</sup> For natal females around 8-13 years is considered within normal range, and within 9-14 years for males.



The rarity of access, and long wait for puberty blockers for transgender children entering Tanner Stage 2 puberty was a major concern for a number of participants in the study. Anne, whose son Tommy was 11 at the time of interview expressed her worries: *“I’m not going to lie, I’m scared in case puberty [starts] because it’s an unknown situation for [Tommy]. Even though I’ve explained the best I can do to her, it’s quite a scary place to be in”*. Tommy had been seeing GIDS for about a year (after spending 8 months on the waiting list). According to Anne, she had been told to expect at least another 6-12 months before referral for PBs were considered.

Arthur remembered a similar feeling waiting for Melanie’s referral for blockers: *“I just didn’t want to think about what would happen to [Melanie] if they said no. I was worried because of the time it was taking.”* Melanie, who was first seen by GIDS aged 12 years, underwent a two year assessment process at GIDS – including a total of eight appointments held at three month intervals – before she was eventually referred to UCLH for PBs, aged 14 years. Melanie and her father, Arthur, recalled the stress of the wait:

*[Arthur] You were very worried about your Adam’s apple and your voice breaking.*

*[Melanie] There would be a period where nothing would happen. Like, I wouldn’t have any changes really, and I’d be like, “yeh that’s ok, just as long as I know it [referral PB] is happening”. Then there’d be other times when – like I’d get a lot of arm hair –*

*[Arthur]: You were starting to develop a moustache!*

*[Melanie]: Yes, and then on my chin..*

*[Arthur]: I was worried. I didn’t tell you, but I was concerned. Because I was thinking – whatever happens – whether you decide to go down that route to become a girl, or not – either*



*way, I wanted [puberty] to stop so that you would be able to have that choice. And be able to make that choice without pressure or anything.*

*[Melanie]: I remember my fear was that once we got to the doctors [endocrinologists] that they'd have to do the same thing as Tavistock and go for another two years of waiting lists! I was a bit paranoid. It was too hard.*

*[Arthur]: I was stressed because I could see the changes. I was worried that it wasn't going to happen in time. I was worried about the damage that puberty would do.*

The eventual timing of Melanie's referral by GIDS to UCLH was not prompted by a medical examination or blood test. Although guidelines state that 'the decision to prescribe [PBs] is based on the client's clinical presentation of gender dysphoria, psychological assessment and Tanner staging', Tanner staging is not done until *after* GIDS have completed their psychological assessment and diagnosis of gender dysphoria and a decision has been made to refer a young people to the endocrinologist team based at one of the associated trusts. Arthur recalled experiencing both the process of assessment at GIDS, and the timing of referral to UCLH, as puzzling and opaque:

*All of a sudden one day we went there and they said "Ok we've decided to do this [refer Melanie for blockers]". What?! [Laughs]. There was no warning or anything – we just went on a normal day. I didn't know it would be then. There wasn't any build up or anything.*

By the time of her referral, Melanie had undergone a number of noticeable physical changes, including the deepening of her voice and development of facial hair. In fact, upon referral to UCLH, it was determined that Melanie had progressed sufficiently through male puberty to render her a candidate for gamete cryopreservation ('sperm freezing'). The development of sperm in males typically occurs during Tanner Stage 4;<sup>52</sup> yet Arthur and Melanie were informed that she had been referred for blockers at precisely the "right time" for hormone blocking treatment. As such, they were ultimately broadly satisfied with the care Melanie had received:

*You have to be at some kind of 'stage 2' or something. I don't know what it is – which is the different stages of puberty. But when we went to see [Consultant], he said: 'Melanie is at the correct age. Everything's ok.' So now I don't worry about it.*

Daisy's daughter, Aria, was first seen by GIDS at roughly the same age as Melanie. At the time of Daisy's first interview for the study, Aria (12) was undergoing assessment for access to PBs. Like Arthur and Anne, Daisy was anxious about the apparent lack of urgency concerning Aria referral; she could see how rapidly her daughter was developing:

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<sup>52</sup> See Tanner Stages. The national library of medicine. <https://www.ncbi.nlm.nih.gov/books/NBK470280/> accessed February 2023.

*I'm frustrated at the time everything takes, I would like not to have a such a wait between appointments. Her voice has deepened in the last 6 months. She's very delicate and very feminine, but testosterone will change that, and the impact that that will have on her mental and emotional health would be massive. I'm worried. She's shot up in the last few months, and where could we be in another 6? At the next appointment I'll be pushing quite hard to understand timelines.*

Aria ended up being referred for PBs around 5 months later. In a follow up interview, Daisy shared how Aria's pubertal development had indeed progressed significantly during these months: *"it came on quite quickly, in a period of about three months, and friends who hadn't seen us for a while would say, 'well, there's a real change in her voice.' It got a lot deeper. Family, friends, noticed."* According to Daisy, whilst the PBs had been effective in preventing any further development, they hadn't reversed the changes that has already occurred. Daisy explained how she was trying to encourage Aria to "make the best" of the situation and reframe her thinking, to try to help alleviate her ongoing dysphoria concerning her voice:

*What I try to do is pitch it as: 'actually there are lots of women with deep voices and it can be an advantage! Lots of females who speak publicly, have vocal training to lower, modulate, their tones. If you were going to work in radio, it is helpful actually!' I try to give her the positives. Of course, what she sees, or hears, is – I sound like a man, and that is really, really bothering her.*

Reflecting on her experience, Daisy did not think there was anything that she could have done to speed the process up, or change the ultimate outcome for Aria. Like Arthur, she only wished that she had initiated the process of referral sooner.

*I don't think Tavistock would have changed [their process]. I don't think they would have reduced the number of sessions, and their waiting lists and caseloads are such that I couldn't see how they could have pulled the sessions forward. I also do wonder if they take the view - we want some natal hormone to hit to see whether or not that changes the young person's view.*

As reflected in Daisy's account, on the one hand Daisy attributed the lack of options for triaging Aria's referral to GIDS' overstretched case load: a function of under-resourcing and the pressure caused by lengthy wait lists. On the other hand, she wondered if the lack of perceived urgency over Aria's pubertal development was part of a more deliberate treatment approach: to allow Aria to experience some male puberty, in case the experience might alter her feelings about her gender: *"I think sometimes [clinicians] come from a place of 'well your kid doesn't know who they are. It might be when a bit more puberty hits, that will affirm her as male and she'll change her mind."*

Indeed, the idea that the discovery of one's "true" gender identity may occur during (or as a consequence of) the process of undergoing endogenous puberty is historically popular amongst

medical experts (Drescher and Byne, 2012). Firstly it is argued that a young person cannot possibly know whether they have a cross-gender identification until they have experience of themselves in the post-pubertal state of their biological sex (Wren, 2000). Secondly, it is postulated that failing to undergo the ‘natural’ course of puberty (through blocking it’s onset at a developmentally appropriate age) may itself actively contribute to a child’s cross-gender identification and experience of dysphoria (*Tavistock v Bell*; Cass, 2022).<sup>53</sup> Current NHS practice of delaying access to PBs arguably makes better sense when regarded from this perspective: according to such a view, far from rushing to administer blockers at Tanner Stage 2, it is thought there may be benefit in delaying the initiation of hormone blockers for as long as a young person can reasonably tolerate, to allow the experience of endogenous puberty to further elucidate their gender identification (Wren, 2000).

Notably, this perspective implicitly favours a cisgendered norm of embodiment. Gender variance is construed as the consequence of a failure to complete a normalised process of development; suppressing puberty is regarded as steering children further down a deviant pathway of development, while inaction is presented as the ‘neutral’ course, affording children the best chance for a cisgender outcome. A number of participants argued that this has resulted in a skewed policy, whereby health provision is focused on indiscriminately striving to “avoid” a “trans outcome” at all costs, without appropriately weighing the potential risks and harms caused to individual trans children: *“they are working from a premise that trans is a bad outcome, and that we should be doing as much as possible to prevent that”* (Chloe); *“I think they still come from a place of to be transgender is bad. Rather than, actually either pathway is okay; the critical issue is making sure that the person is on the path that’s right for them”* (Daisy); *“they’ll take their chances to do everything to avoid the outcome that someone is trans”* (Ezra). Clare explained:

*[GIDS] feel that you just wait, keep waiting, keep waiting, see what happens. It’s all very well for them waiting, they’re not doing the watching! They’re not seeing the havoc that’s it’s reeking on your child. It’s all very well saying ‘wait and watch’, but it depends what you are watching! You know, if what you are watching is a slow motion car crash then waiting isn’t the right thing to do. It’s not! I think their approach is over cautious and because it’s cautious, it’s reckless!*

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<sup>53</sup> PBs [puberty blockers] prevent the child going through puberty in the normal biological process. This means that the child is not undergoing the physical and consequential psychological changes which would contribute to the understanding of a person’s identity. There is an argument that for some children at least, this may confirm the child’s chosen gender identity at the time they begin the use of puberty blockers and to that extent, confirm their GD [gender dysphoria].’ (High court judgement). The most difficult question is whether puberty blockers... effectively ‘lock in’ children and young people to a treatment pathway which culminates in progression to feminising/ masculinising hormones by impeding the usual process of sexual orientation and gender identity development. Data...demonstrated that almost all children and young people who are put on pubertyblockers go on to sex hormone treatment (96.5% and 98%) the reasons for this need to be better understood. (Cass Review)

These reflections were echoed by many other participants who pointed out that a delayed approach to intervention arguably fails to take seriously both the psychological stress and the physical “damage” caused to transsexual children by failing to act: *“so the do no harm thing, that people always quote when talking about trans kids, actually, it’s kind of the opposite, it’s doing harm by not putting this child on [hormones]”* (Daxton); *“to have to go through the puberty that you’re not meant to go through is awful. They’re able to stop that before it happens; there shouldn’t be an age limit for having the treatment [you] need”* (Chris). Jade explained that she had waited between 18-24 months for a referral for PBs. Meanwhile, she pointed out that while the effects of PBs are generally understood to be ‘reversible’, many changes caused by endogenous puberty are not: *“[PBs] prevent further irreparable damage from [male] hormones”*. Daisy expressed her desire for Aria: *“to do things in a measured way, not jumping into anything”*. However, she also worried that delaying Aria’s access to PBs might lead to more invasive interventions down the line: *“[PBs] prevent further pubertal changes, [so] she won’t have to have an operation to undo them!”*

Ezra pointed out that the overriding reluctance of clinicians to offer gender-affirming interventions to trans children, derived from an anxiety and fear about intervening, ironically results from a sharp recognition of the acute pain and harm it might cause someone to be *“forced into the opposite gender role”*, all the while failing to recognise that: *“being trans is like that already.”*

#### 5.1.5. PBs as a standalone, ‘first step’ intervention

Whilst many younger adolescents were concerned about delays in access to PBs, older adolescents often expressed frustration about the *requirement* that they spend a period of time (almost always at least a year) on PBs before accessing HRTs. Several older adolescents explained that they had opted out of a referral to GIDS on the grounds that they had already passed through the early stages of puberty: *“not really any point blocking something that’s already here!”* (Alex); *“it just wouldn’t have done anything. If anything it would have slowed down my mental process – thinking”* (Rory). Daxton explained he had started accessing testosterone through private sources for this reason: *“I was about 15, pretty much past puberty, and there wasn’t really much point [in PBs].”* His mother, Brenda, agreed: *“Dax shouldn’t go on blockers for a year, having gone through puberty. That’s actually wrong – medically wrong. I think you should see each child as an individual”*.

GIDS’s policy is justified on the principle that an initial period of time spent on PBs may offer adolescents the benefit of more time for reflection before embarking on more ‘permanent’ interventions. Expanding on this idea it is also thought that PBs may offer adolescents the benefit of time spent in a ‘sex hormone-neutral’ state, in order to create ‘space’ for ‘thinking’ and more

dispassionately consider their gender identity and desire for future interventions (*Tavistock v Bell*: 52). (Curiously, this idea stands somewhat in contradiction with the idea that blocking biological puberty exacerbates gender confusion and dysphoria,<sup>54</sup> and yet both arguments are commonly used to justify current protocol). Nell recalled his clinician explaining:

*'Blockers free you from the monthly hormone cycles. They put your reproductive system to sleep, to give you breathing space'. 'Breathing space' is a phrase they like to use a lot, to have less variables and sit with how you experience gender before making an irreversible change of going on hormones.*

Nell's clinician's idea that time spend on blockers might induce calming 'space' for mindful reflection contrasted sharply with Nell's turbulent account of his experience on this medication: "oh mama – hormone blockers have been quite the ride!" Nell had spent over two years on PBs, starting age 15. (At the time of interview Nell was 18 and had just started testosterone therapy). He provided a detailed account of his experience:

*There were good things about it. There have been awful things about it. I'll just say good things first. It was really great not to worry about menstruation. It was great to not worry about sexuality. I wasn't very sexual before, but when I started hormone blockers, that just died. I was fine with that. I think my chest got a little bit smaller too – not very much, but that was good.*

After acknowledging these positive aspects, Nell proceeded to describe the powerful and detrimental side effects he had experienced and the severe impacts these had had on his broader health and wellbeing: "I could not have prepared myself for the way in which it just changed my life in a bad way." Nell explained that his problems started with hot flashing: "they were really bad. I would have maybe six in an hour. It was awful. In class, people joked: 'Nell, you're always taking your clothes off and on!'" These hot flashes became so extreme and debilitating Nell was unable to sleep; he ended up being prescribed a synthetic form of oestrogen, together with the PBs, to mitigate some of the effects. Nell explained that this had helped with the hot flashing, but then he started experiencing an "intense" and relentless fatigue, which had a profound impact on his coping and functioning in all aspects of his life. Nell had to move to a part-time schedule at school because he was so exhausted. Both his mental and physical health began to deteriorate. He described how he started finding it hard simply to "sit up". In addition he described suffering from recurrent UTIs, and worrying about his bone density:

*Looking at the scan of my bone was terrifying. It was visibly thinner than before. I took a note down of the density and I googled it. It was borderline osteoporosis, which was scary because I'm*

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<sup>54</sup> It also contradicts medical evidence on the importance of sex hormones for cognitive function (Boss *et al.*, 2014).

*17. I don't want to have osteoporosis at 17. It's had quite a negative effect on my physical health.*

Jade shared a similar account of her experience on blockers: “[PBs] just like completely zapped me of all my energy. I was like burning up with hot flushes every 20 minutes, it was really awful.” Jade spent over a year on PBs before transferring to adult services; during this time she became so unwell that she had dropped out of school. Without any hormones in her system, Jade described feeling like she just “kind of died, metaphorically.” Jade also reported feeling very physically unwell and suffering from constant headaches. Given that Jade was so far through puberty before starting PBs, her mother Clare characterised her experience as akin to having gone through “a kind of menopause”.

Jade and her mother Clare were deeply angry with GIDS's service: they had lodged a complaint which was under review by the health ombudsman at the time of interview. They both expressed the view that GIDS's protocol and practices were inappropriate for a young person in Jade's circumstances, and accused the service of actively causing Jade harm:

*Someone like Jade – who was at Tanner – I can't remember how high the numbers go, but her voice had broken, she had facial hair and so on. She had a diagnosis of gender dysphoria, so there was literally no point in her just being on blockers. They made Jade really ill. Tavistock made Jade really poorly. (Clare)*

*The blockers on their own – it's not a good protocol! To improve the services at the Tavistock, I think they should stop treating everyone like they are the same person. (Jade)*

Nell expressed more ambivalence. On the one hand he described feeling “held at gunpoint” to take PBs. Desperate to start testosterone, Nell acquiesced to the treatment after learning that refusing PBs would imply a longer wait for HRT. Nell disagreed with the decision to put him on PBs and felt that he should have been presented with other options: “it really messed with my mental state for a while, I was not happy. I would have preferred if my endocrinologist offered alternatives such as birth control and would have let me start testosterone in a similar time frame”. And yet, at the same time, Nell had built a strong relationship of trust with his clinician at GIDS. Although he had found the wait for testosterone difficult – “Jesus, yes, it was really hard” – in retrospect he felt that the delay had compelled him to do some important “self-work”, including exploring his gender identity and presentation, and working on his confidence and communication skills.

*I was always honest about my feelings to my Tavistock clinicians, I did tell them - I want to start hormones, and I'd ask questions about the timescale of things. We talked about how other people started hormones and they weren't ready, and actually they had a really hard time, or realised that they didn't need to start hormones: they needed to work on themselves. Once I*

*started working on communicating to other people and being honest, that helped me get access to testosterone for some reason. I trust the verdict of my gender therapist. She's very straight to it. She doesn't sugar-coat things. Yes, it sucked, it really sucked. But I think it's almost like I had no choice but to improve myself. It worked. In the long run, it has helped.*

Nell's account of his therapeutic journey towards obtaining a referral for HRT is illustrative of GIDS assessment model, which, along with psychiatric assessment and diagnosis, requires young people to engage in a process of psychosocial exploration of their feelings about gender, as well as a broader range of personal, family and social issues. This 'exploratory' assessment process is discussed in detail in Chapter 6.

#### 5.1.6. Minimum age threshold for access to HRT

Whilst Nell and Jade had started on PBs in the later stages of puberty, Aria was one of the few children who was able to obtain a referral for PBs in the early stages of puberty (age 12). (Aria had recently started PB at the time of her mother, Daisy's, second interview). According to Daisy, Aria was fairing relatively well on the medication: she explained that Aria had experienced a couple of hot flashes, but no other side effects to date. She described Aria as being "*in a very good place*", explaining that PBs had alleviated "*what was really critical*" for Aria: the pubertal changes happening in her body that were causing her "such distress".

At second interview, Daisy's major concern was the long wait (almost 4 years at minimum<sup>55</sup>) that Aria now had for access to HRT: "*at 12 that seems like a really long time, it's [almost] a third of your life!*" Daisy reflected on the potential emotional and social impacts of Aria being held back from progressing through puberty on an ordinary developmental pathway alongside her peers; she worried Aria might become isolated from her peers, with potentially widespread implications for her wellbeing:

*Her friends are developing, and changes are happening, and she has this artificial gate of 16 years. It might be that she will be needing therapy, because actually, she's struggling with that. We're almost in a holding pattern. It's like you're waiting to land or to take off, and that's it now for the next four years. She's going to find that really, really difficult. We're doing things like buying padded bras, so that when she goes back to school in September, she doesn't look as out of place with her peers. Every summer holiday, we'll go up a size. We're going to, obviously, play a slight game. It's about how we can keep her mentally resilient and happy and healthy, for the next four years.*

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<sup>55</sup> Regardless of the age at which PBs are started, access to HRT is not allowed until 'around 16 years' at earliest.

While Aria was at the beginning of her four years on PBs, Isla had just finished hers. Sophie expressed that she “understood” why the age for HRT was set at 16 years, given the partially irreversible effects of synthetic sex-hormones: *“clinicians don’t want to be accused of over prescribing, rushing people. There will be children who hold off and then decide they don’t want to go ahead”*. Nevertheless, from the standpoint of Isla’s needs, she characterised the protocol as “frustrating” and “detrimental”.

*[Sophie] For Isla, it would have been beneficial to have [hormones] a lot sooner.*

*[Isla] Oh a lot sooner!*

*[Sophie] But Isla’s always been so definite and so sure.*

Isla believed that the years she had spent on PBs had caused her to grow taller than expected. (Indeed, this is recognised in the medical literature as a potential consequence of delayed exposure to sex hormones<sup>56</sup> (Notini *et al.*, 2020)). Isla characterised her height as “depressing” and explained that she would often stoop to try to appear shorter: *“I’m leaning about 45 degrees that way!”* Sophie tried to reassure her: *“but you know there are tall women. Tall women are beautiful.”*

## 5.2. Experiences of sex diverse youth

While health provision for GD youth is delivered through a standardised protocol, establishing fixed age thresholds for access to physical interventions; healthcare for children and young people diagnosed with DSD is quite different. Indeed, the needs of sex diverse youth are highly diverse, reflecting a multitude of different presentations of sex variance, and their vastly different implications for health more broadly. Whilst some sex variations are associated with an underlying medical diagnosis, and require long term medical attention and support, others do not entail any immediate or long health consequences or risk (Government Equalities Office, 2019). Regardless, young people with a VSC may be offered, or seek out, a range of medical interventions, to bring their sex characteristics more into alignment with medical and social norms which define typically ‘male’ or ‘female’ bodies.

Interventions, including surgical procedures, for treating forms of sex variance may occur at any age, and will depend on an individual’s specific diagnosis, as well as the timing of that diagnosis. Whilst some variations may be identified at birth (e.g. those that result in unusual appearance of the genitals), or even in utero (e.g. in the case of chromosomal difference), others may only become

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<sup>56</sup> This is due to the role that sex hormones play in the fusion of growth plates.



apparent in adolescence, when puberty does not develop or progress as expected, or later in life when fertility issues are discovered. (Indeed in some cases, people may never know about their variation if they do not have a visible physical difference or any symptoms) (Ahmed *et al.*, 2016). In cases where variations are discovered at birth, investigations and diagnosis will be triggered immediately, sometimes leading to early interventions, such as infant surgeries. For variations discovered later in life, access to specialists, typically an endocrinologist, gynaecologist or urologist, is facilitated through a GP referral (Ahmed *et al.*, 2016). Many individuals with VSCs require HRT to induce the development of secondary sex characteristics. The age at which these are given depends on the medical diagnosis, but will typically be initiated around the average age of onset of puberty: for example, guidance recommends prescribing testosterone for assigned boys with hypogonadism at age 12 years (El-khairi, Shaw and Crowne, 2018).<sup>57</sup>

Unlike for transgender healthcare, there is currently no standardised clinical pathway for persons affected by DSD, although NHS England are in the early stages of scoping the feasibility of commissioning one for children and young adults (Government Equalities Office, 2019). Whilst some hospitals across the UK have specialist multi-disciplinary teams who provide care to people with VSC (typically comprising a psychologist, endocrinologist, urologist, gynaecologist and a clinical nurse), and clearly defined clinical standards of care, many others do not, and the standard of care is patchy and inconsistent across different parts of the country (Government Equalities Office, 2019).

### 5.2.1. Satisfaction with services

Twenty young people in the survey with a VSC answered a question asking them to rate how well their needs were met in specialist care. These young people rated their care particularly poorly (relative to GD youth). Ten (50%) respondents gave a highly negative rating (1-3), with the lowest rating (1) being the most frequently given (6 participants, 30%). Eight respondents gave a mostly positive rating (6-9), and 2 gave a 'neutral' rating of 5. The most common rating given was the lowest rating of '1' with almost a third (30%) of the small sample of respondents giving this rating (Table 11 and Figure 12).

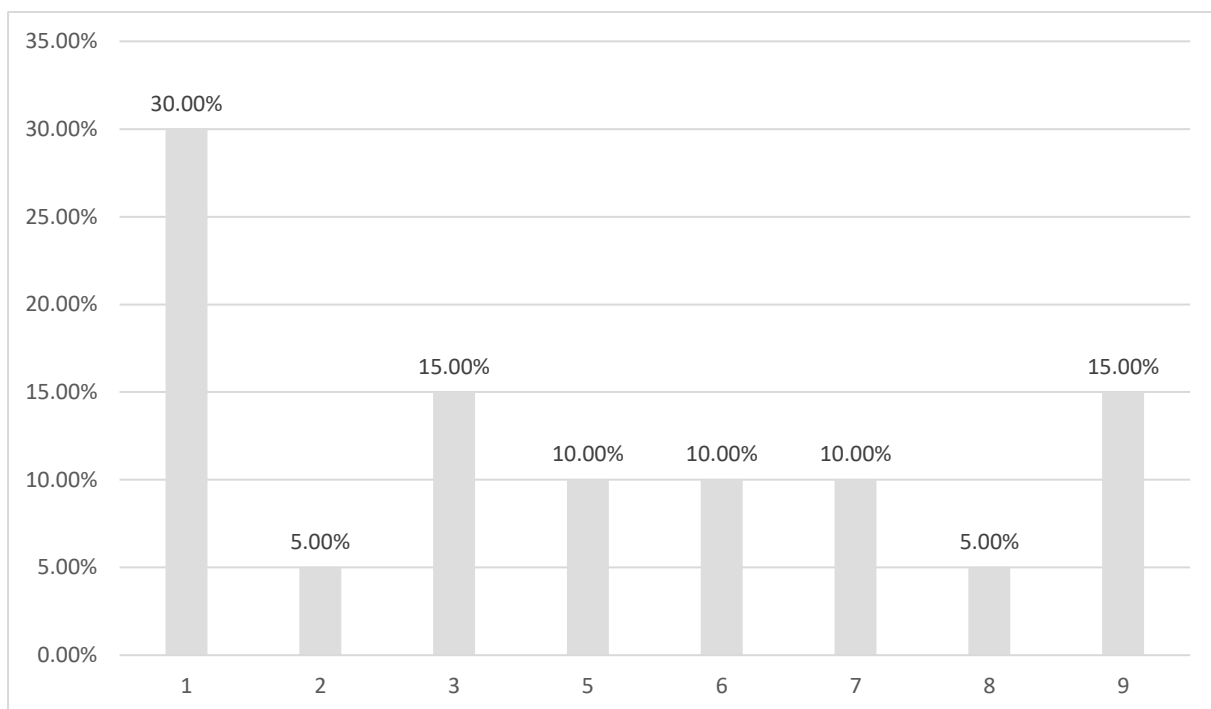
*Table 11: sex diverse youth rating of specialist services*

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<sup>57</sup> Use in children is unlicensed but recommended in national guidelines for the induction of puberty and replacement therapy in boys who are hypogonadal due to testicular or pituitary disease from the age of 12 years, or 14 years in the case of the induction/augmentation of male puberty in puberty delay.

Rating	Number	Percentage
1	6	30%
2	1	5%
3	3	15%
5	2	10%
6	2	10%
7	2	10%
8	1	5%
9	3	15%
Total	20	100%

*Figure 12: sex diverse youth rating of specialist services*



Two sex diverse youth, interviewed in the qualitative research, provided an in-depth account of their experiences of diagnosis and care, which are explored below, which may help contextualise some of these results from the survey. Blake and Olivia were both women, registered female at birth, who had a variation in sex development resulting in a ‘mismatch’ in their genetic sex and their sexual morphology. Whilst Blake’s variation had been diagnosed in infancy, Olivia’s variation wasn’t discovered until after she had turned 16. Both women described experiencing a profound lack of agency and decision making over the course of their medical care; previous research has identified this as a common concern amongst VSC groups, linked to highly negative experiences

of medical services and poor wellbeing outcomes (e.g. Karkazis, 2006; Zeeman and Aranda, 2020; Naezer *et al.*, 2021).

### 5.2.2. Blake's story

Blake's variation was diagnosed after she developed a inguinal hernia just 9 months old. It was discovered that Blake's hernia had been caused by the presence of internal gonads, which had not descended from her abdomen. Following some investigations, Blake was diagnosed with Complete Androgen Insensitivity Syndrome (CAIS), and referred for a gonadectomy (surgery to remove her gonads).<sup>58</sup>

At interview, Blake did not question the necessity of this early surgery. Gonadectomies used to be performed as a matter of routine in assigned females with CAIS, the primary medical justification being the increased risk for the development of malignant tumours within intra-abdominal gonads (Döhnert, Wunsch and Hiort, 2017). However, in recent years NHS policy has changed and the procedure is no longer recommended prior to puberty.<sup>59</sup> It is now recognised that the risk of developing cancer before adulthood is extremely low, and removing the gonads poses its own risks and harms (Deans *et al.*, 2012).

As a young child, Blake was not told about her diagnosis. She recalled having regular medical appointments and "check-ups" throughout her early years, however she described the purpose of these being kept "hidden" and "vague": *"probably thinking I wouldn't understand? I wish they had told me"*.

One of the central benefits of leaving the gonads in situ is that they produce endogenous hormones that can help induce spontaneous puberty; since Blake's had been removed, she would need synthetic oestrogens to develop female secondary sex characteristics. According to medical guidelines continuous and long-term use of hormone therapy in women with CAIS is necessary to achieve maintenance of sexual function, psychosocial well-being, and bone health (Bertelloni *et al.*, 2011), yet, there is a distinct lack of research that examines different hormonal medications,

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<sup>58</sup> It was routine practice at the time to perform gonadectomy on infants with CAIS, the primary medical justification being the increased risk for the development of malignant tumours within intra-abdominal gonads (Döhnert, Wunsch and Hiort, 2017).

<sup>59</sup> Gonadectomies are no longer recommended until after puberty in girls with CAIS, including in cases where there is an occurrence of inguinal hernia. <https://www.nhs.uk/conditions/androgen-insensitivity-syndrome/treatment/> accessed February 2023.

their dosage and routes of administration necessary to obtain these aims (Döhnert, Wunsch and Hiort, 2017).

It was decided that Blake should start HRT age 11 years. At the very same appointment she was prescribed her first treatment, Blake was finally told about her diagnosis. Blake reflected:

*I guess I was told at the moment where I had to start having the hormone therapy so I kind of had to know. Before that, maybe it was deemed I didn't really need to know? So there was no point [telling me]. From that appointment when I found out, their focus [was] on sexual development. I started taking [HRT].*

Blake couldn't recall having any input into the decision of whether or not she should start HRT at that particular time: “*I had to start, I suppose.*” She described decision-making about her care as something outside of her “control” and entirely managed by her parents: “*I didn't personally receive letters from erm doctors and things.*” Looking back Blake felt that, had she been offered a choice, she probably would have wanted to start HRT age 11, yet she still seemed hazy on the primary purpose of the medication:<sup>60</sup>

*The reason for it, I suppose, is to trigger growth? I guess it was important in terms of height, but I suppose it was mainly so that I would develop breasts? And erm – it's things like that - I don't really remember. I don't remember there being much choice about it. But equally, I think I did want to go down that direction – I think. I wanted to, yeh, I suppose, become more feminine, so that I could fit in more with the people I was in school with. [To] sort of at least try and look like I was going through the same things that they were.*

As reflected in this passage, the benefits of treatment, from Blake's point of view included her desire to ‘feminise’ her appearance and to ‘fit in’ with her peers at school. (Notably, these desires echo those of trans adolescents wanting to start HRT in early adolescence and undergo puberty alongside their peers).

The next step in Blake's treatment constituted an investigation of the development of her vagina: “*just to kind of see – my external genitalia were kind of normal – it was to look at what was going on inside, I guess.*”<sup>61</sup> Blake was just 14 years when it was decided she should undergo this investigation: despite being many years away from being sexually active, and unsure of her sexuality. “Compulsory” and

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<sup>60</sup> According to medical guidelines continuous and long-term use of hormone therapy in women with CAIS is necessary to achieve maintenance of sexual function, psychosocial well-being, and bone health (Bertelloni et al., 2011), yet, there is a distinct lack of research that examines different hormonal medications, their dosage and routes of administration necessary to obtain these aims (Döhnert, Wunsch and Hiort, 2017).

<sup>61</sup> Often women with CAIS have a short vaginal pouch, referred to in the literature as a “blind” vagina, compromising penetrative capacity (Munoz and Swan, 2010; Callens et al., 2014)

“traumatic” were both words that Blake used to characterise this procedure. She explained how she had to be put under general anaesthetic and take a day off school. She recalled finding the process deeply degrading and distressing:

*I remember really, really not wanting that [investigation] to happen, and getting really upset about it. It meant day off school and people asking: where have you been? Yeh, I really didn't want that. It felt huge, horrible. But like I said - compulsory.*

Blake saw no benefit in this investigation. Firstly, age 14, she had no foreseeable interest in penetrative sex, unsure of her sexuality. Secondly, she couldn't understand why she needed to have a procedure under anaesthetic to determine the size of her vagina. She wondered why her doctors had not thought to simply ask her.

*They were trying to assess basically how long [it] was. I feel like they could have maybe [pause] just asked me? I don't really know how useful it was, it seems like quite a length to go to. They could have just asked me, but that was just never ever asked at all! I think that would have been the easiest way. As much as that would have not been easy in itself, I feel like that would have been much less of an invasion.*

*[Do you feel you would have had a sense of how long it was?] I think so – yeh. I think I would have done. I'm sure I would have gone absolutely bright red, but, yeh I think so. I think have been a better option. Because otherwise it was just all completely out of my control.*

Blake described how objectified and excluded she felt by the failure to even ask her such a basic question and to consider that she might have some knowledge or understanding about her own body: “*having anyone else kind of see me was such a horrible invasion. Dehumanising. Because I think they're kind of looking only at your kind of – purely the physicality*”.

Following this investigation, Blake was diagnosed with vaginal hypoplasia: an ‘undeveloped’ vagina. She was told that sooner or later she would require surgical reconstruction to elongate her vagina and make it large enough for penile-receptive capacity. According to Blake she was given the impression that this surgery was necessary and inevitable; she couldn't recall any acknowledgment or discussion of alternatives:

*I think there was an assumption made: you will want to have heterosexual sex, and the only way you can do that is if you've got space to take a penis basically. So - yeh - they were going down that kind of line, pushing down that line. They never mentioned anything else really. They just didn't talk about any other options. If you want a sex life – that's what it is. And if you don't have that [surgery] it's just like – there won't be anything for you.*

Blake described how the consultant explained the surgery wasn't urgent as Blake wasn't yet sexually active; however, she joked that Blake should “*get it touch*”, as soon as she had decided “*not to live like*

a nun". Blake acknowledged that this was probably an attempt at levity to diffuse an awkward situation, but explained that it only strengthened her feelings of impotence and inadequacy: *"it just massively reinforces – there's one path and you are not really on it and we'll do our best to put you on it"*. In retrospect she wished there had been a broader discussion of her options and alternatives: *"that [path] isn't the be all and end all. Just give me more options, a bit more respect for [my own decisions in it, even if that is the route you do go down."* The "path" Blake felt she was being directed down was one where she would be a sexually active, cisgender woman, with capacity to have penetrative vaginal sex with a male partner. Yet, Blake didn't feel that these assumptions entirely reflected who she was: *"it's such a cis way of looking at it I suppose. I don't think I am straight really, but at the time I thought - if I am to have a relationship, it will be with a man."*

Persuaded that surgery was her only hope for a chance at an intimate relationship, several years later, age 18, Blake made contact with the clinic to say she was ready to go ahead with the procedure. Blake described "hating" the thought of the surgery: *"it was just another thing for me that was disgusting about myself, that I had to have reconstructive surgery. It made it even worse, but I had to do it, because I didn't ultimately want to live like a nun."* Blake was driven by a fear that without surgery she would always be alone:

*No one is going to be in a relationship with me if I can't have penetrative sex. Although I didn't exactly fancy my chances [of having a relationship], I felt I had to at least try... I certainly didn't want to go ahead with any of the surgeries. It felt like I had no choice. Ultimately, that was what came through in my mind: that I just had to.*

The interventions that Blake underwent to elongate her vaginal involved a combination of self-dilation and surgery. She described a drawn out and painful process, which she experienced as isolating, "humiliating" and "shameful": *"I feel so different from everyone else, because I bet no one else is at home [dilating]."* Reconstruction surgery entailed an eight-day, inpatient procedure which Blake characterised as "horrific" and *"the most painful thing I've ever experienced"*. She described: *"they put this metal thing inside you, and these wires come out onto this sort of rack, and they tighten it every day. It was horrible. Very painful. Very, very painful."* Blake told no one that she was having the surgery; not even her parents: *"I went into it alone. It was not a good time, emotionally, a really difficult time"*

Despite these negative aspects, and in contrast to past experiences, Blake described the medical staff at the hospital as kind, approachable and communicative: *"the consultant [was] different to before: very lovely. I wasn't very good at talking about it, but she was easier to talk [to]. Very jolly I suppose. And they*

were all very nice about it.” Looking back, Blake characterised the surgery as “tough” but “worth it”.

Not long afterwards she had started her first sexual relationship, with a male partner:

*In terms of what it sparked - I do think that [was] the beginning of how I started to change how I thought about CAIS and being intersex. And I suppose, in the confines of what I'd been presented, what people had talked about relationships, I suppose it opened that possibility up, which I guess, was worth it, yeh.*

### 5.2.3. Olivia's story

Olivia's VSC went undiscovered until late adolescence. On a school trip to Cambodia, aged 16, Eloise had become very unwell; confronted with questions about her menstrual cycle, Eloise acknowledged to herself that it was highly unusual that, aged 16, she had never had a period. On return to the UK, she decided to approach her GP for investigations. After being initially dismissed, Olivia managed to persuade her GP to refer her for some blood tests and a scan. What followed were months of repeated ultrasounds, CT scans and MRIs. Olivia recalled the withholding and secretive way these investigations were handled by providers. She remembered her anxiety (and the anxiety of her mother who accompanied her to appointments):

*It's all textbook – something's wrong, they rush out of the room and go and get someone else, and we're like: "what's wrong? what's wrong?" Nobody wanted to tell me: there was nothing inside me, that there must be something really wrong. They'd just say: 'oh can you come back on another day? We need another scan'. It was just left in the dark, really. They kept us completely in the dark.*

After about a year of investigations, Olivia remembered being suddenly informed that she required urgent surgery to remove two lumps found in her abdomen: “all that time, we had absolutely no idea what it was until it was – ‘yeh you need to have an operation asap’.” Olivia's memory of precisely what she was told at the time was hazy: “it's hard to really remember.. just being 16 at the time.” According to Olivia, her parents had been lead to believe that the lumps were cancerous tumours. (Her parents hadn't shared this with Olivia at the time, but had reportedly told her about it years later). Olivia reflected: “so scary for them - to think they had to go through that. I just had no idea. I didn't know that then because I wasn't the one making the decisions really”. Despite being 16 years (the minimum age threshold for presumed mental capacity<sup>62</sup>), according to Olivia, she was not given full information about the

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<sup>62</sup> It is well established in law and medical practice that young people aged 16 years and over are presumed competent to make informed decisions on important matters concerning their own medical care. According to the Mental Capacity Act (2005), capacity to consent for persons aged 16 and over must be presumed unless there is evidence to suggest that they are unable to do so: for example the young person does not seem able to understand or retain the information given to them, or is unable to clearly state their decision.

surgery she was about to undergo, or consulted on the different options available, and she did not feel in control of decision-making about her care.

The surgery Olivia had was the same performed on Blake as an infant: a gonadectomy to remove partially formed reproductive glands. Although the clinical justification for performing gonadectomy remains controversial (and increasing numbers of patients are opting not to undergo the procedure when presented the choice (Deans *et al.*, 2012)), Olivia had understood the surgery to be both essential and urgent. At interview, Olivia appeared to lack much knowledge about the risks or benefits of the procedure, beyond a basic understanding that without the surgery, she was at risk of developing cancer.

Following this surgery, and some subsequent tests on the removed tissue, Olivia was finally given some information about the medical findings; she described:

*They called them gonads, I think. So one was actually more similar to a testicle and—the other was just a lump of tissue really - it just hadn't quite developed into anything. And then I had absolutely no uterus at all. And then the chromosomes we found out were called 46,XY, so typically that's male. When they did the operation, they also explored the genitals to see if that had developed properly - it turned out that it hadn't. On the outside it was fine, but it was only an inch deep. I think then it started to ring the bells: the alarms bells were ringing and it must be disorders of sexual development.*

At the time of interview, although knowing she had been diagnosed under the broad umbrella of having a “DSD”, Olivia was lacking clarity about her specific condition; according to Olivia she hadn’t “*really discussed that*” with her consultant. Olivia explained that, through online research, she had learned about CAIS and thought that sounded similar to what she might have. According to Olivia, she had been told her condition was different to CAIS, but she wasn’t sure why: “*we never really had the discussion in depth. I’ve asked him [consultant], ‘is it this [CAIS]?’ He said, ‘No it’s not that.’*” She also remembered that another condition, Swyer Syndrome<sup>63</sup>, had been mentioned: “*he said it’s not quite that, because people with that [Swyer] have a uterus*”.

Olivia explained that she still felt in the dark about many aspects of her condition: “*it’s still a mystery I suppose*”. She explained that she rarely saw her specialist consultant, which meant she had few opportunities to ask questions: “*it’s hard to - if I think of something - to remember that in six months’ time when I go see him*”. As a result, Olivia shared that she had a lot of unanswered questions about her

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<sup>63</sup> A rare genetic condition in which people who have a male karyotype but female morphology. People with Swyer Syndrome have normal female reproductive organs, including a uterus, fallopian tubes, and vagina



body. Some of these were broad questions relating to the aetiology of her sex variation: what had caused it? Was it hereditary or developmental? Why had it happened to her when her mother and sister were sex typical? Other questions related to aspects of her medical care: *“I’m on hormone replacement therapy, I just don’t know if that’s the right thing for me. I don’t know if I stop taking it, how’s that going to affect [me]? What would happen? It’s a lot of questions.”*

Like Blake, Olivia felt that she lacked agency and the opportunity to make autonomous decisions concerning aspects of her medical treatment: *“I don’t know if it was much of a choice like you could develop in this way - or you could not take [hormones]? I don’t really remember if they said, if you don’t take it what would happen.”* She felt that there was a similar lack of discussion of options and alternatives: *“equally, it wasn’t - which hormone [would you like]? It was – so you’re going to take oestrogen and that will help you develop in this way. I don’t think it was much of a choice..”* Olivia was curious about what might have happened if she hadn’t started on HRT, she also wondered whether she might have taken testosterone rather than oestrogen. Her reflections are thought provoking: although it is not standard medical practice to currently consider testosterone replacement therapy assigned females after gonadectomy, some recent research indicates that it could be a safe and effective alternative to oestrogens (Batista and Mendonca, 2018).

Ultimately, like Blake, Olivia shared that she wanted *“to develop as a normal girl”*; in particular, Olivia had felt insecure about her relatively small breasts, and had been keen to grow pubic hair. She had also gathered from frequent check-ups at the hospital, that taking HRT was important for her bone development. Nevertheless, Olivia found the side effects of the synthetic oestrogens debilitating, and had found it difficult to comply with her treatment as prescribed. Olivia had tried different dosages and means of administration (e.g. tablets, gel, patches, implant); she had even stopped using the treatment altogether for a period, because she couldn’t cope with the unpleasant physical and emotional impacts.<sup>64</sup>

*I’ve gone through a bit of a love/hate relationship with them [hormones]. I started with just the tablets but I didn’t really get on with them, or would forget to take them sometimes. Then they offered me gel. You rub it into your legs twice a day. I didn’t really get on with that. It’s really sticky and just didn’t feel very nice. I didn’t like that, so I stopped. Tried a patch. The patch was really itchy. I didn’t like that either, so then eventually I went back to taking tablets. Implants I just didn’t really get on with them either. There are effects of every hormone, and I think it was a synthetic form of oestrogen as well, so it just has some side effects I suppose like on*

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<sup>64</sup> Olivia’s experience of HRT is shared by many women with CAIS. Indeed, one of the arguments against gonadectomy is the adverse effects many women experience on synthetic oestrogen, particularly with regard to reduced psychological wellbeing and sexual satisfaction (Cools et al., 2016; Döhnert, Wunsch and Hiort, 2017; Batista and Mendonca, 2018).

*the skin, on my mood as well. More recently I've gone back to the patch. They're supposed to be a more natural form of oestrogen and a lower dosage as well. Really, really low [laughs]. So just as low as possible because I had actually stopped taking them for about a year and a half really. They said the bone density was a bit low so that's why I should really start taking them again, so that's that...*

Olivia's account resonates with broader research which has considered patients' difficult experiences on synthetic oestrogens, and challenges in complying with treatment as prescribed, and has led patient support groups to emphasise the aspects of bodily harm caused by gonadectomy (Döhnert, Wunsch and Hiort, 2017). Olivia wondered whether she would have to take hormone replacement for the rest of her life; she was unsure of the long term prognosis: "There's no end in sight. Am I perfectly developed yet? I don't know", she laughed. "It's not even clear. When do you stop?" She concluded by reflecting that, if possible, she would rather explore alternative options to continuing with her current treatment; she wondered why she had never been provided an opportunity to have that discussion:

*I think it could have been handled better really. I think it would have been good to maybe have that discussion. If it's just bone density that they're worried about then there must be something I could take to help strengthen my bone density but does not [cause] other concerns - like [my] skin and moods? I think [I have] questions around that really – the point of them [taking oestrogen].*

Olivia's story reflects how, even in cases where DSD is diagnosed in later adolescence, young people may experience a lack of autonomy and self-efficacy over important aspects of their medical care. Even when procedures, such as gonadectomy, are carried out after puberty, they may be undertaken with little input from young people, and without patient's full comprehension of the life-long implications, benefits and risks.

### 5.3. Desires for physical interventions: impacts on dysphoria and wellbeing

Despite their desire to present as normatively female, both Blake and Olivia expressed some ambivalence about the physical interventions they had received. Uncertainty about their desires for physical interventions was also a feature of GD youth's accounts. Overall, 14 of the 40 young people interviewed for this study were unsure of whether they intended to have any physical interventions; 3 had decided against. The remaining 23 had either accessed or were attempting to access at least one type of physical intervention.

Amongst transfeminine youth who desired, or had received, physical interventions, access to HRT was invariably perceived as most urgent and key for alleviating experiences of body dysphoria: “so like the big goal for me was I really wanted to get on hormone therapy, because it would fix most of the problems that I hated about my body” (Jennifer); “oestrogen was what I wanted from the very start.. I’d been certain for several years and it was like, yeh, hurry up” (Jade). This was similar for transmasculine youth, often with the addition of a strong an urgent desire for chest surgery (amongst those with already developed breast tissue) to alleviate discomforts associated with “binding”.<sup>65</sup>

*Testosterone. Top surgery. That’s what’s on my mind. That’s it. That would just make me feel so comfortable, as myself with my body. Obviously I wear binders, but they’re just very restrictive. You can’t run or lift your arms too high. It’s like I can’t do normal things just because [I] want a flat chest.* (Alex)

PBs, on the other hand, were rarely desired in isolation, but rather seen as a necessary means of achieving access to HRT: “I was really very intent on getting on hormones very fast. I didn’t know about the blockers, that I had to pick them basically” (Nell). Amalia explained that whilst taking PBs had taken some of the edge of her distress, she was mainly focused on being able to start oestrogens as soon as possible: “for me to feel a lot more comfortable oestrogen would be what I’d like.”

Other surgeries, particularly ‘bottom surgeries’ were generally regarded of lesser importance, or a longer term goal: “I’m not having to rush [bottom surgery]. I can decide later down the line” (Layla); “I haven’t thought about bottom surgery, that’s not something I feel the need to get. I don’t really pay any attention to what’s going on down there;” (Alex) “bottom surgery is something that I’m sort of, ‘err’ about. I don’t really know how I feel about it. I’ll just cross that bridge when I come to it” (Henry). Only a few young people in the study expressed a definite desire for genital surgeries (all of whom had a binary-female gender identification). Young people’s expressed lack of desire for ‘bottom surgeries’ may be partly a function of the limitations of current medical technologies for achieving successful results, especially in the case of phalloplasty.<sup>66</sup> However, it was also the case that for the majority of young people in this study, dysphoric feelings reportedly centred most keenly around visible secondary sex characteristics produced by hormonal changes during puberty (e.g. voice changes, body hair, chest shape and size, hip shape, facial features, height, etc.), and not necessarily genitals. Layla explained: “it’s really interesting, it’s [genitals] never been a major part of dysphoria for me. It’s always been my upper half of my body I have a problem with.” Similarly, Valerie shared: “I never really bothered to care about

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<sup>65</sup> Binding refers to the process in which an individual utilizes some form of multi-purpose garment to compress their chest for the appearance of a flatter chest.

<sup>66</sup> Phalloplasty is the construction or reconstruction of a penis or the artificial modification of the penis by surgery. It is a complex surgery that typically requires multiple procedures.

*the nether regions. It works. I can go to the toilet. It's fine. It's not causing me aggro or grief of anything"* (Valerie). Like Blake, Valerie explained that she thought that genital surgery was mostly only relevant for enabling access to a hetero-typical relationship. Valerie explained how she had initially thought she might want surgery until she met her girlfriend Layla:

*You tend to think of the surgery aspect as important in order to get a relationship. You think that to be [someone's] girlfriend, you need to have genitals that match, but I'm very fortunate in the fact that I found Layla. Neither of us particularly care what's in the pants. We met online. I didn't know what she had in her trousers and she didn't know what I had. It didn't really matter.*

Isla was one of the few young people who did express a definite desire for 'bottom surgery', however, she was comfortable waiting until she was an adult: *"I think the [minimum legal] age for the surgery is good. The visible changes are more around the face and the hips."* Her mother explained that Isla's dysphoria mostly centred around her features that were immediately visible to others on a day-to-day basis:

*[Bottom surgery] is not going to affect how a person treats you. The things that affect your actual day to day experiences are actually more to do with hormone related things rather than reconstructive [surgery] if that makes sense. The blockers and hormones have basically solved this issues of growing facial hair, having a broken voice, having the physique of a man. Anything after that is kind of a private affair I think, between you and your pants!*

Isla agreed: *"I think the age for the surgery [18] is good. Honestly realistically you are not going to be using any of it very much before then anyway. The visible changes are more around the face and hips"*.

As reflected in these accounts, for the majority of young people, in this study, what appeared to be most important for alleviating dysphoria was the ability to live inconspicuously in their experienced gender. Given this goal, young people's particular focus on HRT makes perfect sense; HRT is often sufficient for achieving this purpose, given that, as Serano (2007) points out, it is through the immediate visual cues produced by sex hormones that most social perceptions and judgements about gender are made. Daxton explained how he felt a desperate need for testosterone having just started 6<sup>th</sup> form college, to enable him to fit in with his male peers: *"a lot of the guys around me were really tall and had beards and deep voices and stuff, and I was getting misgendered all the time because I had quite a high voice and stuff like that."* Similarly Nell explained how, for him, access to testosterone was most "key" to successful "passing as male": *"if I was on hormones then other people will use the correct pronouns"*. Amalia explained how despite taking PBs, she still suffered quite intense dysphoria: *"I [still] don't feel like other people see me as a proper female... In my head, people don't see me the way that I see myself."*

### 5.3.1. Physical interventions, gender presentation and wellbeing

By the time of interview, both Nell (through NHS) and Daxton (through private means) had started on HRT; both described how the treatment had, as hoped, alleviated their gender-related discomfort and distress: *“taking testosterone does ease dysphoria: it helps me feel more safe”* (Nell); *“it was definitely urgent that I needed to be on testosterone. Once I started that I started seeing changes. I relaxed. It’s helped”* (Daxton).

Indeed, all young people interviewed for this study who had started HRT expressed a positive impact on their wellbeing. Some characterised these positive effects as profound and life changing. Jennifer described her decision to pursue private options for treatment as *“my favourite decision of my life”*, claiming that access to HRT had “solved” most of her issues related to gender dysphoria. She elaborated:

*Starting medication was like such a weight off my shoulders: that was a pretty instant relief. As for dysphoria relief, it came over slowly as my body started to shift – my facial shape especially. After a year on hormones my face had changed to the point where I was happy to go out and present in public, and be taken as female.*

Phoenix described how their dysphoria had become so unbearable, they had made an attempt at taking their life. After taking testosterone, and having ‘top surgery’, Phoenix explained how they were now “happy” with their body, and their mental health generally had improved: *“dysphoria is such a huge weight on you [one] reason why I am so stable now is because I am on testosterone.”* Similarly, Ember had taken an overdose of sleeping medication after her dysphoria had become too much to manage: *“I [was] just feeling so dysphoric, there wasn’t any point in like living you know? Like I was just really unhappy, pretending to be this [male] person”*. After Ember started on HRT and her appearance started to feminise, she described how she started to feel more “comfortable” and grow in confidence:

*[It’s] not even just like the physical stuff, your whole like, mental, [the] way you think just changes. I felt so conflicted about loads of things but once I started taking hormones, everything started balancing out. I was like it all makes sense now. I just felt so much more comfortable. I had so much more confidence doing stuff, and I just felt way more myself.*

Like Jennifer, Ember explained that it was the oestrogens she had sourced online that had made her finally feel able to “come out” and start presenting as a woman in public

*Once I started taking the hormones and stuff I started to find my feet: this is me, who I am. If you don’t like it, don’t respect it, I don’t need you in my life. I need me in my life, and I need a happy me. It’s not about other people. Once I was on the hormones a few months I was like, I’m just going to tell people, what’s the issue with it? And I was more secure in myself, because*

*I was like I know who I am, I feel more comfortable now. I just felt more powerful, if that's a way to put it, more comfortable to speak. Because [hormones] was kind of like back up: 'well look at me - would you really want to call me [birth name] now?' I just felt more comfortable physically, mentally, to just like own it.*

Emily (whose intensity of dysphoria had led to an episode of acute psychosis described in Chapter 3) was the only young person who, at the time of interview, had undergone 'bottom surgery' as well as HRT; like Ember, she explained how access to these interventions had led to a radical transformation in her mental health:

*Ignoring [the dysphoria] wasn't working as a tactic, disassociating wasn't working as a tactic, you know, even cross dressing, presenting socially [without transition] wasn't working either... Mostly for me it's been like a physical dysphoria - my body had been developing wrong since puberty, and there was no way of stopping it or undoing it. It felt like I was living in an alien body. The social side - I hated being called [male birth name], 'sir' and stuff like that. Just generally physical, primary, secondary, sex characteristics were wrong. And coming out and transitioning really helped with that. Basically after I came out [as a woman], the psychotic symptoms, the delusions and hallucinations, the persecution thoughts, basically just dissipated - they went away really quickly.. I also had pretty severe depression and anxiety at the time as well. And the social transitioning, without hiding it from anyone, really helped with the anxiety side. It was just this notable improvement in my mental health, the fact that I was able to be open and honest and I was happy to go out and do stuff again. [Surgery] kind of resolved the last bit of dysphoria for me, there's no problems I get now, and I'm kind of just living my life as normal, which is what I always wanted really.*

#### *Findings from the survey*

The survey did not include questions about use of specific medical interventions such as puberty blockers or hormone replacement therapies, however, young people were asked to rate how comfortable they currently felt with their current gender presentation, on a scale of 1 'not at all', to 9 'completely'. Regression analysis was used to explore the relationship between young people's answers to this question and their wellbeing, as measured by the WEMWBS score, controlling for other demographic variables. Independent variables comprised four binary variables to measure whether: a respondent had a self-reported disability<sup>67</sup>; was black or ethnic minority (BME); identified as LGBQ; and was assigned female sex at birth. Two scalar variables were also included describing a respondents age in years, and information about their socio-economic background. The model was adjusted to account for the clustered sampling design using cluster robust standard

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<sup>67</sup> Including a physical disability, learning disability, Autism Spectrum Disorder, Long term mental health condition or other disability.

errors. Comfort with current gender presentation was associated with significantly higher levels of wellbeing, even when controlling for a range of other demographic variables.<sup>68</sup>

*Table 12: regression model: demographic factors associated with wellbeing, GSD youth*

N=258	Coef.	Confidence interval	<i>p</i> value
Comfort with gender presentation	0.93	0.20 - 1.68	0.02
Has disability	-1.03	-4.38 - 2.31	0.4
Female sex assignment	-3.11	-5.71 - -0.51	0.03
LGBQ	-2.93	-5.06 - -0.80	0.01
BME	-.10	-6.19 - 5.99	0.97
Age	0.20	-0.20 - 2.05	0.28
SEC score	-0.47	-2.36 - 1.41	0.58

#### 5.4. Discussion and conclusions

This chapter has explored the experiences of children and young people in specialist clinics, with a particular focus on aspects of care related to physical interventions. Section 5.1 focuses on the experiences of young people diagnosed with gender dysphoria. My data suggests that experiences in specialist services are diverse. Participants with positive experiences tended to emphasise that they had been provided efficient and timely access to treatment. Negative accounts centred around the significant administrative and policy barriers that exist in obtaining referral for physical interventions, causing long delays in access to services. These delays are partly a function of a heavily centralised and standardised system of care, with no triage based on clinical urgency and fixed criteria, including minimum age thresholds, for access to different treatments. I suggest that, this model of care may be ill-equipped for meeting the diversity of young people's needs, with negative implications for their wellbeing.

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<sup>68</sup> Additional variables that were associated with significantly lower wellbeing included having a disability, being LGBQ, being female. Age and ethnicity were not associated with the Doctor Satisfaction Score.

Section 5.2 moves on to exploring experiences of young people diagnosed with a DSD. In contrast to health provision for gender dysphoria, medical care for sex variance is variable, with no fixed age thresholds for access to different physical interventions and no standardised provision. Although the sample is small, sex diverse youth in this study expressed particularly negative views of specialist care.

Health policies and practices for GSD youth appear to reflect a series of contradictions concerning the benefits and risks of different procedures for different groups of children at different ages and stages of development. For example in the context of trans healthcare, a delayed, and (so-called) ‘cautious’<sup>69</sup>, approach to physically intervening (particularly in early adolescence) has been justified on the grounds that there are serious risks associated with prescribing children hormonal treatments, with potentially ‘lifelong and lifechanging’ effects (*Bell v Tavistock*: 143), particularly given the lack of robust scientific data on the long term outcomes associated with different interventions (Hidalgo *et al.*, 2013; Cass, 2022). However, there are a similar lack of studies supporting different treatment protocols in the field of medical care for DSD (Döhnert, Wunsch and Hiort, 2017), and yet the same medical treatments (e.g. HRT), with the same medical effects, have been routinely offered in early adolescence, in the interests of *minimising* risk.

In this study, trans teens (e.g. Jade and Melanie) faced barriers in access to physically reversible<sup>70</sup> interventions (PBs), while Blake and Olivia described undergoing permanent surgeries (gonadectomies) as children, without their informed consent. The clinical justification for these surgeries remains controversial and some data suggest that increasing numbers of SV women are opting to leave their gonads in situ when offered an informed choice (Deans *et al.*, 2012). One of the most adverse effects of gonadectomy is that it removes the capacity of the body to produce hormones (Döhnert, Wunsch and Hiort, 2017). Meanwhile, the importance of exposure to endogenous hormones is used to justify delay of access to PBs for GD adolescents at Tanner Stage 2, in favour of preserving options for natural and spontaneous maturation and development (Wren, 2000; Cass, 2022). In particular, it is feared that lack of exposure to endogenous sex hormones may exacerbate children’s confusions about gender (Wren, 2000). And yet, at the same time, trans children in the later stages of puberty are *required* to spend time on PBs: on the grounds

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<sup>69</sup> (cite Cass review p. 47) ranging broadly between Critics of those who take a more gender-affirmative approach to those who take a more cautious, developmentally informed approach

<sup>70</sup> GIDS advise that the effects of PBs are reversible, but the potentially long term psychological effects of the medication remain controversial. See *Bell v Tavistock*. Also <https://www.nhs.uk/conditions/gender-dysphoria/treatment/> accessed February 2023.



that inducing a ‘sex-hormone neutral environment’ may promote clarity of thought about gender (*Bell v Tavistock*: 52).

There was widespread consensus amongst service users in this study that PBs are beneficial when offered in the early stages of puberty, enabling more effective (social and medical) transition without the need to surgically reverse or otherwise mask (already developed and unwanted) secondary sex characteristics. Young people who had already passed through significant pubertal changes rarely saw any direct benefit in being placed on PBs (as a standalone measure). Those who acquiesced to the treatment did so to facilitate earlier access to HRT; they described undergoing a “menopausal” experience with profoundly adverse physical and mental effects. Meanwhile, for young people in this study, subjective wellbeing was (only) determinedly improved with access to gender-affirming interventions, most particularly HRT, which facilitated young people’s core desire to have their experienced gender known and recognised by others on an everyday basis.

Clinical and policy debates concerning the use of PBs for treatment of gender dysphoria display a concerning lack of insight into these dynamics. For example, attention is often given to research demonstrating a link between the use of PBs and improvements in children’s overall mood and psychological wellbeing using standardised psychological measures (e.g. see Carmichael *et al.*, 2021).<sup>71</sup> Absence of conclusive studies evidencing such a link have sometimes led to a conclusion that PBs are an ‘experimental’ treatment, with ‘unknown’ effects, in terms of ‘the degree to which it will or will not benefit’ children (*Bell v Tavistock*: 43). Yet, if we take seriously children’s own views that the purpose of PBs is to prevent the development of endogenous secondary sex characteristics, then benefit is demonstrated through medical research establishing that PBs are indeed effective in temporarily suspending spontaneous puberty (e.g. Franzini *et al.*, 2018).

It is not at all surprising that the evidence on the direct impact of PBs on children’s mood is mixed and inconclusive.<sup>72</sup> On the one hand, when offered in the early stages of puberty, access to PBs can relieve children’s stress concerning the onset of unwanted bodily changes. On the other hand, it is known from medical research that sex hormones have a vital role to play in promoting individuals’ physical and mental health and overall wellbeing (Casey, 2017). Indeed, it is for this

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<sup>71</sup> Also see the discussion of the preliminary results of this study in *Bell v Tavistock*.

<sup>72</sup> In the Early Intervention Study, 44 young people received early pubertal suppression. 23 (52%) reported an improvement in mood since starting the blocker but that 27% reported a decrease in mood. There was no overall improvement in mood or psychological wellbeing using standardized psychological measures (Carmichael *et al.*, 2021)

(latter) reason, that SV children are offered HRT to induce puberty around a developmentally typical age (e.g. 11-12). For these children, it is understood that timely induction of puberty is necessary for promoting psychosocial wellbeing and physical health, with delays posing a range of potential physical, psychological and social harms.<sup>73</sup> Physical harms are thinly evidenced but thought to include impaired fusion of bone growth plates (potentially resulting in a taller than expected final height) and reduction in bone density, leading to an increased risk of osteoporosis and fractures (Notini *et al.*, 2020).<sup>74</sup> In terms of brain development, there are questions as to whether puberty delay may have an adverse effect on young people's cognition, given that adolescence is a time where executive functions and abstract thinking develop (although studies empirically demonstrating such a link are lacking) (Notini *et al.*, 2020). Meanwhile, the psychosocial effects ascribed to pubertal delay have included depression, behavioural problems, psychosomatic complaints, low self-esteem, poor school performance, reduced peer contact, aggression and general social immaturity (Hershey, Pennsylvania and Kulin, 1996).

Many of the same potential harms of delayed puberty (e.g. to bone and brain development) have been cited in caution against the prescription of PBs to trans adolescents. They might equally present a case for bringing forward access to HRT, especially for adolescents who are started on PBs at Tanner stage 2. It is reasonable to think that delayed puberty would cause the same medical and social issues, regardless of the cause of delay, such that long term use of PBs are likely to have the same effects as untreated hypogonadism (Notini *et al.*, 2020). Certainly, the experiences of trans youth on PBs (explored in section 5.1.6), reflect many of the same concerns (e.g. Isla's concerns about her height, and Daisy's worries about Aria's psychosocial wellbeing).

There are important questions as to why initiating puberty for SV youth should be considered more urgent than for GD youth, especially trans adolescents who have early access to PBs.<sup>75</sup> This issue was raised at a recent Medical Practitioners Tribunal Service (MPTS) hearing, concerning the case of Dr W., who was accused of practicing medicine outside the rules and regulations of the GMC, including through prescribing testosterone to a 12-year-old trans boy (*Webberly v GMC*). In a curious line of argument, counsel for the GMC raised that, since concerns around capacity to

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<sup>73</sup> Furthermore, according to medical guidelines continuous and long-term use of hormone therapy is necessary to achieve maintenance of sexual function, psychosocial well-being, and bone health (Bertelloni *et al.*, 2011), yet, there is a distinct lack of research that examines different hormonal medications, their dosage and routes of administration necessary to obtain these aims (Döhnert, Wunsch and Hiort, 2017).

<sup>74</sup> Although the absolute risk remains low and the effects temporary: bone density is thought to return to comparatively normal strength upon starting HRT.

<sup>75</sup> According to NHS guidelines, hormone replacement therapy (HRT) is required after gonadectomy in order to maintain secondary sexual characteristics, bone and cardiovascular health and to promote general wellbeing and sexual function.

consent to testosterone therapy sometimes arise *even* amongst 12-year-old (cisgender) boys with hypertrophic gonadism, it was unreasonable to think that a 12-year-old *trans* child could possess such competency. Counsel reasoned that children must (self-evidently) be understood to have greater competency to consent to receive testosterone therapy when they are seeking to masculinise in accordance with “*gender assigned*”, (e.g. boys with hypertrophic gonadism), rather than their “*gender identity*” (i.e. trans boys).<sup>76</sup> This reasoning is revealing of a underlying view of children as lacking in decision making capacity, not only concerning matters of medical treatment, but also concerning matters of gender (subjectivity). According this logic, in evaluating children’s capacity to weigh the medical effects of testosterone, it is essential to consider whether the hormone is intended to ‘confirm’ a child’s gender as (externally) assigned, or as (internally) generated. The pivotal question might be one of *who decides* a child’s gender: do we privilege an objectified understanding of a child’s gender, designated by medical and scientific knowledge, or do centre the situated gendered-authorship/subjectivity of the particular child in question?

In their (2021) article ‘we just want the best for this child: contestations of intersex/DSD and transgender healthcare interventions’, Naezer *et al.* explore the different and sometimes contradictory perceptions of gender and the maleability of bodies that underlie the assumptions behind current medical practices.<sup>77</sup> Yet the authors point to one common thread that underlies medical practice in both areas: a reluctance to offer children and adolescents more control over their healthcare trajectory, and a scepticism concerning the autonomy and self-efficacy of children. Naezer *et al.*’s conclusions reflect the accounts of young people and caregivers shared during this study. Whilst GD and SV youth may have distinct experiences of health systems and different pathways into care, for both groups of young people, a loss of decision making authority over their own bodies, a sense of vulnerability and powerlessness in the face of (often opaque) medical authority and decision making, and difficulties in establishing informed consent to medical treatments, were common experiences and concerns.

These practices are revealing of the unexamined assumptions and concerns that lie beneath medical responses to gender and sex variance in childhood, including naturalised understandings of gender, sex, (hetero)sexual desire, and indeed ‘childhood’. Blake’s allegory of feeling like she was being pressured into accepting medical interventions to direct her down a particularly “path”

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<sup>76</sup> See [https://www.mpts-uk.org/-/media/mpts-rod-files/dr-michael-webberley\\_25-may-22\\_.pdf](https://www.mpts-uk.org/-/media/mpts-rod-files/dr-michael-webberley_25-may-22_.pdf) accessed February 2023.

<sup>77</sup> For example, in the field of intersex/ DSD care, interventions to reconstruct sexed bodies are viewed as possible and effective, whilst in the field of transgender care, emphasis is placed on the limitations and problems with current technologies.

of gendered and sexual development (that of a cisgender, heterosexual woman), mirrors the language used by clinicians, policy makers and advocates who caution *against* facilitating social and medical interventions for trans children; for example, it is often asserted that PBs may effectively ‘lock’ children into a transsexual ‘pathway’, ‘by impeding the usual process of sexual orientation and gender identity development’ (Cass, 2022: 38). For trans and non-binary youth, it is feared that (even physically reversible) medical interventions might deviate them from a developmental pathway in which sex and gender are naturally aligned; for sex variant youth it is *lack* of intervention that poses such a risk. Meanwhile, both groups of children are understood to lack capacity to make decisions on matters concerning sex, gender and bodily autonomy.

Health provision concerning gender-affirming physical interventions for GSD children and youth reflects a range of contradictions concerning medical decision making and the perceived autonomy of children and adolescents at different ages or stages of development. These contradictions are best understood as rooted in a particular set of assumptions about sex, gender and childhood. First, there is the foundational belief in the natural alignment of sex and gender (also informed by normative accounts of heterosexual desire); second, and inextricably linked to this, there is an absolutist view of sex, which views sex as binary, and rooted in biological ‘fact’. And third, underpinning and regulating both suppositions, lies an evolutionary perspective on childhood: one that views children as primitive in their cognitive development, lacking decision making capacity, and governed by a universal and biologically determined, pathway of natural development and growth

## Chapter 6 “We really do have to talk about this”: psychiatric diagnosis and psychosocial assessment and support for GSD youth

This chapter explores psychosocial support for GSD youth within specialist services. Assessment and support for *gender* diverse youth and their families is rooted in a psychotherapeutic tradition which aims to explore the psychoanalytic and cognitive-behavioural aspects of sex and gender development and social learning (McGee, 2013). Over time, there has been an evolution in theory and practice, from an overtly ‘reparative’ model of care (which sought to ‘cure’ gender incongruence through therapies seeking to reinforce traditional gender roles and norms), towards a so-called ‘exploratory’ model which emphasises ‘the multiplicity of the potential outcomes in young people’s physiological and psychological development’ and evokes feminist theorisations concerning the unstable and oppressive nature of gender categories (e.g. see Wren, 2019a). This paradigm particularly informs assessment practices in GIDS,<sup>78</sup> but also features in Sandyford clinic in Scotland, as well as to a lesser extent adult services (although the assessment process for over 18s tends to be shorter, and relatively closer to a model of ‘gender affirmative’ care).<sup>79</sup>

The concept of ‘exploration’ sits alongside GIDS’s ‘developmentally informed’ framework which emphasises ‘slowing down’ and delaying medical interventions, to allow more time for reflection before embarking on life-changing treatments. Trans youth are expected to undergo psychosocial exploration through ‘an extended process in time’ prior to referral for physical interventions (Wren, 2019a: 203). During this process they are encouraged to reflect on the complexities of biology, sex and gender, and develop an understanding of how their identity might evolve over time, ‘as they come to grasp... what might be meaningful and liveable about different kinds of non-binary gender lives’ (Wren, 2019a: 210).

For sex variant youth, this is not a requirement. While the importance of psychosocial support for individuals and families affected by VSC is increasingly recognised in health policy and guidance, evidence suggests that mental health support may not be well-integrated into medical care (Hughes *et al.*, 2006; Ahmed *et al.*, 2016; Government Equalities Office, 2019; Lampalzer,

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<sup>78</sup> GIDS summarise their current approach on their website: ‘our specialist assessment is a wide-ranging one, aiming to explore and understand the child or young person’s past and current gender identification, as well as their development across a number of areas of their life.’

<sup>79</sup> [https://www.sandyford.scot/media/4173/304280\\_2\\_0-yp-gender-service-information\\_s-1.pdf](https://www.sandyford.scot/media/4173/304280_2_0-yp-gender-service-information_s-1.pdf)

Briken and Schweizer, 2021). Indeed, historically, medical services for sex variant youth have adopted a model of ‘concealment’, whereby information about diagnosis and treatment is withheld from patients, to avoid opening up complex questions concerning the uncertainty or ambiguity of a young person’s gender (Tamar-Mattis, 2013). Such practices are based on a theory that early and conclusive assignment of gender is essential for promoting healthy development and wellbeing (Money, 1994; Hutson *et al.*, 2020).

In this chapter, I argue that the significant mental health needs of GSD youth are not well supported by services. Current systems of care may neglect the emotional needs of sex diverse youth, while placing excessive emphasis on mental illness as causal of *gender* incongruence, reinforcing stigma and compromising access to gender-affirming interventions for trans youth (Tosh, 2016; Ashley, 2019).

The chapter is divided into two major sections. In Section 6.1, I explore data from the survey and qualitative interviews concerning the mental health experiences of GSD youth. I show that GSD youth may have substantial mental health vulnerabilities, and that outcomes may be particularly poor for sex variant youth. GSD youth may be particularly likely to come into contact with mental health services and be less likely than SGT youth to feel that these services appropriately addressed their needs.

In Section 6.2, I explore the psychiatrising discourses that shape medical understandings of the ‘authentically’ transgender subject. I argue that the conceptualisation of gender dysphoria as a form of psychiatric illness creates a range of contradictions and obstacles in the provision of effective support. Furthermore, I show that participants’ experiences of the psychotherapeutic model of assessment offered in NHS gender clinics, particularly GIDS, are often different to how they are conceived and framed in the clinical literatures (Wren, 2014, 2019b, 2019a; Clarke, 2019; Spiliadis, 2019). Through placing emphasis on gender related ‘distress’ as secondary to a range of other psychiatric problems, resolvable through therapeutic treatments ‘exploration’ may function to police the boundaries of ‘legitimate’ gender expression, resulting in a stigmatising and distressing experience for young people and their caregivers.

I conclude that effective psychosocial support for GSD youth continues to be hampered through pathologising accounts of gender and sex variance, which view these differences as deleterious

deviations from a healthy norm. I argue that these framings may have detrimental impacts on young people's wellbeing through reinforcing stigma and creating barriers to appropriate care.

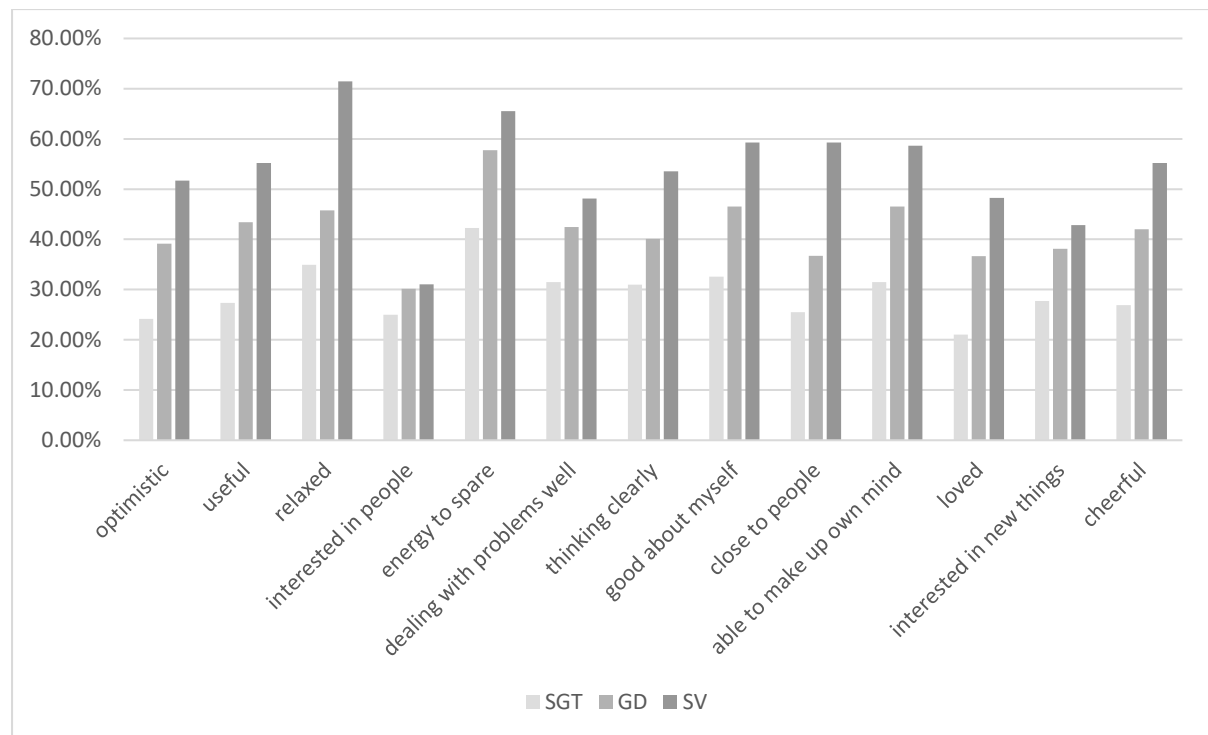
## 6.1. Mental health experiences of GSD youth

### 6.1.1. Evidence from the survey

The survey included a range of questions to measure young people's mental wellbeing. The data across each indicator shows a clear and highly consistent pattern: while SGT youth reported significantly better wellbeing compared to GD youth, SV youth had the worst outcomes across all measures.

The mean wellbeing score for SGT youth as measured by the WEMWBS was 44.80, compared to a reduced 39.34 for GD ( $\beta = -5.46, p < 0.0001$ ), and 35.04 for SV youth ( $\beta = -9.76, p < 0.0001$ ). Figure 13 visualises the proportion of young people responding 'rarely' or 'none of the time' when asked how often in the last month they had experienced each subcomponent measure of subjective wellbeing contained in the WEMWBS. As demonstrated by the graph, SV youth were most likely to say they had rarely or never felt optimistic, useful, loved etc., over the last 30 days, followed by GD youth.

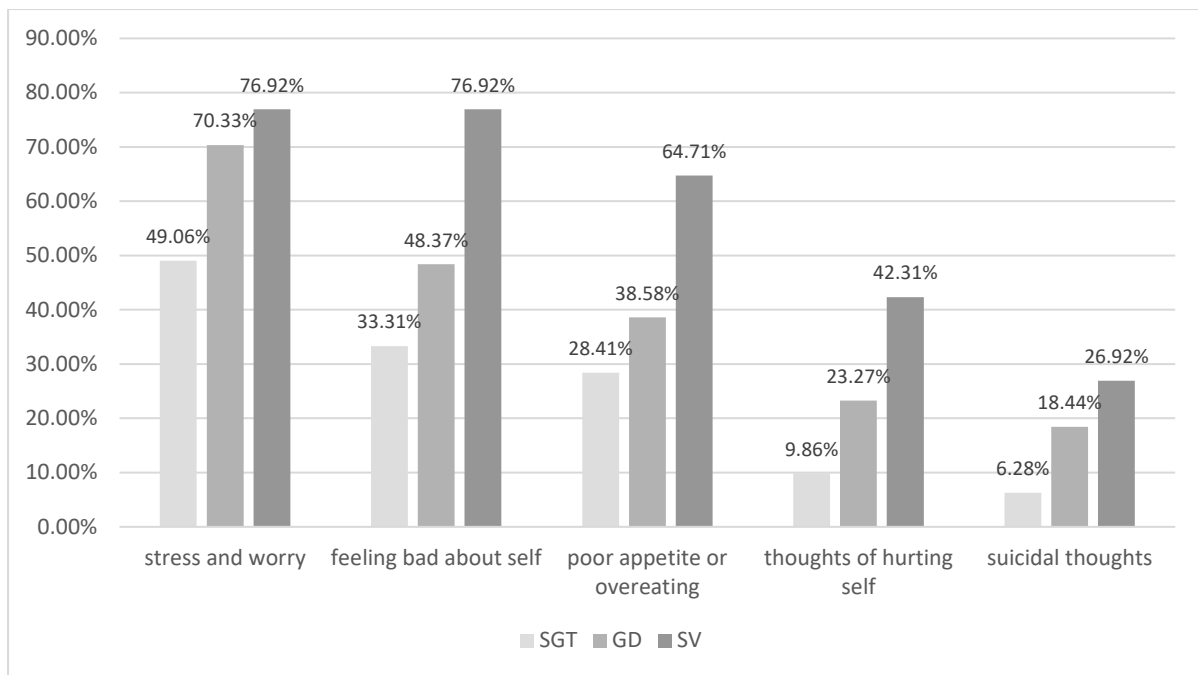
Figure 13: % of young people reporting that they rarely or never felt the following in the last 30 days



Furthermore, as visualised in Figure 14, over three quarters (76.92%) of SV, and two thirds (70.33%) of GD youth said that for all or most of the last 30 days they had experienced “stress and worry”, the same proportion (76.92%) of SV youth said that they had felt “bad about themselves or like they had let themselves down” every day or most days, along with almost half (48.37%) of GD youth. Over a third of GD youth (38.58%) and almost two thirds of SV youth (64.71%) also said that they had frequently experienced poor appetite or overeating. Concerns about self-harm amongst GSD youth have been widely reported (Bradlow *et al.*, 2017); in this study, over a third (35.05%) of GSD youth said that they had thoughts of self-harm every or most days over the last month, and, again, rates were particularly high for SV youth.

Figure 14: % of young people reporting feeling the following 'everyday' or 'most days' in the last 30 days





Almost 1 in 4 (23.21%) of GSD youth reported having a long term mental health disability, compared to just 3.11% of SGT youth. GSD youth were seven times more likely than SGT youth to say that they had ever been referred to a mental health service (OR=7.12,  $p<0.0001$ ), and significantly less likely than SGT to feel that these services had met their needs ( $t(1129)=4.08$ ,  $p<.00001$ ). A little under half (47.69%) of SGT youth referred to a mental health service had felt the service had mostly met their needs, compared to only 2 out of 5 (40.82%) of GD youth, and less than a third (29.63%) of SV youth.

#### 6.1.2. Evidence from life story interviews

Evidence from qualitative interviews corroborates and contextualises these findings from the survey. In this section I narrate the stories of 6 young people who shared their mental health journeys and care experiences in some depth. Common themes that emerge from participants' accounts include: feelings of loneliness and isolation; experiences of violence and stigma, due to a failure to conform to normative categories of gender; a sense of shame and needing to hide aspects of their identities; learning to internalise suffering and deal with problems alone; feeling let down by support services; struggling in education, and resorting to self-harming coping strategies.

##### *Ember's story*

Ember recalled struggling with issues concerning her gender and sexuality since early childhood; as a child she never spoke about her feelings, but she found ways to express her femininity through clothing and makeup. Age 13 she remembered seeing a transgender girl for the first time on

YouTube and thinking: *“that’s me”*, at the same time Ember felt helpless to act: how would she find the resources to transition, and what would everyone think?

*No one spoke about that stuff, and the people that did, it was like, oh drag queen, tranny – such a negative connotation: tv shows of old men in dresses. I don’t want people to look at me funny. I’m going to look so stupid.*

Ember determined to keep quiet about her feelings: *“I never wanted to say anything. I just pushed it to the back of my head”*. Her fear of “coming out” as trans was reinforced by the violence and bullying she was already experiencing at school because of her effeminate appearance and mannerisms: *“if they are giving me such a hard time now - imagine.”*

Ember described being subject to “constant” abuse throughout her teenage years, including name calling (*“that gay boy”* and *“fagot”*), physical assaults and vandalism of her property: *“some kid got up in class one day and just punched me in the face. One time in the lockers, I went in, and my bag was on the floor and my phone had been scratched”*. According to Ember, no action was taken to address this bullying; instead Ember received the message that she had *“brought this on herself”* for failing to conform. Ember described how she became accustomed to *“putting on a brave face”*, and *“having to deal with that myself”*.

Age 16 years Ember left school and started an apprenticeship in a hair salon. Continuing to live as male, she began experimenting with an increasingly feminine appearance. By age 18, however, the pressure of “pretending”, to be *“a guy that wears makeup”*, became too much. Ember described how she was just “so unhappy”. She decided something needed to change: *“I know who I am but this isn’t it. I need to just like make some room for myself, to find my feet, and just get comfortable”*.

Ember approached her local GP and asked for a referral to a gender clinic. After received a letter that the wait to see a specialist would be at least 12 months, Ember decided to take matters into her own hands. She started purchasing hormones from an overseas website,<sup>80</sup> funding her medication through posting videos of herself on YouTube. Ember described how stressful she found it to source her medication this way:

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<sup>80</sup> Ember learned about this website through social media forums, where she met a group of young trans women living in the USA, who had advised her on where to buy the medication.

*I was paying like 200-300 pounds every 2-3 week for the drugs. You didn't know whether it was going to come, and you had no recourse to get your money back.. you could be taking rat poison! There are some nasty people out there and they know people are desperate.*

Despite her concerns, she kept sourcing and taking the pills, recalling her thought process: *"I'm doing this because I have to"*. Overtime she realised the medication was working; her appearance began to feminise and she started growing breast tissue. As she became aware of these changes, Ember recalled her mood lifting; she grew in confidence, describing feeling more "secure" and "powerful": *"I just felt so much happier, more comfortable: physically, mentally."*

Almost 16 months later, two months before her long awaited appointment at the GIC, Ember made the decision to stop taking the tablets. She was afraid that her actions could be seen as evidence of mental instability and poor decision making, and therefore compromise her eligibility for treatment on the NHS<sup>81</sup>: *"I thought I don't want to jeopardise a legit prescription over an illegal one. I was panicking – what if they know I was taking them? I need to get rid of it all out of my system"*.

As the effects of the feminizing hormones began to reverse, Ember rapidly descended into crisis. Having got used to living as a "passing" woman, she began to feel increasingly unsafe and dysphoric: *"I can't go anywhere.. All those changes were reversed. I lost all that tissue, and I masculinised. Hair everywhere. My boobs just – gone. My voice went down really low again"*. Ember characterised these changes as coming "like a bang" and "a thunderstorm". She described how her dysphoria intensified to new levels: *"even ten times worse than before"*, having coming so far, only to have everything taken away again, she "spiralled": *"I was like, I've come so far, I've seen the grass on the other side, and I really need to get back on that grass"*.

Ember started drinking and smoking heavily and taking drugs: *"I was so depressed, and my anxiety was going crazy."* Unable to sleep, her behaviour became increasingly erratic, and she started losing the support of those around her: *"I was like off the rails, and just like severing all my relationships with everyone."*

Ember made an appointment with her GP to discuss her difficulties sleeping and anxiety attacks; She was prescribed some medication and referred to talking therapies. Ember felt sceptical about therapy: she was desperate to be back on HRT and didn't see how simply talking to someone who

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<sup>81</sup> According to GIDS's protocols self-administration of hormone blockers or cross sex hormones without an NHS prescription is considered a clinical contra-indicator for young people's access to cross sex hormones (NHS England 2016) (however, there is no mention of this in guidance for adult GICs).

“didn’t understand” or “know her life” could help. Nevertheless, she agreed to the referral. According to Ember, her appointments kept being cancelled, due to staff absence and administrative matters. These issues only exacerbated Ember’s feelings of loneliness, abandonment and being let down by services, and she decided to discharge herself: *‘I was just like sod it. You’re not even any help. It goes back to that whole - nobody cares, nobody gives a shit’*.

After a period of turbulence at home, Ember was evicted by her mother, and started moving between various friends’ houses, sleeping on couches and floors. Just weeks later, Ember made an attempt at ending her life; she described the night that she overdosed on her prescription sleeping pills:

*It was like no one cared. I’m here, just feeling so dysphoric. There wasn’t any point in like living you know? That night I went to a house party and I got absolutely disgustingly drunk and I told my friend, ‘I’m just going to kill myself.’ I remember, it was just a blur, but I was walking down the street with no shoes on and like screaming and crying, I just took a whole packet of sleeping tablets, and um, then I don’t know what happened, but... I woke up.*

Ember described waking up to a fire engine and an ambulance parked outside and paramedics “banging at the window”. She recalled them breaking the door to get in, carrying out some basic medical checks, asking a few questions, and then leaving. She described the paramedics as “insensitive” and abrupt: *“then they just left – like, ‘we’ve got to go’. And I was like ‘ok. You’ve broke the back door, but ok.’*

Ember decided to keep quiet about her suicide attempt and seek no further support, either from the GP or Talking Therapies, afraid that any disclosure might compromise her GIC referral and assessment for gender dysphoria (an issue discussed in further depth in section 6.2 below). Shortly after Ember had her first appointment at the clinic. She shared nothing about her mental health struggles. She characterised the appointment as “really weird”:

*There was some questions like - were you abused as a child or something? Things like that. It goes back to that old mindset, like just because someone was molested as a child, does not mean that they are gay, or they are on a... I dunno it just seemed really weird, like there was some odd questions.*

After a couple of appointments, Ember was offered a referral. At interview, Ember had recently started on an NHS prescription for oestrogens; she was living back at home with her mother, and feeling more emotionally stable.

### *Jennifer's story*

Jennifer's account of her experience shared many similarities with Ember. Jennifer described suffering from dysphoric feelings for as long as she could remember, intensifying age 12 as her body started masculinising due to puberty. Jennifer described how she "despised intensely" the changes happening in her body, especially her "voice dropping" and "the facial hair"; she found herself feeling "jealous" her female peers. Jennifer couldn't make sense of her feelings, recalling: *"I didn't know what was wrong with my brain. I had nowhere to pin my thoughts"*. According to Jennifer her only knowledge of trans people was from TV comedies from the 1990s: *"you know where they say 'hey, this woman has a penis and everybody laughs and goes 'oh that's disgusting hababa'. Or weird fetishes – cross dressers who put on women's clothing an masturbate"*. According to Jennifer, she just "sat" through her pain and felt "sad for a while".

Like Ember, Jennifer started experimenting with a more feminine presentation, wearing "eyeliner" and "skinny jeans". She increasingly became a target of violence and abuse: *"I'd get shouted out, and shoved about. You know – bullying"*. She became fearful of using public bathrooms and worried for her general safety.

Age 18, Jennifer made her first contact with other trans people on the internet, which she described as finally making "sense of everything". However, like Ember, she lacked confidence to "come out", fearing that everyone would "hate" her, she might lose all her friends, and become a *"laughing stock"*. Meanwhile, Jennifer's feelings of discomfort and dysphoria were becoming so acute that she started having regular thoughts of ending her life.

Two years later, Jennifer went to see a GP, who insisted on referring her for psychiatric assessment. According to Jennifer, this doctor (who was not specialised in gender issues) spent most of the appointment asking a series of detailed questions about her sexual activities and preferences: *"he starts getting really specific about you know, who are you attracted to, do you like anal sex?"* Jennifer felt stigmatised by the encounter; she found the questions intrusive and inappropriate and was uncomfortable sharing such personal details: *"why do you need to know? Strange questions about my sex life, don't really tie in to gender specifically. Really intrusive questioning. He was really stubborn when I said I didn't want to go into that."*

Following this assessment Jennifer was referred on to a GIC. Jennifer waited a year for her first appointment. During this year Jennifer slowly descended into crisis: her relationship with her

girlfriend broke down and she was evicted from their shared flat. Jennifer started sleeping on friends' couches; shortly afterwards, she dropped out of university: "*[I was] not doing well [in] my studies. I couldn't take the gender dysphoria, suicidal ideation, being dumped, and being homeless all at the same time so I dropped out.*"

Jennifer recalled her optimism and sense of relief when the time for her first GIC appointment arrived: she recalled thinking she was finally going to get some help for her dysphoria. Jennifer's hopes were dashed when the clinic refused a referral for hormonal interventions. Instead, Jennifer found herself required to attend what she described as regular "therapy meetings". She felt her clinicians were focused on trying to externally judge the authenticity of her gender identity: "*oh, no, we have to really make sure you're definitely trans before we do [anything]*". Jennifer found their questions repetitive and time wasting: "*they're asking me the same questions over and over again, me giving responses like, yeh, no, I definitely, definitely hate being a boy, definitely don't like that. This was all while I was really dysphoric, wanting to kill myself.*"

After two years of "wrestling" with the GIC, Jennifer decided to source HRT herself through an online provider. Jennifer described weighing up the risks of taking unregulated medication, against the risk of suicide if she continued as she was: "*I'm like ok.. one [option] has a light at the end of the tunnel the other doesn't!*" Jennifer said she had no regrets. At the time of interview, she was living as a "passing" woman and felt relatively comfortable in herself. Jennifer had stopped attending the appointments at the GIC, and never received any follow up.

#### *Rory's story*

Rory recalled feeling that "*something was wrong*" about his gender around age 11. Two years later, he "came out" to his family, because he felt unable to continue tolerating wearing the girls' uniform at school. Rory's family did not receive the news well; he recalled the night that he decided to speak to his mother, sister and grandparents: "*they were just screaming at each other. It was so bad*". Rory's revelations about his gender put further strain on already fragile familial relationships, and he found himself becoming increasingly distant and isolated: "*we didn't talk, I just wasn't going to deal with them. I'm definitely not close with them. I don't really want to be around them.*"

Meanwhile, at school Rory had become a target for homophobic and transphobic bullying. He explained that he had "no friends" and was subject to daily harassment and abuse: "*there was never*

*a day where I [wasn't] bullied. They called me any kind of slight you can think of. It was creative."* He described having rocks and food thrown at him and feeling "petrified" to go to class.

Age 12, Rory had been referred to CAMHS after he was found self-harming. According to Rory the school insisted on the referral and his mother agreed. Rory characterised CAMHS as "*not at all helpful*" and "*a waste of time*"; he described his therapist as "completely clueless" concerning issues around gender, and reluctant to discuss the issue "*she didn't want to go too deep into it*".

Around the same time he came out, Rory pursued a referral to GIDS, desperate to obtain access to testosterone. A year later he had his first appointment, followed by another year of bimonthly appointments to assess his treatment options. Rory recalled being asked "*everything they could possibly ask*." He characterised the appointments as focused on: "*trying to figure out what's going on in your head*."

In Rory's view he was "so ready" for hormones, but, following a year of appointments, GIDS determined he was not even eligible for a referral for PBs. Rory described being "shattered" by this decision: "*that was a massive step back for me mentally. I think I had so many expectations [of GIDS], and.. it was so different*". Rory's frustrations were compounded when he learned that another trans boy in his school had started PBs, despite entering the service after him: "*their wait was so short, which really confused me. Their entire experience has been completely different, and I have no idea why. I don't know if it's the psychotherapist.. It's so weird*". At interview, Rory remained confused about GIDS' decision not to refer him to endocrinology, but suspected it was because he was so mentally fragile. He also wondered if the absence of his biological father (who left home when Rory was an infant) was an additional barrier.

Following GIDS' determination, Rory's appointments were scaled back. According to Rory he wasn't informed of this change, which sent him into a state of "panic": "*you become so used to appointments, then I didn't hear anything for six months... what the hell is happening? That horrified me. I didn't know what was going on*". Rory remembered repeatedly calling GIDS to ask for an explanation. Eventually he was allegedly told that GIDS' could neither discharge him, nor "*do anything else*" to help; all they could do was "*wait and see if anything changes*".

Meanwhile, Rory started truanting from school. His self-harming behaviour intensified and he started having regular thoughts of ending his life. Rory decided that his last hope to "save his life"

was to try and change schools: *"I couldn't go on. If I had stayed at that school I would have killed myself. The day that I left was the [first] day of half term.. I wouldn't have gone back."* Telling no one, he wrote to a local college, detailing the bullying he was exposed to on a daily basis, and requesting an emergency transfer. Rory's email was persuasive, and after an interview and further arrangements, he was offered a place at college.

This move was the beginning of some positive change for Rory. He started college as a socially transitioned male. He described the environment as "LGBT friendly", and he had started making some friends: *"people actually liked me. That was a pleasant surprise. It felt weird though."*

At the time of interview, Rory was still attending appointments at GIDS. According to Rory, they were now doing a "reassessment"; he described:

*It's long, and I don't want to say boring - but boring. It just takes up so much time. I understand why they need to know [stuff about me] - but it's not going to help me mentally in anyway with anything to do with being trans because, I know all of this [already]. Obviously, they don't [know], and they might need to know, but it doesn't help towards transition at all. I don't completely see the relevance.*

#### *Blake's story*

Blake's difficulties with her body started age 11, when she was told about her sex variation, CAIS, at a doctor's appointment. Prior to this, Blake didn't recall ever really questioning her gender:

*I was always what would be described as 'tomboy-ish', I wasn't really a girly girl in any way, but I didn't really have any feelings of not being female before that point. It's something that I didn't really think about. I just took it as 'read'.*

The sudden discovery of her diagnosis threw Blake into a state of mental turmoil. She described herself as "reeling" from the news, as if from a "bad dream". Meanwhile, she remembered the approach to her diagnosis being "very practical", with little attention to her emotional experience:

*The consultant gave me information and then I just went back to school that same day! And, erm, that was it really. There wasn't any emotional support, anyone saying 'it's ok if you find this hard'. I think it's a failure in how it was dealt with at the time, because really I think it's normal to not be fine in that situation. As much as I was saying no I'm fine, I feel like there should be someone who sees through that. That side of it – the side of emotional support has always been quite lacking really.*

Blake was afforded no opportunity to discuss the complexities of her feelings; the only thing she did recall was the doctor repeatedly emphasising: *"you **are** a woman, you **are** a woman. I remember, the[dr] - trying to very strongly make that point I remember that being the focus."* Blake, however, was not



convinced; she describe a feeling of suddenly “losing” who she “was”, and a sense that the entire future she had imagined for herself had evaporated. Blake remembered keeping quiet about her feelings. Lacking any external support, or outlet for her pain, she tried to internalise: *“I didn't speak about it at all, but I was very, very upset.”*

Blake told no one about her diagnosis, viewing it to be a shameful secret that she had to keep hidden from everyone. She believed that if she told anyone “the truth” about her body, the response would be “revulsion”, “disgust” and “rejection”, and the consequences, “loneliness”.

Blake’s sense of needing to hide was reinforced by the secrecy around her diagnosis, including the decision not to tell her about her AIS until she was 11 (and needed to start HRT). Furthermore, Blake described feeling “in the dark” about her medical care, and kept on a “needs to know” basis, told only pieces of information when she was about to receive particular treatments.

Blake was unsure why her AIS had been kept hidden from her for so long. She speculated that perhaps her parents and her doctors were trying to “protect” her, presuming she “wouldn’t understand” as a younger child. Far from protective, Blake felt this decision had only intensified her suffering. In Blake’s view had she “always known” about her AIS, it would have helped to normalise her condition. She could have grown accustomed to the idea of her body *“at a time when I wouldn't have been embarrassed about it, it would have just been just who I was”*. She also felt that she would have been spared the trauma caused by the ‘event’ of her diagnosis, which lived so vibrantly in her memory as so sudden, catastrophic and life changing.

Continuing to undergo medical interventions and unable to share her experience with anyone, Blake described becoming increasingly “paranoid”. She feared that people might find out about her CAIS, or that they already “suspected” or somehow “knew”. She started to experience a sense that people were always “watching her”. Blake also described living with a profound sense of “guilt”: feeling like she was “living a lie” and not being truthful with those around her about who she really “was”: *“I was, I suppose, a fake?”* The more she tried to internalise and repress her feelings, the more they grew: *“it became quite extreme really, because I didn't talk about it with anybody, my emotions, how I felt about it was so negative”*.

Age 13, Blake started self-harming. She described self-harm as “a big part of her adolescence” and something she used as a “coping strategy” until she eventually stopped aged 20-21. Blake explained

that self-harm offered her both a “release” for her pain, and a sense of control: she couldn’t change her body, but she could choose to hurt herself:

*I felt such strong feelings towards the AIS. One feeling I had was a lack of control. AIS was something that I wanted to change and couldn't, and self-harm is a release of emotions, and your little thing that you are in control of. I think that's quite important.*

Blake kept this behaviour hidden from everyone; she described it as “a very private thing”, and made sure that she always dressed to cover her injuries. Blake explained that she would have found it impossible to talk to someone about self-harming, as, in doing so, she would have to disclose her sex variation: *“people ask you 'why?' and then if I was to be honest I would have to explain the AIS.”*

Blake’s injuries went undiscovered until she was admitted to hospital for vaginal reconstructive surgery aged 18 years. Blake recalled her sense of relief, when a consultant finally noticed and suggested she might need some mental health support: *“abb - yes please! because I can't - I just feel like I can't come forward and ask for it. I needed someone to say, here, it's ok, you don't need to seek it out, it's just here if you need it”*. Blake was referred for a psychiatric assessment and began to have bi-monthly meetings with a psychologist. Blake described these meetings as somewhat helpful but limited. She explained that they weren’t regular or consistent enough to offer substantial support; furthermore, rather than dealing with her history of struggle concerning her diagnosis, the appointments were more practical and forward focused. Blake still felt a strong need for more mental health and therapeutic support and considered this the biggest gap in her medical care.

At interview, age 24, Blake said that she was still very private about her sex variation. She had yet to tell her partner of four years. According to Blake, she had never even had an honest conversation about it with her parents: *“the odd occasion it comes up, it was always a very emotional kind of outburst. It wasn't a conversation where I could ask questions. It was – lots of crying – nothing really clear.”* Blake still experienced a sense of lying to those around her about who she “really was”, and of “never being herself”. She said that one of the reasons she was most keen to participate in this study, was that it provided her an opportunity to *“come to something as who I really am, which is so, so rare”*.

#### *Olivia's story*

Olivia’s story had many similarities to Blake’s. Growing up, Olivia recalled being “such a tomboy”, yet also settled and certain in her femaleness: *“I used to scream if [mum] made me go into a girls' clothes shop. I used to live in my football gear and skateboarding stuff, but I felt, personally, female. I never had questions*

*about that stuff*". As discussed in Chapter 5, Olivia's VSC was discovered when she was 16, after a series of investigations into why she hadn't started menstruating. Like Blake, Olivia was staggered by her diagnosis, which she experienced as very "sudden" in her memory, and life changing. She recalled the interaction with the doctor as "quite limited" in terms of "*the information they were able to share*" and felt unable to ask too many questions. Olivia described:

*It all happened very quickly and then that was it. It was sort of 'done', and there was no explanation really. I was 16, 17 and thinking I was going to go to university soon - how am I going to bring this up with a boy? It was bizarre, I had no idea how to even approach the conversation.*

As Olivia started to reflect on the meaning of her diagnosis, she described a growing sense of isolation and disconnection from others. She felt too embarrassed to discuss the issue with her parents, and wondered how she would ever explain it to anyone else: "*it was really lonely, a really lonely place.*" As she tried to internalise her feelings, Olivia started to feel increasingly anxious and depressed. The implications of her diagnosis felt so totalising that she started to lose her sense of purpose, hopes for the future, and pleasure in everyday activities:

*It honestly got me down so much. I can't have children, what am I going to do? What's the purpose? You go through life and you have children, that's what it's all for isn't it? You work hard and provide a nice life for your children. Why am I working hard?*

Soon she found herself regularly waking up in fits of tears and lacking the strength to get herself to school. She explained that her mind wasn't "*in the right place to be learning*", and she would make up excuses for staying home: "*I'd say I wasn't feeling very well but actually, it was that I just couldn't face going in*". Olivia remembered feeling like she wasn't "good enough", because her body didn't conform: "*sometimes it really hurts, like - why am I not good enough? I felt like an alien.*" These thoughts became so overwhelming, that she started having panic attacks: "*it spirals out of control – that feeling that I wasn't deserving*".

Olivia felt that these feelings were exacerbated by the medicalisation of her sex variation: she described feeling as if she was being treated as if she were "unwell" even though she felt "healthy": "*it's something that's [medically] treated and it's a disorder and all of these things. We're healthy, but we're treated in hospital... It seems like it's an illness but it's not. There's a lot of stigma.*" Furthermore, like Blake, she described how her care was entirely focused on physical interventions, with little attention to her emotional needs: "*nobody was there to see how I was doing*".

At one point Olivia recalled one of her doctors suggesting the possibility of some counselling; however, she remembered that her mother was opposed to the idea of her talking to a therapist, in case it opened up confusing ideas about gender and identity. Olivia laughed at the (in her view) absurdity as she recalled: *“she was worried that [a counsellor] might try and turn me into a boy!”* She remembered her mother insisting that she was “ok”, and *“didn’t need to worry”*. Olivia explained that she didn’t feel able to push the issue: *“I suppose I was still quite young then, so I didn’t really know what was going on.”*

A few years later, Olivia started university. Away from home for the first time, she decided to seek out some mental health support. She was able to access a counsellor through university services. Olivia said that she hadn’t actually found the support particularly helpful, as the practitioner she saw had no particular expertise on issues concerning sex variance: *“it was just focused on more generic counselling for any old person I suppose. Not specific to the diagnosis”*. Olivia explained that she *“went along with it”*, but she wished that she had had the opportunity to speak to someone who knew more about sex diversity and could offer some more specific guidance and support: *“I want to talk about how do I approach it with a boy? How do I go about my life? How do I talk to my friends about it?”*

At the time of interview, Olivia described herself as *“pretty much managing to cope”* on an everyday basis. Nevertheless, she said that she still had “down days”, with many unresolved questions about her diagnosis. Olivia expressed a continued desire to access some specialist counselling to explore her feelings: *“I think just coping mechanisms or something like that might be really useful. More specific support, in terms of mental health, wellbeing.”*

#### *Finley’s story*

Finley’s mental health journey was somewhat different to Blake and Olivia. Whilst Blake and Olivia’s descent into mental health crisis had started with their DSD diagnosis, Finley had struggled with complex feelings concerning their gender and body since early childhood (well before their variation was diagnosed, aged 18 years). Unlike Blake and Olivia, Finley’s variation had conspicuous side effects, including early breast and pubic hair development, excess body hair, weight gain, and an enlarged clitoris. Also, unlike Blake and Olivia, Finley identified as non-binary: *“fluctuating between androgyny and kind of butchy.”* Meanwhile, they explained how, from a very early age they had felt intense pressure to embody an ideal of femininity that they could never fully achieve, resulting in feelings of bodily disaffection and dysphoria: *“these strong pressures to be this pin up, woman, to be incredibly feminine, I felt that pressure like a cage”*.

Finley described how their inability to conform to normative ideals of femininity caused them to feel alienated and disconnected from their peers, lonely and withdrawn: *"it's othering. I did feel on the outside. The female experience, I just couldn't relate to it"*. These feelings were exacerbated when, as a young adolescent, they didn't start menstruating. Unable to participate in everyday conversations amongst female-typical peers, Finley felt like "an outsider", and excessively self-conscious: *"I'm like a 13 year old girl, people bond over this stuff – 'when did you start your period? What contraception do you use?' I'm just mute. I used to be so shy and like anxious."* Overtime, Finley described becoming increasingly self-conscious about their body. They developed an eating disorder, became severely depressed, and started to self-harm: *"I was becoming very thin and sad on my own. It was just all very distressing."*

From a young age, Finley was also a target for gendered violence and bullying. Finley started puberty unusually early (a side effect of their variation) which incited unwanted attention, sexualised mocking and name calling: *"I was called Finley-with-the-boobs", "I hated it, [it] caused me pain"*. At secondary school, they were teased and rejected by their peers due to having excess body and facial hair: *"some of the people at school who were embodying this perfect feminine ideal – straightened hair, makeup, boyfriend, popular, thin, fashionable - they weren't very nice to me. I was ridiculed at school for having a moustache."* Finley described one particularly traumatic encounter as an older teenager, where they were sexually assaulted by a boy in their class; during the assault Finley recalled him repeatedly insisting: *"I don't believe you're a girl, I want to see that you are a girl. Show me that you are a girl."* She added quietly: *"so you learn that this ambiguous place – gender nonconforming place – that made me vulnerable"*.

Age 18, Finley's variation was finally diagnosed: *"I think it really exaggerated this feeling of like - there's something very wrong with you."* Like Blake and Olivia, Finley felt that their concerns about the implications their diagnosis were dismissed: *"[the doctor] just told me not to worry and everything was fine. She didn't attempt to address any of the emotional stuff like around the appearance of my vagina"*. Finley remembered trying to ask questions about their body, and just being told they shouldn't worry: *"[excess hair] was big thing for me.. the [Dr's] response was I have more hair on my nipples than you don't worry"*. Finley recalled finding this approach unhelpful: *"it's like this thing of like not addressing the worry, but just saying– don't worry about it."*

Age 21, Finley finally decided to seek some counselling, through a service and university. Finley described feeling like they had 'overloaded' the counsellor with the complexity of their mental

health issues: “*I came to them as someone who was depressed and self-harming, and then in my sessions, I was like, I’m [also] really gender dysphoric I’m really struggling with food.*” Finley characterised their counsellor as not “*knowing what to do*”, and “*like a rabbit in the headlights*”. Once again, Finley felt like the counsellor was just trying to “*shut the conversation down*”, simply telling them “*not to worry*”. Finley reflected: “*it doesn’t do anything to explore what you are feeling. And give any kind of relief in that sense. It’s kind of like a person saying to you - I’m not attempting to understand*”. Finley wasn’t sure why the counsellor had responded this way, speculating that perhaps she lacked knowledge about issues concerning gender and sex variance, and was afraid of “*saying the wrong thing*”. Finley also wondered if the counsellor found their differences somehow intimidating: “*people don’t know a language around this stuff. Or even more, it just threatens what they know. I just think she didn’t know what to do with the information.*”

#### *Differences in the experience of sex variant compared to gender diverse youth*

While there are strong common themes that thread young people’s accounts, one key difference in the experiences of sex variant youth, compared to sex-typical trans youth, is the attention apparency afforded by specialist services to mental health concerns. While Jennifer and Rory were subject to unwanted psychiatric assessment and therapeutic interventions, Blake, Olivia and Finley desperately wanted mental health support that wasn’t readily forthcoming. In fact, all three recalled being actively discouraged from exploring ambiguities and anxieties surrounding their bodies and identities, by medical providers and caregivers, who rather focused on reassuring them in a definitive, binary and normalised account of their gender, despite the complexity of their feelings (e.g. Blake: “*she kept emphasizing you are a woman*”).

These differences make sense from a standpoint where sex and gender are viewed as binary, biologically determined and naturally aligned. Such a perspective implies that sex variations are physical (congenital) deformities which impair the body’s completion of ordinary sexual development. Forms of gender variance, on the other hand, are conceived as maladaptive psychological responses to social, cultural and environmental factors. It follows, that whilst treatment for VSCs should focus on medical correction of physical bodies, therapeutic and mental health interventions should be prioritized for supporting children experiencing issues with gender, at least as a first line of defense.

Both lenses may compromise the provision of mental health support for GSD youth. In the sections below I explore, in particular, how psychiatrising discourses, that shape medical understandings of gender incongruence can create a range of contradictions and barriers to

support for GD youth seeking help for both gender dysphoria and their mental health more broadly.

## 6.2. The psychiatrisation of gender dysphoria

### 6.2.1. Gender dysphoria as psychiatric illness

The formal diagnostic criteria for understanding (trans)gender variance currently relied upon in the NHS is contained within the Diagnostic and Statistical Manual for Mental Disorders (DSM-5). ‘Gender dysphoria’ is defined as a psychiatric illness, specified by the ‘clinically significant distress or impairment’ marked incongruence between an individual’s experienced/expressed gender and their gender-assigned (American Psychiatric Association, 2013; Duschinsky and Mottier, 2016).

The ‘distress’ criteria has invited particular criticism in trans literatures, on the grounds that it fails to account for the wide variety of modalities of trans embodiments: not all of which imply a negative or distressing experience of the body (Ashley, 2019). Furthermore, as pointed out by a number of participants in this study, it runs the risk of leaving gender incongruence ‘untreated’ until a child, who was previously content, becomes acutely distressed. The problem with this approach can be seen particularly clearly when considering the prescription of PBs to trans children at Tanner stage 2.

*At the moment the Tavistock’s model seems to be that you have to experience really acute distress in order to prove that you are a transgender child. I just can’t help thinking, there must be a better way. Do you really have to wait until they are in so much pain before you do something?* (Clare)

*Some [children] might be just completely happy, I’ve been living as a little girl no problem at all, and it’s not going to be a problem, if you just stop puberty, I’ll be fine.’ But then they’re not dysphoric enough, so we have to make them go through male puberty in order to induce that dysphoria, so that we can prove that you are transgender! But that never goes away.* (Jemima)

This was precisely Sophie’s concern when Isla was due her first appointment at GIDS. Sophie explained that Isla had never really expressed any particular upset around her gender, just an insistence that she was female: *“she’s so pragmatic about the whole thing, so confident”*. Sophie worried that GIDS wouldn’t take Isla seriously: *“I was really quite concerned that they’d go, but Isla’s not showing any actual distress, so why are you here?”*

As it was, Sophie needn't have worried: *"they took us completely seriously"*. Isla's experience, however, was somewhat exceptional: (as mentioned in Chapter 5) she was one of the first children in Britain to receive access to PBs at 12. Her experience is likely to have been facilitated by the fact that she had been under the care of CAMHS since she was six years old. Although Isla was not presenting with any mental health difficulties, CAMHS had suggested that they regularly see Isla to facilitate her referral to GIDS when the time came. According to Sophie:

*So he said, 'we're going to see you every 6 months. Not because I think it's a problem. I don't. But, he said, I want you to have a paper trail, so when I refer you, to the gender services, which I will do, you will have a record, of coming to see me for the last 6 years - so they'll know it's not a whim, it's not a new thing, it's not you being paranoid. You'll have a record'.*

Elizabeth's experience with Liam was quite different. Liam had first been referred to CAMHS, via the GP, at a similar age to Isla. In Liam's case, however, CAMHS had been uncertain how to proceed, as he wasn't presenting with any obvious mental health difficulties: *"they are saying – are you unhappy, confused, anxious? And he's like – no. And they're like well we don't really know what we can do for him because actually his mental health is fine."* CAMHS discharge Liam after referring him on to GIDS. Six months later, Liam was seen at the clinic, Elizabeth described how the psychologist was particularly interested in how happy and comfortable Liam seemed: *"she said, you know, he doesn't seem to be in any distress.. to be in any confusion."*

According to Elizabeth, Liam was discharged from GIDS after just two appointments. Elizabeth remembered a clinician telling her: *"there there's only a 5% chance [he's] going to be transgender"*. She also recalled the clinician advising that, since Liam wasn't distressed, she should try and encourage him towards a more gender-typical presentation: *"I could help by making some decisions for him. Might be easier for him...[to] guide him towards the boys' stuff"*. Elizabeth added that she hadn't followed this advice: *"I'm not sure it's the right thing to do."*

A second, equally significant problem associated with the 'distress' criteria is that mental distress can be a symptom of a myriad of different 'conditions' or experiences, for which there may be a range of different treatments or sources of support. As pointed out in the Cass Review (2022), a process called 'differential diagnosis' constitutes an important part of any clinical assessment, whereby clinicians consider and exclude other conditions that present in a similar way, but may need quite different care. In the context of trans healthcare, therefore, the clinician must seek to 'determine whether the child or young person has a stable identity or whether there might be other causes for the gender-related distress' (p.59). Meanwhile, if a young person is determined to have



other mental health concerns, these might be found to have implications for the perceived stability or coherence of their trans identity, as well as their capacity to consent to potentially life altering hormonal and surgical interventions. Ezra described the contradictions he experienced trying to navigate this diagnostic process:

*You have to prove you are mentally well enough to have a mental illness! Are you depressed or are you trans? You have to pretend you are mentally stable - you cannot admit to feeling depressed. But at the same time you hate yourself, and you have to talk about how you hate yourself, you are in the wrong body, etc. So how can you reconcile hating yourself with being mentally well? It's a fine line to tread.*

For many young people, navigating this “fine line” meant keeping quiet about the true extent of their mental health difficulties, potentially cutting off access to support. As discussed in section 6.1.2 above, Ember had avoided seeking help after her attempted suicide, out of fear that doing so might compromise her referral for HRT: *“I didn't speak to the Drs or anything.. I... was a bit fearful because I was like – [what] if I don't get my hormone prescription because I'm mentally unstable...”* At her first GIC appointment, Ember disclosed nothing about her mental health crisis and history of self-harm:

*I couldn't say anything about any of that stuff, because I was like - if I say that, it's going to be 'oh wait another two years', do you know what I mean? If I have to lie, then I'll have to lie, but if it means I can get my hormones..*

Ember expressed regret at being put in such a position: *“I think that's really sad, like how that has to work like that”*. She explained that having to lie about her mental health struggles had caused her additional anxiety and stress:

*I don't feel like people should feel pressure or anxious about talking to the person who's doing that appointment. Because I was like so anxious, all I was thinking was, if she has any idea that any of that stuff went on.. I can't let that ruin my opportunity.*

Ember pointed out the irony of the negative spiral she had been in. On the one hand, delayed access to treatment for her gender dysphoria had contributed to her mental health crisis. On the other hand, the poor state of her mental health could be grounds for further delaying a referral for hormones, increasing her anxiety and cutting off her access to any help (both physical interventions and psychological support), potentially leading to a further depreciation of her mental health. She explained:

*My mum said this to me, she was like - you were so focused [on] not being mentally unstable to get your tablets you literally became unstable. And it's literally so true! Because I was trying to stay sane for like so long, it just broke... It makes me so mad because the only reason I got so down like that was because my appointments were getting [delayed]. It's almost like – a back*

*hand – I don't know how to word it. Like I got so upset, but then if I was to tell them I was upset, then you were not going to give me something which you made me upset for. Do you know what I mean?*

Similarly, Joe explained that he had avoided disclosing any information about his mental health history at his first GIC appointment: *"I had to be very careful with the stuff I told the clinic because I was like, I need to put myself across in the least mentally ill way".* Joe had been receiving support for anxiety, depression and suicidal thoughts from a local charity; before accessing this service Joe had sought reassurance that nothing he shared could be disclosed to the GIC: *"I had to be so strict about it because if they slipped up then it wouldn't have been good for me."*

Joe explained that he faced an additional complication due to his ASC diagnosis. As with his mental health, Joe was anxious to mask his autistic traits as much as possible during his GIC appointments, fearful that coming across as too severely affected might be viewed as a contraindication for gender dysphoria: *"they know I have a diagnosis but I need to put myself across as only just on the border of autistic. I had to make myself seem as neurotypical as possible because I didn't want to be let down for that."* Joe felt his concerns were validated when he received a written summary of his first appointment at the GIC containing notes about his body language and use of eye contact. Joe believed the clinic were attempting to assess the severity of his autistic traits in order to determine the validity of his gender identification: *"it felt like they were trying to go, 'oh well, that's what that is'. [To] try and make it that I'm not trans, I'm autistic: the push for... me being something else".* He also wondered whether they might be assessing for other mental health conditions: *"if they believe that's the cause then they need to tread a bit lightly. I think the fear is that someone will come in with a mental illness that has made them think they're trans or something like that."*

Like Ember, Joe perceived some irony in his predicament. He explained that his autism had only been diagnosed because he had decided to socially transition. According to Joe, his parents had pushed for a diagnosis after he 'came out' to them: *"they were willing to get me diagnosed as something, to pin being trans on, so like 'oh you're not trans, you are crazy and it's autism'."* Now diagnosed, Joe feared he would face additional barriers to demonstrating eligibility for treatment for gender dysphoria. Sitting in the waiting room for his appointment, he remembered overhearing the clinician say to his parents: *"yes we see a lot of autistic kids come through and they have problems with gender and identity and things like that. Really, really common. It's probably a phase - don't worry about it".*

Reflecting Joe's suspicions, many participants shared concerns that NHS clinics have a tendency to attempt to find an 'explanation' for young people's incongruence, by finding evidence of some pre-existing pathology. George and Chloe remembered their first appointment at GIDS:

*[George:] They were fascinated by [us] as a psychological case study - you know, how did this come to be, and what's the reason and cause for thinking our child is transgender. There's been a long history of [transness] being heavily pathologized, so either it's a delusion, but they don't really believe 3 year olds are delusional, so if it's not a delusional 3 year old then it's crazy parents!*

*[Chloe:] They're stuck in old protocols, written at the time when the world thought it was caused by psychopathology of the mother –it's always the mother's fault!*

Kate recalled her frustration when she arrived at GIDS with Jamie, who had been thriving since being allowed to present as female, including at school. Kate remembered her clinician being puzzled by Jamie's calm, confident, well-adjusted manner at their first appointment:

*[The clinician] said she was surprised at how un-anxious he seemed. [I said] Isn't that a good thing? And she just said: 'well I just thought it was a bit odd, that he would be happy to be left in a room on his own with someone he'd met only once.' And I said - because we had talked about it, and he knew what it was about! I stayed in the room for the first couple of minutes and then said: 'are you ok', and he said 'yeh fine', so off I went to the waiting room. That that could then be turned as something slightly worrying, I think that really sums up the whole approach. they didn't like not having some neurosis there that they could kind of untangle.*

Kate felt that Jamie's clinician viewed their family as "a bit of a conundrum". She explained: "there isn't anything - I mean, we're by no means the perfect family, but we are pretty stable, we are all together. No dramatic events have happened in Jamie's life that could be construed to have had any trauma."

While Kate felt their family didn't have enough dysfunction and trauma for GIDS to work with, Daisy worried her family had too much. She shared how much of their time at GIDS was spent discussing her turbulent marriage and her partner, Keith's, alcoholism. According to Daisy, Aria's clinician had suspicions that Aria was identifying as female to distance herself from Keith, who offered a poor example of a male role model: "I think they are looking for reasons why she wouldn't be transgender. Maybe Aria thinks she want to be a girl because of Dad's drinking - because Dad's in AA'." Daisy worried that this might ruin Aria's ability to obtain a formal diagnosis of gender dysphoria and access to PBs: "I think they are looking for reasons why she wouldn't be transgender". She also expressed her concerns about the message that these sessions were sending to Aria about the acceptability of being transgender, and the impact on her self-worth: "it's almost as though the protocol views being trans as - 'oh no that should be the last option'. Whereas what we're trying to say is - being trans doesn't have to be a death sentence, or an 'oh my god'." Daisy continued:

*I look at Aria and think it's one element of who you are. You know - you're funny, quirky, creative, imaginative, you're a nightmare, you don't tidy your bedroom, you have blond hair and blue eyes, and oh you happen to be 'here' on the gender spectrum. But that's one thing, in amongst all these other things. But in the Tavistock there's a - um.. I'm not saying they necessarily think it's easier to be gay, but I think that's why they explore all the things that they explore...*

A number of other participants shared Daisy's concerns, pointing out the role the assessment approach might play in reinforcing stigma: underscoring the idea that while gender typicality is natural and healthy, transness is somehow artificial, manufactured and pathological. Hannah reflected:

*The sort of message [that] is being sent, it's quite a damaging narrative that there's something wrong with you, you are not normal, this isn't mainstream behaviour. There is something the matter; we have to get to the bottom of this and explore what this is.*

Jade described feeling like her clinicians were “*more like therapists than people trying to help*”. She described finding their approach stigmatising: “*the general tone, their attitude, was quite offensive. Essentially treating transgender people like they have a mental illness and that's not ok*”. Caiden remembered how upset he was by a suggested that his gender dysphoria might have been caused by anorexia. Caiden explained that he had worn skinny jeans to his appointment, which had accentuated his slender figure; he found it degrading when his clinician started to comment on his weight and body size: “*upset is a bit of an understatement, she ended up creating issues about my body shape... I eat like a hungry dog.*”

Despite their rejection of a narrow pathological view of transgender variance, some young people were not adverse to reflecting on the ways in which their feelings about gender might relate (in some degree even causally) to other aspects of their identity or experience. Mason, who had been diagnosed with multiple developmental disabilities including dyslexia, dyspraxia and attention deficit hyperactivity disorder (ADHD), reflected on how their disabilities related to their “non-binary/ butch” gender identity:

*There's definitely an intersection: the way that I feel about my gender is wrapped up in the fact that I have multiple developmental disorders. I guess it's the way that I relate to myself and other people: the way that I see myself, or the way that other people see me. Being a girl comes with a lot of social expectations that I couldn't perform. Like I didn't have the coordination to do makeup or my hair very well. And I have sensory issues, so what I wear wouldn't really be what most girls would wear. You know, I wasn't graceful or quiet or anything that is expected of a girl - with ADHD the way that I behaved would have been more 'read' as a boy. I was loud and quite disruptive, and quite impulsive and stuff.*

Franki opened up about her history of sexual assault and intimate partner violence, and reflected on how her experiences might have influenced both her sexual preferences and her gender non-conformity:

*I'm attracted mostly to women and non-binary people. I think it's kind of a process of healing as much as - I don't know. It almost feels like a choice, but it's not quite as clear as that. I felt for a while like he was still inside me, influencing my every day... I was feeling these gender identity confusions and then in the back of my mind there was this voice that was like – 'oh you just don't like your hair because he always used to say your hair was so lovely'... And then part of me would be like, no, I've felt like that about my hair for ages, and there would be this little argument inside.*

Franki described the internal tensions she felt: on the one hand she felt the influence of her past trauma, on the other, she wondered if her tendency to frame her experience in this way was another manifestation of the psychological control her abuser continued to hold over her:

*I felt like he made me this way, and it was a very disempowering model of how I understood myself. I was tied up in patterns of abuse, the thought patterns that come from abusive behaviour, like self-blame, and feeling like he was the one who had the control but actually, no, that's not right.*

Franki explained that she was working on learning how to reconcile her past with who she 'was' in the present moment, settling on a perspective that there was no simple cause and effect: *"it's just something that happened, it's not an easy arrow to point, it's always a lot more complicated than that."*<sup>82</sup>

Franki and Mason's reflections are shared by some trans scholars. Meadow (2018) argues that since gender is relationally produced: *"it's not a huge leap to imagine that some forms of gender could be made of scar tissue"*. Yet, Meadow argues that since all gender is 'compensatory', atypical presentations should be viewed as no less 'valid' or essential to selfhood than socially normative ones. Similarly, Ashley (2019) argues that the problem with current models of care is not the view of gender (variance) as relationally produced through a complex mix of intersecting factors (e.g. cognition, attachment, learning, transference, the body etc.), but a tendency to place over-emphasis on the presence of co-occurring disabilities, mental illness or trauma as causes of gender incongruity, leading to damaging and dismissive accounts of trans subjectivities.

Reflecting these concerns, young people and caregivers in this study often expressed concern that their clinicians appeared to perceive their (/child's) transness as somehow fallacious or imaginary:

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<sup>82</sup> At interview, Franki defined as queer, and Mason non-binary, and neither were seeking physical interventions.

an unstable and potentially ‘curable’ maladaptation to a range of social, developmental and environmental harms. Melanie described how the repetitive questions she was being asked in GIDS sessions gave her the impression “*they didn’t really think I was trans*”. Reflecting on her family’s experience in GIDS, Chloe concluded: “*[our clinician] just doesn’t believe that trans children exist. That’s the basic problem, so she was looking for possible reasons why we would have made this up.*” Similarly, Clare wondered:

*The more you look into it, it just seems to come down to a question of do you think being trans is a real thing or don’t you? And I honestly start to think that some of the people at the Tavistock actually don’t think that it’s real. If you ask them, they would say different, but that’s the only way you can really explain what goes on there.*

### *Clinician’s perspectives*

Indeed, during interviews with clinicians, theories about various potential ‘causes’ of gender incongruity were often linked to pathologising narratives whereby gender atypicality was presented as somehow artificial and rationalised. Two interviewed clinicians reflected that children might be confused about their gender because they were uncomfortable with their sexuality or had experienced homophobia: “*we’ve got to keep in mind the possibility they will regret [transition]; that there’s some intersection with sexuality, and they’ve experienced a lot of homophobia;*” “*[they think] if I fancy girls and I’m a girl, then I must be a boy, because logically, I don’t know, based on whatever beliefs around me.*” Three clinicians wondered whether the growing prevalence of birth-registered females seeking testosterone might be rooted in contemporary social pressures associated with growing up as female: “*we’ve got to think about their vulnerability as females, as they bodily are, and what that might have meant to them – the symbolic and political, cultural meaning of being female*” argued one. Another reflected: “*is this something about the experience of being a girl growing up in this culture? The increasing sexualisation of being female, and the commercial aspects around it as well? Something about performance of it?*” A third reasoned: “*[children] start off with anxieties about appearance and it’s often girls. They come to think that not liking their breasts must mean they’re gender dysphoria. They have that post-op rationalisation that they must be cross gender*”. One clinician wondered about the influence of social media, the growing “cult of the individual” and “identity politics” and another about the role of “trauma” and a potential need to escape an “old self”. A third reflected on the empirical associations between ASC and transness: “*people on the [ASC] spectrum are more primed to have a gender incongruence because they don’t have good theory of mind, [and] don’t really have an interest in what everyone else is doing socially*”. The same clinician also suggested that fractious family relationships and authoritarian and narcissistic styles of parenting can play a role:

*It [can] be about parents' own needs, which obviously aren't conscious. The parent needs the child to be a different gender for some emotional reason, or even possibly a conflict between two separated parents. Or parents getting something out of their child having some special status.*

According to clinicians, it is these potential complexities that justify the need for extensive psychosocial ‘exploration’ with young people and families, prior to making any referral for physical interventions. The aim of this process is to provide time and space for careful ‘reflection’ before pursuing potentially irreversible gender-affirming interventions, through enabling young people, as well as caregivers, to freely explore their feelings related to gender, alongside a broader range of psychosocial concerns.<sup>83</sup> In the clinical literature, this ‘exploratory assessment’ process is characterised as promoting ‘understanding’ and ‘broadening narratives’ concerning gender related distress (Clarke, 2019; Spiliadis, 2019). Meanwhile, young people and caregivers’ perceptions and experiences of ‘exploration’ in NHS clinics are discussed below.

#### 6.2.2. Experiences of psychosocial ‘exploration’

A few participants expressed that they had found the exploratory assessment process helpful. Spencer explained that his appointment at GIDS had provided an opportunity for him to open up to his dad for the first time about his gender: *“I had three therapist appointments with my mum and dad. It was alright. It was quite nice - to talk to [Dad] and see his views, in a safe space”*. Brenda explained that she had really enjoyed the appointments at GIDS (despite her son, Daxton’s misgivings): *“Dax went off with one person, I got another, and I just talked a lot. For me, it's absolute bliss to just talk about my children because it's my favourite subject”*.

Nell described how the therapeutic work he had undergone at GIDS had helped him to come to the realisation that he was non-binary, rather than fully transmasculine. This shift had not changed Nell’s desire for medical interventions,<sup>84</sup> however, he felt that years’ of probing conversations with his clinician had played a pivotal role in helping him to feel more comfortable and settled in a more ambiguous identity.

*I don't need to prove that I'm 'man enough' anymore. Back then, I didn't really accept myself as being non-100% male. [At GIDS] I had a lot of time to play with how masculine I was and what I preferred. At one point, I talked about the idea of being non-binary. I wasn't admitting it to myself, but I was talking about it. My clinician was like, 'You can totally be non-binary and valid'. That probably meant as much as starting testosterone did, because this was a highly*

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<sup>83</sup> See GIDS’s website <https://gids.nhs.uk/about-us/> accessed February 2023

<sup>84</sup> At the time of interview Nells had started testosterone and was feeling happy and comfortable with the changes they had so far effected.

*qualified, respected person saying, 'this is okay. You're not disgusting, you're not weird. This is legitimate. You can do this and you deserve to be respected.' These were important conversations to have before hormones.*

These reflections were in hindsight. At the time, Nell recalled how desperate he felt, describing the intensity of his dysphoria and the agonising wait for referral to endocrinology.

Like Nell, the majority of young people and their caregivers tended to characterise the exploratory therapeutic work undertaken at specialist gender clinics as painful and prolonged. Furthermore, in contrast to Spencer and Brenda's positive account, many participants described feeling like they were being subject to circuitous, repetitive and often intrusive lines of questioning: *"each appointment feels like starting over"* (Theo); *"I had to spend 6 months telling them the same thing!"* (Jennifer); *"she [the clinician] spent time trying to get to the bottom of everything. She got way too side-tracked about my beekeeping, why I have a tattoo on my wrist, and my skating."* (Caiden). Joe described:

*They got quite in-depth about my whole life story. It was really weird. my whole childhood. About like when I first thought I trans, and that makes sense, but also like: my parents, was I ever a victim of abuse, my sexual life, everything. Do I use drugs? All of these random things - where I worked, and what I did. Everything in my life.*

Hannah explained how her daughter Ivy had initially been willing to respond to questions, but had become increasingly frustrated with the repetitive lines of questioning, and expectation that she should share her feelings on a broad range of personal subjects: *"they do a lot of life story work, which is kind of an invasion - feels like your privacy is being probed at."* Hannah described Ivy as a "typical teenager" who felt uncomfortable exploring her feelings at length with adults, particularly those in positions of authority: *"they want more than she can give in terms of what she is willing to discuss".*

Fiona described how her son James often felt lost in sessions, unable to make sense of the questions he was being asked or how to respond: *"they ask very long questions that don't really have a question to them. He gets quite frustrated and upset when somebody rambles about something and then looks at him for an answer. He goes, 'I don't know what to say.'"*

Caregivers also described finding the process difficult: *"we had to justify ourselves quite a bit... I have to bare my soul as well, do I?"* (Fiona). Chloe and George described their first appointment at GIDS; instead of the welcoming environment they had anticipated, they recalled being interviewed by two clinicians with a cold, distant and aloof demeanour: *"complete stereotypes of old fashioned psychiatrists, who sit there with their legs crossed, a pad and glasses, looking up every now and then, and then looking down. It*



*was hideous*". They described being subject to a meandering and (in their view) irrelevant line of questioning, about family gender roles going back generations: *"all these questions about my childhood, my parents' childhood, and my grandparents' view of gender roles! I'm like how is this relevant to our child being transgender? 'How was your mother brought up' – that was one of the questions!"*

Chloe described how hopeful she and George had been before their first appointment, she recalled their vulnerability and their desperate desire for help: *"at the time I was struggling emotionally because, you know, we'd lost a couple of friends. It was a lot of pressure – stressful"*. She explained that they had been looking for advice and support around a number of issues that they were facing a family, including the criticism and hostility that they had experienced since Mia had made her social transition, as well as some concerns around bullying at school. She expressed her frustration at the gap between their expectations for support, and the reality of what GIDS' had to offer: *"every time we brought up the stuff I wanted support for, they just totally shut it down. But they said we could come back every month, every single month, to talk about our grandparents view of gender roles!"* George added: *"they just didn't provide any guidance. At all. On any subject"*.

Kate's account of GIDS was similar. Kate remembered being received with judgement and disapproval when her family arrived at their first appointment with Jamie in a dress. Kate recalled how she had thought they were going to "the one place" where they didn't have to worry about what Jamie was wearing. Instead, she recalled: *"we got some strong messages that that might not have been the right thing to do - allowing Jamie to wear girls' clothes - [that] it might have been better to have tried to find a way of containing it"*. Like Chloe, Kate described how vulnerable she and her partner felt at their first appointment, their need for support and their sense of despair when they realised this was not what was on offer:

*If you're really suffering, your child is really suffering, you are looking for support, and guidance, and that's really not what they are offering. That's part of what causes the bad feeling, and the despair... We were asking – do you know of any resources, good books, that might be useful to read with Jamie, or for us to read, or for other friends and family. This never crossed her [clinician's] mind! Surely that would be a useful thing for them to know? Or if they think that is totally outside of their remit, that would be useful to know as well. Everyone is putting all their eggs in the Tavistock basket. And, people need much more than what they are offering. If you've waited 12 months for something and then it [isn't] what you think you are getting, obviously the frustrated is so much greater.*

In general, Kate described Jamie's clinician (who they were still having appointments with) as "deeply critical", "negative" and "unsupportive". She described how, instead of offering practical guidance and support, their appointments were focused on: *"looking for a reason, some causal event,*

*that may have led to Jamie deciding he was a girl*'. She recalled her frustrations when one eagerly anticipated appointment got entirely used up talking about the premature birth of her second child. Kate couldn't see the relevance, and had hoped to spend the session discussing some important questions she had about Jamie's gender expression: *"having got waylaid myself, the whole session ended up being about this [birth], and we got near the end and said 'we were really hoping to talk about..', and they said 'oh yes, we've run out of time now'"*. Kate explained that the clinician was trying to piece together a hypothesis about Jamie's gender non-conformity and the trauma of his younger sister's birth: *"I ended up in hospital for a week, and Jamie couldn't see us. I think that was an awful experience for Jamie."* Kate explained the clinician kept pointedly hinting: *"you know the new baby was **a girl**."* Kate herself wasn't at all convinced of the utility of this line of enquiry: *"you know, I'm sure you could piece together some sort of hypothesis, but I just don't think it's true. At a gut level, that's just not what I see."*

Despite her disappointment, Kate described "working hard" to draw some positives from her experiences with GIDS. In particular, she acknowledged, that her clinician always provided her with "food for thought", offering her a "critical voice", which she had used to hone and sharpen her thinking about how best to understand Jamie's experience and how to support him: *"I kind of find it useful in a way to help make sure that our thinking is as rigorous as it can be. I don't agree with most of what she says, and I think she has some interesting points."* At the same time, she described being subjected to a fraught and stressful process, which she had found upsetting and challenging; meanwhile her partner had become increasingly angry and defensive.

*I think we thought we were going somewhere where we would be welcomed with open arms and given lots of support, and that very strongly is not [what] we got. It was gruelling every time we went, every time we went we came out feeling as if we had been through a grilling, and kind of had to justify ourselves... What comes out is a disapproving approach, and a really unhelpfully negative, challenging reaction to whatever situation we are in. My partner has found it really difficult - he experiences [our clinician] as being incredibly critical and challenging and disapproving. I also experience her like that, but also, I do always take away something. I would much prefer it not to come in that form. I've worked very, very hard to allow us to benefit from it. It took me a long time to be able to get to a place where I could say, okay, this is useful as well as being painful and unsupportive and all the other negatives.*

### *Logic of interrogation*

Resonating with Kate's words – *"every time we went we came out feeling as if we had been through a grilling"* – many participants described an experience that only served to exacerbate, rather than ease feelings of confusion, anxiety and distress: *"I thought I was going to be helped. The way she asked questions was patronising and wild. I'm trying to forget about how horrific it was. I requested not see her again because she caused great distress."* (Caiden) Fiona described how her son Stewart (15) would leave his appointments

feeling like he had been through a cross-examination: she said that the lines of questioning pursued by clinicians would often reduce Stewart to tears: *“sometimes he sits there crying and they don’t even offer him a tissue. Fundamental lack of empathy that’s what that is. It doesn’t feel supportive.”*

According to Fiona, the conversations Stewart was expected to have during appointments were less about his experience and more about a particular “agenda” dictated by the service: *“this is about being pushed, repeatedly questioned about something where you don’t want to go. It doesn’t feel like it’s about what the issues are for him.”* For example, Fiona explained that Stewart was being repeatedly pressed to talk about sexuality and romantic interests, which caused him to feel deeply uncomfortable. According to Fiona, Stewart had not necessarily yet formed ideas about his sexuality, certainly not ideas he was ready to discuss: *“it’s something he’s got little interest in. It was a real pushing - like he should have a view. He was talking about being asexual. He was going – ‘that is not necessarily a part of who I am’.”*

Similarly, Lucy explained how Amber found the process coercive and upsetting. According to Lucy, 7-year-old Amber rarely wanted to talk about “being trans”: *“the spotlight’s on her, she has to talk about her shit, and she doesn’t want to talk about it, because she doesn’t identify with it.”* Lucy characterised these conversations as “horrible” and “like torture” for Amber; she explained that during appointments Amber would curl up into a foetal position on her chair with her back to the clinicians: *“she crumbles, it’s very raw, stark.”* Lucy described how she had to spend weeks preparing Amber for each appointment: *“I can’t just say to her ‘oh we’re going to the Tavi today’, I have to sort of drip it. She’ll say: ‘mum I don’t want to talk about it’ and I say: ‘sweetheart you know you have to’.”* Lucy said she would remind Amber that this was part of the procedure that were enable her to access PBs: *“you’ve been talking about your worries about puberty progressing and all that. We can’t just go straight to [UCLH] they [GIDS] have got to send us there. So, you’ve got to tell them what they want you to say”.*

#### *GICs as gatekeepers to medical interventions*

Lucy’s account – *“you’ve got to tell them what they want you to say”* - highlights the dysfunctional dynamics that may arise out of the imbalance of power that exists between clinicians and young people, given the role that clinicians play in deciding young people’s access to desperately desired medical services. Indeed, many participants described feeling like they were being forced into an involuntary type of therapy: *“how long does this therapy last, and why are you forced into therapy in order to access blockers? Why do trans groups have to jump through burning rings of fire?”* (Hannah); *“all those forced conversations, it was so hard”* (Nell).

Within children's services, this power imbalance is intensified by the fact that currently access to care is facilitated through only one single specialist providers for England and Wales, and one in Scotland.<sup>85</sup> Many participants described fearing that their clinicians would ultimately decide against a referral for hormones, cutting them off from any opportunity to access affordable treatment: *"it feels like this massively high-stress situation because they could easily turn around and go, 'no, I don't think this is required' or something like that;"* (Irene) *"my greatest fear is if in 3 months' time they turn around and say 'no she's not going to be referred for blockers'. And if they say that, we'll be saying, ok we'll go privately."* (Daisy)

Given these dynamics, it is unsurprising that few participants described an environment where they felt comfortable and safe to openly share their feelings: *"I didn't really feel 100% comfortable"* (Amalia); *"it was really strange.. uncomfortable.. weird."* (Joe) Clare described being withholding and cautious in her words during appointments. She explained that her family were clear that Jade needed a referral for hormonal interventions: *"we knew what we wanted and we were just going as a means to get it and they don't like it when parents are like that. They want to explore everything, in a very therapeutic way"*. According to Jade, the kind of therapeutic relationship GIDS were seeking was unfeasible, given the power that clinicians held over Jade's access to treatment, and the lack of transparency and trust on both sides:

*We weren't able to communicate with them, because we wanted to be careful. And they were so secretive about everything - so we would never get any sense of what they were thinking or where we were going. We didn't want to piss them off. We knew what we wanted for Jade, and they were the only people who could let her have it, and so we were really worried about saying anything. We didn't feel that we could be open.*

Unlike Clare, Kate's family had no immediate or fixed demands of the service, in terms of what type of care they were seeking. Jamie was only 6 when he entered the service. At the time of interview for this study, he was 9 years, and thriving: presenting as female (including at school), but using a male name and pronouns: *"he's incredibly happy, joyful, he has lots of friends. He's doing very well at school. His sense of himself, I couldn't wish for it to be any better. He's just full of life."* Nonetheless, Kate remained anxious of Jamie's future: *"I'm conscious that things are going to get trickier as he gets older."* She was unsure whether Jamie would ever need or want physical interventions, but she was concerned that Jamie had a clinician who was opposed to both social and medical transition:

*Her viewpoint would be to absolutely minimise the use of blockers. That, a non-medicalised path would be appropriate. It may be that for Jamie is right, however, it may not be, because we don't*

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<sup>85</sup> This is changing: it was announced in the summer of 2022 that GIDS is to be closed, to be replaced by more localised, regional centres, to improve the accessibility of specialist care.

*know, we've got no idea what will happen at puberty, and Jamie can't know what's going to happen at puberty.. So yes, I have concerns that if 3 years from now Jamie feels very strongly that he wants to have hormone blockers.*

Kate said that she was acutely aware of these undercurrents when speaking with Jamie's clinician, cautious not to say anything that might have implications for Jamie's future care:

*It was really hard for us to talk about our anxieties, our concerns... I'm conscious always when I'm talking to her about how this may play out long term. You know, I'm quite circumspect about what I say. I'm always aware that I don't want to overplay the fluidity of where he's at, because at some point down the line we may need her say-so to get blockers.*

#### *Lack of clarity over the assessment process*

This power imbalance is further exacerbated by a lack of clarity concerning the format or goals of the 'exploratory' process. Young people and caregivers often shared feeling at a loss about the ultimate purpose of their appointments, causing frustration and stress. According to Clare the longer their family appointments continued, the more confused they became about what the objectives were *"it was so hard to understand what they were doing!"* She explained how she had thought they were doing a "type of therapy", only to be told at one point that this wasn't the case: *"there was one time that we were talking about how difficult Jade found the therapy aspect of it, and one of them said 'oh I wouldn't call what we are doing therapy'!"* Jade expressed her confusion and frustration:

*If it's not therapy – then what, what is it? We just felt completely disoriented the whole time, because it was really hard to understand what they thought they were doing. The people we saw just had a way of working that's so opaque. And a way of talking to you where they just go all the way around the houses, and you just think, would you just come to a point, you know, like actually make a statement?*

Clare's feelings were reiterated by numerous other caregivers. Irene wondered: *"so what are [they] doing? I don't know what they're up to. They don't tell you anything; they like to keep you in the dark as far as possible."* Arthur was generally positive about his and Melanie's experience at GIDS, and yet, at one point during his interview he reflected:

*Sometimes I feel the meetings are - I don't know - what was the point of that? We travelled all the way to London, which is like four hours on a train, and across the underground. We sit there for an hour, and then it's another five hours back. We'd just sit there and they'd ask some random questions and then we'd go. I didn't feel like anything was happening.*

Similarly, Kate shared: *"it has been generally our experience with Tavi, that things aren't clear..."* Kate explained how anxiety-provoking it was to not know what was going to happen from one appointment to the next, with long periods of wait between each.

*At the end of each one, she'll say, 'so I think we should meet again in 6 weeks, 12 weeks, whenever'. And... it was really anxiety inducing, going - I don't know where we are going with this: what's going to happen?*

Like Clare, Kate wondered if they were undergoing 'therapy', and if they were having therapy, she wasn't sure why or to what end. After a couple of appointments, Kate remembered tentatively asking her clinician: "so, so, so, what is – what is your role?" Kate explained her clinician had responded "I think we're just here to accompany you on the journey". Kate explained that, although this was not exactly what she wanted to hear, having some clarity about the purpose of their appointments was helpful in relieving her levels of stress: "ok I need to change my expectations. I can live with that – now that I know." Kate wondered why there wasn't more openness, transparency and communication from the service:

*I think that they kind of forgotten, or maybe never thought about, what it's like to be on the other end of their services. They are so lost in their own bubble. They are just not communicating with people, the overall, macro level of what's on offer here.*

Whilst Kate attributed her lack of clarity to poor communication with caregivers, recent audit reviews of GIDS have repeatedly criticised the service for the lack of clarity and consistency in the delivery of services, that there are no standardised questions used for conducting assessments, and that record keeping provides no clarity on why one particular client may have been referred for physical interventions whilst another had not (Cass, 2022).

### 6.2.3. Assessing gender (authenticity): the role of stereotyping

This lack of clarity concerning current modalities of assessment arguably derives from more foundational and complex questions and disagreements concerning the very conceptualisation of gender related distress and how to define and interpret (trans) gender subjectivities (Wren, 2021; Cass, 2022). Such conceptual troubles have significant implications for young people's access to care, because in order to qualify for a diagnosis of 'gender dysphoria' and access to physical interventions, it is not sufficient for young people to demonstrate 'clinically significant distress', they must also show that this distress relates specifically to a mismatch between their 'experienced/ expressed gender and gender assigned'. Yet there remains significant confusion over the clinical tools and theoretical paradigms that can and should be used to establish the certainty of a young person's gender as 'experienced/ expressed'.

Clare explained that her initial hope for Jade's GIDS assessment was that they would be able to "put a stamp" on her struggles, to say: *"yes - this isn't psychosis, [or] some kind of personality disorder - it is gender dysphoria"*. She explained her initial concern when Jade came out: *"how can you find out if somebody really is transgender? Is she just delusional?"* According to Clare, their family hit a barrier in the assessment process, however, when GIDS' determined that Jade wasn't able to *"articulate her felt sense of gender"*. Jade expressed her confusion and frustration: *"we just couldn't understand what they were talking about!"* She continued:

*They would say something like 'Jade won't talk about what her gender means to her'. And then you would sort of say - well do you know what your gender means to you? How would you articulate that? I don't think I could articulate - what do you mean? You can only say it's not the clothes I wear, it's not the way I look - it's not that. But could you articulate your felt sense of gender? I still don't understand what they mean by that.*

Despite Clare's assertion *"it's not the clothes I wear, it's not the way I look"*, the formal criteria for diagnosing gender dysphoria in children set out in DSM-V, does, in fact, include: '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'. Another criterion comprises: 'a strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender' (Cass, 2022: Appendix 3). Furthermore, it is an explicit requirement in GIDS' protocol that in order to be eligible for cross sex hormones, an adolescent must be able to provide 'some evidence of presentation coherent with gender identity' (NHS England, 2016). Whilst, in adult services this requirement is not specified for access to hormonal treatments, in order to qualify for referral for surgical interventions, young people must demonstrate 'evidence of 12 continuous months of living in a gender role that is congruent with their gender identity' (NHS England, 2013: 9). The specification further notes: 'this must not entail a requirement for the individual to conform to externally imposed or arbitrary preconceptions about gender identity and presentation.' (p.9) However, no further clarification is provided as to what presentations would be considered 'coherent' or 'congruent', as opposed to 'arbitrary' or 'externally imposed'. Jemima expressed her frustration with this situation:

*Okay, show me the rulebook. Show me how a girl should dress. Show me how a girl should talk. Show me what magazines they should read. There's this whole thing - you're not 'trans' enough. You are not proving to me that you're ready to live as a woman. It's just insulting. Who wrote the book on how to live as a woman? Who sets the standards by which we can tick it off?*

According to Jennifer her referral for HRT had been delayed because she had been unable to demonstrate the authenticity of her "femaleness" through her gender presentation. Jennifer

explained that she rarely wore skirts or dresses, partly because dressing in such overtly female clothing made her feel unsafe as she knew that she would fail to “pass”: *“the pre hormones me - I would just look like a fucking man in a dress. And I wasn't ready for that. I don't think I was every going to be ready for that.”* She explained that she was expressing her femininity in more understated ways: *“I was wearing, skinny jeans, a bra, mascara”*. According to Jennifer this wasn’t sufficient: *“they were like – that doesn’t count. That’s not fem enough. Skirts - that's what [they] want. I just felt it was this really arbitrary line of what I should have experienced to say that I'm comfortable with femininity”*. In Jennifer’s opinion, her GIC were fixated on *“a certain brand of feminine.”* She added sarcastically: *“they are like – ‘ah - you really show you are a woman that way’. And it's like - do you really think that's a natural aspect of womanhood?! I don't....!”* In any case, Jennifer explained that she wasn’t really “in to” dresses and skirts: *“I was shooting for more – Indi’ girl”*.

While, Jennifer was allegedly denied oestrogens for failing to present sufficiently stereotypically “feminine”, Nell said that he was held back from a referral for testosterone on account of presenting *too* stereotypically masculine. Nell explained: *“I’d try so hard to be masculine. I’d try and walk masculinity, talk masculinity. I used to lose my voice trying so hard to speak low.”* According to Nell his clinician had told him: *“you’re not being yourself. Until you’re yourself, until you’re starting testosterone for the right reasons, I’m not letting you on”*. In Nell’s case, demonstrating he wanted testosterone for the “right reasons” allegedly involved being willing to express a less binary and more gender non-conforming identity. Meanwhile, like Jennifer, Nell was acutely aware of the implications his presentation had on his personal safety: *“being safe is important to me... [conforming] helps me feel more safe that in public, people won't have confusion about what gender I am.”* By sixth form, however, he was growing in confidence, and willing to experiment with a more fluid or ‘non-binary’ presentation: *“I actually did wear nail polish, wore a skirt once. That kind of thing”*. According to Nell, these changes had been instrumental in finally achieving a referral for HRT: *“my gender therapist was like ‘cool, now you’re on your journey to live with your more authentic self’. Then she let me on [testosterone]”*.

Meanwhile, Jade was reportedly told that she might not be eligible for hormones because she *“wasn’t presenting as stereotypically feminine enough”*. Jade explained how angry this made her: being told she couldn’t “pass” triggered her dysphoria, reinforcing her distress around her masculine appearance: *“they said all the time - that was really offensive - they were like ‘oh you’re not female enough to get hormones, and I’m like – do you mind fucking off!”* Clare recalled being aghast that Jade’s clinicians could make such a statement:



*It was just such an extraordinary thing to say to anybody! Really shocking – the idea that if you wanted to be a girl you would have to wear girly clothes and makeup and, you know, present in a stereotypically feminine way. We just couldn't understand what they were talking about.<sup>86</sup>*

Clare added that at the same time Jade's clinician "absolutely refused to be pinned down" about what would count as a proper social transition: "so it was like they were saying well you definitely haven't jumped through the hoop but we're not going to show you where the hoop is."

Like Jade, Ivan described feeling offended and distressed when he realised that his appearance was apparently being judged against normative standards of "masculinity". He described a letter he received in the mail after his first appointment at Sandyford: "he [clinician] wrote things like – he has a male appearance or a male haircut and things like that. First of all, what does that mean?" Reading this blunt description triggered Ivan's feelings of dysphoria, he felt clinicians were calling into contention his ability to successfully "pass" as male:

*What if I felt short of looking male? As a 16-year-old, who is doing their best to present as male, and then you read that, it is very back-tracking. They're supposed to be helping people. Pointing out things about being male or female- they shouldn't be doing that.*

Similarly, Joe described feeling "horrified" and "disgusted" after reading the report of his first GIC appointment. According to Joe, the clinician "picked apart" what he "looked like" and "judged" his clothes and hairstyle:

*It was really weird. They commented I had dyed hair. I guess it's not seen like a very stereotypical masculine thing to dye your hair, but like – okay, it's fashion, it doesn't really dictate gender, they shouldn't have been able to use that against me.*

Participants' accounts highlight some of the confusions and inconsistencies concerning how assessment criteria related to gender 'presentation' are applied in clinical contexts, and the negative impacts these may have on young people's wellbeing.

### 6.3. Conclusions

This chapter has explored the intersections between mental health (diagnosis) and pathologizing discourses that shape medicalised understandings of the authentically (trans)gendered and sexed subjects. Section 6.1 presents evidence related to the mental health experiences of GSD youth.

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<sup>86</sup> These statements to Jade were part of a formal complaint that their family had made against GIDS, that at the time of interview was still under review. In their initial response to the complaint, GIDS denied making these statements, but Clare insisted that they had: "they absolutely did – I wrote it down!"

Common experiences threading the mental health histories of both gender and sex diverse youth included: feelings of isolation and disaffection; experiences of stigma, harassment and violence, and a lack of access to effective specialist mental health support. One significant difference is that while GD youth are required to undergo extensive psychosocial ‘exploration’ prior to accessing hormonal and surgical treatments, SV children may undergo physical interventions without any offer of counselling or mental health support (Government Equalities Office, 2019). For the few SV youth interviewed in this study, the lack of opportunity to explore the emotional side of their experiences of sex variance only added to their feelings of shame, disquiet and suffering. Indeed, evidence from the survey suggests that SV youth may have particularly poor wellbeing outcomes.

Section 6.2 explores some of the implications of the continued ‘psychiatrisation’ of (trans)gender variance. Participants accounts highlight the challenges with a model of care that waits until a child or young person is in ‘clinically significant distress’ before offering access to medical treatment.<sup>87</sup> Furthermore, while the presence of clinically significant distress is an integral part of medical constructions of the authentically transgendered subject, distress may also paradoxically be viewed as a contraindicator for the coherence or stability of a young person’s transness. Instead, emphasis may be placed on cooccurring mental health conditions or disabilities as causes of young people’s incongruence (Ashley, 2019), undermining the perceived ‘authenticity’ of their gendered experience, and their competency to consent to medical interventions.

These problems may be exacerbated by the fact that there are no objective criteria on which the certainty of a young person’s gender identity can be determined (Cass, 2022). The formal criteria on which a diagnosis of childhood gender dysphoria relies has been broadly criticised for drawing on outdated stereotypes and roles, leading to a lack of clinical clarity and consensus around how

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<sup>87</sup> In an interview in 2015 Kenneth Zucker, Chair of the DSM-5 Work Group on Sexual and Gender Identity Disorders discussed some of the dilemmas encountered by the Work Group during the development of DSM-5, in particular the conceptualisation of “gender dysphoria” as a mental disorder, and the role of the ‘distress/ impairment’ criteria in defining diagnosis (Zucker and Duschinsky, 2016). Zucker emphasised the role of disease classification and diagnosis in facilitating access to care, and the lack of clarity on what sort of medical condition gender incongruence might be, if not a psychiatric disorder: “I don’t think that there’s any evidence that it’s a non-medical psychiatric condition. There’s no evidence, for example, that there’s any gross hormonal abnormality from which one could therefore conclude it’s an endocrine condition, etc’.” While Zucker acknowledged the case for separating the diagnosis of the medical ‘disorder’ from the extent to which it caused distress, he curiously logicized that absence of distress would imply less need or desire for treatment: ‘Suppose I have a wart on my nose but I’m not distressed by it: Does that mean I don’t have a wart? No, it’s ridiculous. I have a wart but whether or not I want it treated depends on whether it bothers me and you could say that’s true for a lot of medical conditions. Or you could say it’s true for all medical conditions, you either have it or you don’t. The need for treatment or the extent to which you’re distressed by it could be evaluated separately.’ (p.28) The parallel Zucker draws between gender incongruence and other medical conditions is interesting, particularly because for the majority of medical conditions, whether a patient is subjectively distressed by the condition would not be considered determinative of the need for treatment; although, certainly, many medical conditions might usually become distressing if left untreated. The same might be true for access to care for gender variance youth, especially in the context of access to PBs for trans children entering the initial stages of puberty.

to meaningfully apply these criteria in contemporary contexts (Cass, 2022). In this study, young people and caregivers expressed confusion concerning the clinically endorsed paradigms through which they should justify their gendered experience in order to demonstrate eligibility for diagnosis and services. Meanwhile, GIDS' assessment processes and their outcomes have been judged by recent audit review to be widely variable and ostensibly arbitrary (Cass, 2022).

Indeed, the format and goals of GIDS' assessment process are somewhat nebulous. In this literature, the approach is characterised esoterically as constituting a type of psychotherapeutic 'exploration', whereby young people (and their caregivers) are 'invited' into a 'collaborative' process of 'open dialogue' 'to better understand the meaning-making of their gender(ed) and broader selves' (Spiliadis, 2019: 3). Emphasis is placed on 'tolerance of uncertainty', 'curiosity' 'dialogism' and 'polyphony' (Spiliadis, 2019; Wren, 2019a). Meanwhile, in this study participants commonly described an adversarial and often distressing process of coercive questioning, characterised by mutual mistrust and a lack of transparency.

In a 2019 edition of *Clinical Child Psychology and Psychiatry* Bernadette Wren and Florence Ashley debate the appropriate context and role for therapeutic 'exploration' in the provision of care for gender diverse youth. Ashley contends that there are significant ethical concerns with a model of care that *mandates* exploration as *precondition* for access to hormonal treatments. Instead, she argues that exploration is valuable when offered as a process that can operate through and alongside medical transition. Indeed, participants' accounts point to a current model of care which creates an imbalance of power that may undermine capacity for open and authentic sharing; both young people and caregivers described withholding key information and concerns, fearful that providing too much information, or the 'wrong' information, might compromise access to gender-affirming interventions.

In contrast to Ashley, Wren contends that ethical practice implies that exploration must take place *prior* to referral for medical interventions. She argues that 'exploration' better promotes a 'diversity of outcomes', as for some children 'it is only with time and sufficient support that they come to believe that adverse experiences of different kinds may have driven them to seek a premature medical solution' (Wren, 2019b: 239).

Wren's reasoning proposes a role for psychotherapeutic 'exploration' in changing children's views about pursuing transsexual embodiments. Clinicians may contend that this process is intended to

be supportive, rather than coercive; yet many participants in this study described feeling like they were “forced” into a “type of therapy”, the purpose of which was to try to “look for reasons” why they “might not be trans”, through pointing to a range of alternative, pathological explanations for their (/ their children’s) gender incongruence.

These dynamics raise important questions as to the extent to which contemporary processes of ‘exploration’, as applied in real life settings, can be meaningfully distinguished from past ‘reparative’ models of care, which sought to ‘correct’ gender incongruency by reinforcing traditional gender roles (similar to those historically used for ‘curing’ same-sex attraction). Calls to exclude protection for transgender groups from a new law outlawing ‘conversion therapies’ (and the Government’s oscillating declarations on this) underscore these concerns;<sup>88</sup> so do logics, often displayed in clinical literatures, where evidence on the ‘value’ of exploration is ‘demonstrated’ through pointing to individual cases where children have ultimately decided they are comfortable in their biological gender role (Clarke, 2019; Spiliadis, 2019).

One perspective that Ashley and Wren share is a view of gender as relational and dynamic: co-constituted through a labyrinthine of complex social, psychological and developmental processes. Yet, Ashley argues that clinicians err when they slide from an understanding of gender variance as adaptive, to a view that it is *maladaptive*. She quotes Meadow (2018):

If gender deviance is a maladaptation, then those of us with atypical gender presentations are, in fact, damaged goods...all gender is an adaptation, a call for recognition. The mistake lies in thinking of it [atypical gender] as somehow less real, less constitutive of selfhood, less central to psychic life. (p.91)

Participants accounts (including those of young people, caregivers and indeed, clinicians) suggest that it is, indeed, a pathological framing that may guide the process of psychosocial assessment and diagnosis of gender diverse youth in the NHS. Forms of gender variance are conceptualized as maladaptive *psychological* responses to a range of social, cultural and environmental adversities that might be therapeutically treated to protect a more ordinary and healthy process of gendered development (Cass, 2022). Meanwhile, sex variations are defined as physical disorders of bodies that, as a result of a variety of (congenital) deficiencies, are unable to complete an ordinary process

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<sup>88</sup> In a recent letter to the editor of the British Medical Journal condemning the decision of the British Medical Council to endorse a comprehensive ban on LGBT conversion therapies (e.g. inclusive of transgender groups) one clinician wrote: ‘Any therapeutic exploration or challenge to ideas of existential self-identification can be seen as ‘conversion therapy’. Legislative reassurance regarding the exemption of psychotherapeutic exploration of identity issues from the ‘conversion’ ban are meaningless in real life practice.. ‘Conversion therapy’ for people with gender dysphoria may equate with watchful waiting or exploratory therapy’. See <https://www.bmj.com/content/377/bmj.o1453/r> accessed February 2023.

of sexual development. These framings, rooted in naturalised accounts of binary sexual difference, may only serve to exacerbate the psychological fragilities of GSD youth, including through reinforcing stigma and hampering access to (more) effective (mental) health support.

## Chapter 7 Conclusion: “nobody really knows what transgender is”

This thesis has explored health provision for GSD children and young people in NHS services in Britain. The last decade has been a time of profound challenge to traditional ideas about gender and identity. While young people have been developing increasingly diverse ways of thinking about and ‘doing’ gender (Bragg *et al.*, 2018), there has been a proliferation of young people experiencing issues with gender seeking out health services and support. There has been extensive media and policy debate concerning the appropriate boundaries of civil and political rights for transgender individuals, as well as intense scrutiny on the provision of gender affirming medical interventions in specialist NHS clinics, particularly to adolescents experiencing issues with gender.

Despite the attention afforded to the issue, there is a distinct lack of scientific research on which to ground policy and public discussion. It was in this context that I set out to investigate the healthcare experiences of children and young people living in England, Scotland and Wales. I aimed to understand how these experiences were influenced by the particular conceptions of ‘gender’, ‘sex’ and ‘childhood’ embedded within the logics and practices of health institutions, and the implications of these for young people’s wellbeing.

My research offers both an empirical, and a theoretical contribution to literature(s) exploring health provision for GSD youth. GSD youth are a much discussed yet under-researched population. Academic literatures exploring health provision for transgender children and youth often constitute theoretical discussions of the ethical issues at play, without including empirical data or evidence concerning children and young people’s experiences (e.g. Ashley, 2019; Wren, 2019b, 2019a); those that do, tend to focus on a very small number of specialist ‘case study’ examples (Clarke, 2019; Spiliadis, 2019). Meanwhile the few empirical studies of GSD healthcare experiences conducted in Britain have either focused those aged 18 and above (Ellis, Bailey and McNeil, 2015; Vincent, 2020), or have exclusively used the reports of caregivers as a proxy for understanding children’s experiences (Rickett *et al.*, 2021). My empirical contribution is a large body of mixed methods data providing evidence on young people’s experiences in healthcare. In each chapter, evidence from (life-history) interviews and the survey provide insight into children and young people’s experiences, with the potential to strengthen knowledge and understanding of GSD childhoods, with implications for health policy and practice.

In Chapter 3, I explore sex and gender variance as a developmental experience and field of childhood subjectivity. I offer three core insights into GSD childhoods, derived from my data, that challenge common presumptions about childhood gender identity development, with implications for health policy. First, whilst (as discussed in Chapter 1) dominant discourses of childhood construct children as fundamentally innocent and lacking knowledge concerning sex and gender, my data illustrates that children may acquire a profound psychic investment in embodied gender (incongruence) from the earliest years of childhood. Second, whilst clinical literatures and measures (e.g. ASQ-3) concerning childhood gender development have often been founded on an assumption that children's gender identity will logically follow from their natal sex (Martin and Ruble, 2004; Ruble *et al.*, 2007; Zmyj and Bischof-Köhler, 2015), my data illustrates how children are not just 'outcomes' of singular developmental processes, but active participants in the construction and adoption of varied gendered subject positions, sometimes generating unanticipated forms of diversity. Third, whilst popular academic theorisations have linked transgender variance in childhood to rigid and simplistic ideas about gender (Strang *et al.*, 2018; Wattel, Walsh and Krabbendam, 2022), transgender children in this study tended to express unusually sophisticated and complex understandings of gender relative to their gender typical peers.

Chapter 4 explores the experiences of GSD children and youth in general healthcare settings. Whilst a small number of recent studies, particularly resulting from service audit, have considered the needs and experiences of gender minority children and their families in specialist gender clinics (Riley, Sitharthan, Clemson, & Diamond, 2013), there is a particular gap in information about GSD experience within primary care, and areas of healthcare not related specifically to gender and sex diversity (Vincent, 2016). My data suggest that within healthcare settings significant complications often arise because medical systems rely on naturalised and binary schemas of gender and sex that 'other', exclude or render invisible GSD embodiments. Forms of gender and sex variance that present in *childhood* may be particularly unintelligible to medical providers, sometimes leading to insensitive and discriminatory treatment and a denial of care. Participants' accounts suggest that children often lack agency and confidence in their interactions with providers, relying heavily on their caregivers to negotiate access to care, particularly in the case of referrals to specialist services. Overall, the data suggest that forms of gender and sex diversity are linked to reduced confidence and trust in doctors and increased experience of unmet need, with negative impacts on young people's wellbeing.

Chapter 5 explores the experiences of young people and their caregivers in specialist health care services for treating forms of gender and sex variance. The particular focus on this chapter is experiences of *physical* healthcare interventions for altering individuals' primary and secondary sex characteristics. Data suggest that current health protocols are not meeting the health needs of children and young people, with negative effects on young people's wellbeing. I argue that clinical literature(s) justifying current protocols (NHS England, 2016; Wren, 2019b) reflect a series of contradictions concerning the benefits and risks of different procedures at different ages and stages of development for different groups of GD and SV children. Meanwhile, consistent across different fields of care, is an apparent lack of regard for young people's own views on aspects of their medical care, and a scepticism concerning children's ability to provide informed consent to gender-affirming interventions. I argue that these dynamics are best understood as rooted in a set of intersecting beliefs about the natural alignment of binary, biological sex, gender and sexuality, and normalised accounts of the ideal, innocent and developing child.

Chapter 6 explores the intersections of mental health (diagnosis) and pathologizing discourses that shape medical understandings of gender incongruence and sex variance. My data suggest that while GSD youth suffer significant mental health difficulties, they are not well supported by NHS services, which may only serve to exacerbate young people's distress. While the emotional needs of sex diverse youth are often neglected, children suffering from gender dysphoria may be exposed to a confrontational, prolonged and enforced process of psychological 'exploration'. This chapter contributes a particularly rare empirical insight into children and caregivers' experiences of the psycho-therapeutic model of care offered in NHS gender clinics, particularly, GIDS, which challenge many of the lofty claims justifying these approaches espoused within the academic literature (Wren, 2014, 2019b; Spiliadis, 2019).

### 7.1. Contestations in conceptualisations of gender variance

A common theme that cuts across each chapter is the finding that medical theory and practice in Britain continues to be dominated by a perspective which assumes gender and sex typicality to be 'natural', healthy, permanent and 'real', while forms of gender and sex variance are framed as pathological, deviant, artificial and 'curable'. In recent years, global advocacy initiatives have pushed for the 'depathologisation' of forms of sex and gender variance, as part of work to reduce



stigma and discrimination.<sup>89</sup> Yet a pathologising lens continues to dominate the theory and practice of healthcare for GSD youth in Britain today.

Nevertheless, the conversation is gradually shifting, and traditional, medicalised definitions of forms of sex and gender variance are being increasingly challenged. In particular, there is growing recognition that some of the formal criteria set out in DSM-5 may be outdated in the context of contemporary understandings and theorisations about gender. According to the Cass (2022) review, this has resulted in ‘widely divergent’ and sometimes ‘quite polarised’ clinical disagreements about how gender incongruence in childhood is best conceived and managed, resulting in inconsistent practices and a lack of ‘open discussion’, hampering both research and clinical service provision (p,28).

This lack of clarity has significant implications for children’s experiences in medical care and their wellbeing more broadly. In Chapter 3 I demonstrate how gender variance may manifest in childhood as a deep psychic investment in an embodied ‘self’. Since this ‘self’ cannot be reduced either to the sexed body, or to the performance of social roles, it cannot easily be objectively ‘observed’. Rather, medical assessment to justify clinical intervention must rely on children and young people’s own subjective descriptions of their gendered experience. Yet there is no agreed interpretative framework for making sense of their accounts. And in a context where gender variant subjectivities are still so heavily pathologized, how can a young person’s testimony even be trusted? Clare’s question, posed in Chapter 6 - *“is [Jade] really transgender, or is she just delusional?”* - neatly illustrates a central dilemma: if gender is both a psychic investment in self as a gendered subject and a form of psychiatric illness, how can a young person demonstrate the difference between authentically ‘being’ transgender, and falsely believing they are transgender? And what if the subject in question is a child, viewed as fundamentally lacking in (self) knowledge and competence, and ‘innocent’ of matters of sex, gender and the body?

## 7.2. The role of childhood in constituting gendered categories

This last point relates to the specific theoretical contribution offered by this thesis: an exposition of how notions of gender and sex typicality are constituted through particular discourses of

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<sup>89</sup> For example, in its latest edition of the International Classification of Diseases (ICD-11), the WHO has removed ‘gender identity disorders’ from the mental health section, and created a new section for gender incongruence and transgender identities in a chapter on sexual health <https://www.who.int/standards/classifications/frequently-asked-questions/gender-incongruence-and-transgender-health-in-the-icd> accessed February 2023.

‘childhood’. There are existing literatures, typically drawing on ethnographic work, which have explored how dominant categories of ‘gender’ and ‘sexuality’ organise aspects of children’s lives to construct their identities and broader social worlds (Lugg, 2003; Renold, 2005; Ringrose and Renold, 2010). Yet these literatures do not expand specifically on the role that the social institution of ‘childhood’ plays in compelling gender and sex-typical embodiment, and the forms of exclusion that this creates for GSD children in particular.

Indeed, it is no accident that children’s bodies have become the cornerstone site for negotiating the collective chaos of changing cultural conceptualisations of sex and gender. It is quite predictable that social, political and legal disputes have centred around concerns about social and medical transition in childhood, such that, in recent years, GIDS (a formally fringe health service providing treatment to a rarefied population of children) has come under intense public scrutiny: the subject of inexhaustible media debate, litigation, and several round of audit review.

#### 7.2.1. Discourses of development

In contrast to the model of care offered in adult clinics, GIDS bills itself as a ‘gender identity *development* service’, operating within a ‘developmentally informed approach’. In doing so, GIDS aligns its practice with a particular discursive framework which has come to dominate western understandings of ‘childhood’ (Prout and James, 1997; Robinson, 2013a).

A ‘developmentally informed’ practice is generally understood to imply sensitivity to an individual child’s age and development status (broadly), in the context of knowledge about how children typically learn, develop and grow.<sup>90</sup> The use of this terminology to characterise GIDS’s practice invites some curiosity. Conversely, in this study, young people and caregivers often characterised the service as particularly inept at meeting children’s age-appropriate needs. Certainly, there is some tension between the idea of a developmentally informed practice, and the fixity of the one-size-fits-all protocol that operates within GIDS, which provides that all children must progress through the same progressive treatment model, regardless of their age, development or individual circumstances (for example, the requirement that all children start with PBs regardless of Tanner staging).

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<sup>90</sup> National Association for the Education of Young Children. Developmentally appropriate practice (DAP). <https://www.naeyc.org/resources/developmentally-appropriate-practice>. Accessed February 2023.

In the context of healthcare for GD children, the language of ‘developmentally informed’ functions to signify ‘uncertainty’ about how a child’s gender might evolve. A ‘developmentally informed’ model infers taking pause before embarking on medical interventions: the aim is to avoid too early a streaming of identities at a ‘recognizably fluid stage of development’ and to hold open a range of possible options and outcomes. Wren (2019) writes:

On one hand, we have considerations with respect to young people’s right to self-determination... and their right in law to consent to their own treatment if deemed capable. On the other hand, we have the responsibility... when considering the wisdom of medical intervention, to respect the shifting developmental dynamics of childhood... – and therefore to adopt a more cautious approach, where clinicians do the work of ‘gatekeeping’ with age limits and other criteria for accessing treatments. (p.204)

The clinical ‘gatekeeping’ that Wren refers to, in the context of GIDS practice, means that: social transition in early childhood is discouraged; PBs are rarely available to children at the outset of pubertal development, and a fixed threshold of around 16 is set for access to HRT. Meanwhile, in order to be eligible for HRT, a young people must have first spent substantial time moving through stages 1 (assessment) and 2 (PBs) of the treatment protocol.

Yet, a body of psychological and medical research tracking gender and sexual development (as explored in Chapter 3) has proposed that children typically start to recognise and enact gender differences and roles as early as the preschool years, and that the majority of children acquire gender constancy (an emerging sense of the permanence of being a boy or a girl) by age 6 (Ruble *et al.*, 2007; Olson, Key and Eaton, 2015). Meanwhile, the average age of onset of sexual maturation (development of secondary sex characteristics) is currently ages 10-12, and slowly decreasing (Pierce and Hardy, 2012).

Wren argues that a ‘developmentally informed approach’ infers more time is needed for ‘exploration’ before embarking on hormonal interventions, because of the ‘possibility of regret over a decision regarding identity made at a recognizably fluid period of development and involving ultimately irreversible body changes’ (2000: 228). Yet sensitivity to normal developmental processes might suggest that it is precisely *because* puberty is a developmental stage during which irreversible changes are already happening in children’s bodies, that trans youth may require (urgent access to) medical interventions in early adolescence.

While delayed intervention for trans youth is justified with reference to a complex, fluid and iterative account of gendered development, medical care for children diagnosed with DSD reflects a binary and fixed understanding of sexual embodiment, solidified in early childhood. Historical practices of performing cosmetic surgeries on children with complex genital anomalies at birth were justified partly on the combined assumptions that: 1) gender identity (permanence) was acquired during the first few years' of life; 2) that 'normal' looking genitalia was essential to this development process and 3): that a stable and binary understanding of one's gender was essential for healthy psychosocial development (Ahmed, Morrison and Hughes, 2004). Whilst practices are changing (in recognition of some of the adverse outcomes of early interventions, as well as the ethical concerns surrounding patient consent) both irreversible (surgical) and partially reversible (hormonal) interventions are still part of the routine care that is provided to children with VSC, including in early childhood and younger adolescence (Ahmed *et al.*, 2016).

These inconsistencies are revealing of the unexamined assumptions and concerns that underlie medical responses to gender and sex variance in childhood, including naturalised understandings of gender, sex, and heterosexual desire, and the urge to preserve the ideological notion of oppositional sexual difference, underwritten by 'biological sex' as an definitive, discrete, and strictly binary variable. Participants' accounts were riddled with illustrations of how such fixations may structure the medical care young people receive. While transgender youth like Jade and Jennifer were denied hormonal interventions because they failed to demonstrate that they could successfully 'pass' as stereotypically female, Blake was pressured into vaginal reconstruction surgery as a teenager, in order to create a vagina with enough space to take a penis, reflecting a heterosexist bias and a preoccupation with cis-male sexual pleasure.

These dynamics can also be observed in medical discourses and practices concerning fertility and sexual function. Early surgical interventions carried out on SV children, informed by hetero(sexist) assumptions about the appropriate reproductive and sexual architecture of bodies, have often left patients with impaired sexual sensation and a loss of fertility options (Rowlands and Amy, 2018; Naezer *et al.*, 2021). Meanwhile, potential future loss of fertility (and to a lesser extent sexual function) is one of the cornerstone arguments for denying medical interventions to trans youth, irrespective of young people's own views on these issues. (Naezer *et al.* (2021) point out that the emphasis placed on the importance of preserving fertility amongst trans youth is particularly striking, given that until 2004, all European countries required sterilization for transgender people who wanted to legally change their gender).

Regardless of young people's most intimate desires, and the various impacts of interventions, therefore, gender diverse children are encouraged to grow up 'the way they really are with the bodies they were born in' (Ashley, 2019). Meanwhile sex variant youth must grow into 'who they were supposed to become' through medical modification of their bodies. This is the lens that constitutes the 'developmentally informed' model of clinical gatekeeping operating within GIDS: a discursive frame that emphasises keeping open a range of possible pathways of gendered development in childhood, in order to regulate children's conformity to one normatively prescribed process of sexual embodiment. Presenting inaction as the 'neutral' course disguises its practical effects in denying young people options for transsexual outcomes. The consequences for trans youth may be a lifetime of dysphoric distress, and learning to cope with the social and functional challenges associated with failing to 'pass' (Coleman *et al.*, 2011).

#### 7.2.2. The 'nature'/ 'culture' debate

The hegemony of 'developmental' discourses for understanding childhood gender/ sex variance may also help explain why so much of the debate concerning clinical intervention for trans youth has focused on attempting to answer the question of whether gender identity is biologically or social derived. According to one perspective in the literature, gender incongruence is a psychosocial pathology (potentially caused by a range of environmental factors) that can be therapeutically treated to correct the ordinary course of healthy childhood development (e.g. Coates *et al.*, 1991; Zucker, 2008). An alternative view is that transgender identity is a 'natural' variant of human gender identity development and children are expressing their 'true' selves (Rosenthal, 2014; Saraswat, Weinand and Safer, 2015). This debate is shaped by the framing of childhood itself as a pre-social and biologically determined stage of being; if childhood is viewed through such a lens, then childhood gender variance must either be given in nature, or it must be a 'corruption' or 'perversion', contaminating children from the outside, and disrupting their natural pathway of development into adulthood.

Not enough is yet known about the aetiology of gender identity to resolve questions about the relative contribution of biological and social factors in the development of transness. While some interesting recent research has indicated a role for both genetics and hormones (e.g. Polderman *et al.*, 2018), the science is in its infancy. In this study, children often experienced gender (incongruence) as a deeply essential and immutable part of the 'self'; gender incongruence sometimes emerged in the earliest years of childhood and appeared highly resistant to change. At

the same time, participants' accounts resist any simple attempt to reduce gender to biological 'sex', or positing of sex as a fixed, passive, unambiguous and knowable substrate. They also demonstrate how children are not just passive recipients of objective knowledges about 'sex' and 'gender', but active participants in a process of gendered meaning-making.

One might wonder if a theory of childhood gender diversity that acknowledges children as proactive agents in the creative co-construction of gender and sex could also simultaneously be (in the words of Wilson, 1999) 'deeply and happily complicit with biological explanation' (p.8). Yet, the oppositional framing of nature vs nurture debate sets up a series of arguably false and simplistic dualisms (gender as innate vs constructed, authentic vs fictitious, fixed vs mutable) which may never adequately account for the lived diversity of gender and sex (Hester, 2004; Lane, 2009; Elliot, 2016). Certainly, participants' accounts illustrate how the impress of *both* bodily propensity, and social knowledge and experience, exists within each child to shape children's embodied experiences.

One central fallacy of the nature/nurture framework is the oppositional positioning of 'culture' as the realm of possibility, compared to 'nature' – the realm of constraint. Yet, as Lane (2009) writes 'evolution and nature are full of diversity and dynamism, while human society and culture has much rigidity and fixity' (p.143). In fact, when it comes to 'sex' and 'gender' and 'childhood', it may be the very rigidity of 'culture' that has obscured the creative potentials of 'nature'.

It is the social silencing of atypical gendered subjectivities in childhood, and the cultural shielding of childhood 'innocence' from diverse forms of gendered knowledge, that sustains the normative presumption that there is only one logical form in which gender may naturally manifest. GSD children belong to the 'domain of unthinkable, abject, unliveable bodies' (Butler, 1993: xi), because through the assertion of their presence and display of their difference, they make visible what was supposed to be invisible: namely, the use of childhood as a cloak for the regulation of normative gendered embodiment. This regulatory process gives rise to the foundational belief in (binary) biological sex as an unequivocal truth: the cornerstone of heterosexuality, the nuclear family, the normative citizen and ultimately, the nation. It is for these reasons that gender has come to signify such a critical field of childhood surveillance.

Neither sex nor gender, nor childhood may be reducible to a singular, given, biological reality or developmental process. Yet children and young people's experiences of medical care were so

often defined by a requirement to conform to naturalised assumptions about gender and sex, enforced through either the *denial* of services, or the *obligation* to undergo interventions, both physical and psychological. Together, these practices function to limit the possibilities of viable childhoods, with severely detrimental consequences for children's wellbeing.

The wellbeing of GSD children may be better protected by an alternative system of care: one which better recognises the heterogeneity and multiplicity of sexed and gendered experiences, and welcomes and accommodates the creativity and agency of children. There is need for a medical practice that values and validates a diverse range of pathways of gendered development and sexed embodiment, without either naturalising or pathologizing any particular course, most particularly through offering children and young people more autonomy to shape their own identities, bodies and healthcare trajectories.

## Chapter 8 References

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# Gender Diversity & Wellbeing Survey

You are invited to take part in a research study by filling out this survey. The study is about how gender diversity affects young people's wellbeing, experiences in school/ college and at the doctor. The study is being carried out at Cambridge University in partnership with Coram International, a charity in London supporting children and young people.

Please read the attached 'information sheets' carefully and decide if you want to fill out the survey. Filling out the survey means that you have voluntarily decided to participate in the study, and have read and understood the information correctly.

## SECTION 1: DEMOGRAPHIC INFORMATION

1.1 What is your age? \_\_\_\_\_ (Write number in years)

1.2 Are you attending any of the following?

1 ☐ School

3 ☐ University

2 ☐ College

4 ☐ None of the above

1.3 What year are you in (at school/ college/ university) \_\_\_\_\_ / 99 ☐ not in education

1.4 Which of these groups do you feel best describes you? (Tick one option from the table)

1.	White	<input type="checkbox"/> 1.1 White (English/ Welsh/ Scottish/ Northern Irish) <input type="checkbox"/> 1.2 White Irish <input type="checkbox"/> 1.3 White Gypsy/ Irish Traveler white background <input type="checkbox"/> 1.4 Any other
2.	Mixed/ Multiple ethnic groups	<input type="checkbox"/> 2.1 Mixed white and black Caribbean black African <input type="checkbox"/> 2.2 Mixed white and

		<input type="checkbox"/> 2.3 Mixed white and Asian background	<input type="checkbox"/> 2.4 Any other mixed background
3.	Asian/ Asian British	<input type="checkbox"/> 3.1 Indian <input type="checkbox"/> 3.5 Any other Asian background	<input type="checkbox"/> 3.2 Pakistani <input type="checkbox"/> 3.3 Bangladeshi <input type="checkbox"/> 3.4 Chinese
4.	Black/ African/ Caribbean/ Black British	<input type="checkbox"/> 4.1 African <input type="checkbox"/> 4.2 Caribbean <input type="checkbox"/> 4.3 Any other black background	
5.	Other ethnic group	<input type="checkbox"/> 5.1 Arab <input type="checkbox"/> 5.2 Any other ethnic group	

1.5 Which of the following best describes your religion/ religious group? *(Tick one option)*

- ☐ 1. No religion      ☐ 2. Christian      ☐ 3. Muslim      ☐ 4. Hindu  
☐ 5. Jewish      ☐ 6. Sikh      ☐ 7. Buddhist      ☐ 8. Other

1.6 Do you consider yourself to have a disability?

- ☐ 1. No disability      ☐ 2. Physical disability      ☐ 3. Learning disability  
☐ 4. Autism/ ASD      ☐ 5. Long term mental health condition  
☐ 6. Other disability \_\_\_\_\_

## SECTION 2: Gender and Sexuality

*Some people think of sex and gender as binary, others see them as more of a spectrum. This section of the survey is about YOUR gender identity.*

2.1 What was your sex at birth (The sex put on your birth certificate?)

- ☐ 1. Male      ☐ 2. Female

2.2 On a scale of 1-9, where 1 means 'not at all', and 9 means 'completely', to what extent would you say you still identify with your birth sex? (The sex put on your birth certificate?)

1	2	3	4	5	6	7	8	9
Not at all								Completely

2.3 When you think about how you feel now: which of the following words best describes your gender identity? (You can tick multiple responses)

- ☐ 1. Male ☐ 2. Female
- ☐ 3. Intersex ☐ 4. Transgender (male to female)
- ☐ 5. Transgender (female to male) ☐ 6. Non-binary/ genderqueer/ genderless
- ☐ 7. Not sure/ gender questioning

2.4 Do you think a person's gender identity remains the same throughout their life?

- ☐ 1. Yes ☐ 2. No ☐ 3. It depends ☐ 4. I don't know

2.5 Do you think your gender identity has/ will the same throughout your life?

- ☐ 1. Yes ☐ 2. No ☐ 3. Don't Know

Many people describe themselves and others as some combination of feminine (girlish) and masculine (boyish) because of how we feel, act, talk or dress. The next questions are about how you describe yourself.

2.6 On a scale of 1-9, where 1 means 'not at all', and 9 means 'completely', to what extent would you say that your **interests** are mostly those typical of a **boy/ young man/ masculine person**?

1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---

Not at all		Completely
←		→

2.7 On a scale of 1-9, where 1 means 'not at all', and 9 means 'completely', to what extent would you say that your **interests** are mostly those typical of a **girl/ young woman/ feminine person**?

1	2	3	4	5	6	7	8	9
Not at all								Completely
←								→

2.8 On a scale of 1-9, where 1 means 'not at all', and 9 means 'completely', to what extent would you say that you **do** most things in a manner of a **boy/ young man/ masculine person**? (Circle one number)

1	2	3	4	5	6	7	8	9
Not at all								Completely
←								→

2.9 On a scale of 1-9, where 1 means 'not at all', and 9 means 'completely', to what extent would you say that you **do** most things in a manner of a **girl/ young woman/ feminine person**? (Circle one number)

1	2	3	4	5	6	7	8	9
Not at all								Completely
←								→

2.10 On a scale of 1-9, where 1 means 'not at all', and 9 means 'completely', how **masculine** do you think you **look**? (Circle one number)

1	2	3	4	5	6	7	8	9
Not at all masculine								Completely masculine
←								→



2.11 On a scale of 1-9, where 1 means 'not at all', and 9 means 'completely', how **feminine** do you think you **look**? *(Circle one number)*

1	2	3	4	5	6	7	8	9
Not at all feminine								Completely Feminine

2.12 On a scale of 1-9, where 1 means 'not at all', and 9 means 'completely', how **masculine** do you **feel**? *(Circle one number)*

1	2	3	4	5	6	7	8	9
Not at all Masculine								Completely Masculine

2.13 On a scale of 1-9, where 1 means 'not at all', and 9 means 'completely', how **male** do you **feel**? *(Circle one number)*

1	2	3	4	5	6	7	8	9
Not at all all male								Completely male

2.14 On a scale of 1-9, where 1 means 'not at all', and 9 means 'completely', how **feminine** do you **feel**? *(Circle one number)*

1	2	3	4	5	6	7	8	9
Not at all feminine								Completely Feminine

2.15 On a scale of 1-9, where 1 means 'not at all', and 9 means 'completely', how **female** do you **feel**? *(Circle one number)*

1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---

Not at all female		Completely female
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2.16 On a scale of 1-9, where 1 means 'not at all', and 9 means 'completely', how comfortable do you feel with your current gender presentation (how 'masculine' or 'feminine' you appear to others?)

1	2	3	4	5	6	7	8	9
Not at all								Completely

2.17 Are you currently living as your preferred gender (tick the best response)?

- ☐ 1. Yes always
 ☐ 2. No never
 ☐ 3. Only at home
 ☐ 4. Only at school/ college/ university
 ☐ 5. I don't know what this

question means

2.18 Have you ever been diagnosed with "gender dysphoria" or "gender identity disorder"?

- ☐ 1. Yes
 ☐ 2. No
 ☐ 3. No but the description might fit
 ☐ 4. Not sure/ I don't know what this is
 ☐ 99. Prefer not to say

2.19 Have you ever been diagnosed with "DSD" (Disorders of Sex Development)?

- ☐ 1. Yes
 ☐ 2. No
 ☐ 3. No but the description might fit
 ☐ 4. Not sure/ I don't know what DSD is
 ☐ 99. Prefer not to say

2.20 People are different in their sexual attraction to other people. Which of the following describes your feelings?

- ☐ 1. I'm only attracted to men/ boys/ male/ masculine people

- ☐ 2. I'm mostly attracted to men/ boys/ male/ masculine people
- ☐ 3. I'm only attracted to women/ girls/ female/ feminine people
- ☐ 4. I'm mostly attracted to women/ girls/ female/ feminine people
- ☐ 5. I'm equally attracted to people regardless of their gender
- ☐ 6. I'm not attracted to other people
- ☐ 7. I'm not sure/ questioning

2.21 In the last 2 years who have you had romantic/ sexual relationships with? *(You can tick multiple responses)*

- ☐ 1. Men/ boys
- ☐ 2. Women/ girls
- ☐ 3. Non-binary people
- ☐ 4. Multiple genders
- ☐ 5. I've never had a romantic or sexual relationship

2.22 Which of the following words do you feel best describes your sexual identity or orientation? *(You can tick multiple responses)*


- ☐ 1. Straight
- ☐ 2. Gay/ lesbian
- ☐ 3. Bisexual
- ☐ 4. Queer
- ☐ 5. Asexual
- ☐ 6. Pansexual
- ☐ 7. Not sure

### SECTION 3: Experiences of healthcare


*This section of the survey asks some questions about your experiences visiting the doctor/ health services.*

4.1 Please read the following statements and rate your agreement with each on a scale of 1-9:


- a. When I have a health problem I feel comfortable going to a doctor..

1	2	3	4	5	6	7	8	9
Strongly disagree								Strongly agree


b. I feel I can talk openly to my doctor about my physical health problems..

1	2	3	4	5	6	7	8	9
Strongly disagree								Strongly agree


c. I feel I can talk openly to my doctor about my mental health problems..

1	2	3	4	5	6	7	8	9
Strongly disagree								Strongly agree

d. I feel that my doctor is knowledgeable and understand the health problems that are affecting me...

1	2	3	4	5	6	7	8	9
Strongly disagree								Strongly agree

e. My doctor addressing my health needs appropriately...

1	2	3	4	5	6	7	8	9
Strongly disagree								Strongly agree

f. I trust my doctor to support me to access the health care and services I need...

1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---

Strongly disagree		Strongly agree
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g. I prefer to see the same doctor each time I go to the doctor/ need health services...

1	2	3	4	5	6	7	8	9
Strongly disagree								Strongly agree

4.2 Have you ever been to visit a doctor services to get support because you were experiencing stress about your gender identity?

☐ 1. Yes

☐ 2. No (if no, SKIP to question 4.4)

4.3 (If yes to 4.2) How well on a scale of 1-9 did you feel that your Doctor addressed your gender related needs?

1	2	3	4	5	6	7	8	9
Not at all								Perfectly

4.4 Have you even been referred to a mental health service?

☐ 1. Yes

☐ 2. No (if no, SKIP to question 4.6)

4.5 (If yes to 4.4) On a scale of 1-9 how understanding and knowledgeable did you feel this service was about your needs?

1	2	3	4	5	6	7	8	9
Not at all								Completely

4.6 Have you ever been referred to a mental health service for reasons related to your gender identity?

☐ 1. Yes

☐ 2. No (if no, SKIP to question 4.8)

4.7 (If yes to 4.6) On a scale of 1-9 how understanding and knowledgeable did you feel this service was about your gender related needs?

1	2	3	4	5	6	7	8	9
Not at all								Completely

4.8 Have you ever been referred to a gender identity development service?

- ☐ 1. Yes, and I've had at least one appointment waiting list
- ☐ 2. Yes, but still on the waiting list
- ☐ 3. No
- ☐ 4. I don't know what this is

4.9 (If answered 1 above) Did you feel the clinic was helpful and knowledgeable about your issues related to gender?

1	2	3	4	5	6	7	8	9
Not at all								Completely

**SECTION 4: Mental Wellbeing**

5.1 Please read the following statements and tick (✓) the box that best describes your experience of each over the last 2 weeks

Statement	None of the time	Rarely	Some of the time	Often	All of the time
a. I've been feeling optimistic (happy) about the future	1 None of the time	2 Rarely	3 Some of the time	4 Often	5 All of the time
b. I've been feeling useful	1 None of the time	2 Rarely	3 Some of the time	4 Often	5 All of the time
c. I've been feeling relaxed	1 None of the time	2 Rarely	3 Some of the time	4 Often	5 All of the time

d. I've been feeling interested in other people	1 None of the time	2 Rarely	3 Some of the time	4 Often	5 All of the time
e. I've had energy to spare	1 None of the time	2 Rarely	3 Some of the time	4 Often	5 All of the time
f. I've been dealing with problems well	1 None of the time	2 Rarely	3 Some of the time	4 Often	5 All of the time
g. I've been thinking clearly	1 None of the time	2 Rarely	3 Some of the time	4 Often	5 All of the time
h. I've been feeling good about myself	1 None of the time	2 Rarely	3 Some of the time	4 Often	5 All of the time
i. I've been feeling close to other people	1 None of the time	2 Rarely	3 Some of the time	4 Often	5 All of the time
j. I've been feeling confident	1 None of the time	2 Rarely	3 Some of the time	4 Often	5 All of the time
k. I've been able to make up my own mind about things	1 None of the time	2 Rarely	3 Some of the time	4 Often	5 All of the time
l. I've been feeling loved	1 None of the time	2 Rarely	3 Some of the time	4 Often	5 All of the time

m. I've been interested in new things	1 None of the time	2 Rarely	3 Some of the time	4 Often	5 All of the time
n. I've been feeling cheerful	1 None of the time	2 Rarely	3 Some of the time	4 Often	5 All of the time

5.2 How often in the last 30 days have you experienced the following:

a. Feelings of stress, and worry.

☐ 1. Everyday    ☐ 2. Most days    ☐ 3. Some days    ☐ 4. Once or twice    ☐

5. Never

b. Feeling really bad about yourself, or feelings that you have let yourself or you family down.

☐ 1. Everyday    ☐ 2. Most days    ☐ 3. Some days    ☐ 4. Once or twice    ☐

5. Never

c. Thoughts of hurting self.

☐ 1. Everyday    ☐ 2. Most days    ☐ 3. Some days    ☐ 4. Once or twice    ☐

5. Never

d. Suicidal thoughts.

☐ 1. Everyday    ☐ 2. Most days    ☐ 3. Some days    ☐ 4. Once or twice    ☐

5. Never

e. Poor appetite or overeating.

☐ 1. Everyday    ☐ 2. Most days    ☐ 3. Some days    ☐ 4. Once or twice    ☐

5. Never

**SECTION 5: Household information**

6.1 Did any of your parent(s)/ guardian(s) complete a degree course or equivalent?



☐ 1. Yes

☐ 2. No

☐ 99. Don't Know

6.2 Does your household receive income support (benefits)?

☐ 1. Yes

☐ 2. No

☐ 99. Don't Know

6.3 Does your household qualify for free school meals?

☐ 1. Yes

☐ 2. No

☐ 99. Don't Know

6.4 What are the first 3 digits of your home postcode?

\_\_\_\_\_ (Write Postcode) /

☐ 99. Don't know

**Thank you for completing the survey!**

If you would like more information about this study, or you would like to participate in a follow up interview please contact Liz at: [email address redacted], or leave your email address in the space below:

\_\_\_\_\_

*All interviewees receive a £30 gift voucher in appreciation of their time.*

# Development and Validation of the Gender Variance Scale

## 1. Introduction

This paper explores the development of a new composite scale for measuring gender variance, for use in survey research and statistical analysis. In the context of qualitative sociological research, “gender” has been extensively conceptualised as complex, layered, subjective and multidimensional. However, in most quantitative sociological studies, gender has been operationalised as fixed, objective and binary. Amongst other limitations, this has led to the exclusion of many sex and gender diverse groups, including transgender, non-binary and intersex persons from evidence collection and analysis.

On the other hand, over the last decades, various scales for measuring gender differences quantitatively have been developed by psychologists. However, these are typically ‘standalone’ scales, composed of a large number of questions (e.g. 50+ items), making them cumbersome for survey respondents to fill out, and impractical for use in the context of a broader survey. Furthermore, they typically focus on assessing whether participants’ personalities, preferences, behaviour, etc. conform to a set of predetermined (stereotyped) masculine or feminine norms or traits. For example, one popular and influential measure from the 1970s asks respondents to rate how “analytical” and “competitive” they are, in partial measure of masculinity, compared to “yielding”, “flatterable” and “childlike”, to measure aspects of femininity (Bem, 1974). Yet, it has since been convincingly argued that a person’s adherence to traditional gender roles or stereotypes is not necessarily a reliable predictor of their identity (Hoffman and Borders, 2001).

In a contemporary world where young people are developing increasingly diverse ways of thinking about and ‘doing’ gender (Bragg *et al.*, 2018) there is urgent need to develop new sociological measures that can account for the complexities of gender beyond the traditional sex binary. This paper explores findings from a research project aimed at contributing to such an end. The goal was to develop and integrate a new scalar tool that could identify and measure gender diversity on a spectrum, in the context of a broader sociological study exploring how gender variance affects young people’s experiences and wellbeing.

The developed “Gender Variance Scale” (GVS) measures individuals’ self-perceived adherence to masculinity/ femininity norms across multiple aspects, including their interests, behaviour, appearance and identity. Results are then scored in relation to natal or assigned sex to measure the extent to which a respondent’s gender identity aligns with, or deviates from, dominant expectations associated with their birth sex. The tool aims to capture diversity amongst both trans and non-trans persons.

The second part of the paper explores the relationship between the GVS and other key demographics. The analysis reveals some interesting results that complement qualitative and theoretical sociological literatures that have explored the relationship between gender diversity and its intersections with other aspects of identity.

## 2. Methodology

### 2.1 Development of the GVS: adaptation from the SIS

The GVS (‘Gender Variance or Non-conformity Scale’) was adapted from a lesser known tool developed by Stern, Barak and Gould (1987) called the ‘Sexual Identity Scale’ (SIS). The SIS asks respondents to self-assess themselves as typically ‘masculine’ or ‘feminine’ with regard to four functional areas or dimensions of the ‘self’ (previously identified in both sex and age role literature):

1. Feel - Personality/Emotional
2. Look - Physical/Biological
3. Do - Societal/Occupational
4. Interest - Cognitive/Intellectual

The SIS was judged to have several advantages compared to more commonly used multi-trait gender difference measures, leading to its selection for adaptation in this study. Importantly, it relies on a respondent’s direct, self-rating of themselves as typically “masculine” or “feminine” (as opposed to asking individuals to self-report on their adherence to pre-selected personality traits, coded “masculine” or “feminine” by the researcher). This approach recognises that cultural definitions of maleness and femaleness are varied and complex, and that individuals are not just passive recipients of cultural meanings about gender, but active participants in the constructions of those meanings. Further, it fits with how gender identity has been widely conceptualised in transgender and queer literatures: as a psychic investment in ‘self’ as a masculine, feminine or non-binary person (Elliot, 2016). Additionally, the scale is designed to be short and simple, easily

interpreted by researcher and respondent alike, rendering it ideal for inclusion in a larger survey, and for use with adolescents and young people.

On the other hand, a central limitation of the SIS is its conceptualisation of “sexual identity” as bipolar; respondents are required to rate themselves on a continuum ranging from masculinity at one end to femininity at the other. Whilst a powerful masculine/feminine dichotomy underwrites hegemonic understandings of gender difference, the principle of bipolarity is not absolute. Masculinity and femininity have also been understood as two distinguishable and bendable traits which may coexist to variable degrees within different individuals (Marsh and Myers, 1986).

The GVS was developed through building upon and adapting the SIS in the following ways. Firstly respondents were asked to self-assess their femininity and masculinity separately (with regard to each of the four dimensions, “feel”, “look”, “do”, “interests”), generating an independent “masculinity score” and a “femininity score” for each respondent. Secondly, more variability was introduced into the scale: whilst the SIS uses a 5 point Likert scale, the GVS uses a 9 point scale from 1 “not at all” “feminine/ masculine” to 9 “completely” “feminine/ masculine”. Third, as a result of empirical piloting a decision was made to ask respondents to first assess the extent to which they “feel masculine/ feel feminine”, and then separately the extent to which they “feel male/ female”; this allowed respondents to express feelings of femininity/ masculinity that did not necessarily directly relate to their sexed embodiment. Finally, each respondent was asked to answer a question about their sex registered at birth (sex as recorded on birth certificate).

Responses to each item component were aggregated to create two separate scores for each respondent: a “masculinity score” ranging from 5-45, and a “femininity score” ranging from 5-45. These scores were then combined to create a final gender variance or ‘transness’ score for each respondent according to the following formula:

$$\textbf{\textit{GVS = (45-masculine score) + (feminine score-5) IF natal/assigned sex=male) OR (45-feminine score) + (masculine score-5) IF natal/ assigned sex=female.}}$$

The GVS measures an individual’s level of (transgendered) variance or deviance from a prevailing ‘cisgendered’ norm: on a scale from 0 (minimum possible variance) to 80 (maximum possible variance).

## 2.2 Piloting of the GVS

Between 2019-2020 1,776 young people ages 14-24 years filled out a structured survey. The survey had several parts, comprising questions concerning: sex and gender identity (including the items in the GVS scale); other demographic factors; experiences in school and healthcare; and aspects of wellbeing.

Young people were sampled through a mixed approach. 1,509 respondents were accessed through 10 schools and further education colleges. Six of these schools/colleges (including 1,358 respondents) were selected randomly from an online directory. Schools/colleges were grouped into districts across England, Wales and Scotland; a random number generator was used to select one school in each district to be contacted about the study. Those who responded positively were then asked to distribute the survey to all students ages 14 and above, to be filled out on a voluntary basis. An additional 4 schools (including 151 respondents) were access through convenience/ personal contacts. Finally an additional 267 young people were recruited online, through social media groups/forums specifically for gender and sex diverse adolescents and youth. This was to ensure a larger sample of gender/sex diverse young people were included in the study.

## 2.3 Testing for Validity

To test GVS validity, the study considered its relationship to a number of comparison measures. Relationships between the “masculinity scores” and “femininity scores” were also compared for both ‘binary’ and ‘non-binary’ individuals.

The data was then explored to investigate relationships between gender variance as measured by the GVS and other demographic variables, including sex registered at birth, disability, sexuality, ethnicity, age, and socio-economic factors.

# 3. Analysis

## 3.1 Assessment of validity and reliability

To test for validation *t*- tests were conducted to measure average GVS scores against different gender populations (Table 1). As would be expected, the mean score for respondents whose gender identity did not align with their sex registered at birth was significantly higher than for those whose gender identity matched their birth-registered sex. Binary trans respondents had the highest mean

GVS score, followed by non-binary trans respondents. Cisgender youth who said they were “questioning” their gender also had significantly higher mean GVS scores compared to those not questioning their gender. Furthermore, respondents who said that they were suffering from gender dysphoria had significantly higher GVS scores than those not affected by dysphoria.

Table 13: *t* tests between different gender populations and GVS scores

	Sample	Mean	Difference among means	<i>p</i> value.
Total population (1,766)				
Cisgender youth	1,545	12.96		
Trans youth	229	54.88	-41.92	<.00001
Trans population (229)				
Non-binary trans	117	45.93		
Binary trans	112	64.23	-18.30	<.00001
Cisgender population				
Not questioning gender	1,517	12.53		
Gender questioning	28	36.29	-23.75	<.00001
Total population (1,704)				
No dysphoria	1,503	13.3		
Gender dysphoric	201	54.65	-41.38	<.00001

\*\*\* significant (two-tailed probability <.001).

An additional question asked respondents: “on a scale of 1 ‘not at all’, to 9 ‘completely’ to what extent do you identify with your birth sex?” Pearson correlation revealed a strong and significant inverse correlation between this variable and the GVS ( $r=-0.79$ ,  $p<.00001$ ).

Pearson correlations between self-reported gender identity and the masculine and feminine scores, revealed that respondents who identify as men/ boys typically perceive themselves as masculine ( $r=0.87$ ,  $p<.00001$ ), and those who identify as women/ girls perceive themselves as feminine ( $r=0.87$ ,  $p<.00001$ ). Correlations between these scores and respondents who identified as nonbinary, “other” or “questioning” were all weak and insignificant.

Pearson correlation also revealed a strong and significant inverse relationship between the masculinity and femininity scores ( $r=-0.95$ ,  $p<.00001$ ). This relationship was particularly strong for gender binary respondents ( $-0.95$ ,  $p<0.000$ ); and much weaker, but still significant, for non-binary respondents ( $-0.47$ ,  $p<.00001$ ).

Relationships between the four sub-dimensions of gender self-perception (“feel”, “do”, “look”, “interests”) was tested in Stern, Barak and Gould's (1987) original paper. The GVS scale differs from the SIS in that respondents were asked separately whether they feel “male” and/ or “female” and whether they feel “masculine” and or “feminine”. *T* tests revealed the mean scores between these questions was significantly different for different gender populations, indicating that it was meaningful to ask two separate questions (Table 6). Feeling “male” or feeling “female” was found to be a stronger predictor of gender identity than feeling “masculine” or feeling “feminine”.

*Table 14: t tests comparing boys and girls responses to “feel male/ female”, “feel masculine/ feminine”*

Sample	Mean	Difference among means	<i>p</i> value.
Young men/ boys (N=737)			
Feel male	8.34	0.60	<.00001
Feel masculine	7.73		
Feel female	1.41	-0.42	<.00001
Feel feminine	1.82		
Young women/ girls (N=949)			
Feel male	1.52	-0.48	<.00001
Feel masculine	2.00		
Feel female	8.27	0.61	<.00001
Feel feminine	7.65		
Non-binary/ other youth (N=125)			
Feel male	4.59	-0.32	0.08
Feel masculine	4.91		
Feel female	3.66	-0.90	<.00001
Feel feminine	4.56		

Assessment of internal consistency of the subcomponents of GVS in terms of Cronbach’s alpha showed a coefficient of 0.965 for both the natal female and natal male populations, providing good evidence of the scale's reliability in the present study.

Overall, these findings indicate that the GVS, and its subcomponent masculine and feminine scores, contain both face and construct validity, when compared to other variables measuring gender identity and diversity.

### 3.2 Application of the GVS: comparison with other demographic variables

*T* tests were performed to ascertain whether there were any differences in GVS scores across different demographic variables measured in the survey, including disability, sexuality, sex registered at birth and ethnicity (Table 3). Amongst the cisgender population: disabled, LGBQ and female-registered youth all had significantly higher GVS scores; there were no differences in scores observed between the white British and black and ethnic minority (BME) populations.

Whilst significantly higher proportions of trans youth, compared to cisgender youth, had a disability ( $\chi^2=152.69$   $p<.00001$ ), were LGBQ ( $\chi^2=418.47$ ,  $p<.00001$ ) and were female-registered ( $\chi^2=11.44$ ,  $p=.001$ ), within these trans subpopulations, significant differences between GVS mean scores were not observed, except for sexuality, where LGBQ trans respondents had a slightly lower mean GVS score than trans youth who identified as straight. This may be because LGBQ trans youth are more likely to identify as non-binary, thus scoring lower on the GVS.

*Table 15: t-tests of GVS scores by demographic sub-population*

	Sample	Mean	Difference among means	<i>p</i> value.
Cisgender				
No disability	1,258	11.95		
Has disability	195	17.24	-5.23	<.00001
Straight	1,247	10.37		
LGBQ	295	23.99	-13.61	<.00001
Male registered at birth	640	9.80		
Female registered at birth	905	15.20	-5.39	<.00001
White British	1,198	12.87		
BME	249	13.24	-0.37	0.67
Trans population (223)				
No disability	117	55.91		
Has disability	106	54.13	1.77	0.38
Straight	35	61.94		
LGBQ	189	53.62	8.32	0.003
Male registered at birth	68	54.04		
Female registered at birth	161	55.24	-1.19	0.58
White British	177	55.08		
BME	47	52.36	2.72	0.27



Regression analysis was then used to further explore the relationship between these variables and the CVS within the cisgender population (Table 7). Independent variables comprised four binary variables to measure whether: a respondent had a self-reported disability; was BME; identified as LGBQ, and was registered female sex at birth; two scalar variables describing a respondents age in years, and information about their socio-economic background<sup>91</sup> were also included in the model. The model was adjusted to account for the clustered sampling design using cluster robust standard errors, and the non-normal distribution of the GVS was accounted for using a bootstrap approach.

Factors associated with significantly higher GVS scores were disability, LGBQ attraction, female sex registration, and older age. Ethnicity and socio-economic factors were not significantly associated with respondents' GVS scores.

*Table 16: regression model: demographic factors associated with GVS score in non-trans sample*

N=1,358	Coef.	Confidence interval	<i>p</i> value
Has disability	3.56	1.97-5.16	<.00001
Female birth registered	4.56	3.01-6.12	<.00001
LGBQ	11.51	9.17-13.86	<.00001
BME	0.49	-1.36-2.34	0.61
Age	0.54	0.14-0.95	0.008
SEC score	0.22	-0.53-0.98	0.56

#### 4. Discussion

The development of the GVS constitutes an exploratory effort to develop and test a new tool for measuring gender variance/ conformity on a spectrum. The GVS constitutes a measure of deviance from a cisgender norm, based on respondents' self-assessment of their own adherence

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<sup>91</sup> Young people in the survey were asked three simple questions to measure their socio-economic status: "does your household receive income support", "is your household eligible for free school meals", and "did either of your parents complete a degree course or equivalent". Young people received a point for answering "yes" to either of the first two questions, and for answering "no" to the final question. These responses were aggregated to form a simple scale (SEC) ranging from 0 (least deprived) to 3 (most deprived).

to masculinity/ femininity norms across four key domains: looks, feelings, actions and interests. The results of this first study, indicating both validity and reliability, suggest that the tool may be usefully applied across both gender-typical and gender-atypical populations, to identify experiences of gender beyond a traditional male/female sex binary.

An initial pilot of the tool identifies some interesting associations between demographic factors and gender variance as measured by the GVS. Firstly, there are significantly higher levels of gender variance observed in the (non-trans) LGBTQ population compared to the straight cisgender population. Meanwhile, trans youth in the sample were less likely than non-trans youth to identify as “straight”. These findings complement a body of theoretical feminist and queer literature which has explored how heterosexuality regulates gender as a binary relation (Butler, 1990).

Secondly, there’s an association between the GVS and age, with lower levels of gender non-conformity reported in younger adolescents, compared to young adults. A body of ethnographic research has explored how adolescence can be an especially “gender-policed” stage in human development, where strict conformity to rigid hetero-gendered norms is punitively enforced (Pascoe, 2007), providing one possible (at least partial) explanation for this relationship.

Third, the significantly higher levels of gender variance observed in the cisgender female population compared to the cisgender male population, aligns with a body of literature which has explored the especially inflexible and restrictive nature of constructs of masculinity, especially amongst adolescents (Reigeluth and Addis, 2016).

Finally, the results reveal a significant association between disability and gender variance. The high empirical co-occurrence of forms of neuro-diversity, particularly autism spectrum disorder, and gender dysphoria has recently been observed in clinical settings, and is a topic of increasing academic interest and debate (Strang *et al.*, 2014). In this study, whilst trans and non-binary youth reported higher rates of all types of disability (47.53%) compared to gender-typical youth (13.42%), disabled youth within the *non-trans* population also reported significantly higher mean GVS scores (Table 15).

The findings from this study may be of interest for building a stronger empirical understanding of gender diversity and its intersections with other aspects of identity. At this stage, further empirical testing of the GVS would be valuable to better ascertain its usefulness.

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