A Qualitative Study Using Interpretative Phenomenological Analysis to Explore the Experiences of Young People Presenting with Gender dysphoria within a Child and Adolescent Mental Health Service.

A thesis submitted for the degree of Professional Doctorate in Child and Adolescent Psychoanalytic Psychotherapy.

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Date of Resubmission: March 2023

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Abstract

Research Thesis Title

A Qualitative Study Using Interpretative Phenomenological Analysis to Explore the Experiences of Young People Presenting with Gender dysphoria within a Child and Adolescent Mental Health Service.

Background information

Children's mental health services have experienced an exponential increase of referrals over the last ten years where GID is a clinical feature (Tsoukala, 2018). As a child and adolescent psychotherapist in clinical training it was apparent that my own clinic was seeing the national increases reflected in gender dysphoria referrals. A significant proportion of my own psychotherapy clinical work was with patients with gender dysphoria. Many children and young people with gender dysphoria will also experience mental health difficulties. They are at an increased risk of experiencing suicidal ideation, self-harm, anxiety, and depression (Aitken, et al, 2016 and Röder, et al, 2018). Transgender adolescents also have significantly lower psychological well-being scores (Röder et al, 2018). The emotional affect is that of profound distress relating to identity about the disharmony between an individual's self-perception and their body (Di Ceglie, 2009).

CAMHS is often the main service that this vulnerable patient group is referred via their GP. CAMHS will then refer to the nearest Gender Identity Dysphoria Service if appropriate. Once a referral is made to GIDS it is expected, and recommended by GIDS that CAMHS will continue to work with the young person:

"You don't need to be a 'specialist' in order to help young people who are exploring their gender. In fact, following the assessment process, most of the therapeutic input is provided outside of GIDS, usually in CAMHS. Where possible we ask local CAMHS to stay involved alongside our team…." (The Tavistock and Portman NHS Foundation Trust, 2019).

The surge of referrals to GIDS and to CAMHS is likely to continue, therefore increasing knowledge to inform the support and interventions offered to young people is vital. Although gender dysphoria is not a new presentation, there is limited body of knowledge in this field particularly regarding treatment; Zucker (2008) refers to this gap as “a large empirical black hole in the treatment literature for children with GID” (p.359). However, in the last ten years there has been a considerable increase in research and papers published. However, as research is undertaken and understanding is increased, practices are also constantly evolving, which is overall positive, however it may cause difficulties for clinicians working in the field (Di Ceglie, 2009).

Focus of the Study

Young people presenting with gender dysphoria or who are questioning, will be interviewed using a semi-structured approach. Their hopes, expectations, and experiences of using a child and adolescent mental health service will be captured and explored. This will contribute towards the body of knowledge in the field, and the information may then be used to inform planning of CAMHS provision to further understand and meet the needs of this vulnerable group.

Gap

Although gender dysphoria is not a new presentation, there is limited body of knowledge in this field particularly regarding treatment. Most recent empirical clinical studies have emerged from Canada and America with the bulk of the data used in studies obtained using parental questionnaires. There have been some empirical and non-empirical studies, which have used clinical notes and case studies. However, there are very few studies or papers published which uses self-report measures (Durwood et al, 2017). Service user participation or more recently termed as ‘experts by experience’ is part of the NHS long-term plan and is defined as young people who have personal knowledge of services, through their own use of

of those services (CQC, 2023). However, most of the studies do not reflect this and particularly, transgendered and non-binary young people's voices are under-represented.

Methodology

A qualitative service evaluation sought to evaluate the service user experience of a Child and Adolescent Mental Health Service (CAMHS). A small number of young people with gender dysphoria or who are questioning their gender were interviewed using a semi-structured approach over the telephone. The interviews were analysed by using an Interpretative phenomenological analysis (IPA). Countertransference reflections were incorporated as an integral part of the process providing an extra layer of analysis and understanding.

Conclusion

The use of semi-structured interviews in conjunction with the interviewer's countertransference enabled participants to share their experiences of accessing a CAMHS service. The use of interpretative phenomenological analysis (IPA) provided unique insights into the participant's world and experiences offering significant contributions to our understanding of gender dysphoria and helping to shape the services gender variant young people access.

Chapter 1: Introduction

Children's mental health services have experienced an exponential increase of referrals over the last ten years where gender dysphoria is a clinical feature (Tsoukala, 2018). As a child and adolescent psychotherapist in clinical training it was apparent to me that gender identity referrals to my clinic was reflecting the national increases. A significant proportion of my own psychotherapy clinical work was with patients with gender dysphoria. It was clear to me that alongside the therapeutic aims of reducing mental health difficulties it was also valuable for them to have a space within our sessions to explore and reflect upon their thoughts and feelings regarding their gender identities. Many children and young people with gender dysphoria will also experience mental health difficulties; they are at an increased risk of experiencing suicidal ideation, self-harm, anxiety, and depression (Aitken, et al, 2016; Röder, et al, 2018). Transgender adolescents also have significantly lower psychological well-being scores (Röder et al, 2018). Gender dysphoria is defined as "a sense of unease that a person may have because of a mismatch between their biological sex and their gender identity" (NHS, 2020). The emotional affect is that of profound distress relating to identity about the disharmony between an individual's self-perception and their body (Di Ceglie, 2009).

There has been substantial media coverage in recent years about the prevalence and treatment of children and young people presenting with gender dysphoria. It has become a controversial area with often very polar stances aggressively asserted. The danger for therapists and clinicians within CAMHS is that they may inadvertently work from a polarised stance (Di Ceglie, 2009). This polarity is reminiscent of Winnicott's (1966) 'pathological splitting' which may occur within the environmental provision, but in this context occurs within all spheres. It is apparent that an approach which does not generalise but considers the individual's needs informing care planning and interventions is necessary, requiring clinicians and services to refrain from external pressure.

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"You don't need to be a 'specialist' in order to help young people who are exploring their gender. In fact, following the assessment process, most of the therapeutic input is provided outside of GIDS, usually in CAMHS. Where possible we ask local CAMHS to stay involved alongside our team…." (The Tavistock and Portman NHS Foundation Trust, 2019).

The surge of referrals to GIDS and to CAMHS is likely to continue, therefore increasing knowledge to inform the support and interventions offered to young people is vital. Although gender dysphoria is not a new presentation, there is limited body of knowledge in this field particularly regarding treatment; Zucker (2008) refers to this gap as "a large empirical black hole in the treatment literature for children with GID" (p.359). However, in the last ten years there has been a considerable increase in research and papers published. Most recent empirical clinical studies have emerged from Canada and America with the bulk of the data used in studies obtained using parental questionnaires. There have been some empirical and non-empirical studies, which have used clinical notes and case studies. However, there are very few studies or papers published which uses self-report measures (Durwood et al, 2017), despite it identified as good practice to seek children and young people's views in the planning and delivery of services. Midgley et al (2016) concluded that the way young people engage with treatment will be based upon their expectations, and without identifying the expectations this can lead to potential treatment breakdown. It is therefore vital that young people's views are gained. Indeed, service user participation or more recently termed as 'experts by experience' is part of the NHS long-term plan. Sadly, much of the studies do not reflect this and particularly, transgendered and non-binary young people's voices are under-represented.

This qualitative service evaluation sought to evaluate the service user experience of a metropolitan city Child and Adolescent Mental Health Service (CAMHS) based in the north of England. The service evaluation was designed prior to Covid 19. Unfortunately, the pandemic caused significant disruption to being able to recruit and interview participants. It was always envisaged that the participants would be interviewed face to face However this was not possible and instead, telephone interviews were conducted. Six young people identifying as transgender or non-binary were interviewed using a semi-structured and psychoanalytic approach. Young people's views of their expectations and experiences of receiving treatment/intervention were captured, explored, and analysed by using an Interpretative phenomenological analysis (IPA). The interviews were also analysed through a psychoanalytic lens with the countertransference experience explored. This approach ensured that rich and detailed accounts were obtained. The information may then be used to inform planning of CAMHS provision to further understand and meet the needs of this vulnerable group. The participants relayed that they were keen for this to be implemented.

Main Aim and Objectives of the Service Evaluation

The overarching aim of the service evaluation is:

1. Explore the Experiences of Young People Presenting with Gender dysphoria within a Child and Adolescent Mental Health Service.

This aim will be met by focusing on the following objectives:

1. Interview 6 participants and transcribe the material.
2. Undertake a qualitative analysis of the transcriptions using Interpretative Phenomenological Analysis and approach the material with a psychoanalytic lens to explore counter-transference communications.

Overview of the Service Evaluation

The following is summary of the structure and content of the research thesis. This thesis is comprised of chapters: 1. Literature Review. 2. Methodology. 3. Findings and Discussion and 4. Conclusion.

The literature review will evaluate literature within the four subject areas: Section 1: A Brief History of Gender dysphoria and Background and Policies. Section 2: Children's and Young People's Presentations to Services (Transgender, Non-Binary and Questioning). Section 3: Psychoanalytic Perspectives of Gender dysphoria and Section 4: Children and Young People's Participation. It is envisaged that by evaluating both empirical research papers in section 2 and considering psychoanalytic perspectives of gender dysphoria within section 3, it will provide a comprehensive review.

The methodology section will provide details of the study design and the process of participant eligibility criteria and recruitment. The data collection process of semi-structured interviews and the data analysis of interpretative phenomenological analysis will be described providing information about why they were selected and the advantages for this study.

In the presentation of findings and discussion section, three superordinate themes have been identified and will be illustrated by the participants quotes from their interviews. The three themes: 1. Will CAMHS Help Me? 2. The Merging of Gender dysphoria and Mental Health Difficulties. and 3. The Transgender Journey. There will be a detailed discussion at the end of each section which will link the themes of the study to gender dysphoria literature, to build on my findings or to contribute something new.

Finally, the conclusion will consider the strengths and weaknesses of the study design and application and the specific benefit of using semi-structured interviews and undertaking interpretative phenomenological analysis of the data. The implications of undertaking a study during the Covid 19 lockdown will also be briefly explored. The findings will be summarised with recommendations for the clinical significance and implications of the findings for future research in gender dysphoria will be made.

The use of Terminology

The participants shared within their interviews the importance of the use of correct terminology and pronouns. This is echoed within Losty's (2018) qualitative research design study which sought to explore the psychological realities of 6 individuals, aged between 19 and 29 years, who identified as gender variant. One of the themes was of 'correct and incorrect language'. The participants' identified choice of name and pronoun will be used e.g., he/ she and they/them when they are referred to in this research thesis. Alex identified as binary and elected to be referred to as "he" within this thesis. The terms gender dysphoria, gender variant, transgender, non-binary and gender identity will be used throughout this research thesis.

CHAPTER 2: Literature Review

Rationale

A narrative literature review design was chosen because it seeks to gather what has been published and what research or knowledge has been accomplished, so that gaps may be identified (Grant and Booth, 2009). The review will also utilise some systemic design methods, including reporting methodology, search terms, databases used, and inclusion and exclusion criteria to provide rigour. A whole systemic design was applied to Section 2 of the literature review (Young People's Mental Health Presentations to Services (Gender dysphoria) as the studies reviewed and appraised were quantitative in design, otherwise the literature is primarily qualitative. Baumeister and Leary (1997) describe five goals of conducting a narrative literature review, three of which are relevant and will be used. The first is to provide an overall summary of the knowledge of a particular subject matter. The second is to provide a historical account of the development of theory and research of a subject matter. This is a particularly appropriate goal within the sections 1 and 3 of this review as considerable material is based upon historical sources, e.g., non-contemporaneous psychoanalytic literature. The third goal is to reveal "weaknesses, contradictions or controversies" (p. 312). This seeks to establish what is known and what remains unknown, looking for gaps so that recommendations for future research may be suggested. Two of the perceived weaknesses of this type of literature review is that first, authors may select literature which supports their world view and second it does not maximise scope or analyse the data collected (Grant and Booth, 2009). The first perceived weakness of the author selecting material is largely purposeful, except for section 2 (Young People's Mental Health Presentations to Services (gender dysphoria). This enables for material which is both historical and/or psychoanalytic to be used alongside contemporary literature. This is elaborated further within the eligibility criteria section.

Method

The literature review was conducted utilising the databases and additional searches outlined in Table 1.

Table 1 – Databases and Additional Searches

Databases Used
1. PsycINFO (via EBSCOhost)
2. The Pep Archive (via EBSCOhost)
3. Psychology and Behavioural Sciences Collection (via EBSCOhost)
4. PsycArticles (via EBSCOhost)
5. PsycBOOKS (via EBSCOhost)
6. Medline (via EBSCOhost)
7. PubMed
Additional Searches
1. Citation Search
2. Handsearching specified journals and books.
3. Manual search of reference lists from articles.
4. The Association of Child and Adolescent Psychotherapy Website.

Guided Search Term

A guided search was conducted using the research question.

Research Question:

What expectations [C1] and hopes do young people [C3] presenting with gender identity dysphoria [C4] have about CAMHS [C5]?

Table 2: Guided Search Terms

Concept 1	**Concept 2**	**Concept 3**	**Concept 4**
Expectations	**Young People**	**Gender Identity Dysphoria**	**CAMHS**
Beliefs	Teenagers	GID	Child and Adolescent Mental Health Services
Perceptions	Teens	Transgender	Young people's Mental Health Services
Hopes	Adolescents	Trans	Mental Health Services
Assumptions	Youth	Non-Binary	GIDS
Desires	Juveniles	Gender Questioning	Gender Identity Dysphoria Services
	Children		

Search terms were developed and tested through scoping searches in order to ensure that relevant articles were included and reflected the study. For example, in respect of finding papers for the presenting difficulties of young people with gender dysphoria the following terms were initially used: Trans*, Adolescence (13-17), Empirical*, Mental/Emotional Health. In order to expand my searches, terms were adapted e.g., young people instead of adolescent. I also utilised the Journal of Child Psychotherapy, google scholar and relevant papers within references.

Eligibility Criteria

The eligibility criteria was determined by the theme that I was searching for. Literature pertaining to adults was excluded within two of the themes, for example within themes 2 and 4: Children and Young People's Presentations to Mental Health Services (Transgender, Non-Binary and Questioning) and Children and Young People's Participation. However, adults were not excluded within the searches for themes 1 and 3: Background and psychoanalytic literature. As well as there being limited research within these themes pertaining to children and young people, adult literature was pertinent. A considerable proportion of psychoanalytic literature on gender identity concerns adults, although in

recent years more literature pertaining to children and young people has been published. Wherever, possible I have attempted to focus on children and young people. The English language was selected as a limiter during searches.

This review has been approached with a bias towards psychoanalytic material, this is first because the author is undertaking a professional doctorate within Child and Adolescent Psychoanalytic Psychotherapy and second, because this is the area which has consistently interested and challenged me. The literature search pertaining to this theme was not confined to recently published literature as many of the psychoanalytic and background literature, including central concepts predated the 1980s. However, contemporary literature was sought for section two and section four. The table below provides a summary of the exclusion/inclusion criteria for each section:

Outline of the results of searches

The literature review was firstly conducted using the databases and additional searches outlined in Table 1. There were four subject areas, referred to as sections which were identified. A comprehensive search of each of these four themes was undertaken beginning with EBSCO host which incorporates all major journals. It became clear that the majority of literature returned focused on two of the themes: 1. Background GID although policies was not represented, 2. Children and Young People's Presentations to Mental Health Services (Transgender, Non-Binary and Questioning). I decided to operate further searches adjusting the guided search terms to find literature pertaining to gender dysphoria policies and children and young people's participation as these themes seemed relevant to the study. I also refined the search to gain additional psychoanalytic literature using specific journals such as Journal of Child Psychotherapy.

Introduction

The papers were read, and notes were made encompassing the aims, study type themes and conclusions. The review is comprised of 4 sections which address the research question. The first section aims to provide a brief history of the background of gender dysphoria and examine the current policies in place. The second section is a comprehensive review of the types of difficulties that young people with gender dysphoria typically present with. Many of these studies are empirical and contemporary (most within the last fifteen years). The third section explores psychoanalytic perspectives of gender identity dysphoria. The last section examines the studies undertaken in mental health services with young people, which have focussed upon eliciting young people's hopes and expectations. Policies surrounding the importance of young person participation will also be briefly described.

Although, gender identity and sexuality are often considered separate areas, during Freud's time homosexuality was confused with a gender dysphoria; a gay man was attributed with possessing a female mind (Rohleder, 2019). The narrative around homosexuality and transsexuality was around "cure" rather than treatment (reference). Much of the minority literature, especially in respect of shame does refer to lesbian, gay and bisexual people, However, some of it is relevant as there are shared experiences of stigma and discrimination. Therefore, some of the literature does pertain specifically to LGB, but it is also relates to the experiences of gender variant young people.

Section 1: A brief history of Gender dysphoria Background and Policies

"Whenever, wherever on this earth, we will find people who contravene gender boundaries" (Whittle, 2010)

Whittle (2010) argues that all cultures throughout time will have a history of transgender people. Indeed, depictions of transgender emerged from 700BC where Neolithic and bronze aged drawings from the Mediterranean have been found of figures with female breasts and male genitals (Talalay, 2005). Many cultures have developed their own terminologies to describe gender variant people including the Fa'afafine of Polynesia, the Hijra of India, the Takatāpui of New Zealand, and the ladyboys and the tomboys of Thailand (Whittle, 2010).

The term 'transsexual' was first used in 1949, by Cauldwell then 'transgender' in 1971, by Oliven (Whittle, 2010). The first book published in Europe, Psychopathia Sexualis in 1877 which explored the sexuality of transgendered people was written by Krafft-Ebbing (1840-1902), a professor of psychiatry at Vienna. In consequence to The Criminal Law Act of 1885, which strengthened existing legislation for homosexuality, transgendered people sought a cure and a new field in medicine developed: sexology (Whittle, 2010). However, Magnus Hirschfeld, a German physician and sexologist, is thought to be the "father of transgender healthcare" and introduced the term 'transvestite' in 1910 at his Institute for Sexual Science in Berlin (Khan, 2016; Whittle, 2010). Hirschfield offered his patients the opportunity to change their gender through either hormone therapy, operations, or both. This was a controversial shift away from psychological treatment which had been the treatment of choice, for what was believed to be a mental health problem to instead utilising 'adaptation theory' (Khan, 2016). In 1922, Dora Richter became the first person to undergo surgical castration, later completing her gender reassignment in 1931. Notably, surgeries carried significant risk; one of his most famous patients was Danish painter Lili Elbe (born Einar Wegener) whose story was fictionalized in the film The Danish Girl and who subsequently

died from infection-related complications of her final surgery in 1931. Hirschfeld was forced to go into exile due to Nazi Germany, and consequently the institute closed, ending its work.

However, advances were emerging in America in the 1940s, with the most notable, Dr Alfred Kinsey, the biologist who founded the Institute for Sex Research at Indiana University in 1947 (now known as the Kinsey Institute). He was one of the first to use the term transsexual in his gender studies. The first American, Christine Jorgensen, travelled to Denmark to receive gender reassignment surgery completed by Dr Christian Hamburger with her story appearing in the New York Times in 1952. Hamburger referred other interested American patients to endocrinologist Dr Henry Benjamin, located in the US who had spent time with Hirschfield at the Berlin Institute and shared similar principles, "notably hormonal therapy and reassignment surgeries and not psychotherapy for a cure" (Khan, 2016). Benjamin published his book The Transsexual Phenomenon in 1966 and is accredited for laying down the foundations for current transgender healthcare policies. However, transsexuality/transgenderism was still regarded by many in psychoanalytic circles as a mental health condition. Stoller, an American Psychiatrist is credited with creating the term 'gender identity' (Rodgers and O'Connor, 2017). Although there was a recognition of the universality of gender identity issues amongst "ordinary people whose struggles regarding gender identity are much less intense, more secret and more or less unconscious" Stoller goes onto describe male childhood transsexualism as a "clear cut, potentially malignant personality disorder" (1968, p.89). Transgenderism or non-binary was still perceived as pathological deviating from the binary perspective (Rodger's and O' Connor, 2017). Psychoanalytic literature has received some criticism for its historical pathological stance. However, there is now a growing body of knowledge within both adult and child and adolescent psychoanalytic literature, which arguably takes a curious and compassionate stance. Some of the psychoanalytic concepts relating to gender identity will be explored later within section four.

In 1980 the addition of "gender identity disorder" to the American Psychiatric Association's (APA) third Diagnostic and Statistical Manual (DSM-3) paved the way for greater accessibility

to patients seeking treatments, although there was controversy over the term of disorder. In the UK, The Equality Act of 2010 defined gender reassignment as a protected characteristic and paved the way for the term disorder to be replaced by the term "gender dysphoria" in the 2013 DSM-3. Hormone therapy and surgical reassignment are now recognised in the UK as the only successful treatment for transexual people. Gender dysphoria (as described in DSM-5, APA, 2013) was previously referred to as gender identity disorder (GID), gender incongruence (GI) or atypical gender identity organisation (AGIO). 'Dysphoria' is defined as "a state of unease or generalized dissatisfaction with life"; the renaming places emphasis upon the distress experienced (Wright, 2018, p.60).

Under The Equality Act of 2010, all workplaces should have equality policies in place for their employees. The NHS care trust pertinent to this research, clearly states that gender dysphoria is not a mental illness and not only sets out standards such as ensuring that gender variant people are to be treated with dignity and respect; it is the responsibility of every member of staff to create a positive and welcoming environment for service users and colleagues. In the policy it refers to the trusts commitment to ensuring that neither an employee or a service user will experience "harassment, harassment, discrimination or victimisation of any sort, either conscious or unconscious" (p.5). The term 'unconscious bias', synonymous most recently with BAME, but also relevant to any minority group is used to describe biases that we are not aware of. In respect of a young person disclosing that they may be gender dysphoric the employee is to treat the disclosure with sensitivity and understanding. They are to make a referral if appropriate or provide treatment considering the Gillick Competency and Fraser guidelines.

Professional bodies are also clearly defining their positions regarding diversity and policy in respect of young people with gender dysphoria. The Association of Child and Adolescent Psychotherapy emphasises the inclusiveness of the profession stating:

"We aim to be a profession that people of all backgrounds see as for them, feel at home in and can contribute to." (2021).

The subject of conversion therapy has received some attention with the UK government drawing up policy to illegalise it. The ACP have also released a statement about this, stating that whilst it does support the ban on conversion therapy, referring to it as “coercive and abhorrent practices” they However impress upon the need for LGBTQ young people to be able to explore their sexuality and gender preference and ask for a tighter definition of what conversion therapy is:

“The definition of conversion practices needs to make a clear distinction between an ethical professional dialogue and an attempt to pressurise someone into making choices that are not right for them, i.e., to push or coerce them in one direction or another. Specifically, it is important that legislation makes clear that therapeutic interventions that involve supporting children and young people to explore their sexuality and gender preference are not unlawful and criminalised by this legislation.” (2022)

Section 2: Young People's Mental Health Presentations to Services (Gender dysphoria).

This section will explore the presentations of children and young people with gender dysphoria to services. The most common presentations will be explored.

Suicide and self-harm

Children and young people with gender dysphoria have been associated with high rates of self-harm and suicide. One of the earliest empirical studies conducted was by Di Ceglie et al in 2002. Their study was not solely based upon suicide and self-harm but sought to explore the clinical features and demographic characteristics of children and adolescents referred to their service with gender identity issues. The study uses 124 cases seen from 1989-2002 at the Gender Identity Clinic in London and uses both quantitative and qualitative methodology. They found that boys and girls are equally likely to self-harm and share the same risk of suicide However self-harm, was found to increase by age. As it is a retrospective study one of the limits is that the information is obtained from a secondary source and not from the patient directly.

Aitken et al's (2016) more recent study, which was a comparative analysis design of children aged between 3-12 years with gender dysphoria. They had 572 children referred to the clinic for gender dysphoria and compared them to control group comprised of siblings (N=425) and non-referred children (N = 903) from the CBCL standardization sample. Significantly higher scores for self-harm were found for the gender-referred children. One limitation of this study was the use of a measurement tool which did not adequately differentiate self-harm from suicide. However, the use of a large sample and a control group increased the overall validity.

Aitken et al (2016) and Di Ceglie et al (2002), both used the Child Behaviour Checklist (CBCL), a standardized care-giver report form to measure self-harm and suicidality of children. The main limitations of this study are that the use of a measurement tool which better differentiates self-harm from suicide would have increased the accuracy of the data. The CBCL is also based on caregiver reports rather than self-reports. A drawback to this way of collating data is that Children and young people do not often share incidents of self-harm or suicidal thoughts). It is also best practice to gain the information from children and young people directly. This will be explored in more detail within section 4 (Children and Young People's Participation).

Depression and Anxiety

In Di Ceglie et al's (2002) study 42% of their patients experienced depression which was found to increase by age. Similarly, Strang et al (2014) found that amongst participants with gender variance there were elevated rates of anxiety and depression symptoms in contrast to participants with no reported gender variance (further information about this study will be provided within the neurodevelopmental section below).

Röder et al's (2018) study further supports the prevalence of depression amongst children and young people with GID. The study sought to examine what the physical and emotional quality of life is for transgender adolescents who had been referred to the gender identity clinic in Hamburg to subsequently improve understanding about transgender adolescents' needs. Adolescents aged 11 -18, filled out a standardized self-report form which focussed on health-related quality of life. Care-giver forms were also completed in conjunction as part of the study. A European norm sample was used to contrast the data.

In contrast, Durwood et al's (2017) study focused upon examining the prevalence of depression and anxiety amongst socially transitioned transgender children and adolescents

between the ages of 9-14. In contrast to previous studies incorporated self-report and care-giver measures. This study used control groups of socially transitioned transgender children (N=63) with two control groups: siblings of transgender children (n = 38) and children of the same age and gender (n = 63). Additionally, the same approach was applied to groups regarding self-worth (N = 116 transgender children, N = 122 controls, N = 72 siblings). The same levels of depression and self- worth were reported across all the same groups. There was a slight increase amongst transgender children in respect of anxiety. The use of control groups increased the validity whilst the inclusion of a self-report measure places the participant's views as an integral aspect of the study. Participants were recruited and it is possible that there was an element of bias in this process. As this was one of the first studies to research socially transitioned children the findings cannot be contrasted to other studies where the participants were gender nonconforming.

Relationships, Self-Worth, and Body Image

Zucker et al (2002) investigated the associated demographic characteristics and behavioural problems of children and adolescents with gender identity issues. 358 children and 72 adolescents were assessed in the Child and Adolescent Gender Identity Clinic in Ontario between 1975 and 2000. Demographic measures were used to contrast the two groups e.g., sex and ethnicity and the CBCL, a care-giver report form and Peer Relations Scale, a self – report form were used. Age was found to be a factor in determining behavioural issues within children with gender identity issues. Social Ostracism and poor peer relations experienced in childhood or early adolescence due to gender identity issues lead to greater relational and emotional difficulties which emerge during adolescence. This was a large study which captured and utilized data over 25 years. As the data was captured within a clinic it may lack some validity but is arguably representative because of this. This was not tested within the study, but the authors ponder whether the emergence during puberty of same sex-erotic feelings increases the adolescents desire to seek gender change. There appears, in their clinical experience, to be more discomfort experienced by the individual and their family about sexuality than seeking to change gender. Further, for some

adolescents it is harder to explore issues of both gender and sexuality due to lacking flexibility in problem solving.

Authors cite research which demonstrates that gender dysphoria in children does not necessarily persist into adulthood (Steensma et al, 2010). The age of participants also appears to contribute towards whether it persists. A Netherlands study (Steensma et al, 2010) undertook a qualitative study to understand factors contributing towards the persistence and desistance of adolescent gender dysphoria. It consisted of twenty-five adolescents aged 14-18 diagnosed with a gender identity disorder. Participants were interviewed using a semi-structured biographical approach. They found that participants considered the period between 10-13 years of age most critical in terms of whether the gender dysphoria persisted or desisted. Regardless of whether it persisted, or desisted participants attributed changes in their social environment, the anticipated male, and female changes of their body and the first experiences of sexual and romantic relationships as influencing their gendered interests, discomfort, and behaviours.

The participants who persisted explicitly stated that they felt they were the other sex, in contrast to those who did not, and reported feeling like a ‘girly boy’ or a ‘boyish girl’. The first factor was mainly due to the differences between girls and boys becoming apparent in school, where gender roles were more distinct (this was felt most acutely by male-female). The onset of puberty and bodily changes were reported as agonising. This was a time of when hatred of one’s body particularly emerged and where destructive thoughts were eminent. The participants who persisted with gender dysphoria all reported to be exclusively attracted to the same natal sex. Steensma et al (2010) suggest that heterosexuality helped to confirm their gender identity: “They did not consider themselves homosexual or lesbian” (Steensma et al, 2010, p. 10).

In desisters, the gender discomfort decreased aged 10-13 due to changing interests, and pubertal changes. Their first experience of a romantic and sexual relationship also were

factors which resulted in the disappearance of their gender dysphoria. They recommend that clinicians should concentrate on the phase of development from ages of 10-13. They advise to consider several factors, such as the anticipation/actual puberty and emerging sexual/romantic partnerships before any medical interventions (e.g., to suppress further pubertal development). They caution that psychosexual outcomes are unpredictable and that a certain trajectory may be liable to change.

Di Ceglie et al's (2002) study found that relationship difficulties with parents (57%) and peers (52%) were a common feature. Participants also experienced victimization (33%) and it was a common feature to experience an intense dislike for bodily sexual characteristics which also increases within age (50%). 16 years later, Röder et al's (2018) study found that internalising difficulties and body image problems were the two main areas of difficulties for participants. Interestingly, in Aitken et al's (2016) study, poor peer relations were not found to be linked to suicidal ideation. However, participants were aged 3-12 years of age, which might be a factor in this, as most studies show an increase in suicide and self-harm with age.

Neurodevelopmental

There is a growing number of contemporary literature and studies which link the prevalence of neurodevelopmental difficulties (mainly autistic spectrum disorder) with that of gender dysphoria. This study will explore the psychoanalytic literature which has emerged later within section three of this literature review. Strang et al (2014) investigate the prevalence of gender variance in children diagnosed with autistic spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD) or epilepsy. As part of this quantitative study, care givers filled in the CBCL in respect of children and adolescents aged between 8-16, with a diagnosis of ASD (N =147), ADHD (N=126), epilepsy or NF1 (N=116). Data was compared with two non-referred groups; a control sample (N=165) and non-referred participants in the CBCL standardization sample (N=1,605). Gender variance was assessed within the CBCL. Significantly elevated rates of gender variance were found with participants with ASD (7.59

times more common than the large non-referred comparison group). Similar results were obtained with the ADHD participants. This study used a large sample group, and the inclusion of control groups increases validity. Strang et al. (2014) acknowledge the limitation of clinical data and recommend future studies which use total population samples. Self-reports in addition to care-giver reports would have been beneficial. It was identified that managing gender variance could be especially challenging for children and young people with a diagnosis of a neurodevelopmental disorder. This study suggests that there is a link between children diagnosed with ASD and ADHD and experiencing gender variance.

Di Ceglie (2014) et al undertook a study testing for systemising and empathising scores with adolescents with gender dysphoria. They were interested to see whether adolescents with gender dysphoria reflected the patterns seen within the general population (systemising is higher amongst males and empathising is higher within females) in respect of their identified gender or whether they tended to reflect adolescents with ASC. Adolescents with ASC are reported to score below average on the Empathy Quotient (EQ) and average or above average on the Systemising Quotient (SQ). The researchers hypothesized that adolescents with gender dysphoria would share similar score results. The study consisted of 35 parents of adolescents with gender dysphoria aged 12-18 attending the Gender Identity Development Service (London) using parent report questionnaires. Parents of 156 typically developing adolescents aged 12-18 were used as a control group. They found that that on average adolescents with gender dysphoria, specifically those who are female-to-male, have lower empathy than controls (females). However, the male to female group showed empathy levels more like the control males. There were no significant differences with the systemising scores between adolescents with gender dysphoria and the controls. They concluded that lower empathy may impact an adolescent's ability to consider bodily incongruence, and it may be helpful to offer psychological interventions which improve "…their ability to take on board other people's views" which would aid them to make better informed decisions regarding physical treatment. The researchers suggest that there may be different pathways which contribute towards gender dysphoria. This area of research may also be useful where there is rigidity of thought and behaviour present, such as

anorexia nervosa and severe body dysmorphic conditions. The researchers acknowledged that the use of the parental questionnaire and small gender dysphoric group were limitations of the study.

Summary

Most recent empirical clinical studies have emerged from Canada and America. Older studies tend to use care giver reports whereas contemporary studies include self-reports often in addition to care-giver reports. A greater emphasis has been placed on capturing the child and young person's own report. Gender variant children increase higher rates of mental health difficulties than the general population. They are more likely to self-harm (Aitken et al, 2016), which also increases with age (Di Ceglie, 2002). There are also elevated rates of anxiety and depression symptoms (Strang, 2014, Order et al, 2018) amongst gender variant young people with age also increasing depression symptoms (Di Ceglie, 2002). Transitioning may make a difference in reducing distress and symptoms of anxiety and depression (Durwood et al, 2017). Di Ceglie et al (2002) found that participants experienced victimization (33%) and it was a common feature to experience an intense dislike for bodily sexual characteristics which also increases within age (50%). Röder et al's (2018) study also found that internalising difficulties and body image problems were the two main areas of difficulties for participants.

Zucker et al (2002) found that social ostracism and poor peer relations experienced in childhood or early adolescence due to gender identity issues lead to greater relational and emotional difficulties which emerge during adolescence. There appears, in their clinical experience, to be more discomfort experienced by the individual and their family about sexuality than seeking to change gender. Young people with gender variance considered the period between 10-13 years of age most critical in terms of whether the GID persisted or desisted (Steensma et al, 2010).

Strang et al (2014) found that significantly elevated rates of gender variance were found with participants with ASD (7.59 times more common than the large non-referred comparison group), and similar results were obtained with the ADHD participants. Zucker et al (2002) identified that participants lacked flexibility in problem solving.

Section 3: Psychoanalytic Perspectives of Gender dysphoria

Critics argue that historically, psychoanalysis approached transsexuality through the theoretical filter of perversion (Lemma, 2013, Gherovici, 2019). Indeed, there are more contemporary psychoanalytic views being expressed where the emphasis is to move away from a pathological stance about non-normative gender expressions. Gherovici (2019), is one such psychoanalyst who wishes to move away from what she calls, “blanket generalizations” of transgender or non-binary as pathological. There has also been a gap within the literature about gender variance, which concentrated on male to female transition which has tended to become merged with sexual minority literature (Rodgers and O’Connor, 2017). Rodger’s and O’Connor (2017) identify two psychoanalytic approaches: 1. The pathological view of the transexual as a narcissist impermeable to psychotherapy because of the rigidity of wishing to change their body. 2. The transgender patient who requires support to mourn their original body and challenge assumptions of an often-unrealistic idealised body.

This section will explore some of the key psychoanalytic concepts which may contribute towards gender dysphoria. Some of the concepts, such as attachment theory and mirroring may not fall into classic psychoanalytic thought, but psychoanalytic writers view them as important alongside other more psychoanalytically embedded concepts such as the Oedipal Complex and the Depressive Position. Child and adolescent psychoanalytic psychotherapists and adult psychoanalysts have contributed towards the body of understanding by presenting case studies drawn from their work with children, young people and adults who have queried their gender identity. A few case studies will be included which will help to illustrate the link between theory and clinical practice.

Early Relationships, Mirroring, and Identity Incongruence.

"Seeing oneself reflected in another's eye is to know one's self, and
to exist" (Ayers, 2003, p.68).

The quote is taken from Ayers' book which is entitled 'The Eyes of Shame'. Ayers words above convey the power of relationships, moreover the way that we perceive ourselves throughout childhood and into adulthood is heavily influenced by others, especially in our formative years from our parents/carers.

There is a growing view within mental health that some of the struggles experienced by transgendered or non-binary people is in consequence to object relations and attachment difficulties (Stoller, 1968, Lemma, 2013, Wright, 2018). Stoller (1968) was one of the first psychoanalysts to state so explicitly this link, stating that transsexuality begins in infancy with "the full-blown picture obvious by age 2 to 3" (1968, p. 93). In order to explore this link, we must first explore object relations and attachment theory. Eminent psychoanalysts Klein, Winnicott, Bowlby and Bion, all identified and contributed towards the understanding of an early dyadic experience for the infant's development. Bion's (1961) concept of containment emphasized the importance of the dyadic interaction of the infant and caregiver. The mother receives the infant's distress, and responds, and provides both containment and meaning to his experiences and "The baby thus comes to know and understand himself through being known" (Rustin, 1989, p.xxvi).

Bowlby's (1969) concept of attachment theory emphasizes the importance of the infant's first relationship informing his core beliefs about the world and himself. Winnicott (1965) also emphasized the importance of the relationship with the primary caregiver (usually mother): he proposed that there is an initial state of merger between the infant and their primary caregiver. The infant is of the illusion that "his mother's care is a function of himself, a matter of his own creation…", unaware of any sense of separateness (Hopkins, 1996, p. 409). Winnicott's (1965) concept of primary maternal preoccupation identified that that the mother should be 'preoccupied' with her infant; both in terms of physical and emotional

needs and regarded this as essential for the baby's development. Winnicott (1956) proposed that when the baby looks at the mother, he will come to recognise his own internal state as held in his mother's expression. It is thought that Bion (1967) elaborates on this by his concept of containment which not only sees the mother taking in the infant's projections but then helping the infant to make sense of them which supports the development of a thought (Lemma, 2013, p.11).

Likierman (1988) extends the importance of containment further by regarding the mother's projections of her own love, a "selfish pleasure", as fundamental to her baby rather than only her capacity to receive and contain her baby's projections. She likens it to Bion's concept of "reverie" which is an unconscious aspect of the mother's interaction (p.29). However, when a baby does not experience this from a caregiver they are left with their own distress. They introject an object which is devoid of understanding and "together with that frightened part of himself which is divested of meaning through not eliciting a response" (Harris, 1975, p.36). Subsequently, this is experienced as a 'nameless dread' (Harris, 1975, p.36). Primary disappointment theory describes the failure by the parental object to meet the infant's innate expectations (Emmanuel, 1984). The concept double deprivation describes how first deprivation is inflicted by external circumstances, e.g., trauma and then second, by his own internal objects.

The infant's (and later child's and adult's) identity and internal sense of themselves is shaped by their relationship with a primary caregiver, who acts as a mirroring figure (Winnicott, 1967). However, there are severe consequences when there are early difficulties within the mother's emotional capacity to meet the needs of her infant:

"The patients' early experiences of his mother's gaze, which was 'fuzzy sighted' and the perception of the reflection he received, which at times may have been 'distorted' led him to develop an internal sense as 'someone all wrong' (Wright, 2018, p.9).

Wright (2018) is using one of Lemma's (2013) adult transgender patient's, Ms A, phrase of 'all wrong' when she likened being in a public space to a hall of mirrors where she felt she looked 'all wrong'. The terminology used by Wright (2018) and Lemma's (2013) patient powerfully illustrates that an individual may be left with a profound sense of inadequacy when his infantile experience is far from optimal. The emotional availability of the primary caregiver (usually the mother) during infancy and childhood is widely attributed to be a significant factor in understanding gender dysphoria (Coates, 2006, Wright, 2018).

Lemma's (2013) case study of Ms A illustrates the link between gender dysphoria and object relations. Ms A (male to female transgender patient) was seen for psychoanalytic psychotherapy once-weekly for five years . Ms A was in her late twenties who underwent sex reassignment surgery during this time. She was referred for help as part of her decision to seek SRS. She was also feeling depressed and suffered with panic attacks associated with being in outside spaces. Ms A was an only child whose early life was described as a miserable experience, witnessing frequent and at times violent rows between her parents. Her father died during late adolescence and her mother was an alcoholic. Both parents were emotionally unavailable and physically unaffectionate.

In Lemma's work with Ms A, the experience of a misattuned relationship with her mother and the lack of a mirroring experience was evident in the transference. Lemma (2013) describes the experience of incongruity and the failure of mirroring in Ms A's early relationships and how this played out in the transference.

However, Winnicott (1965) also thought that an infant requires frustration in order to develop and that continued preoccupation or prevention of some frustration by the mother past six months could also prove to be damaging. The infant does not develop a sense of himself as separate nor of making objects real; in consequence, his internal world reflects:

"… a permanent state of regression and of being merged with the mother" (Winnicott, 1965, p.51). Winnicott (1965) also provided an explanation for the development of male childhood transsexualism. 1. Excessive identification with their mothers, "caused by the inability of these mothers to permit their sons to separate from their mothers' bodies" (p. 97).

Winnicott is referring to a merged state between mother and son, which extends from a psyche level to that of a bodily one. In identifying so strongly with the mother, he may lose his own sense of identity. It is thought that at the centre of gender dysphoria, there is an issue of identity (Di Ceglie, 2009, p.4). Identity incongruence is becoming increasingly attributed to some gender dysphoria cases (Lemma, 2013, Fonagy, 2006, Rodgers and O'Connor, 2017). Lemma points to a lack of mirroring of the child's "felt incongruence at the level of the body regardless of its aetiology" (Lemma, 2013 p.3). Normally, the infant or child may experience discomfort, distress or pain associated with his body, for example when defecating, or weaning. However, it is the reaction/mirroring of the primary caregiver which will help the infant or child make sense of their experience. The parent's accurate understanding and reflection of the infant's or child's thoughts or feelings enables the child to not only feel understood, but also accepted. This leads to the internalisation of self-acceptance and self-awareness (need reference for mirroring definition). However, if this process does not occur, Lemma (2013) states:

"…the child is then exposed to an intolerable internal experience of feeling dissociated from the given body, which feels 'unreal' and remains unintegrated into a coherent experience of the self. This may then lead to the search for the 'right' body that is anticipated to guarantee relief from the pain of incongruity" (p.4). Winnicott thought that it was a developmental achievement for cohesion to develop between the psyche and the body, which he refers to as "the lodgement of the psyche in the body" suggesting that invariably he believed that not all individuals managed this (1988, p. 122).

The Role of the Oedipus Complex and the Depressive Position

Contemporary literature links the Oedipus Complex, the Depressive Position, symbolism, and triadic capacity with gender dysphoria (Wright, 2018). These concepts shall be explored with the links between them, and gender dysphoria illustrated.

Freud (1905) regarded the Oedipus Complex as a universal and monumental time within a child's development, which "… constitutes the central organizer of mental life, around which the individual's sexual identity is structured" (Quinodoz, 2013, p.63). He located this development at the genital stage i.e., when a child is about 4 or 5 years of age and has a more realistic perception of parents as they are and based on observation of the parental relationship (Freud, 1905). In the normal course of development, a girl develops penis envy while a boy develops rivalrous and hateful feelings towards his father and an object of affection for his mother who he wants to possess exclusively. They both must relinquish these desires; the boy develops castration anxiety, fearing that his father will learn of his feelings for his mother and retaliate, and identify with the parent of the same sex (Quinodoz, 2013). Object Cathexes (desires) are replaced by identifications; the child's desires are sublimated through the process of identification and change to into feelings of affection (Freud, 1924).

Freud named the super-ego as being the heir to the Oedipus complex due to its formation in consequence to the latter's repression. The character of the super-ego (also known as ego - ideal) is "the representative of our relation to our parents" (Freud, 1923, p.36). Freud attributed the main quality of the super-ego as morality and the stronger the Oedipus complex was and the more quickly it was repressed, the more dominating the super-ego will be over the ego, as the person's conscience or "unconscious sense of guilt" (Freud, 1923, p.35). However, the process of the super-ego's formation was complicated due to "… the constitutional bisexuality of each individual" (Freud, 1923, p. 31). He identified that the positive Oedipus complex is stronger than the negative However depending on how strong the child's feminine and masculine sexual dispositions are will affect whether the child

identifies strongest with the father or mother following the Oedipus complex (Freud, 1923). The inverted version of the Oedipus complex is where a boy or girl may experience sexual urges to the same gender parent. The normal course of development would see the child replace the sexual urges with identification with the parent of the same gender (Freud, 1905).

Klein also held the concept of the Oedipus complex as a highly significant point of development referring to it as ‘ubiquitous and omnipresent’ (Britton, 1989). In contrast to Freud, rather than the introjection of the father and mother, Klein identified that the infant introjects the good and bad objects which become established within his ego and form "the nucleus of the super-ego" (Klein, 1945, p.67). She also thought that the Oedipal complex develops prior to the genital phase and takes its character from oral/anal processes that dominate early development; in particular, weaning arouses Oedipal frustrations. Early infancy also heralds the Paranoid Schizoid Position in which emotions of frustration and possessiveness predominate. The infant possesses what Likierman (2001) refers to as an inherent intuition of the threat of rivals for his life supply e.g., mother's breast causing intense paranoia. This is intensified by his desire to discover and conquer the territory of the mother's body (‘epistemophilic instinct’).

characterized by frustration, aggression, and paranoia. In order to cope with frustration and aggression, the infant ‘splits’ objects and projects (projective identification) his own frustration/aggression onto them. He further creates sadistic phantasies against the objects However, in his mind these objects become retaliatory and thus persecuting. This creates a strong need in the infant for a loving object; he idealizes the ‘good breast’ while the ‘bad breast’ becomes a frightening and persecutory object. Klein (1945) viewed that a securely established good object feeds the ego with those good feelings which in turn enables the infant to project these feelings into the outside world. The infant within the depressive position is concerned about the "whereabouts and condition of his loved object" which leads to an increase of his awareness of surroundings (ibid, p.56). This stimulates in the

infant a sense of curiosity and in doing so he experiences "Oedipal anxieties and conflicts" (ibid, p.56). He can imagine his parents intimately together and feels on the outside. Many current psychoanalysts support Klein's theory that the infant's first object relationship would determine the move from the paranoid-schizoid position to the depressive position and the subsequent resolution of the Oedipal complex (Britton, 1989; Burhouse, 2001).

Symbolization, Rigidity of Thought and Triadic Capacity

The consequences of those with unresolved Oedipal difficulties is widely written about. If an infant cannot tolerate the sense of loss brought about because of the realization of a different relationship between parents, this can produce a "sense of self grievance or self-denigration" (Britton, 1989, p. 84-85). It can also cause a "violent severance" or splintering in the mind to protect from the Oedipal situation (Britton, 1989, p.91). Feldman (1989) identifies that the way that the person views the Oedipal couple determines the ability to combine thoughts:

"...the phantasy of the oedipal couple is closely related to the way in which the patient is able to use his mind to create links between his thoughts and feelings, and to tolerate the anxieties that result from such links (Feldman, 1989, p.125).

Waddell emphasises that during adolescence Oedipal issues are invariably raised, although this is regarded as 'normal' development, sometimes there can be what she refers to as an "Oedipal Impasse" (Waddell, 2003 p.53). The adolescent will be exploring and integrating their gender and sexual identity, while navigating Oedipal issues of parental separation. This may trigger a move from a depressive towards a schizoid-paranoid position; both are positions which are not set and can change throughout life. The two positions are regarded as states of mind and are present during adulthood, not only limited to infantile states and regarded as "... the two elemental structures of emotional life" (Roth, 2001, p. 33). Waddell (2003) argues that "…excessive splitting and projection, denial, concretization, mindlessness

and omnipotence, will flood in and swamp the personality's efforts to grow" (Waddell, 2003, p. 54)

As well as the possibility of experiencing the paranoid-schizoid state whilst struggling with Oedipal issues and integrating their gender and sexual identities, some adolescents with gender variance will be experiencing other difficulties. The depressive position is regarded as the catalyst for the development of symbol formation and triadic capacity, both of which are prominent themes amongst psychoanalytic writers in respect of the Oedipus complex. Triadic thinking is a skill obtained through loss e.g., the capacity to bear exclusion from the parental relationship and being the third of a parental couple (Burhouse, 2001). Britton (1989) identified the key characteristics as the process of reflection upon oneself comprised of an ability to observe relationships between others and for him to bear another's opinion without losing his own. There is now a developed awareness of 'self' and 'other'. In respect of symbol formation, Segal (1957) described the origins of the word 'symbol' as derived from the "Greek term for throwing together, bringing together, integrating" (p. 397). She explained that one of the processes of symbol formation is of the integration of the internal with the external. Incongruence, as previously explored is a disconnect or disharmony between two things, within gender incongruence it is the sense of incompatibility between the mind (psyche) and their body. Klein (1930) also thought that without a child developing symbol formation there would be serious consequences, including an arrested development of the ego and the child having some autistic features.

Di Ceglie (2009) argues that the difficulty of symbol formation and symbolic thinking could account for the rigidity of thought often seen in GID:

"It is possible to hypothesise that the capacity for symbolic thinking and exploring other representations of the self correlates to the persistence or desistence of the GID" (Di Ceglie, p.6).

The capacity for symbolic thought and being able to explore "…other representations of the self", is regarded as a difficulty for young people with gender dysphoria. Psychoanalytic writers are increasingly exploring the link between a rigidity of thought often seen in autism and the co-occurrence of gender dysphoria (Di Ceglie, 2009; Lemma, 2013; Tsoukala, 2018). In Wright's (2018) work with a patient with gender identity dysphoria and an eating disorder she described how the initial presentation of a more concrete thinking position changed to a more symbolic way of thinking, which allowed emotional change. Lemma (2013) refers to the absence of a receptive mind within the individual which can tolerate ambiguity and uncertainty, and which the individual locates in their body. Control over one's gender, and body may provide certainty, especially during adolescence which is a time beset with uncertainty. Tsoukala (2018) writes that she was concerned that her patient may be defending against 'not knowing' by seeking certainty and waiting to undergo surgery. The lack of certainty or "disturbing discontinuity in the experience of the self" leads individuals to search for their 'true' body which will relieve them of their distress (Lemma, 2013, p.3). Tsoukala (2018) refers to her patient moving to a less binary position, taking the middle ground and in so doing so, was transitioning from a paranoid schizoid position to a depressive position.

Two Case studies of Tsoukala (2018) and Di Ceglie (2009) will illustrate the importance of enabling patients to develop symbolic thinking and formation, and tolerate uncertainty moving from less rigid thinking.

Konstantina Tsoukala (2018) undertook psychoanalytic psychotherapy once a week with a transgender male patient aged 16, called Alex. Alex was previously referred to CAMHS in respect of 'restricted eating' at the age of nine, as well as low mood and deliberate self-harm between the ages of 13 and 14. It was felt that a space that would allow Alex to explore his thoughts and feelings, and psychotherapy, was suggested by the team.

Alex's birth mother, Nancy suffered with post-natal depression for two years following Alex's birth and was prescribed anti-depressant medication. Nancy reported that her relationship with Alex was strained, describing him as a 'difficult child'. He would struggle to struggle to eat, sleep or become attached. Alex was bullied during the final years of primary and beginning of secondary school. However, he did gradually manage to establish a number of friendships. During his therapy, Alex was in a sexual relationship with a boy, Matthew, who is of the same age.

Tsoukala (2018) describes an increased trepidation about undertaking work with Alex due to both her inexperience as a trainee child and adolescent psychotherapist and her ignorance in the area of gender identity dysphoria which she describes "made me feel like an incompetent, unprepared mother about to have her first child, whose gender she does not yet know". Tsoukala (2018) realised the importance of the difficulties in Alex's relationship with his mother, and was interested in Eshel (1998) work about Black holes, which has been thought to occur in patients with depressed mothers. Tsoukala (2018) linked this to Alex's feelings of emptiness and his description of an image of a soulless body wandering the earth. She made a parallel with Tustin's conception of the depressive 'black holes' (1988), described as the mental experience of many of the autistic children she worked with. She linked maternal depression, black holes, rigidity of thought (autistic traits) and the frequent occurrence gender dysphoria and autistic spectrum disorder (cites De Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010). She references Tustin's view that the defences used by infants during trauma becomes increasingly pathological.

As they began to work together Tsoukala (2018) noticed the various somatic expressions of distress or discomfort (eating difficulties, self-harming, gender identity) and wondered whether there was any likelihood that Alex would be able to represent his conflicts rather than then being somatised. In the course of Tsoukala's (2018) work with Alex she explored with him the potential formulation that his anger and rage could not be directed towards his fragile mother, and had become somatised as an eating difficulty, then self-harm and then a distress about his female body. Tsoukala (2018) described herself "emphatically"

verbalising her patients feelings and compares the quality of it to Winnicott's (1967) concept of the mother's capacity to mirror her infant's feelings. The infant subsequently develops a sense of self that is separate from the mother. Additionally, in her work she supported her patient to bear the uncertainty of not knowing, and brought in the positive and negative countertransference into her work to help her patient integrate what she refers to as the 'good' and 'bad' , to help challenge her patient's binary thinking. By doing this she refers to Winnicott's concept of the integration of the psyche and soma: to heal 'the split in the individual's personality with weakness in the linkage between psyche and soma' (Winnicott, 1989, p. 113 cited by Tsoukala (2018).

In his 2009 paper Di Ceglie aims to demonstrate that there are often two states of mind in terms of children and young people's gender identities within GIDS; these are belief and fantasy. He provides an example of a boy who presented with a fantasy state of mind and whose gender identity was not rigidly fixed.

Timothy is a seven-year-old child who presents with features of a gender identity dysphoria. During a session involving his family, he and his brother decided to draw their family. Timothy quickly drew his dad but then focused a lot of care and attention upon the drawing of his mother. He drew mother with long hair (she kept her hair tied up) and in a wedding dress. Then Timothy proceeded wrote the names above the people he had drawn; he wrote 'Dad' and above his mother's picture he wrote his own name. Di Ceglie (2009) pointed this out and Timothy quickly crossed it out with a slight sense of embarrassment and wrote 'Mum'.

Di Ceglie (2009) argues that Timothy was able to symbolise and his unconscious identification with his mother , had more the quality of a fantasy rather than a belief, which he could disavow. Therefore, Timothy's gender identity was quite flexible and more amenable to change in the course of development. Di Ceglie (2009) emphasises that a therapeutic aim will be to support the development of symbol formation and symbolic thinking.

The Development of Shame

The damage inflicted by an early misattuned relationship between the infant and primary caregiver has been explored in relation to identity incongruence and the links with difficulties of symbolization, rigidity of thought and triadic capacity. It is also thought that shame develops and becomes internalized in relation to others, primarily in respect of caregivers and anxieties about rejection (Rohleder, 2019 and Levin, 1971). Kaufman (1989) defines shame as an individual experiencing feelings of exposure and self-consciousness about a deficiency. Rohleder (2019) points out that this leads to people experience a myriad of unpleasant feelings including worthlessness and fearing rejection. Levin (1971) stated that shame appears in early childhood and may be reinforced during the oedipal phase or latency period. However, Rohleder (2019) also proposed that shame may develop in consequence to experiencing discrimination and victimization. Shame therefore develops in response to others, whether it occurs during childhood or later in life. A study conducted by Scheer et al (2020) found that interpersonal forms of traumatic events caused greater shame in participants than impersonal forms of traumatic events. There is limited literature in relation to transgender or non-binary individuals, However, there is more literature linking shame with other minority groups. In respect of the gay, lesbian and bisexual community Rohleder (2019) argues that there remains homophobia in society which leads individuals to growing up with “with a sense of there being something ‘wrong’ with them, something to be ashamed about” (p.40-41).

Morrison (1989) and Rohleder (2019) argue that Shame has historically been neglected within psychoanalytic literature. Morrison (1989) argues that Freud viewed shame as a reaction formation against the wish for sexual impulses and perversions and was more concerned with pursuing oedipal conflicts and repression, where the importance of guilt rather than shame was emphasized as the affective experience. However, since Freud, other psychoanalytic writers, have sought to develop the structural theory, and in doing so, shame has become more prominently thought about (Morrison, 1989). Morrison (1989) refers to psychoanalysts possessing a disparaging view of shame, regarding it as socially constructed rather than internal. In contrast, Rohleder (2019) comments that psychoanalytic writing has

tended to concentrate on the impact of childhood experiences upon homosexuality rather than later social influences. Di Ceglie (2009) has more recently addressed the prevalence of shame and stigma which many gender variant young people may have internalised.

Rohleder (2019) is critical of the use of binary language in psychoanalytic literature which defines sexuality and gender – he provides examples of these: “masculine/feminine; homosexual/heterosexual; passive/active; maternal/ paternal” (p.47). He draws upon Schafer’s view that these are “organising concepts” and not necessarily truthful or factual. For example, current societal anxieties about ‘trans identities’ focuses on “boys to be boys and girls to be girls”, as if the word “boy” or “girl” reflects a set of truths”? (Rohleder, 2019, p.44).

Rohleder (2019) emphasises that most individuals will experience some level of shame about their sexual lives, However, shame may be more dominant where there is a social sanctioning. Societal values may be experienced by a child through the responses of family, peers, and teachers etc who will come to believe that there is something to be ashamed of and something wrong with him (Rohleder, 2019). Rohleder (2019) points out that it is generally a lonely and isolated experience as a gay child – other minority children, will have parents who will share their experience and help to provide a counter-narrative. He points out that there can be a lack of help for the child to understand who they are, and that parents can add to the child’s distress by being hostile. The same can be said of transgender young people’s experiences, which is less understood and where there is greater societal judgement and hostility.

Psychological Difficulties as a Consequence of Discrimination and Shame.

Studies have been conducted which demonstrate the link between trauma and shame (Scheer et al, 2020). The LGBT community are at an increased risk of experiencing traumatic incidences, including hate crimes, intimate partner violence as well as reporting higher

incidences of adverse childhood experiences such as sexual and physical abuse (Scheer et al, 2020). Shame in consequence to discrimination can cause serious psychological difficulties (King 2011 McDermott, Roen, & Scourfield, 2008, as cited by Rohleder, 2019). Shame is often hidden; powerfully repressed and denied (Levin, 1971). Through the denial and repression, the individual attempts to avoid rejection and the feeling of self-loathing which is “intra-psychic and internal” (Morrison, 1989). Shame may be expressed through other feelings, such as embarrassment, humiliation, lowered self-esteem and interestingly, rage. Contempt is a type of aggression whereby the shame is projected into another. Levin (1971) states that the therapist’s role where there is shame apparent, is to focus upon what he has labelled as ‘shame anxiety’ which is the fear of experiencing shame. that a therapist’s task is to enable the patient to become aware of their shame (Levin, 1971).

The concept of internalised racism or homophobia has become more mainstream in recent years. Rohleder (2019) describes it as “feelings of self-hatred and shame among some gay men and lesbian women arising from the introjection of negative and hostile responses from significant and important others including social messages.” (Rohleder, 2019, p.50). This is pertinent to transgender and non-binary children and young people who will have shared experiences with LGB, of introjecting negative projections. Rohleder (2019) questions if gay activism is an attempt by some to deny and silence shame and humiliation: “Gay pride, then, stands as a repudiation of this oppression”. The experience of discrimination and shame may then become projected onto others (Rohleder, 2019).

In psychoanalytic literature, the development of the ego has been linked to shame. Winnicott identified that psycho-somatic disorder relates to a weak ego mainly due to not good-enough mothering. He referred to a failure of ‘in-dwelling’ which is “the dwelling of the psyche in the personal soma”. Shame tends to become focused/displaced onto parts of an individual’s body, seen by others and leads to preoccupation (Levin, 1971). Other emotions may also be somatised, for example Tsoukala (2018) found that her patient had expressed distress and enormous anger through the body which were not able to be

directed against the patient's fragile mother e.g., first eating difficulties, then self-harm and which finally manifests in gender dysphoria.

Di Ceglie (2009 argued that the issues of shame and stigma need to be thought about more in gender dysphoria. He was aware of how these could become internalised and could further impact upon well-being and risk. His case study will now be explored which will illustrate the role of shame:

Kevin is a 15 year old boy referred to the gender identity development service as he presented with GID. He was convinced he was a girl and wished to live in a female role. He was very close to his mother, however any separation from her would cause minor physical or psychological symptoms. After feeling rejected by his parents he had attempted suicide and had periods of intense despair, and of feeling empty. He had a very poor self-image and his sense of identity would fluctuate. For example, he had previously had an intense desire to convert to Catholicism, and while he was fixated on this his desire to be female became less intense or disappeared.

It appeared that Kevin's parents had strongly supported his psychotherapy, as there was a hope that it would change him as they found it difficult to accept and love Kevin as he was. There was a concern that professionals had gone along with the parents powerful projections and sought to change him. It was agreed that Kevin would be offered individual sessions alongside family therapy sessions would be appropriate intervention to address these issues.

Kevin experienced considerable shame about his gender identity, in part, by his family's reaction to it. Di Ceglie (2009) describes how he walked hunched up and looking at the floor, (suggestive of a neurological condition although this was ruled out). It transpired that Kevin walked in this strange way because he did not want to be seen. There were other behaviours which served the purpose of hiding himself. Kevin's desire to become invisible was his way of managing the shame, and discomfort of being in his body.

The work enabled Kevin’s parents to become more accepting of him, and Kevin found his sessions provided the space to think about his own feelings of discomfort and his desires and needs. At the age of 18, although Kevin remained uncomfortable as a boy he did not identify so strongly as a girl, and ultimately decided against pursuing any treatment aimed at changing his body.

Section 4: Children and Young People's Participation

The views of young people to inform services are important and directed by government (Worrall-Davies, 2017). The National Service Framework for children, young people, and maternity services: The mental health and psychological wellbeing of children and young people was a Department of Health 10-year plan that set national standards for the first time for children's health and social care. It advocated for children, young people, and their families to "actively participate in identifying service needs, designing services and evaluating the way in which they are provided" (Stallard, 2005, p.122). The NSF states that best practice, which is also the central theme of the NHS plan "…is to design and deliver services around the needs of the person using them, with an emphasis on developing partnerships between patients and professionals" (p.92, Interventions: 3.1). It cites the UN Convention for the Rights of the Child, Article 123 that children have a right to be involved in decisions in their care. It emphasises that efforts should be made to encourage participation from children and young people who may normally be excluded e.g., disabled children or looked after children. Young people with gender dysphoria would fit into these criteria (DoH, 2004).

However, there has been criticism that these measures have not been reflected in CAMHS practice, especially recommendations from studies, However Worrall-Davies (2007) places some responsibility of the authors who often did not seek to ascertain whether changes were made. One of her biggest criticisms is that it is unethical to elicit young people's views and then not act on them. Indeed, when Worrall-Davies (2008) conducted a review a year later of best practice in eliciting children's and young people's views of CAMHS. She argues that there is a clear evidence base within adult mental health of service user participation, but this is lacking within children's mental health. She analysed 13 studies which were in a range of settings including in-patient and community services, independent sector establishments and community, as well as two within the US with the remaining 11 in the UK. She found that the wide age range of 7-25 posed an issue in terms of a method to gain children and young people's views. They looked at the methodologies of the studies (data

collection and data analysis) which were a combination of semi-structured interviews, questionnaires and focus groups. It was found that the studies in the review with the highest scores on the quality frame was face to face interviews. Most were analysed using thematic analysis.

Overall, there are limited studies which seek to gain children and young people's views, especially within mental health. Most studies utilise parent questionnaires with the minority using interviews as part of their data gathering. Considerable studies have focussed on parental expectations of treatment (Day & Reznikoff, 1980; Nock & Kazdin, 2001; Shuman & Shapiro, 2002 as cited by Midgely et al). There have been some studies pertaining adolescents, whereby patients have greater autonomy in decision making. Studies include Sigelman & Mansfield, 1992 and Stewart et al, 2014.

Young people's hopes and expectations is at the "heart and soul of change" (Cooper, 2008, p.60, cited by Midgeley et al (2016)). However, young people's expectations, particularly regarding therapy has been neglected. Several studies where children and young people's views are ascertained will be explored. Midgeley et al (2016) only found two qualitative studies where adolescents and young adults were asked about what they had expected therapy to be. Sigelman & Mansfield (1992) interviewed 89 children and adolescents at school to assess differences in knowledge and attitude towards psychologists and psychological treatment. They found that resistance to treatment was impacted by perceptions of what is a psychological symptom. They referred to adolescence as an age of non-conformity towards adults and increased autonomy seeking. However, none of the participants were being referred and the study did not state if any had any mental or emotional difficulties. Receptivity among older children and adolescents to treatment depends on the problem e.g., depression and psychosis were deemed to require psychological help. Anti-social behaviour or aggression is less likely to be deemed as requiring support. They recommend that there should be room for honest disagreement to surface between youths and parents and professions in order to explore resistance.

In Swales (2005) report commissioned by Barnardos of CAMHS user and carer participation, the author was employed as a participation worker within Leeds CAMHS (10 teams) to engage young people. There were various ways that the participation worker did this including creating a young people advisory group called UR Voice. The group was made up of 8 young people aged from 16-20yrs who are potential, existing, and ex-service users of CAMHS. The majority were males and all white. A consultation (Youth on Health) was also undertaken which consisted of 66 young people, ranging from Year 3 to Year 11. 32 schools citywide represented the 66. The groups were a mixture of male and female with an ethnic breakdown of majority being white, two black individuals and a handful unknown. This sought to elicit perceptions of emotional wellbeing and mental health, the title of CAMHS and stigma attached, looked at introductory service information wanted by potential users, the environment, the skills and qualities of staff, the involvement, and rights as a user. and did not reflect the demographic of the area. However, both groups did not reflect the demographic of the area.

A newer study by Midgley et al in 2016 explored the hopes and expectations for therapy amongst moderately to severely depressed adolescents aged 11-17. Justification for their study: Only a few studies looked at expectations of adolescents, and many of these are questionnaire based and are not qualitative. They were interviewed using semi-structured interviews and analysed using framework analysis with five themes were identified. They concluded that the way young people engage with treatment will be based upon their expectations, and without identifying the expectations this can lead to potential treatment breakdown. Studies have demonstrated that adolescents who possess an understanding of what to expect and who feel motivated by psychotherapy will engage in the process and benefit from it as opposed to adolescents who do not know what to expect and who may be resistant (Adelman et al 1984; Day and Reznikoff 1980; Szajnberg and Weiner 1989 and Taylor, Adelman, and Kaser-Boyd, 1985 as cited by Sigelman).

Chapter 3: Research Methodology

Background

As a child and adolescent psychotherapist, it became apparent to me, of the benefit of young people with gender dysphoria receiving a service from CAMHS alongside GIDS. Two of my own patients in long-term weekly psychotherapy treatment identified as transgendered. The sessions provided the opportunity not only to provide treatment for issues such as depression, anxiety and relational difficulties but also provided space for my patients to explore and reflect upon their identities. CAMHS has seen an exponential surge of referrals for young people with gender dysphoria; this appears likely to continue. CAMHS is one of the main services that this vulnerable patient group accesses. The prevalence of mental health difficulties amongst young people with gender dysphoria has been explored within the introduction and literature reviews sections. They are at an increased risk of experiencing suicidal ideation, self-harm, anxiety, and depression (Aitken, M. et al, 2016; Röder, M., et al, 2018).

Although gender identity dysphoria is not a new presentation, there is little current body of knowledge in this field. Most recent empirical clinical studies have emerged from Canada and America. There are some limitations to these studies including, the majority use parent questionnaires and are often quantitative. The views of young people with gender dysphoria are under-represented. This qualitative service evaluation seeks to redress some of the current imbalance by capturing young people's views. This will not only enable the views of young people with gender dysphoria to be heard and contribute towards the body of knowledge in the field, but the information may then be used to inform planning of CAMHS provision to further understand and meet the needs of this vulnerable group.

Design

A service evaluation which is qualitative sought to evaluate the service user experience of a Child and Adolescent Mental Health Service (CAMHS). A small number of young people with gender identity dysphoria or who are questioning their gender were interviewed using a semi-structured approach over the telephone. The service evaluation was designed prior to Covid 19. Unfortunately, the pandemic caused significant disruption to being able to recruit and interview participants. It was always envisaged that the participants would be interviewed face to face However this was not possible and instead, telephone interviews were conducted.

The interviews first sought to explore what the young people's understanding of their difficulties and hopes/expectations were of treatment from CAMHS at the time of referral. Second, it explored their experiences of a CAMHS service; whether their expectations have been met, if they feel they have been helped and if there was anything that they feel could have been done differently. Third, the young people were asked about their future hopes; both generally and more specifically pertaining their gender identity. Psychoanalytic processes were also used during the interviews, for example the practice of active listening, something which is one of the qualities used by therapists, assisted the participants to speak freely, without interruption, whilst the interviewer sought clarification and expansion when appropriate, so that the interviews gained a true account of the participants experiences.

The interviews were analysed by using interpretative phenomenological analysis (IPA) as it seeks to describe an experience as it is lived by the person. Semi-structured interviews alongside IPA are an established combination e.g., Pugh and Vetere (2009). In addition to this, psychoanalytically informed processes. The semi-structured nature of the interviews enabled participates the opportunity to speak freely, and to free associate. The benefit of this is that the participant may share material which is more significant (Rodgers and O'Connor, 2017). A rich account of both thought and emotional processes of the participant were captured. In addition, the countertransference reflections of the interviewer formed an integral part of the process. The term countertransference is defined as the emotional

reaction to patient's communication (Alvarez, 2007). . The interviewer wrote down her own countertransference thoughts and feelings following each interview. This enabled a relational dynamic to be captured, and subsequently enabled a greater insight into the participant's emotional communication to be thought about and discussed. The counterstransference and the IPA were both explored within the discussion sections.

Alongside the interviews, participants were also asked to complete a Strengths and Difficulties Questionnaire (SDQs) at the time of the interview. One way to establish validity of interview data is to compliment it with other methods (Breakwell, 1995). Unfortunately, recruitment of participants for the interviews was difficult during periods of lockdown caused by Covid, and those that did agree to the interview did not complete and return the SDQ when they were asked. The SDQ is a self-report inventory behavioural screening questionnaire for children and adolescents aged 2 to 17 years old. This is a type of outcome measure routinely used within CAMHS to assess difficulties and track any improvement. Participants should have been asked to complete these within their first appointment with CAMHS. The first SDQ and the SDQ completed at the time of the interview would then have been compared and the information obtained analysed using graphical analysis and summary statistical measures. This would have been a useful tool to compare the narratives of the participants with a well-being score.

Data Collection:

Setting

The service evaluation setting is within a large Child and Adolescent Mental Health Service (CAMHS) based within a metropolitan borough of a multi-cultural city in the north of England. At the time of planning and then interviewing participants the thesis author was undertaking clinical training as a child and adolescent psychotherapist.

Participants

In the TREC proposal it was stated that between 8-10 participants would aim to be recruited. However, as the study progressed it became apparent that this was an impractical number given the time it takes for one interview to be analysed. Samples in IPA studies are usually small to enable a detailed and time-consuming analysis in order for the participant's account to be fully appreciated (Pietkiewicz and Smith, 2014).

Six Participants were selected with three main characteristics: first, based on their gender identity dysphoria/querying, second, their age (13-17) and as a CAMHS user. The section pertaining to the inclusion/exclusion criteria expands upon this, However, in line with the study aims, participants are selected purposely: "this allows one to find a defined group for whom the research problem has relevance and personal significance" (Pietkiewicz and Smith, 2014, p.10). Three of the six participants identified as female to male transgender, two participants identified as male to female transgender. One participant identified as non-binary (birth gender: female).

Table 1. Participant profiles.

Participant	Age	Gender Status	Length of Time in CAMHS	Intervention Received	Clinician
Cyrus	**16**	**Male transgender**	**21 months**	**Case Manager Support.**	**Experienced Social Worker**
Alex	**14**	**Non-Binary**	**9 months**	**Case Manager Support.**	**Experienced Social Worker**
Julia	**17**	**Female transgender**	**45 months**	**Case Manager Support.**	**Advanced Nurse Practitioner**
Sophie	**15**	**Female transgender**	**16 months**	**Case Manager Support.**	**Mental Health Practitioner (nurse background).**

Ari	**15**	**Male transgender**	**24 months**	**Case Manager Support and Short Intervention of Family Therapy.**	**Advanced Nurse Practitioner – Family Therapy Trained.**
Rod	**13**	**Male transgender**	**9 months**	**Case Manager Support.**	**Mental Health Practitioner (social work trained).**

Young people were assessed and then allocated a case manager (often the same clinician who assessed them). If the case was an urgent referral (normally where the young person was deemed at high risk) they would be allocated to one of the nurse practitioners as their case manager who undertook a crisis role. They may remain allocated to this clinician or become allocated to another , especially if the risk reduced. In other cases where the presenting risk was lower, they would be assessed and allocated a case manager, normally a clinician not in a crisis role.

The team was quite established with many clinicians with more than 5 years' experience in their roles. Retention was also very good. Therefore, most young people retained their CAMHS case manager for the duration of their time in CAMHS. In cases where a young person was referred for therapy they would keep their case manager in addition to receiving the therapy. Increasingly, many CAMHS do not allocate the majority of young people to a case manager unless they are deemed at high risk, and will be placed on a waiting list for a therapeutic modality and contacted occasionally by any clinician to review the risk and care plan, while they are waiting for therapy. Therapy waits may also be extensive.

The majority of the participants did not experience an intervention from a qualified therapist (Cognitive Behavioural Therapy, Family Therapy or Psychoanalytic Psychotherapy). Instead, they were provided support and strategies from their case manager. One of the case managers is trained to CYP IAPT Certification and will need to undertake a further two

years to qualify as a Family Therapist. One of the other case managers (first allocated to Ari) is a qualified family therapist with extensive experience and did provide brief family therapy sessions. The other practitioners are qualified as social workers or as nurses. One of the advanced nurses is a nurse prescriber but to my knowledge, she and the remaining clinicians are not trained in therapeutic modalities but do have interests in counselling, dialectical behavioural therapy and CBT approaches.

Inclusion and Exclusion Criteria

The participants were purposefully chosen because they fitted the study's criteria. Participants were recruited between the ages of 13-17. They must present with either gender dysphoria or querying their gender identity. All participants must have been open to CAMHS for at least 6 months to have gained a sufficient length of time within the service.

Young people expressing suicidal ideation or active psychotic symptoms were excluded due to the increased risks; taking part in a service evaluation would not only be ethically inappropriate but it is unlikely that the young person would be able to participate wholly with the interview. Young people with a diagnosed moderate to severe learning disability would also likely not be able to participate wholly with the interview. The interviewer will not have had prior professional contact with the participant.

Recruitment

Recruitment took place between June 2020 and April 2021. Clinicians in the service were initially sent an email introducing them to the service evaluation which included general details about inclusion and exclusion criteria of participants. Clinicians were asked to contact me if they were working with a young person who would fit the criteria. A brief conversation was followed with the clinician to check suitability and provide further information (an information sheet). The clinician then contacted the prospective participant and parents, who were provided with information by the clinician. If an interest is

expressed, the information sheet and consent form was provided, which included information about the use of audio-recording.

Unfortunately, it was difficult to recruit young people. This seemed to be largely due to lockdown. I found that clinicians had varying engagement with their patients and the lack of face-to-face appointments exacerbated this. Sometimes clinicians were unable to manage to speak with prospective participants or their family due to a general disengagement. Sometimes, a clinician would report interest from a prospective participant or family but then either they did not respond to my contact or on one occasion a parent declined because of concerns of how an interview might impact their child. A couple of clinicians asked me to approach their patient directly.

Semi-Structured Interviews

Semi structured interviews were used to gather data. An interview proforma was created and used as a guide during the interviews. This approach was the most suitable to answering the study question. Semi-structured interviews are open ended which allows the participants to answer the questions to the degree/depth that they wish to and feel comfortable with. Comparatively, one of the limitations of using structured interviews is that they do not allow for participants to expand out of the set questions and participants are constricted in the information that they can give. Whilst unstructured interviews risk the questions/themes being unanswered. Semi-structured interviews have the benefits of both; ideally, the approach allows "…the interviewees to speak for themselves, telling their own story" (Breakwell, 1995, p.240). Semi-structured interviews have a great deal of flexibility within the Interview schedule; questions do not need to be asked in any order. This enabled a flow to develop and questions to be asked at natural intervals.

The Covid 19 pandemic has meant that face to face interviews have not been possible and therefore participants have been interviewed over the phone. However, increasingly

researchers are using the phone and achieving similar results as face-to-face interviews (Breakwell, 1995). The first couple of participants were offered the choice of either a Zoom video call or a telephone call with them opting for a telephone call. In the interests of keeping the interviews as similar as possible, the further participants were offered a telephone call. The interviews ranged from 30 minutes to 1hr 20 minutes, with the average 60 minutes. Participants were contacted by telephone and the call was placed on loudspeaker (in a private and confidential setting). Two of the participants (Sophie and Alex) requested that their mother was a part of the call for support. The mother's voice was an integral part of the interview and was transcribed and analysed. The interviews were audio recorded using my trust's encrypted voice recorder software. The recordings were then held onto a secure and confidential trust drive before being uploaded onto a secure transcription service.

Data Analysis

The data collected was analysed using Interpretative phenomenological analysis (IPA) which is a standard method of analysing data within qualitative research. IPA was developed by Smith and used within health psychology research in the UK (Smith, Harré & Van Langenhove, 1995) As a qualitative approach it is used widely in psychology and increasingly within psychotherapy. IPA is based on three philosophical foundations: 1. Phenomenology;2. Hermeneutics (Interpretation) and 3. Idiography (Pietkiewicz and Smith, 2014). Its aim is to explore in detail how participants make sense of their experiences and the meaning that is ascribed to it (Smith and Osborn, 2015). "Thus, IPA researchers attempt to understand what it is like to stand in the shoes of their subject" (Pietkiewicz and Smith, 2014, p.8). For this reason, samples in IPA studies are usually small, which enables a detailed and very time-consuming case-by-case analysis (Pietkiewicz and Smith, 2014, p.9). As part of the process the researcher is required to use their subjectivity:

"Access depends on, and is complicated by, the researcher's own conceptions; indeed, these are required in order to make sense of that other personal world through a process of interpretative activity. Thus, a two-stage interpretation process, or a double hermeneutic, is involved. The participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world (Smith and Osborn, 2015, p.53).

This method compliments the therapeutic skills of psychotherapists who are able to experience their patients' feelings, and in time support understanding through providing interpretations. Data was analysed by the interviewer in this study. The interviewer is a white, gender conforming female aged 40. At the time of the research, the interviewer was towards the end of her 4-year doctoral training within Child and Adolescent Psychoanalytic Psychotherapy.

As part of analysing the data using IPA the interviewer reads the interview transcript and writes 'exploratory comments' alongside stating what the participant is saying. Themes are then written in a separate column. The interview transcripts are analysed to identify emerging themes which are then grouped, producing thematic clusters (Chapman & Smith, 2002). These clusters consist of superordinate themes with subordinate themes below. This process is repeated for every interview and a master table of themes is constructed which captures the shared experiences of the participants (Pugh and Vetere, 2009).

Validity/Rigorousness

Data obtained using qualitative methods usually take place in naturalistic settings. All participants have been in their homes during the interviews. Originally, interviews would have occurred within the CAMHS clinic However due to Covid participants opted for a telephone call from their home. One benefit of this, is that participants were more likely to feel comfortable, and therefore feel comfortable to participate in the interviews and freely share their experiences. However, it is likely that those participants that have not engaged

with their clinicians are less likely to engage and agree to interviews. Those that have a good relationship with their clinician and are engaged will likely agree to the interviews. It is common even in random sampling that people will talk who have had generally good experiences (Breakwell, 1995).

Interviews are an established method which yields data which are just as reliable and valid as other methods (Breakwell, 1995). However, as with other methods there can be limitations, for example Interviewing involves researcher effects, whereby participants willingness to participate and to answer accurately will be impacted by their view of the interviewer (Breakwell, 1995). One way to control for this is by using the same interviewer (this was the case for this study). There can also be interviewer bias which can be excluded by audio-recording the interviews. It is important to note that there is no evidence to suggest that recording participants constrains their responses (Breakwell, 1995, p.249).

One of the challenges of interviewing young people is that they may either give the information they think the interviewer wants or else try to contradict (opposite bias). Therefore, one way to mitigate against this to not use closed questioning and to help encourage the young person to share their own opinions (Breakwell, 1995). This was mitigated against using semi-structured interviews and the lack of a previous relationship with the interviewer. Additionally, respondent validation is a technique used within interviews, and used within these interviews to ensure the researcher had an accurate grasp of what was being communicated (Pugh and Vetere, 2009). Another way to convey reliability and plausibility is for the study to be 'grounded' using direct quotes alongside interpretations (Elliott, Fischer, & Rennie, 1999; Vetere & Dallos, 2005 & Pugh and Vetere, 2009).

Ethical considerations

This study has gained ethical approval of research involving human participants from the NHS Trust's Service Evaluation Department that this study was located and by the Tavistock

and Portman Trust Research Ethics Committee (TREC). An application which provided details of the study was submitted as part of the approval process. The participants are anonymised throughout the process and were given the option of choosing their own pseudonym.

It has been important to bear in mind that the participants have all been referred to CAMHS because of concerns about their emotional and/or mental well-being. Although, the interviewer encouraged participants to answer questions in some depth, consideration was taken of noticing any distress or discomfort caused by the process. At the beginning of the interviews, it was emphasised to the participants that they could stop at any point or that they could choose not to answer a question if they felt uncomfortable. If any participants expressed any distress the interview would have been stopped and appropriate support would have been assessed and provided. This did not occur although one participant chose not to answer one of the questions but continued with the rest of the interview.

It was envisioned that the semi-structured interview would enable an opportunity to reflect and therefore, would likely be beneficial. The experience of reflection may have an empowering effect leading to the participants to think about and request further support and treatment from CAMHS or to seek this from another agency. Moreover, the participants have all appeared to find the interviews a positive experience. They have seemed to appreciate the opportunity of self-reflection and of feeling heard. One expressed how the time had gone quickly and another said that it was a cathartic experience. The participants involvement of this study will help to inform future CAMHS interventions which will contribute to support other young people experiencing gender dysphoria.

Chapter 4: Presentation of Findings and Discussion

Introduction

After careful analysis of the interviews using an interpretative phenomenological approach three superordinate themes were identified: 1. Being Transgender in CAMHS. 2. Mental Health and 3. The Transgender Journey. In addition, there are subordinate themes explored within each superordinate theme. Material from the six interviews will be used to illustrate the themes and to capture the voices of the participants. Alongside this, the interviewer's countertransference will also be explored and contribute to the themes. After each Superordinate section there will be a discussion and analysis of the themes with consideration of any literature reviewed and its relevance to the current study. Time is also spent considering new literature and comparison with previous research studies.

1. Will CAMHS Help Me?

Referral

"Honestly, from what other people said, CAMHS isn't really painted in the best light, so I didn't have any good expectations. (Laughter)" **Julia. Lines 32-33.**

Although there was hope expressed by some participants, this was overshadowed in the majority of situations with negative expectations of the help that they would receive. Most of the participants expressed feeling at best unsure about the referral to CAMHS, and at worst scepticism for two reasons: 1. Negative accounts from other young people who had accessed CAMHS and 2. Prior negative experiences of not being helped. In Julia's quote above she expresses a lack of 'good' expectations; the inclusion of 'good' in front of

‘expectations’ suggests that she did have expectations, However, these were negative due to accounts from previous/current service users. Alex expresses his doubts of receiving help in respect of his previous experiences:

“I guess I was kind of hopeful that I’d actually be able to get help. But at the same time, I didn’t get my hopes up too much because before CAMHS I hadn’t really got any proper help” **Alex. Lines 77-79.**

Alex manages his feeling of hopefulness, anxious that his prior experiences of not receiving help will be repeated by CAMHS. It is likely that many of the young people referred to CAMHS may experience a degree of uncertainty, and possibly scepticism about whether they will be helped. It was therefore unsurprising that participants shared these same concerns. However, in addition to these quite usual feelings of trepidation, it became apparent that many of these participants had previous experiences of feeling let down which contributed towards their perceptions of whether CAMHS could help them. Ari provides an explanation for this:

That it'd be the same as the other people, that they couldn't help me, they would push it off and never actually care to help. I felt like I couldn't be helped because of the amount of times people wouldn't, so I was thinking they'd be the same and I wouldn't get anywhere with them. Ari. Lines 57-62.

Ari identifies that he feels he has not received help before, he refers to “the amount of times” which suggests that he feels he has been let down on numerous occasions. His choice of words with “push it off” and “wouldn’t suggests that he feels that there was an unwillingness of others to help which is very different to feeling that people were unable to help. Similarly, Cyrus explains that he was also sceptical:

"At first I was a bit sceptical, you could say. Because I'm not really great with having people help me with things. And quite a few of the people that I know who have been to CAMHS, they didn't have great experiences with it. So I was sceptical at first" **Cyrus. Lines 58-64.**

Cyrus shares that he is not great with having people help him. His scepticism appears to be reinforced by the negative accounts that he has heard about CAMHS. However, he conveys quite considerable insight about his difficulty to accept help. Additionally, Ari also shares that as well as feeling sceptical about whether someone will want to help, and if CAMHS are able to help he also he finds it difficult to accept help:

"I'm one of those people that, personally, I don't like to admit that I need the help and I try and fight on my own. It's one of those things that I struggle with, accepting that, yes, I needed to go there, I needed help. Sometimes it's like a feeling of weakness" **Ari. Lines 88-91.**

Ari proceeds to explain that it was also hard for him to accept the help due to his suicidal thoughts:

Interviewer: ***"There was a part of you that didn't want the help?"***

Ari: ***"I felt like I was wasting their time that they could have spent with someone else helping them. I thought, "There's no point in helping me. I'm going to die anyway." Ari. Lines 118-122.***

A couple of participants shared that they had been previously referred to CAMHS and then discharged before they felt they were recovered. Alex was first referred after experiencing low mood and suicidal ideation. He received a service for a short period of time but was

then discharged. He expressed considerable upset and frustration about this and attributes his worsening mental health and his subsequent suicide attempt to this first discharge:

"Then later on, when I'd more mental health problems, I was sent back to CAMHS but I wasn't really taken seriously until I ended up taking an overdose, which really annoys me because if it was taken seriously, then the overdose might never have happened" Alex. Lines 32-36.

The overall impression is one of invalidation; that CAMHS staff did not understand his difficulties sufficiently and his difficulties were not taken as seriously as they should have been. In consequence, he was extremely sceptical about being referred to CAMHS again. This experience appears to profoundly affect Alex. He describes how he sabotages his own progress:

"Yes, and it starts to feel like- I'm still suffering with the side effects of that, trying to make myself worse. I know that sounds really, really strange, but I haven't been letting myself sleep, I haven't been letting myself eat. Yes, not fun" Alex. Lines 113-116.

There appears to be a dilemma for Alex of well versus unwell; he equates any improvement in his mental health with discharge from CAMHS, and therefore sabotages his own recovery. If he remains unwell, he may continue to receive support from CAMHS indefinitely, or at least until he is 18.

Overall, participants felt that they were helped by CAMHS and that their difficulties had decreased. Perhaps, the most noticeable improvement in wellbeing is experienced by Julia:

Julia: ***I definitely think it was the right decision. It has helped me in every way, to be honest. It has brought my confidence on, so it has helped me in my life.***

Interviewer: ***And has it helped with the social anxiety?***

Julia: ***Definitely. I don't have social anxiety really at all anymore. I never used to be able to speak on the phone, but I'm speaking on the phone right now.*** **Julia. Lines 23-29.**

Rod identified that he feels that CAMHS have helped him with his depression and gender identity:

Rod: ***"Mainly just being able to talk about how I am feeling, and that has helped."***

Interviewer: ***"When you say about how you are feeling, is that to do with depression or is that to do with your gender identity?"***

Rod: ***"Both."*** **Lines 196-202**

Alex attributed being helped specifically by his CAMHS key worker (explored further within 'Experience of CAMHS Practitioners') whilst Ari identified that it has been both CAMHS and a youth worker at a youth group that has helped improve his mental health. He describes quite significant changes:

"I don't have suicidal thoughts anymore. There are days I will look back on that and think about how I was, but genuinely, I don't think about actually wanting to end it. It's very rare I'll have urges to self-harm. I still suffer with my depression, but that's something that is still being worked on. It is getting better. Overall, it's a lot better and continuing to get better." **Ari. Lines 259-264**

Cyrus identifies that CAMHS has helped him most in acceptance of his current situation with his gender dysphoria; he has done everything he can in terms of transitioning e.g., changing his name, and dressing as male and now needs to wait for GIDS. The theme of acceptance is further explored within the third section (The Transgender Journey). In contrast to all the participants, Sophie expressed ambivalence about whether CAMHS had been helpful. His mother responds to my question:

"I got a shrug and a, "Not sure, to be honest." **Sophie's mother. Line 65.**

Experience of CAMHS Practitioners.

"Whatever. I'll sit here, let you say what you wan't and I get paid for it." Ari. L 316.

In this quote, Ari is stating what he is imagining are the thoughts of a CAMHS worker; his perception is that the worker is only motivated by money and is uninterested in helping him. The perceived disinterest of the worker powerfully affects Ari, to the point that he feels worthless:

"He just made me feel like I was worthless, I didn't mean anything, that it was pointless me being here" **Ari. Lines 306-307.**

Many of the participants emphasised the importance of both CAMHS clinicians and other people they met in the course of their daily lives to exhibit attributes of curiosity and a desire to understand, both in the context of them as a patient within CAMHS and within their personal lives. The importance of feeling understood seemed especially pertinent to participants, many of whom shared that they had at the beginning of discovering their gender identity experienced strong feelings of isolation, shame, and loneliness. A few of the participants emphasised that it is ok for people to make mistakes in terms of names and

pronouns, if it is not purposeful. Ari shares below an interaction with a CAMHS clinician who had questions about his gender identity:

“I can't remember who it was, but I spoke to one worker there and they've been the only person to actually bring it up as a topic. They went, "Can I ask you something about it? I don't mean anything offensive by this. I am curious to know more about it." I said, "Yes." It was like, "How does it genuinely feel being trans? Is it you want to be or you know you are?" They were asking questions genuinely trying to understand it. Though that might sound that it'll make me feel uncomfortable, it actually makes you feel more accepted knowing people genuinely want to understand what's going on.” **Ari. Lines 905-915**

It suggests that his experience overall is that CAMHS clinicians may avoid the subject of gender dysphoria, preferring other territories, such as mental health issues which feel more understood and safer for them.

After Ari’s the incident with the CAMHS clinician (not his key worker) he also asked to change key worker and explains why:

“Over time, it was becoming harder to talk to my keyworker because we didn't click as well, which was just because sometimes you don't click with certain people as easily as you do with others. The reason it wasn't a problem in the first place is because of how bad the area was that we were in. It was just more of anything and everything, whereas during the actual recovery it was more, "Can I please have someone else as a keyworker that we can talk to more freely?" That happened and now I have another keyworker”. Ari. L 206-212

Ari identified that initially, whilst in Crisis the relationship with his key worker was not as important as when he was in recovery. He states the importance of being able to speak with

his key worker “freely”. He clearly wanted to engage and build a therapeutic relationship and did not feel he was able to achieve this with his first key worker. He does not disparage his former key worker but instead perceives the issue as two people not “clicking”, suggesting that he feels a relationship is an evolving interaction between two people. Indeed, one of the most positive aspects about the participants CAMHS experience, expressed by the majority of participants was a positive relationship with their key workers. In addition, the help and support provided by their key worker genuinely helped them:

“It’s really good. She’s helped me with a lot of things. I felt I could speak to her about anything, no matter what it is. I feel quite well supported.” Julia. Lines 108-110.

Julia refers to being able to speak with her key worker about “anything” which is the main reason Ari requested a change of key worker. The majority of the participants liked it when they felt able to speak with their key worker about a range of issues, including their gender identity. Although, most of the participants thought that they could, and indeed have already spoken about their gender identity with their key worker, one participant expressed feeling frustrated about this. Alex conveyed a desire to talk about his gender variance but expressed feeling that he was met by confusion from practitioners:

“Yes. I was very, very scared to open up about things. If I ever mentioned something that I wanted to be dealt with, I really meant it. When I said, "Hey, can we really talk about gender and stuff?" A couple of times people were really confused. They'd be like, "Wait, what does that mean?" I'd be like, "Okay, well, that means that." Alex. Lines 376-381.

Alex goes on to explain that CAMHS staff possessing some understanding of terminology would be helpful, so that he does not have to constantly explain terms. All the participants said that they would have found it useful to be able to talk about and explore their gender identity with an adult, such as a CAMHS key worker earlier in their transgender journeys. Julia explains that she was socially anxious and perceived judgement from others when she

was first referred, but attributes becoming more accepting and confident of her gender variance because of the support from her key worker:

“I always understood who I was, but they’ve helped me- A lot of it came around the social anxiety, I couldn’t accept- Like everyone was judging me and stuff like that, and I felt like people just laughed at me if I was presenting 100% as female. But they’ve helped me build my confidence and be- What is the word? Just more confident to be myself” Julia. Lines 78-82.

Alex also attributes the support given to him by his key worker specifically as the thing that has helped, not a therapy, medication, or intervention but because it was from a particular person:

“This is going to sound like a very, very weird example, but it's like if you want something and someone giving it to you on Christmas, Christmas hasn't helped you. That person giving it to you has helped you, but they're a direct result of that because of Christmas, if that makes any sense. It's just the first thing.” **Alex. Lines. 487-492.**

Discussion

The theme of ‘help’ was the over-riding subordinate theme which all participants were able to share their thoughts and feelings. The participants shared concerns of accessing a new service; balancing feelings of hope with anxieties that they would not be helped, which were increased by negative accounts of previous/current service users. The participants unique experiences of being trans or questioning and their experiences of being bullied by peers and discriminated against appears to be an additional factor in how they perceived CAMHS, and whether importantly it could help them and/or whether they would want or could make use of the help that was offered. Ari inferred that there has been an unwillingness of

others to help whilst Cyrus acknowledged his difficulty of accepting help. Indeed, most of the participants shared that it was difficult for them to access CAMHS and enter a therapeutic relationship because of their experiences of being let down. In my clinical work as a child and adolescent psychotherapist I encountered both a desire to seek help but also a fear of being, in my sessions with a trans male adolescent patient I was seeing for weekly psychotherapy. We would have a 'good' session where we seemed to be making progress only for him to miss the session the next week. The 'help' would be rejected because of the exposure and vulnerability he felt. Di Ceglie (2009) refers to 'self-sufficiency' being a feature of many patients presenting with GID which presents a challenge for the therapist trying to engage their patient:

"The child may feel very vulnerable in becoming involved in a relationship that requires a certain capacity to tolerate dependency. This needs to be acknowledged in order for a trusting relationship to develop" (Di Ceglie, 2009, p. 7).

The fear of dependency for my patient meant that the work was in a constant state of toing and froing; a step forward, and another back again. Although, I regularly tried to explore this in my sessions, it culminated in us taking a break from the therapy after several review sessions were missed. However, it was my patient who then got in touch a few months later asking for sessions to be resumed. I agreed, and over the coming months we were able to explore the value of the sessions to him but equally the difficulty this caused him, and the default position of withdrawing.

The experience of bullying, discrimination, and isolation through a lack of understanding from others and of one's own gender variance may lead to the development of a distrustful and suspicious view of others. The concept 'double deprivation' first used by Henry (1974) describes how the first deprivation upon the child is external, for example neglect and/or abuse whilst the second deprivation is caused by the child's internal world which created defences to keep the child safe, but which are now harmful. The notion of 'help' is

therefore complicated to some young people with gender variance. There was considerable emphasis by the participants on the perceived helpfulness/unhelpfulness of CAMHS, other services and professionals. Alex had previously been referred to CAMHS and then discharged, in his opinion too soon, and attributed blame towards CAMHS for his deteriorating mental health. Klein (1946) introduced the concept of 'projective identification' in which parts of the self are split off and projected into another, so that they become imbued with the parts. The 'help', in this case CAMHS, is perceived initially by participants as capable of inflicting damage. At best CAMHS is useless and at worst it is damaging. The distress about one's body and a desire to inflict damage creating lasting change to the body by gender reassignment may not be possible to think about. The aggression, and what is 'damaged' becomes located within CAMHS.

It was troubling to hear Ari's account of his interaction with one of his CAMHS workers. These quotes are snippets of a much longer conversation with Ari about his experiences, but they capture the despair experienced by him. My own counter-transference response was quite strong and provoked a desire to investigate and seek justice for him as the 'victim'. I was pulled out of the interviewer stance and provided him with details of the complaint's procedure; it might be argued that my actions were appropriate However the feelings that were aroused were powerful. My assistance placed me into what felt like an alliance with him. My counter-transference response caused me to think about the importance of the term "click" he and Julia used. Ari used it to describe a desirable relationship with his CAMHS key worker. It was a term that is normally associated with a friendship or a romantic relationship: for example, "we just clicked". Indeed, the dictionary definition of "click" is: "become suddenly clear or understandable" and in the context of relationships it means: "quickly become friendly or intimate" (Cambridge Dictionary, 2022).

Most of the participants said that they valued the relationship with their key worker. It has been documented that a positive relationship with a mental health clinician is a central aspect of an individual's recovery.. Several of the participants referred to being able to talk to their key worker about anything. It was a theme which most of the participants talked

about in some detail. It does pose the question of whether it is more desirable and important for young people with gender variance to seek alliances and establish intimate relationships with CAMHS staff than it is with other service users? In the interviews with Ari and Rod I was acutely aware of the interviews possessing a different quality than with the other participants. The interviews went very well and there was an ease with speaking to them, with several exchanges interspersed with humour and laughter. At the end of both interviews they asked me if they could ask me a question, this exchange was with Rod:

Rod: ***"Can I ask you a question though?"***

Interviewer: ***"Yes, you can."***

Rod: ***"Okay. How has your day been?"*** **Lines: 110-114.**

I was surprised to be the one on the receiving end of a question and wondered if it served to make the interview more relational or perhaps 'friendly'. I ended the interviews particularly liking them and felt that 'click' that had been described. However, I am of the impression that it felt important to them that I liked them. This need to be liked may be attributed to experiences of discrimination and judgement by others as a catalyst for them to seek out relationships with people where they experience warmth and approval. Moreover, in some cases, young people with gender dysphoria may have experienced inadequate early experiences of containment and mirroring from a caregiver, as an adolescent they may seek out such an experience.

It made me wonder about the distinction between the help wanted, and the help that is needed. If the relationship with a CAMHS clinician is not quite a 'click' it may be considered as inadequate. What constitutes a 'click'? Does the clinician need to agree completely or is it possible that being alongside is enough? There has been much written on the rigidity of

thought and a concreteness amongst young people with gender variance. This alongside the distress experienced about one's body may compel the drive for young people to regard help as concrete physical interventions and outcomes. 'Help' may also be highly subjective, especially with different expectations and not always easily definable outcomes in mental health. One of the benefits of the IPA method is that it enables the interviewer to understand what it is like to stand in the shoes of the participants. Certainly, I was aware of feeling a strong pull towards the idea of a medical intervention (something physical and tangible) as a solution to resolve most of the participants distress. Most of the difficulties were attributed towards GIDS, and I found myself creating an internal monologue about the deficiencies of the service, such as long waiting times. Upon reflection I realised that GIDS had become a depository of a significant proportion of the 'badness' felt by the participants; the pain of feeling you are in the wrong body, the experience of discrimination and of difference and the frustration of bearing uncertainty. I could relate to how it was appealing to believe, and enabled hope within the participants, that a medical intervention; a concrete object full of certainty could provide the solution to their difficulties. For some, medical interventions are required but for others it will not provide the solution to an internal conflict. Invariably, clinicians who work with young people with gender dysphoria will be experiencing the projections of distress and uncertainty, will therefore feel the pull towards such a solution.

However, most participants identified that as well as some interventions involving medication (depression and anxiety) and school and referral to youth services, they valued and benefitted from the relationship with their case manager in which they could talk freely. Most of the participants were supported in CAMHS by their case managers.It appears that it was the availability and the support provided by a professional with whom the participant was able to feel rapport and trust, which was important. All of the clinicians were experienced, and in consequence potentially they were able to engage young people and provide containment, more so, than an inexperienced clinician would be able to. However, not all participants experienced this, struggling with engagement and many of the participants also formed what they considered to be stronger relationships with other professionals working in youth services. Therefore, some of these participants may have

benefitted from a relational therapy such as psychotherapy, where there is a reliable space in which to develop a therapeutic relationship and explore difficulties. This was also a time prior to the repercussions of Covid; many CAMHS are struggling with the increase of referrals and issues with resources and capacity. This will have an impact on whether a young person is allocated a case manager and/or the frequency of appointments a clinician can provide.

Many of the participants said that they would have found it useful to be able to explore their gender identity with an adult, particularly earlier in their transgender journeys. This corresponds with Steensma et al's (2010) qualitative study which explored the factors involved in whether gender variance persisted or desisted. Participants considered the period between 10-13 years of age most critical to them, and this was a time in which Steensma et al (2010) identified as an important time to provide support. A couple of participants shared possible discomfort and ignorance about gender dysphoria amongst some CAMHS clinicians. It does raise the issue of whether CAMHS clinicians feel they receive enough training to understand the issues and provide support to young people with gender identity dysphoria.

One of the themes highlighted from participants was the importance of correct pronouns, names, and some awareness of gender issues. The desire for me to please the participants was also evident to me at times during the interviews. I became acutely aware of using the correct terminology and becoming the 'good' interviewer – ensuring that the pronoun and name I used was correct. Perhaps to some extent I was affected hearing about the discrimination experienced by participants, that I was trying to correct a 'wrong' inflicted on them. I was also extremely aware during the two interviews with Sophie and Alex when their mothers would use the incorrect pronouns; I felt myself oscillating between identifying with the participant and the mother. However, it did enable me to explore the use of pronouns with Julia, Sophie, and their mothers, allowing insight into the perspective of child and parent. Tsoukala (2018) identifies some of the difficulties and concerns of working with a late adolescent transgendered male patient called Alex. Thoughts emerge of whether she

should she refer to her patient in the feminine or masculine? Thoughts about 'collusion' and 'political correctness' and being regarded as trans-phobic are eminent in her mind.

2. The Merging of Gender Identity Dysphoria and Mental Health Difficulties.

The main mental health difficulties of the participants were depression, suicidal ideation, and anxiety. In terms of the anxiety, it was centred around the participant's gender variance and feelings in respect of their own body as well as societal and familial acceptance. Participants mental health difficulties and gender dysphoria appeared to be quite merged when they were referred to CAMHS. Julia suffered with social anxiety:

***"I was having quite bad social anxiety, I didn't really leave my house that much or interact with people."* Julia. Lines 8-9**

Alex explains that he was initially referred for mental health problems which CAMHS attributed to bullying. He was then discharged due to an overdose attempt:

***"Okay, well, first off, when I was in Year 8, so this was two years ago, I was with CAMHS because I had severe mental health problems that were mainly caused by bullying. Instead of helping me deal through those mental health problems, while simultaneously giving me alternatives from the bullying in order to deal with it, they just discharged me and told me that it was my school's problem to deal with the bullying. Then later on, when I'd more mental health problems, I was sent back to CAMHS but I wasn't really taken seriously until I ended up taking an overdose, which really annoys me because if it was taken seriously, then the overdose might never have happened."* Alex. Lines 25-36.**

Cyrus explains that he was referred due to experiencing suicidal ideation:

"I was very suicidal. I had a plan. I was dealing with a lot of issues at the time, like family issues, bullying issues." **Cyrus. Lines 47-48.**

Sophie also struggled with depression and suicidal ideation. Her mother, explains:

"[___ 0:00:23] it was ___ struggled with depression…He was having a lot of problems with anger and stuff, and outbursts and feeling suicidal. Putting himself at risk." **Sophie's mother. Lines 4-7.**

Rod went to his GP regarding being transgender, and he was referred to CAMHS. After a little exploration he shared that he also suffers with depression:

"Depression, but I am sure there is other stuff that I am not aware of, but that is definitely the main one, you know." **Rod. Lines 96-97.**

Ari suffered with a few mental health difficulties:

"Suicidal thoughts, really bad depression, suffered with hearing voices" **Ari. Lines 18-19.**

Participants were asked about why they think they were referred to CAMHS. The majority attributed their gender identity as a reason alongside mental health difficulties. A couple of participants thought that their gender dysphoria was the main reason. Julia approached her GP specifically about thoughts of being transgendered:

"I spoke to my GP and told them I think I'm transgender, and then [___ 0:00:23] CAMHS. I don't think I waited that long either" **Julia. Lines 3-4.**

The implication that Julia may have experienced from this, is that being transgendered may require a mental health service rather than GIDS. Rod is another participant referred to CAMHS by his GP after identifying as transgendered:

"It was after I came out to my parents as trans and then I was referred here through my GP." Rod. Lines 62-64

Whilst all participants shared that they struggled with their mental health, for the most of them it their gender dysphoria which was eminent in their minds at the point of referral to CAMHS. Julia and Rod both link their referral to CAMHS with identifying as transgender, rather than because of mental health difficulties, such as depression. Rod tells me that he thinks he might have been referred to CAMHS so that he could go to GIDS. Initially, when I ask if he suffered with any mental health difficulties at the time of the referral he replies:

"Yes, I struggle with my mental health, but it is not really a problem at the moment, I guess" Rod. Lines 80-81.

He does not appear to place much weight on his mental health difficulties:

"I mean, not really. It has been the same, but sometimes it gets worse. Like, it is just itself, (Laughter) you know." Rod. Lines 86-87.

The mental health has its own agency when Rod refers to it as "…it is just itself". There is also an acceptance of it, which contrasts with some of the other participants who at the point of referral talked candidly about how debilitating their mental health was for them. The priority for Rod was in respect of his gender identity and not mental health difficulties. Although Julia appears more concerned about the mental health difficulties she was suffering with (social anxiety) she attributes her gender identity as the cause, and the area she wanted help with. As the interview progressed it is evident that Julia had experienced considerable distress about being perceived by others as male and at the point of visiting her GP, she was also seeking a referral to GIDS:

"I didn't understand what I was doing at first with CAMHS. Because I knew [___ 0:01:37] but I was more focused about the gender thing, and I didn't know how they could help me with that, at the time." Julia. Lines 21-23.

Julia explains that she was confused by being referred to CAMHS, and more focussed upon her gender identity. She may have attributed the referral to CAMHS as being predominantly about her gender identity and inferred that her GP and CAMHS may view gender variance as a mental health problem. Similarly, although Cyrus and Alex were referred due to suicidal ideation and attempted overdose, (respectively), as the interview progressed it was apparent that being transgendered, and the subsequent difficulties which emerged from it (bullying, family issues and frustration with the transition process), were the main issues requiring CAMHS support. The participants shared insight on the connection between their gender dysphoria and mental health heath. Firstly, they attributed discrimination and bullying and secondly, due to their own feelings of shame associated with being transgendered or non-binary and in respect of their bodies. I will explore this further within this the third section (The Transgender Journey). Alex links the bullying he experiences to a deterioration in his mental health:

"My mental health was bad because of the bullying" Alex. Line 42.

Later in his interview, Alex refers to the struggle of fitting in neither with the boys or the girls at his primary school and consequently bullied by the girls and boys:

"I wished it was okay for me to do both without being bullied by one or the other." Alex. Lines 266-267

Alex struggled to find a place where he could feel accepted. Cyrus also explains that he experienced mental health difficulties following homophobic and transphobic bullying at school, and subsequently changed schools. Although, Ari refers to mental health difficulties as the reason for his referral to CAMHS, later in the interview he tells me that he was aged 8 when he realised that he was transgender, which was the same age when he first began to self-harm. He explains that it was at this age when he began to suffer quite badly with mental health difficulties:

"… at that age it was when I started going really downhill with my mental health, when my depression was becoming more obvious, when I started struggling and other issues came to the surface. There was quite a lot at that age that caused it, but it did have a part to play in it." Ari. Lines 716-720.

Ari is referring to his gender dysphoria as one of the reasons why his mental health declined. Sophie also shares that her gender identity has impacted upon feelings of confidence:

"It definitely made an impact" **Sophie. Line. 736.**

The participants describe struggling with their gender identities whilst also experiencing a deterioration in their mental health. Ari provides an explanation:

"…at that age it was when I started going really downhill with my mental health, when my depression was becoming more obvious, when I started struggling and other issues came to the surface. There was quite a lot at that age that caused it, but it did have a part to play in it". **Ari Lines. 716-720**

Ari describes there are being other factors, but he also attributes his gender variance to contributing towards his mental health deteriorating. He proceeds to explain the connection between being transgender and self-harming:

"The part it had to play in self-harm was, being transgender, I have gender dysphoria. I can't look at my body without feeling disgust, without hating myself. Being only eight years old and feeling that, it was a hard thing to deal with, so the way I dealt with it was self-harm. The pain that I felt was taking the internal pain of hatred, of suffering from being trans, and the mental health and the feelings of disgust I hurt myself because of. It will release that pain, but also that's what I felt I deserved. I felt I was weird, I was wrong, I was disgusting and no one can know. It was a punishment to myself, as well as releasing the pain." **Ari. Lines 725-733.**

Ari powerfully describes the feelings of shame and disgust he was experiencing about being transgender, and specifically regarding his female body which led him to self-harm.

Discussion

Although the participants may have wanted their GP to refer them to GIDS, the participants generally all acknowledged that their mental health difficulties required help. Although four of the participants were referred to CAMHS for mental health difficulties such as suicidal ideation, depression and anxiety, as the interviews progressed it was apparent that being transgendered, and the subsequent difficulties, including bullying which emerged from it were the main issues requiring CAMHS support. Participants themselves attributed difficulties with their mental health to both their gender variance and discrimination/bullying. It was clear from most of the participant's accounts that they believed that the three areas (mental health, gender variance and bullying/discrimination) are merged.

Most of the participants were first referred to CAMHS presenting with depression, anxiety, self-harming, and suicidal ideation. This correlates to studies which have shown the prevalence of self-harm and suicide amongst young people with gender variance, with the risk increasing with age (Di Ceglie et al, 2002; Aitken et al, 2016 and Röder, et al, 2018). The participants realised/acknowledged their gender identities approximately from the ages of 11-13 which is when they also began to experience mental health difficulties. However, in most cases, they were not referred to CAMHS until the difficulties had increased to the point of crisis.

Wright (2018) suggests that gender identity issues may be a manifestation of an avoidance of puberty and becoming an adult. Certainly, most of the participants experienced distress and proceeded to identify as trans or non-binary around the onset of puberty. This may be attributed to the distress of the beginnings of changes in the body which reflect male/female gender but another factor, could also be a wish to delay adulthood. The participants all shared at best discomfort, and at worst disgust with their bodies. Ari's account of the disgust that he experienced was palpable, and deeply moved me as the interviewer leaving a lasting impression, powerfullyillustrating the degree of despair that he and other transgender people may experience. Earlier, in the first discussion section (Will CAMHS Help Me?) the role of projective identification in relation to the participants own

feelings of aggression and damage which was projected into CAMHS – a potentially damaging service, was explored. Ari's own description of his bodily disgust illustrates the place of projection when he refers to self-harming as a way to get rid of his feeling as well as serving as punishment. Unsurprisingly, Di Ceglie et al (2002) found in their study that it was a common feature amongst children and young people to experience an intense dislike for bodily sexual characteristics which also increases within age (50%). 16 years later, Röder et al's (2018) study found that Internalising difficulties and body image problems were the two main areas of difficulties for participants.

Julia and Rod went to their GP because of their gender dysphoria and not about their mental health difficulties, suggesting that this was eminent in their minds above that of their mental health. They both wanted to be referred to GIDS. Julia explained that she was confused about why she was referred to CAMHS. Indeed, Julia and the other participants may have questioned if their gender variance was a mental health issue; either to themselves, or in the eyes of others (GP, CAMHS, Family and society), especially if they sought a referral to GIDS and was referred to CAMHS instead. Being transgendered may evoke in the minds of transgendered and non-binary young people, as well as society that it is an illness. The perception that they are 'someone all wrong', is likely to be a pernicious aspect of their struggle with their identity. Levin (1971) points out that shame tends to manifest in a preoccupation about a person's body. In body dysphoria, including some cases of gender dysphoria, typically feelings of shame, and self-worth are avoided, and instead become focused and displaced to a preoccupation of parts of their body. One of my trans male patients had experienced physical and emotional abuse from his birth mother and then later with his foster mother. He had experienced more warmth from male figures and identified strongly with an older male family member who was both kind to my patient but also possessed masculine qualities of being physically fit and strong (he was in the army). My patient attributed feelings of disgust, vulnerability and shame to his female body parts while also seeing women as 'cruel'. Identifying as male appeared provide him with a solution (albeit temporary solution) to replace the femaleness he associated with the abuse, and avoid his feelings of shame, with a stronger and less vulnerable body. However, whilst I have had experience of working with complex GID presentations, I have been quite shocked

by my own counter-transference responses, which in the moment of interviewing were often strongly identified with the participants distress and desire for a medical solution. I felt a pull to a treatment which would be able to provide a quick solution; such was the strong projections of the participants distress.

Finding one's identity and place in life is a challenge for most adolescents, However, this struggle appears to occur during latency age or earlier with gender variant young people. Alex shared that he was bullied by boys and girls and that it was not possible to fit in as either gender. Most of the participants were bullied throughout their childhoods and into adolescence. The male to female participants, Julia and Sophie appear to have experienced a greater degree of social anxiety, in respect of their bodies than compared with the female to male participants. It is likely that this is in part due to the difficulty of disguising male bodily features during/after puberty than it is for the female born participants. It might also be that society may possess a less hostile, and more accepting views of male to female gendered identities. This could be a factor which directly correlates to the severity of mental health difficulties, and one which could be explored within future research. All participants identified that their future plans are to proceed with medical interventions to aid their gender transition (this is explored more fully within the next theme section entitled the transgender journey'). It is conceivable that Julia and Rod, and the other participants all share the view that their future gender transition will alleviate, if not resolve their mental health difficulties.

3. <u>The Transgender Journey</u>

"A Monster in the Room": discovering the transgender 'monster'.

The participants described how they had experienced feeling 'different' during their childhood and into adolescence. Cyrus illustrates this:

"Well, it's something that's always been in my head. You know, when you're a real little kid you don't really know, you don't really see gender much. It's just people are people, you don't really see much of that. It's not something that's really thinking in your head. However, I was an only child until I was four and when I was four my younger brother was born. And when my younger brother was born, that's when I sort of realised that there was differences in genders…So from being about 4 to 13, I sort of knew that something wasn't right but I didn't know to explain that" **Cyrus. Lines 228-248.**

It was the arrival of Cyrus's younger brother that heralds the beginning of him realising that there is a difference in genders. Julia describes the moment that her 'difference' made sense:

"I always knew I was different, but I really realised I was transgender when I was about 11. I followed some page on Instagram and they posted the definition of transgender and it just clicked with me instantly" Julia. Lines 48-50.

Until the age of 11 it appears that she did not quite possess the understanding or vocabulary to express her feelings. She describes how the definition of being transgender "clicked" which provides her with an understanding and vocabulary. Cyrus was also aged 13 when he first told his mum and similarly to Julia, he felt different and did not possess the understanding or vocabulary to express his feelings until he reached adolescence:

"So from being about 4 to 13, I sort of knew that something wasn't right but I didn't know to explain that. And then once I'd turned 13, so three years ago, I told my mum and stuff and since then I've been transitioned as far as I can be". Cyrus. Lines.249-253

Cyrus describes a significant period from the age of 4 until 11 when he experienced feeling that "something wasn't right". Rod began questioning when he was aged 11 and then

legally changed his name on his 13th birthday with his parents' support. Similarly, Ari also describes 'coming out' when he was aged 13, which he describes as "scary." (Ari. L.738.) Sophie and Alex were both also aged 13 when they realised that they were transgender and non-binary respectively. Alex also expresses lacking the understanding and vocabulary to express his gender:

"I was just like, "Okay, well, that's cool, but that's also cool, so can I be both? I never asked, "Oh yes, I'm non-binary. I go by they/them," because God, 10-year-old me didn't even have a clue what a gender was" Alex. Lines. 252-256.

Ari develops on lacking understanding and vocabulary to make sense of his gender dysphoria, and uses the metaphor of a young child's experience of feeling that there is a monster (in the cupboard etc):

"It's like when you were a young kid. For some reason, every young kid thinks there's a monster in the room, but you don't know why it's there, that feeling that there is. It's the same. It's like you know there's something there and you're trying to figure out what that thing is, whereas with a monster, you feel there's a monster there but you don't know. You're trying to figure out why you feel there's a monster there. It doesn't make sense to you until you click and realise the monster isn't there or, "I am trans," or, "I am this and that," whatever it is. Once you click, that's the realisation" **Ari. Lines 818-825.**

Ari provides the metaphor of when a young child realises ('clicks') that monsters do not exist and compares this to the realisation of being transgender: a sudden 'clicking' into place: all the thoughts, feelings of difference and distress make sense. The participants shared that they reached clarity and understanding during adolescence.

Discrimination, Acceptance and Confidence.

The clarity of realising one's gender identity does not bring relief from the sense of 'difference' which remains. This is exacerbated by the discrimination and judgement of difference from others. Alex provides an account of his experience of discrimination at school:

"One thing that has been pretty tricky is coming to terms with the fact that a lot of my friends are homophobic. In my school, almost everybody you meet is going to be on some spectrum of racist or homophobic or transphobic. It's so hard being friends with people like that, because the majority of my friends are. If you're not willing to be friends with someone that's racist, if you're not willing to be friends with someone that's transphobic or homophobic, you're not going to have any friends. It's horrible having to put up with that and not speak my mind. At the end of the day, if I do speak my mind I'm just going to be beaten up. Alex. Lines.313-323

In order to be accepted Alex explains that he needs to compromise on his own views, and essentially hide his own identity. He believes that he would be physically attacked if he were to disagree and share his own views. Many of the participants describe experiencing discrimination and bullying at school. Julia expressed that he had not experienced any issues with family but that "school wasn't really that great" describing how others were "horrible" but that college is a lot more accepting (Julia, Lines. 68-70). Alex describes how it was impossible to find his place amongst the female or male students at his school:

"Yes, I was pushed out by the girls and the boys. The girls pushed me out because I acted too much like a boy and I didn't like the music they liked, and the boys pushed me out because I was a girl. I was stuck on my own". Alex. Lines 223-226.

Cyrus changed school because of the discrimination and bullying he experienced:

"I was manage-moved from my school when I was in mid-year 8 for bullying issues with ex-stepsiblings, which led to a lot of homophobic and transphobic bullying that I deal with. At the time, just after that, my dad disowned me." **Cyrus. Lines 122-127.**

Cyrus explains that it was initially his stepsiblings who began to bully him, and because they were popular, other pupils at the school continued this. This is confounded by his father's rejection of him who he describes as being "very anti LGBT" (Cyrus. Line. 245). Sophie also experienced overt discrimination from her family. Her mother describes how initially Sophie told her family that she was bisexual and received this response from her paternal grandmother:

"So, it was basically, you first came out as bisexual, didn't you? Then his grandma said, what was it? "At least you are not transgender, because I would have a problem with that." Sophie's mother. Lines 232-234

Although Rod required some support for his mental health, he appeared to be the least impacted compared to other participants. In contrast to some of the other participants experiences of rejection from some family members, his experience was unique in that he did not experience rejection, but in contrast described feeling supported by his family:

"I mean, at first it was definitely hard for them, like really. But they tried a lot and we finally got to a point where I am being called the correct name, the correct pronouns, even if it is they, them pronouns, they are still correct. I don't mind going by them. And they changed my name. They have sent me to the support groups. They are awesome." Rod. Lines 709-713.

It does appear that the acceptance and support that Rod received from his family enabled the development of his own acceptance of his gender identity.

Understandably, participants grappled with the desire for acceptance from others outside of family, and shared feelings of frustration and upset when this is not given. Rod refers to 'dead naming' many times throughout his interview. I was interested to hear what this term meant to him:

"Dead naming is where you purposely call someone by their name that they were born with when they have told you that they go by a different name" **Rod. Lines 602-604.**

Rod seemed equally offended and upset by being called his birth name. It does seem to imply a desire for the death of his previous identity and to replace it with a rebirth, a new identity. Perhaps, to be referred by his birth name not only invalidates his belief, but it also reinforces a lack of understanding and acceptance by others. Therefore, for Rod, it is not only about his own feelings of being transgendered, but it is also the acceptance from others which feels equally vital. The participants shared that 'coming out' to parents, family and friends was anxiety provoking for them; they were often unsure of the reaction they would receive. However, "coming out" is not necessarily a single occurrence and that essentially, when they meet new people and access new services, it can feel like 'coming out' all over again, with a resurgence of anxiety. Cyrus illustrates this by providing an account of the first time he went to CAMHS:

"So in the beginning it was hard because on the desks and when you first go in and first appointment and stuff was hard, because they hadn't been told my preferred name, they hadn't been told my pronouns or anything at that point. Cyrus. Lines 540-545.

Cyrus explains that it "was hard" that staff did not know his preferred name or pronoun. Cyrus explains further within the interview that once CAMHS staff were aware, there were no problem with his preferred name and pronoun from that point. Entering a CAMHS service for the first time is one of these 'coming out' moments. Stepping through the door as a new CAMHS patient may be already quite daunting for young people, However stepping through as a transgendered young person does appears to add another level of complexity and anxiety. There is clearly an increased difficulty of accessing a CAMHS service as a transgender person. Rod describes the difficulty of choosing between going into a female or male bathroom:

"I definitely feel uncomfortable going into the female bathrooms. All the time, because I think I get dirty looks if I go into the female bathrooms because I definitely [prove 0:19:06] then more masculine than feminine. But if I go into the men's bathrooms, I am slightly worried that I might be judged there if I look more feminine. I mean, it doesn't really bother me, but I am definitely not going into the women's bathrooms any time soon. So, going into the men's bathrooms, absolutely fine." **Rod. Lines 376-382.**

He decides to choose the male bathroom although worries that he may be judged if he looks feminine. As well as the process of realisation of one's gender identity and subsequent challenge of receiving acceptance from others, one's own acceptance seemed to be an essential next step for the participants. Julia illustrates the difficulty she had with her acceptance:

"When I first went into CAMHS, I did not really know- Well, I did, but I was not accepting it. I was not accepting it myself. I was, to put it nicely, a bit of a [___ 0:46:29] (Laughter) when it came to gender stuff" **Julia. Lines. 968-971**

It is unfortunate that the audio cuts out as it would have been interesting to know what name Julia refers to herself. She proceeds to explain how, with the support of CAMHS she has become more confident about presenting as female:

"It's a bit of a struggle, but friends have fully supported me and helped me with most of my issues. I think, if I didn't have the support of CAMHS, I wouldn't be in the position I'm in right now, I would still be struggling, not confident, not ready for, like… I always accepted myself but I wasn't presenting as myself fully when I first realised". **Julia. Lines 53-57**

Similarly, Ari describes the difficulty of being transgender at school until he decides to fully claim his identity:

"School was the hardest. Someone found out through one of my mates and spread it around the school, so I got bullied a lot. This was in Year 9. Yes, Year 9. Then the 6-week holidays, going from Year 9 to 10, I got my hair cut. I just decided to turn up in Year 10 as a boy". **Ari. Lines 830-833**

I was struck by Ari's description of deciding to take matters in his own hands and cut his hair before returning to school. The haircut appeared to serve as his 'Samson' moment, and rather than deplete him, as it does for Samson, it gave Ari courage to face up to the school bullies and claim his gender identity. One's own acceptance of gender identity was also bolstered by hearing of other's experiences. Rod found that watching YouTube videos of trans people who were confident helped him:

"I guess it means a lot knowing that there are people going through the same stuff as me" Rod. Lines 442.

Most of the participants hopes for the future involved being able to transition and 'pass' as the desired gender. In their minds, living and being accepted by society would reduce anxiety and depression. Julia shares her future plans:

Julia: ***"I'm hoping to get sex reassignment as well as some plastic surgery, as soon as I can."***

Interviewer: ***"What would the plastic surgery be?"***

Julia: ***"Just like some of the things I'm insecure about, like my Adam's apple and my brow bone, and things like that."***

Cyrus shares his future hopes:

"So my hope for the future is to get surgeries and get on hormones. You know, just live my life properly without the constant stress of not knowing how people are going to see me". Cyrus. L. 501-505.

Rod shares his happiness of 'passing' as a boy by a new friend he had met:

"I mean, I was fine with it. I was laughing because he didn't realise, but I was like super-thankful of him. And I don't really think he understood at the time why I was really appreciating what he had said because I mean, it really meant a lot, and it still does". **Rod. Lines 524-528.**

Rod conveys the importance of being seen and accepted as male. Ari also shares the importance of this:

Ari: ***"I'm not going to lie, a lot of them do not have a clue I am trans."***

Interviewer: ***"Do you mean that they see you as male?"***

Ari: ***"Yes, they think I was born male and they don't have any idea at all."***

Interviewer: ***"What do you think about that?"***

Ari: ***"I love it. (Laughter) That's the goal. The goal is for them to see who you are and them not having any idea and seeing you for who you are without having a past opinion on you and knowing your past. It's genuinely the best thing ever."*** **Lines 948-960.**

As well as there being an acceptance of being transgender or non-binary, participants have been helped by CAMHS to tolerate (and some extent accept) the waiting involved in the transition process. Cyrus explains:

"But CAMHS has helped me get closure with that, too. You know, sort of, in a sense, relieving some of my anxiety around the fact that I know that I can't change anything for now." **Cyrus. Lines. 288-292.**

Alex shares that they are accepting of 'not knowing' what their gender is and does not need to necessarily define it:

"Yes, but I have no clue. Honestly, at this point it feels like people are more worried about my gender than I am. A while ago I identified as a trans guy because a lot of people told me, "Oh yes, you seem like a trans guy." Unfortunately, because of peer pressure, I ended up just saying that because I didn't want to hurt anybody, because I was just like, "That's the easiest thing to explain." At the moment -I talked to my mum about this recently – honestly, I don't know what my gender is and I think I'm alright with that." Alex. Lines 271-279

Discussion

Participants shared their experiences of being gender variant describing how they have all encountered confusion, discrimination, and bullying. All the participants shared that they had felt different as children but lacked the understanding and vocabulary to explain it. Ari compares the childhood 'monster in the closet/room" metaphor to explain his realisation of being transgendered; at some point children realise that there is not a monster there, just as he realised that he was transgender. Several of the participants emphasize that their gender identity was latent and a discovery, of who they really are. Ari illustrates this when he tells me about his goal regarding his gender identity: "The goal is for them to see who you are" Lines. 956-957. This suggests that it was for the participants a discovery of something which is already known, albeit not fully understood.

Consistent with Steensma et al (2010) study, participants did not seem to have given their gender identity much thought during early childhood. Most of the participants acknowledged/realised their gender identity around adolescence. It was noticeable that this was the time when the participants mental health issues first became noticeable, and overwhelming. Social ostracism and poor peer relations experienced in childhood or early adolescence due to gender identity issues have been shown to lead to greater relational and emotional difficulties which emerge during adolescence (Zucker et al (2002). The emergence of puberty appears to have been the catalyst for the participants to begin to explore and question, what they had previously experienced as difference when they were children. Accessibility to the internet and social media seems to have helped the process of reaching some understanding, and for many of the participants the online descriptions of transgender and non-binary appeared to have been illuminating, providing much needed vocabulary and answers. The participants had all shared their gender identity with family and peers by early adolescence. However, accessing new places and meeting new people invariably raised anxieties in some of the participants. For example, the necessity of telling CAMHS about one's gender variance status will immediately cause discomfort.

All of the participants experienced forms of discrimination and rejection; most were at school, a few were familial, and then more generally in the community. Initially, my countertransference feelings were of disappointment, anger, and a desire to protect after hearing that Cyrus was the one to change schools because of bullying. It was surprising that Cyrus appeared accepting that he should be the one to leave his school and find another; I wondered about the apparent absence of his own sense of injustice or outrage which were projected and then held by me instead. Some feelings can be too painful to hold and attempts to rid one of the pain is not uncommon. Perhaps, this difference was felt by the (later) rejecting parent and in turn projected to their child. Such an early and key rejection is significant and alongside societal and peer discrimination, produces considerable anxiety and a sense of shame in a gender variant young person.

I have further questioned my views prior and since conducting the interviews, influenced by the principles of unconscious bias. I have reflected upon being a child in the 80s and 90s, and recalling overt discrimination, in society as well as by members of my family. These incidents will continue to influence me, and although I may not believe myself to be a person with discriminatory views, I have no-doubt that my unconscious bias will inform my interactions. Undoubtedly, young people questioning their gender identity will have been, and will continue to be exposed to prejudice and discrimination, whether it is overt or more subtle, which they have likely internalised arousing feelings of shame.

The participants own acceptance of their gender identity was one of the most difficult challenges for them to overcome. Ari's compares his discovery of being transgender with the child's imaginary monster; there are possible parallels to both: something which is terrifying, likely to consume them and invisible to adults. The child's fear of the monster can also be dismissed and invalidated by the adults. Similarly, the participants experience of being transgendered or non-binary, may feel as if their feelings are not only invalidated but also ridiculed, bullied, and discriminated against. Monsters are invariably hunted which is not dissimilar to the experience of transgender or non-binary people where verbal and physical assaults are not uncommon. Although, Ari might be outwardly accepting and proud

of his gender status, it is telling that he links transgender with that of a monster, something which may be viewed as both scary and ugly. Shame has regularly been cited within gender variance literature as a key cause of presenting mental health difficulties. Experiences of bullying, rejection and discrimination may lead to feelings of difference and shame becoming internalised. Indeed, participants gender identity may often feel inextricably linked to feelings of shame which is often defended against with displacement leading to symptoms such as depression, rage, and contempt (Morrison, 1989). Most of the participants experienced suicidal ideation and depression and approximately half of them self-harmed, including Ari who self-harmed due to feeling disgust about his body.

Morrison (1989) points out that the patient's shame can feel contagious, in that the patient will experience strong counter transference feelings of shame which can lead to the therapist colluding with the patient's own defences. It is possible that as clinicians we are more likely to rush into treating symptoms and providing medical interventions first before thinking about the patient's underlying difficulties, including their internalised shame. My own countertransference at times was of indignance about the participants experience of discrimination, and I was in touch with their distress and desperation to receive treatment that I could find myself feeling frustrated about the process and the long wait to be seen by GIDS. This was most acute, with the male to female patients where it did feel that time was of the essence as the puberty effects were most difficult to conceal.

All participants shared the desire to be considered 'normal' and to pass in one's chosen gender. Although, most of the participants were aware of their gender identity at the time of referral to CAMHS, most were struggling with their own acceptance, which seems to be a vital aspect of transitioning. Most of the participants did report a reduction of mental health difficulties and an increased confidence after socially transitioning. This corresponds with Durwood et al's (2017) study which provided some evidence that the social transition for children appears to alleviate symptoms of depression and anxiety.

Two of the participants, Alex and Sophie wanted their mothers to join their interviews. It served to provide support and for both, their mothers became their mouthpiece. Their mothers would often answer the questions or provide more detail to their views and clarifying. It was as if the participants were merged with their mothers and lacked their own independence and capacity to engage with the interview as a separate individual. Winnicott (1965) proposed that there is an initial state of merger between the infant and their primary caregiver (usually the mother). However, the developmental task of an infant is to tolerate separation from the mother. Winnicott (1965) attributed excessive identification with mothers as an explanation for the development of male childhood transsexualism.

Chapter 5: Conclusion

Findings

This service evaluation has sought to decrease the gap of qualitative research with young people with gender dysphoria. Current policies emphasise the importance of service user participation within the NHS, therefore it was particularly important that young people were able to provide their thoughts and opinions about the service that they are receiving. This is a particularly under-developed area within gender dysphoria as most studies conducted regarding young people are quantitative using data obtained from parent questionnaires.

The experiences and thoughts of young people presenting with gender dysphoria within a child and adolescent mental health service have been explored. Six participants aged between and 13 and 17 who had all experienced a service from CAMHS for a minimum of 6 months took part in semi-structured interviews. After the interviews were analysed using an interpretative phenomenological approach three themes were identified: 1. Will CAMHS Help me? 2. Merging of Mental Health and Gender dysphoria and 3. The Transgender Journey.

Participants shared their scepticism about whether CAMHS would help which were based on three factors, first they had heard negative accounts from others about CAMHS, second, they had not been helped before and third, their own difficulties of accepting help impacted what they would be able to accept. The participants previous experiences of discrimination and rejection clouded their initial feelings, but for the most part they were able to develop a relationship with their CAMHS key worker where they felt supported. The opportunity to speak freely was highly valued. They all said that they would have welcomed the opportunity to have explored their earlier feelings about their gender variance with someone. The majority of the participants said that they felt that CAMHS had helped them, with significant improvements described.

The second theme was of the merging of mental health difficulties and gender dysphoria. The participants all shared that their mental health difficulties either emerged during a time they were first realising they were gender variant or that it deteriorated after this point. The participants themselves linked their difficulties to their gender dysphoria. The presenting difficulties were consistent with findings from empirical studies, and from papers written about gender dysphoria. Most of the participants shared that they required support for suicidal ideation, depression, and anxiety. Many of the participants also attributed their difficulties specifically to bullying, and the rejection from others. Wider discrimination, or perceived judgement from others as well as familial rejection were also contributing factors to the participants wellness.

The third theme was of the participants' transgender journey. One's own acceptance was a necessary achievement and essential stage of the participants overall journeys, supported by CAMHS and other services which largely contributed towards their mental health recoveries. Participants described feelings of difference and shame which over time and with support from CAMHS and other services they seemed to reach a point of acceptance, both about their own feelings about their gender identity and of the gender transitioning process. The claiming of one's gender identity and social transitioning does appear to have reduced participants mental health difficulties and contributed towards their own acceptance and confidence. However, the female to male transgender participants struggled the most with the long wait at GIDS. Many of the participants shared that they liked when they 'passed' as their preferred gender. However, again this also appeared to be more difficult to achieve for the two male to female transgender participants, especially as they had developed masculine bodily features. They were more likely to be anxious of others perception and struggled with social anxiety.

Significance and Implications of the Findings

According to Di Ceglie (2009) 20% of pre-pubertal children will persist with gender dysphoria into adolescence. This suggests that some uncertainty and exploration of one's gender is a common occurrence in children. There is an identified need for children and young people with gender dysphoria to have an opportunity to reflect upon their thoughts and feelings during their journey (Doward, 2019). The findings support this and emphasise the importance of CAMHS being alongside young people with gender dysphoria who also experience mental health difficulties. The participants mental health deteriorated during adolescence, so providing an opportunity for them to access support prior to adolescence or early adolescence is crucial. This may be achieved through the provision of mental health professionals at school or in the community, which may form part of supporting exploration of one's gender identity and acceptance, as well as intervening with practical sources of help, e.g., bullying at school.

Participants emphasised the process of 'discovering', rather than 'questioning' their gender identity. This assertion suggests that participants feel that their gender identity is innate. Any rhetoric or exploration which overtly challenges this stance is likely to be immediately rejected, in contrast most of the participants valued and benefitted from exploring their feelings with their CAMHS key worker or a Local Authority youth worker. A lack of capacity to symbolize and a rigidity of thought has been linked to gender variant young people However it was not the author's experience that the participant's struggled with these skills, in contrast most were able to put themselves in other's shoes and seemed to possess reflective capacities. All the participants persisted with their gender dysphoria into adolescence and said that they would have benefitted from exploring their gender identities when they were first beginning to discover it. Therefore, providing gender variant young people, with this opportunity particularly when they are first struggling with their gender identity, is likely to be welcomed.

The concept of Henry's (1974) double deprivation was pertinent to the participants perception and willing to engage with CAMHS. Previous experiences of bullying, discrimination, and rejection meant that many of the participants were sceptical of the help that CAMHS could provide them. Services such as CAMHS may be inclined to close the referral if they feel that there is a lack of engagement, and they deem it safe to do so. This was the implication that Alex provided about why he was first discharged from CAMHS before his risk increased and he was re-opened. It appears to have caused further distrust and strain on his relationship with CAMHS. Fortunately, in most cases the participants were able to build and develop a relationship with their CAMHS key worker. Moreover, the participants shared that they valued and benefitted from having a relationship with their CAMHS key worker. The opportunity to talk about 'anything' felt particularly important. It is therefore necessary that time is given to help a young person with gender dysphoria to support engagement and make use of the support offered.

Participants linked their mental health to both their gender identity and experiences such as bullying and discrimination. Participants appear to have internalised shame which is one of the most debilitating aspects for them to manage. Any physical intervention is unlikely to help the internal feelings which are the root cause of the distress. Shame may be displaced and often manifest as a bodily issue, therefore, surgery and other medical interventions may not alleviate the sense of shame (Levin, 1971). Whilst the participants emphasised their future hopes of fully transitioning, opportunities for them to reflect about their desires and hopes, as well as questions and uncertainties they may have, is an essential aspect of any NHS support package to young people with gender dysphoria.

The desire to form a close relationship with a key worker was shared by the majority of the participants. Ari described his desire to experience a 'click' with his CAMHS key worker and requested a change of worker in order to achieve this. Eminent psychoanalysts Klein, Bion, Winnicott, and Bowlby all provided key concepts towards the understanding of an early dyadic experience for the infant's development. There is a growing view within mental health that some of the struggles experienced by transgendered or non-binary people is in

consequence to object relations and attachment difficulties, and identity incongruence is becoming increasingly attributed to some gender dysphoria cases. (Stoller, 1968, Lemma, 2013, Wright, 2018). The caregiver's capacity for mirroring and containment is seen as essential for the establishment of the infant's sense of worth and identity. It is possible that there was a desire from some of the participants for their relationship with their CAMHS key worker to resemble something more akin to an early optimal dyadic relationship.

Gender identity research and knowledge is evolving all the time (Wright, 2018) which is not dissimilar to the rapid physical and emotional changes experienced during adolescence. As a result, CAMHS clinicians may feel easily 'out of touch' with new developments particularly at a time where gender identity is increasingly polarised and controversial. Although, one participant did recommend that CAMHS staff could be more knowledgeable in this field, overall participants valued a clinician who was alongside them in their journey and provided them with space to talk. However, it can only be beneficial that CAMHS staff feel adequately trained to work effectively with any service user group. Services may also be unconsciously contributing to perceptions that gender dysphoria is as an illness by their processes, for example, there were a couple of participants who appeared to solely attribute their gender identity as the reason for their GP referral to CAMHS. Young people with gender dysphoria should be informed that their referral to CAMHS is regarding their presenting mental health difficulties e.g., depression rather than specifically pertaining to their gender identity.

There are further clinical implications which have arisen from this service evaluation about working with young people who are exploring their gender identities. The complexity of working with this group has been explored and demonstrated theoretically, through clinical material and from the interviews and analysis of the participants. The participants emphasized the importance of building a therapeutic relationship with a clinician where they had the opportunity to explore their gender identities. This exploration is an essential part of not only helping the young person to understand themselves, and their gender identities but it also will help to reduce overall risk to self. Child and adolescent psychoanalytic psychotherapists possess skills and knowledge which could be utilized to

provide supervision of and support for non - CAPT colleagues undertaking direct work. In particular, supervision would allow a clinician to understand communication from the young person which may not be initially clear, and to explore the transference and countertransference in the room, which may be unintentionally causing blocks in the relationship and treatment.

The Implications of Covid

This service evaluation was designed prior to the Covid 19 pandemic and subsequent lockdowns which considerably impacted the service provided by the CAMHS this author was based within. CAMHS is an already stretched service, often crisis driven However during this time there were reduced resources to engage and build meaningful relationships with patients. CAMHS clinicians were not routinely (except risk assessments) offering face to face appointments, instead offering telephone or video calls. It had always been planned that this service evaluation would undertake face to face interviews with patients However this was not possible, and telephone interviews were provided instead during lockdown. It was difficult to recruit young people who met the eligibility criteria and there were occasions when I thought that I would not be able to recruit a sufficient number of young people. It is perhaps testament to the relationships that the key workers had already developed with the participants that they agreed to take part in this service evaluation. It could have been a time where some young people may have withdrawn, but these six participants engaged with the process and felt that it was important to share their views.

The Specific Benefit of the principles of 'Experts by Experience' through the use of Semi-Structured Interviews and undertaking an IPA of the Transcriptions.

One of the weaknesses of many studies undertaken about young people with gender identity issues is the lack of both qualitative data and the absence of young people's own experiences and views. Therefore, it was important to undertake a qualitative study which sought to redress this imbalance. The principles of 'Experts by Experience' underpinned

the research methodology implemented through the inclusion of semi-structured interviews and IPA.

Although, there were questions asked as part of the semi-structured interviews, a relational dynamic was created, which enabled participants to expand upon and free associate allowing for a true reflection of the participants experiences to be captured. The author's countertransference could also be thought about, which again resembles the processes within a psychotherapy appointment. The use of IPA also enabled 'Experts by Experience' principles to be used as it seeks the interviewer to place yourself in "the participant's shoes", gaining a deeper understanding of their experiences. The interviews yielded rich data and the use of IPA provided unique insights into the participant's world and experiences. The author's use of countertransference provided an additional emotional communication which enhanced overall understanding.

Strengths and Limitations

This service evaluation interviewed six young people who identified as transgender or non-binary between the ages of 13 and 17. It is a small sample, and it is arguable that there is the potential for more reliable patterns to emerge when there is a larger sample. The confines of this service evaluation did not allow for a larger group size; However, the advantage of a smaller sample is that it can provide rich and detailed data consistent with the underpinnings of IPA (Pietkiewicz and Smith, 2014).

The difficulty of recruiting participants during Covid has been explored, it is therefore likely that as well as wishing to share their experiences of CAMHS, they may have also wanted to please their key worker. It is likely that the participants engagement and relationship with their key workers was a factor in their decision to participate. However, the experiences and views that were provided by the participants outweigh this possible limitation.

Gender dysphoria is very much a bodily experience; a disconnect between one's actual body and self-perception. It is interesting to note that the participants physical body was absent from this study due to the impact of Covid 19. The replacement of face-to-face interviews with face-to-face interviews might have enabled greater opportunity to reflect on the counter transference, of what was 'felt' and explore any disparity between what was being said with what the participants body language was communicating. It is possible that by seeing the participants the author may have regarded them differently e.g., male/female, forming her own opinion more readily due to unconscious bias. It is also possible that telephone interviews allowed the participants to feel more confident and less exposed, than if they were meeting face-to-face.

Another limitation which was exacerbated by Covid was the lack of triangulation which would have been obtained from the participants completing the SDQ questionnaires. Participants failed to complete the SDQs and as contact was undertaken solely via telephone and email it was difficult to pursue this. Face to face interviews would have enabled SDQs to have been completed prior to an interview. It would have been useful to have compared the SDQ measurements with the themes obtained through the method of IPA and strengthened any of the findings.

The strength of this service evaluation has been the opportunity to interview and gain young people's views directly from them. There is limited research where young people's views are ascertained, and less involving young people with gender variance. Therefore, it provides a unique insight into the participant's world and experiences offering significant contributions to our understanding of gender dysphoria.

Suggestions for future research in GID

There has been some speculation that for many transgender people, choosing to become a different gender alleviates feelings of homosexuality. In some cases, individuals and family

members may hold the view that it is unacceptable to be homosexual; transgenderism offers a solution to this issue, and the shame associated with their sexuality. The participants did not explore this within their interviews, and it has therefore not been possible to explore within this study.

The manifestation of shame has been explored, in consequence to the experience of a less than optimal early dyadic experience and in consequence to experiencing discrimination. It is likely that one cause of gender dysphoria does not exist but there are many factors. However, studies which explore the role of shame further would be useful.

The male to female participants, Julia and Sophie appear to have experienced a greater degree of social anxiety, in respect of their bodies than compared with the female to male participants. It is likely that this is in part due to the difficulty of disguising male bodily features during/after puberty than it is for the female born participants. It might also be that society may possess a less hostile, and more accepting views of male to female gendered identities. This could be a factor which directly correlates to the severity of mental health difficulties, and one which could be explored within future research.

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Appendix One: Young Person Information Sheet

Young Person Information Sheet

I would like to invite you to take part in my service evaluation study. Before you decide, I would like to give some information which tells you about the study and what it would involve for you. Please take time to read this information and discuss it with others if you wish. If there is anything that is not clear, or if you would like more information, please do not hesitate to contact me.

Title of the Service Evaluation: What expectations and hopes do young people presenting with gender dysphoria have about CAMHS? Are we meeting these expectations?

Your Participation

I would like to meet with you where I will ask you questions about your experiences prior to and while you have attended CAMHS. The semi-structured interview will be recorded and will last approximately between 50 minutes to 1 hour and 15 minutes. I would also like you to complete a Strengths and Difficulties Questionnaire (SDQs) prior to the interview. This is routinely used within CAMHS and you should have been asked to complete this within the first appointment. I will then compare both SDQs to see whether there has been track any change.

Purpose of the Study

I will be evaluating the expectations and experiences of accessing CAMHS by young people with gender identity dysphoria or who are querying their gender. I am interested in what can be learned from your experiences and views and would then like to share this thinking with other professionals so that they can use what has been learned to help other young people in the future.

The service evaluation is part of a Clinical Doctorate I am undertaking at the Northern School of Child and Adolescent Psychotherapy in Leeds, which is a national centre for the training of child and adolescent mental health professionals and is also a major provider of

mental health services. The service evaluation has received formal approval from the Tavistock and Portman Trust Research Ethics Committee (TREC).

Consent and Confidentiality

Your involvement in the study is voluntary and you do not have to agree to participate in this study if you do not want to. You are free to withdraw consent at any time, and to withdraw any unprocessed data previously supplied e.g., interview and your participation will make no difference to any further treatment that you may receive in the future.

There are limitations in confidentiality where disclosure of imminent harm to self and/or others may occur. I will adhere to (deleted) NHS Trust's safeguarding policies.

The number of participants undertaking the study is small which may have implications for confidentiality / anonymity. I will change your name and other details so that you will be anonymised in as far as possible in order to reduce the likelihood that anyone will be able to recognise you or your family. The data generated in the course of the study will be retained in accordance with The Tavistock and Portman NHS Foundation Trust data protection policies.

If you wish, I will provide you with the factual statements I make about you and with information about the way I have changed your details. If you were to disagree with these, we would arrange a meeting together in order to discuss how best to accommodate your views. If you have any concerns about the conduct of the investigator or any other aspect of this service evaluation, you can Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk)

Appendix Two: Parent Information Sheet

Parent Information Sheet

I would like to invite (name of yp here) to take part in my service evaluation study. Before a decision is made, I would like to give some information which tells you about the study and what it would involve for (name of yp here). Please take time to read this information together and discuss it with others if you wish. If there is anything that is not clear, or if you would like more information, please do not hesitate to contact me.

Title of the Service Evaluation: What expectations and hopes do young people presenting with gender dysphoria have about CAMHS? Are we meeting these expectations?

Participation

I would like to meet with (name of yp here) to carry out a semi-structured interview which will last approximately 50 minutes to 1 hour and 15 minutes. I am interested in learning about (name of yp here) experiences prior to and while attending CAMHS. I would also like (name of yp here) to complete a Strengths and Difficulties Questionnaire (SDQs) prior to the interview. This is routinely used within CAMHS and (Name of yp here) should have been asked to complete this within the first appointment. I will then compare both SDQs to track any change.

Purpose of the Study

I will be evaluating the expectations and experiences of accessing CAMHS by young people with gender identity dysphoria or who are querying their gender. I am interested in what can be learned from their experiences and views and would then like to share this thinking with other professionals so that they can use what has been learned to help other young people in the future.

The service evaluation is part of a Clinical Doctorate I am undertaking at the Northern School of Child and Adolescent Psychotherapy in Leeds, which is a national centre for the training of child and adolescent mental health professionals and is also a major provider of mental health services. The service evaluation has received formal approval from the Tavistock and Portman Trust Research Ethics Committee (TREC).

Consent and Confidentiality

This study is voluntary and (name of yp here) does not have to agree to participate in this study. (Name of yp here) is free to withdraw consent at any time, and to withdraw any unprocessed data previously supplied e.g. interview and participation will make no difference to any further treatment that (name of yp here) may receive in the future.

There are limitations in confidentiality where disclosure of imminent harm to self and/or others may occur. I will adhere to (deleted) NHS Trust's safeguarding policies.

The number of participants undertaking the study is small which may have implications for confidentiality / anonymity. I will change the name of (name of yp here) and other details so that s/he will be anonymised in as far as possible in order to reduce the likelihood that anyone will be able to recognise him/her or your family. The data generated in the course of the study will be retained in accordance with The Tavistock and Portman NHS Foundation Trust data protection policies.

If you wish, I will provide you and (name of yp here) with the factual statements I make about him/her and with information about the way I have changed their details. If you were to disagree with these, we would arrange a meeting together in order to discuss how best to accommodate your views. If you have any concerns about the conduct of the investigator or any other aspect of this service evaluation, you can Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk)

Appendix three: Young Person and Parent Consent Form

<u>Participant Consent Form</u>

NAME OF PARTICIPANT:

Title of the Service Evaluation: What expectations and hopes do young people presenting with gender dysphoria have about CAMHS? Are we meeting these expectations?

1. I agree to take part in the above research. I have read the Participant Information Sheet for the study. I understand what my role will be in this service evaluation, and all my questions have been answered to my satisfaction.

2. I understand that that my involvement in the service evaluation is voluntary; I am free to withdraw from the service evaluation and withdraw any unprocessed data previously supplied, without giving a reason.

3. I am free to ask any questions at any time before and during the study.

4 I understand what will happen to the data collected from me for the service evaluation (this can be found within the Participant Information Sheet).

5. I have been provided with a copy of this form and the Participant Information Sheet.

6. I understand that anonymised quotes from me may be used in the service evaluation.

7. I understand that the interview will be recorded.

8. I understand that there are limitation in confidentiality where disclosure of imminent harm to self and/or others may occur. The investigator will adhere to trust policy and procedures.

Data Protection: I agree to the processing of personal data which I have supplied. I agree to the processing of such data for any purposes connected with the service evaluation as outlined to me*

Name of participant (print)…………………………Signed………………..….Date………………

Name of person
witnessing consent (print)…………………………..Signed………………….. Date………………

(This should be the parent/guardian for participants under 16)

PARTICIPANTS MUST BE GIVEN A COPY OF THIS FORM TO KEEP
ADD DATE AND VERSION NUMBER OF CONSENT FORM.

PTO

I WISH TO WITHDRAW FROM THIS STUDY.

If you wish to withdraw from the service evaluation, please speak to the investigator or email them at (deleted) stating the title of the service evaluation.

You do not have to give a reason for why you would like to withdraw.
Please let the investigator know whether you are/are not happy for them to use any data from you collected to date in the write up and dissemination of the service evaluation.

Appendix four: Participant Interview Proforma

Interview Proforma

Title of the Service Evaluation: What expectations and hopes do young people presenting with gender dysphoria have about CAMHS? Are we meeting these expectations?

Opening:

Information about what to expect from the interview, duration and reminder that they are able to stop the interview at any point. Reminder about confidentiality.

Prompts (to be used throughout the interview): (When you say….), (What do you mean by….), (Can you tell me a bit more…), (Ok, so you're saying….).

Referral

1. Can you tell me how you came to be referred to CAMHS?
2. How did you feel about the referral?
3. Did have any hopes or expectations about being referred?
4. Did you have any worries or concerns about being referred?
5. Did you have an idea of the help you would like to receive?
6. How do you feel about the referral now?

Exploration of difficulties

1. What is your understanding of the reasons for the referral?
2. Can you tell me how those reasons/difficulties have affected you?

Gender Identity

1. Can you tell me when you first began to question your gender identity?
2. Can you tell me what it has been like for you from then until now? At school, with family?

Experience of CAMHS and treatment

1. What is your general experience of CAMHS?
2. What is your relationship like with your key worker? Other CAMHS staff?
3. Do you feel that staff have been appropriate and respectful about your gender identity?
4. Have your hopes and expectations of being referred to CAMHS been met?
5. Have you received the support or treatment that you wanted?
6. What treatment have you received?
7. Has it helped? How has it helped?
8. Is there anything different that CAMHS could have done to support you?
9. Is there anything else that you would like to add?

Future Hopes

1. What are your hopes for the future concerning your mental health/emotional difficulties?
2. What are your hopes regarding your gender identity?

De-brief

Check -in with the participant to see how they are following the interview. Information about what will happen with the information. Explanation of who to contact for support and contact details for further questions.

Appendix five: Table of IPA Analysis

Participant:

Exploratory comments Don't summarise or interpret, just state describe what the person is talking about.	Line no.		Emerging themes What meanings emerge from the exploratory comments?
	1		
	2		
	3		
	4		
	5		
	6		
	7		
	8		
	9		
	10		
	11		
	12		
	13		
	14		
	15		

Appendix Six: Example of IPA Themes Table

IPA Themes Table

Super-Ordinate Themes	Sub - Themes	Countertransference