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Working systemically with trans, non-binary and gender expansive people

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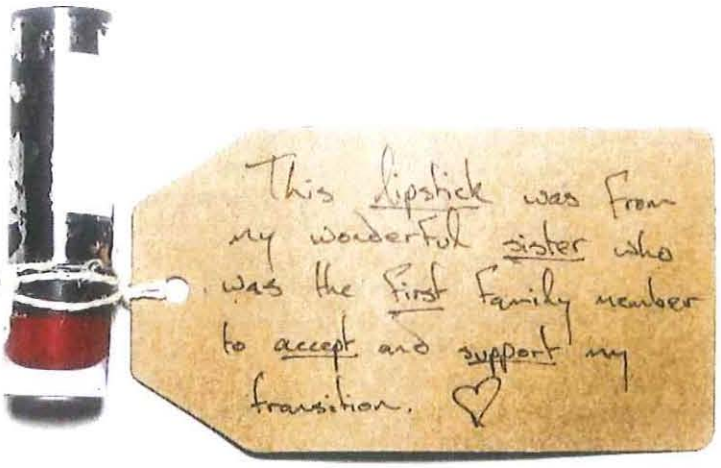
An invitation to explore: *A brief ove*
Gender Identity Development Service

Jason Maldonado-Page and Sarah Favier

Introduction

The Gender Identity Development Service (GIDS) was established in 1989 and is located in the Tavistock and Portman NHS Foundation Trust with two offices in London and Leeds. It provides a holistic and integrated service alongside the endocrinology departments at the University College London Hospital and Leeds General Infirmary. It is the UK's only nationally commissioned highly-specialised NHS service supporting the emotional and physical health needs of gender-diverse children, adolescents, and children of transgender parents. The service had a 100% increase in referrals between 2015 and 2016. It offers a multidisciplinary perspective drawing from a clinical team of qualified, experienced and dedicated systemic and family psychotherapists, clinical and counselling psychologists, child and adolescent psychotherapists, clinical social workers, child and adolescent psychiatrists, paediatric endocrinologists and clinical nurse specialists who represent a spectrum of identities. This article is a brief overview of the service and an introduction to the systemic discipline within the service. It will highlight the assessment and intervention approach, the service's growing systemic voice and invites you to explore its work with gender-diverse young people and their families.



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Assessment and intervention approach

When young people and their families access the Gender Identity Development Service, clinicians offer a series of appointments to explore a young person's gender identity in the context of their family, school or college and community. We work within the GIDS NHS service specification and the World Professional Association for Transgender Health international guidance.

The service's psychosocial assessment offers gender-diverse children and young people, and their families an opportunity to share their stories in a safe and thoughtful environment with at least one, and often two, qualified and experienced clinicians over a period of approximately six months. Around four to six one-hour appointments are offered, at monthly to six-weekly intervals, although this is flexible depending on the child's gender identity development, age, current presentation, additional risks and developmental needs, as well as the complexity of their network and family. The model of often using two clinicians provides an opportunity for multiple ideas to be generated and for families and young people to have their own concurrent spaces to talk. Our therapeutic assessment aims to explore and understand the young person's past and current gender identification across space, time and a number of domains such as family, school, social agencies and online social worlds. It allows young people and parents to explore their own gender development, experiences of gender in their family of origin, current family, in wider society, as well as experiences of their body, sexuality and sexual orientation and puberty. The clinicians pay close attention to the various relationships in a young person's life and every effort is made to work closely with those relevant to offering appropriate support locally such as schools, child and adolescent mental health services, general practitioners as well as voluntary and statutory agencies.

Following this assessment, some young people are referred to paediatric endocrinology teams, in London at University College and in Leeds at the General Infirmary, to consider the use of a hypothalamic blocker – or puberty blocker, which halts pubertal development but does not alter young people's bodies. After the age of 16, some young people who have been on 'the blocker' for a minimum of one year are prescribed cross-sex hormones to develop the characteristics of the gender with which they identify. Medical interventions are offered alongside ongoing appointments and the service can be involved with some young people and families up until the age of 18. This model of exploration of gender identity development, with elements of therapeutic support and psychoeducation is adopted

view of the Tavistock and Portman

Support – to help young people and families tolerate uncertainty of how their gender identity might develop;
Connections – to enable young people and their families to make meaningful connections between their life experiences and how they feel;
Acceptance – to promote non-judgmental acceptance of a range of gender identity presentations;
Curiosity – to help people to remain curious and thoughtful about their lives, and to understand what might get in the way of them doing this;
Freedom of expression – to support young people and families to express themselves freely;
Hope – to sustain hope;
Holistic approach – to provide help for behavioural, emotional and or relationship difficulties that young people or their families may be experiencing in relation to their gender identity;
Mind/body – to keep in mind the relationship between the body, thoughts and feelings. To work closely together as a group of professionals from different backgrounds including paediatric endocrinology;
Independence – to support young people to develop an appropriate level of autonomy and independence;
Loss – to allow young people and their families to acknowledge the sense of loss that can result from change.

Figure 1

from the Dutch team (DeVries & Cohen-Kettenis, 2012).

The aims of the service (see http://gids.nhs.uk), building on the work of the founder of the service, Domenico Di Ceglie, can be seen in Figure 1.

As we are a national service and the children and young people we work with do not live in complexity-free worlds, partnership working is key to ensuring a holistic provision of support. Clinicians see their role as working with wider systems that are more local to a young person and family and able to respond on a day-to-day basis. Often, CAMHS are able to provide more frequent and local support for families and so partnership work is usually sought to fully support young people. Clinicians encourage a network model of care (Eracleous & Davidson, 2009), stressing with networks the importance of effective multi-agency work as best practice in supporting young people with gender identity needs. Network meetings are often useful forums for local services to hear and learn more about gender identity, both in relation to an individual young person and more generally.

Clinicians do not see gender identity issues as a mental health problem but are aware of the impact on young people's mental health of prejudice and stigma, often expressed in transphobic and homophobic bullying. Holt *et al.* (2016), in their research looking at 218 children and young people referred to the GIDS between 2012-13, noted that bullying was experienced by 47%, low mood and depression by 42% and self-harming behaviour by 39% and these difficulties were seen to increase with age (see also Skagerberg *et al.*, 2013). The young people who access the service are often experiencing micro levels of aggression and stress as a result of identifying as and/or being seen as transgender (Hatzenbuehler & Pachankis, 2016). Clinicians try to negotiate between trying to influence a wider system and enabling young people to develop resilience and the recursive link between them. Some of the work is in thinking about the relationships between wider (sometimes transphobic) communities, mental health and gender identity.

The service offers teenagers' and parent/carers' groups in London and Leeds with the aim of offering service users the chance to meet up with and hear from each other. The feelings of isolation sometimes experienced by young people and their families can be countered with these groups and young people often access more local support from third-sector organisations such as Gendered Intelligence, Barnardos, MESMAC. The work of the third sector in supporting marginalised young people often makes a significant difference – providing community, combating isolation and offering a sense of being understood and validated.

Wren (2014) writes passionately about her work within the GIDS and highlights the lack of foundational theory about gender. She outlines her principles to working with gender-diverse children and young people (See figure 2), which offer an additional framework for exploration.

There is no 'cookie cutter' method; our service does not have a set outcome and it is difficult to generalise an approach, as the service offered is tailor made to meet the individual needs of every young person who accesses support. Clinicians, young people and families embark on a journey together, not knowing what the destination(s) might be. A secure therapeutic relationship, where all ideas from everyone in the family are thought about and valued, adds depth to understanding all aspects of identity. Clinicians do not have a set of questions, although there is a framework and a confident clinician is comfortable with being *"clumsy rather than clever"* (Burnham & Harris, 1996). The service effectively draws from an integrative approach in trying to ensure gender-diverse children and young people feel like the experts in their own lives (Anderson & Goolishian, 1992) within the collaborative approach we

- *"I promote a grasp of the possibilities for varied trans identities in order to challenge a passive relationship to diagnosis and classification;*
- *I create spaces in the work to encourage thinking critically about conventional notions of masculinity and femininity;*
- *I question the attraction of fixed categories of meaning, recognising that part of the work of therapy is to help clients to try and evolve new meaning, where the existing categories are limiting and confusing;*
- *I try to be alert to the dangers of a professional preoccupation with causal and developmental stories, while acknowledging the value of a good narrative to a stable sense of self and an intelligible public presence;*
- *If I see knowledge about the origins of gender identity as radically uncertain, and best theorised as contingent, mutable social construction, this does not imply that I will see any individual's experience of gender as tentative and unstable;*
- *I note the struggle for effective communication and adequate self-storying when the linguistic resources for doing justice to the trans experience are so impoverished;*
- *I am, like Harris (2004) 'always mediating multiple levels of awareness', trying to stay attuned to the way that consciousness of the body emerges from the relational, cultural and social context in which the individual lives;*
- *I think about the contexts in which endocrinological and other clinical services may present medical interventions as a way to sidestep complex psychological dilemmas;*
- *I acknowledge that while the technology of altering the body is desired by some to secure a coherent personhood, for some it may make too many demands for conformity within the binary gender divide;*
- *I especially recognise the comforts of certainty and coherence when I see young people apparently suffering from the fragmenting effects of disrupted and unreliable attachments;*
- *I give up wondering **why** people's gender identity evolves atypically, and asked instead **how** they are living their gender (Corbett, 1996), and what support they need to do this well, where the issue of how to live 'well' is central to the therapeutic work."*

Figure 2 (direct quote from Wren 2014, p. 286)

provide. The ultimate aim of the assessment and ongoing support is to work with young people, families and networks to generate an effective plan together to ensure the child and/or young person thrives in all areas of their life. This plan may include further therapeutic space for more exploration of all aspects of identity and/or a referral to the endocrinology service for physical interventions when they are capable of informed consent. Informed consent for young people under the age of 16 is assessed by clinicians through discussion about their hopes and wishes for treatment, their understanding of what treatment entails, possible benefits and/or side effects. Parental views are sought and considered, as are, in some cases, the views of others in the young person's professional network.

The service continues supporting children and young people as long as they need it up until the age of 18, through ongoing therapeutic intervention, supervision and consultation with local services, parent-and-young-person groups, or family days. We will also support young people throughout their social and physical transitions, and with transferring to adult services when they are approaching the age of 18.

An invitation to explore

We as a service have heard at the World Professional Association for Transgender Health and the European Professional Association for Transgender Health conferences, the call for family work and have responded accordingly as a service. The positive impact of family support on young transgender people and those questioning their gender identity has been shown (Resnick *et al.*, 1997; Simons *et al.*, 2013). The Gender Identity Development Service has always maintained a systemic approach to working with children and adolescents, most notably in our network model of care (Eracleous & Davidson, 2009) in multi-agency working and in earlier writings about the service (Di Ceglie, 2008; Wiseman & Davidson, 2011) espousing a systemic approach in engagement and exploration. There has been a growing systemic presence in the team over the last several years and there are now eight substantive family and systemic psychotherapists in post between both offices. These posts are in addition to multiple clinicians employed in a variety of disciplines and who are qualified systemic psychotherapists, systemic practitioners, and those who have completed the foundation years or who are in the process of completing the MSc. This growing systemic voice supports a relational approach to working, a continued exploration of all aspects of identity in the form of the social GGRRAAACCCEESSS – gender, geography, race, religion, age, ability, accent, colour, class, culture, education, employment, sexuality, sexual orientation and spirituality (Burnham, 1992, 1993, 2012; and Roper-Hall, 1998) with young people and families. Burnham (2012) also writes about visible and invisible GRACES, where visible may include aspects of identity such as age, accent and colour, and invisible may include sexuality, spirituality. One of the unique challenges to young people identifying as trans is that they can move from invisible (seen and responded to as their assigned gender) to visible (changing their appearance, name, pronouns). Often the hope of young people is that in adulthood the sharing of their gender identity will be their decision.

Intersectionality (Crenshaw 1989; Butler, 2015) suggests different markers of identity categories overlap and create particular experiences of various levels of privilege and marginalisation, which impact on us all. The young people and families seen may negotiate some of these and sometimes feel them particularly acutely as they go through social transition. For instance, clinicians may talk with young people about what it's like to be afraid of neighbours' responses to coming out as trans in a small ex-mining community; what it's like to be the only Muslim you know who is trans; what it's like as a father to feel more protective of your trans daughter than you did of her older brother – and how these cultural beliefs affect individual lives.

A systemic framework can also include an exploration of trans-generational ideas, dominant and subjugated narratives (White & Epston, 1990) about gender embedded within their worlds. Working systemically offers an effective framework for joint work and for reflective practice, as well as a range of interventive questions (Tomm, 1987a, 1987b, 1988) and playful

action techniques useful to exploring and widening the context of gender.

The service's systemic team

This article grew from a discussion amongst the systemic psychotherapists working in the GIDS teams in London and Leeds. While there is a small and developing family therapy clinic in Leeds, the main work is assessment around gender identity and specifically gender dysphoria; and continuing to offer support, sometimes over years, as they continue to explore their gender identities with or without medical interventions. A rich systemic heritage is drawn from in the work. Clinicians seek to hold on to principles of curiosity (Cecchin, 1987) in clinical work, linking to multiple views and eliciting stories of competence. As in so much systemic work, clinicians negotiate between multiple social and personal discourses, and require flexibility to express a variety of clinical positions. We are interested in how young people and families may perceive us, based on a variety of stories about the service in the public domain and on their experience of us in a clinical room. We seek to retain the systemic commitment to self-reflexivity and an awareness of power and the impact this can have on our relationships with families. Linked to this is an attention to ourselves as embodied, gendered individuals as we talk about bodies, sexuality and fertility with young people.

We find ourselves inviting young people and their families onto an exploratory and evaluative process. Some services would separate evaluation of gender dysphoria and exploratory work. We hold a developmental framework in the service – we work with young people up to the age of 18 sometimes including young children. We are aware how people identify their gender can change over time and there are diverse trajectories for our clients. For example, young people sometimes talk about first identifying as gay or lesbian, over time feeling that does not quite fit and coming to a trans identity. Some young people identify as trans and want physical interventions, and then identify as non-binary or gender queer and do not want medical treatments. Many young people who come to us hold unswervingly to the gender identity they state when they first meet us. We are aware that identity is a developing and dynamic process for everyone. Evaluation and exploration are clearly difficult to separate in a developing area of work and there is a hope to make assessment therapeutic and useful to young people and their families as much as possible.

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Some theoretical ideas

As systemic therapists, we may use the ideas of Lang, Little and Cronen (1990) to think about our overarching domain of aesthetics. We suggest that we may think about two ethical tenets – seeking consent for work, including the discussion of meanings, and an acknowledgement of our prejudice and preference and experience that reflective discussions are useful. Our systemic framework leads us to think talking can help families and young people adjust to the transitions in their lifecycle, often precipitated by social and physical changes. How can we invite people into the domain of explanation (Lang *et al.*, 1990) when they would prefer to stay in the domain of production? In the domain of production, young people may come to us clearly requesting medical intervention in the form of hormone blockers and/or cross-sex hormones to alleviate their experience of gender dysphoria. We can be seen as powerful gatekeepers and, sometimes, the invitation to explore can be seen as a denial of the young person and their 'privileged access' (Wren, 2014) to their subjective experience of gender identity. Often, young people have done much thinking and research before they come to see us and we may be able to facilitate further discussion and/or help them communicate some of their thinking to their family. We seek to avoid polarised positions that are unlikely to facilitate exploration through the use of curiosity, self-reflexivity (Hedges, 2010) and thinking about process as well as content.

We try to attend to how people 'do' gender expression and the range of gender expressions available to them in their communities. We ask about relationships and whether LGBTQ+ people are visible and acknowledged in the communities young people live in. We therefore pay attention to the embedded (Hardham, 1996) nature of gender and the meanings ascribed to it in particular contexts, whilst paying close attention to the narratives of gender diversity young people are aware and part of – be it through YouTube or a local LGBTQ+ support groups. As we hope to have shown, we engage with the complexity of young people's lives.

Conclusion

There is limited research in this area of work although, as mentioned above, we do know family support is significant in helping young people questioning their gender identity to thrive. Clinicians maintain a dedicated approach to ensure gender-diverse children and young

people are thought about and supported in the most effective way possible at this time. No clinician has a crystal ball to foretell the future, but our collective hope is each young person we work with can develop, and we meet them where they are to ensure the best way forward.

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