Carmichael, Polly and Davidson, Sarah (2009) *A gender identity development service.* The Psychologist, 22 (11). pp. 916-917

We work in the UK service based at the Tavistock Centre in London, offering assessment and intervention for children and adolescents experiencing difficulties with their gender identity development. In addition, we work with children with a transgendered parent. The multidisciplinary team includes clinical psychologists, psychiatrists, social workers and child psychotherapists, working in association with two consultant paediatric and adolescent endocrinologists at UCLH who provide regular adolescent liaison clinics.

Our assessments consider the holistic context of such a presentation, including the history of the gender dysphoria, the family history and young person's developmental and medical history, the attitudes

of the family and school, and sources of stress and supports. We particularly focus on areas of gender identity such as the young person's identity statements, cross-dressing, toy and role-play, peer relations, mannerisms and voice, anatomic dysphoria, and rough-and-tumble play (Zucker &?Bradley, 1995). We also include risk assessments around any self-harm and possible suicidal ideation and, with the family's permission, liaise with any local services and the school.

The service operates a network model of care, and team members regularly convene and attend local meetings to discuss the needs of the young person in relation to their gender identity development, and agree roles with all involved professionals.

Following our assessment, we might recommend family and/or individual work to monitor the gender dysphoria and address associated difficulties, such as low mood and distress and problems with bullying and stigma in the family, local community or school. We also work closely with schools and local services in order to reduce shame and secrecy, consider the boundaries between what is public and private with regard to information sharing and to manage risk and promote support and coping. Our interventions involve a staged model of care, which include:

Stage 1: Following assessment, further therapeutic exploration of the nature of gender identity. In adolescents, reversible physical interventions are considered if their gender identity disorder (GID) persists and shows a high level of consistency.

Stage 2: Includes wholly reversible intervention to produce a state of biological neutrality – known as hormone-blocking treatment. This occurs alongside continued psychological exploration, support

and physical monitoring by a consultant paediatric endocrinologist.I Stage 3: Is considered if the GID persists during Stage 2. Includes partially reversible interventions, e.g. the administration of cross-sex hormone that masculinises or feminises the body.

Stage 4: Includes irreversible interventions, such as surgical procedures. This is not considered before the age of 18, and so the Gender Identity Development Service would facilitate a smooth transition to the adult Gender Identity Service who are able to provide these interventions. Transfer to adult services would usually happen prior to the introduction of cross-sex hormones.

The figures usually quoted suggest that for individuals presenting with GID prior to adolescence about 80 per cent do not persist and find a solution other than gender transition. The most common outcome in this group is homosexuality and bisexuality. Conversely for those who present to the service in adolescence the figures are reversed and about 80 per cent pursue physical sex re-assignment. The recent newspaper articles assume that allowing the young person to live in a role of their perceived identity necessarily leads to gender reassignment. Our experience shows that some young people who lived in role from the age of nine or ten changed during their pubertal development.

There is currently much debate around the timing of physical interventions. In a number of countries in Europe and America the hormone blocker is being offered in earlier stages of puberty. If the young person decides not to pursue physical gender reassignment the blocker is stopped, and their own sex hormones resume. But the debate revolves around the reversibility of this intervention – physical and also psychological, in terms of the possible influence of sex hormones on brain and identity development.

Zucker, K.J. & Bradley, S.J. (1995). Gender identity disorder and psychosexual problems in children and adolescents. New York: Plenum Press.