Exploring clinicians' views about their roles when working with young people presenting with gender identity issues: a qualitative enquiry

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Abstract

Objectives There has been a sharp increase of referrals to NHS child and adolescent mental services (CAMHS) in the UK for young people presenting with gender dysphoria. Little has been documented about how a range of clinicians understand their role when working with this clinical population. This study aimed to make an enquiry into how child and adolescent psychotherapists, clinical psychologists and family therapists understand their role when working with transgender and gender non-conforming (TGNC) young people.

Method I carried out semi-structured interviews with eight clinicians (three child and adolescent psychotherapists, three clinical psychologists, two family therapists) working routinely with TGNC young people. I transcribed the interviews verbatim and analysed them using Thematic Analysis.

Results Thorough analysis of the clinicians' interview material produced the following five key themes: *finding meaning; contextualising; containment; self-reflection;* and *practical support.*

Conclusions All clinicians highlighted the importance of thinking, exploring, seeking meaning and deeper understanding in the face of the complex presentations of TGNC young people in their care. Key to this involved clinicians' capacity to be able to contain anxieties within the young person, parents/carers and the wider professional networks. Child psychotherapists felt that close observation and monitoring of ones' own response to clinical work with TGNC young people was key to their role. This was considered imperative to being able to manage personal prejudice/bias in a field of work that can provoke strong opinions, but also using it as a potential communication that might further our understanding of a TGNC young person's state of mind. Confusion about role was an important finding that demonstrates that, for many clinicians, they still feel that they have a lot to learn about the most helpful ways in which they can support young people questioning their gender identity. This study highlights the pressing need for continued dialogue amongst professionals and academics in order for us to remain open and curious about the unique situation of each TGNC young person who comes into our care.

Key words

Gender dysphoria; role; clinicians; qualitative research

1 Qualitative Research Report

1.1 Introduction

1.1.1 Conceptual and clinical rationale

It was my clinical experience of working with young people with gender identity issues, during my training as a child and adolescent psychotherapist, which fuelled my interest in this field of research. There were two clinical cases that I was seeing for weekly individual psychotherapy that particularly triggered me to question my role as their therapist. One was a very young child who had not wanted to identify with their biological sex prior to the age of five. The parents were highly anxious and desperately seeking a sense of certainty about their child's developmental trajectory in relation to their gender. A specialist gender service had clearly stated that a psychotherapeutic space was crucial at this point to allow the young person to explore their experience of being in the world. However, in the face of parental anxiety for certainty and a wish for clear cut answers, it was challenging to slow things down and get to know this young person more generally, aside from their gender dysphoria. It became apparent that there were complexities to address with regards to this young person's family context including a history of maternal post-natal depression and an acrimonious parental couple. The professional network became fraught with polarized opinions about the case and safeguarding concerns were raised with social care resulting in formal complaints being made by parents. In the face of a wide range of views about the nature and trajectory of the case, holding the subjective experience of the young person in the forefront of our minds was often a challenge.

The other case was a young person approaching their transition to secondary education. This coincided with a planned ending to our piece of therapeutic work and it was at this time that the young person expressed their desire to socially transition from female to male. Again, there were complexities to consider; this was a young person

with an early history of severe neglect on a special guardianship order. It felt significant that this sudden desire to socially transition gender came at a time of significant transition in their life. I, along with other colleagues, found ourselves wondering about what purpose this transition might serve for a young person who was perhaps struggling to tolerate feelings of vulnerability in anticipation of establishing herself in the new environment of secondary school. Having the space to consider these important questions rather than rushing to clear decisions/solutions was a battle in the context of high levels of anxiety in the carers who felt an urgency to quickly alleviate her distress.

These specific cases encouraged me to reflect on my own therapeutic stance and evoked curiosity about how other clinicians were thinking about their work with young people questioning their gender identity. In a wider context, this field of clinical work has provoked increasing interest and debate, with a sharp rise in the number of referrals to mental health services for presentations within this sphere (Spack et al, 2012). Important therapeutic and conceptual standpoints have been called into question and quandaries about whether these young people should be eligible for treatment at all remain in the spotlight. Clinicians continue to enquire about the nature of the treatment these young people are receiving (Lament, 2014) and the recent changes to the 2013 Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5), which replaced Gender Identity Disorder with Gender Dysphoria (Reisner et al, 2015), is indicative of the evolving conceptual landscape.

The gender identity development service (GIDS), established in 1989, is currently the only nationally commissioned highly-specialised NHS service supporting the emotional and physical health needs of gender-diverse young people. Referrals to GIDS have grown from 27 in 2009/2010 to 2,017 in 2017 (Butler, de Graaf, Wren & Carmichael, 2018) Clinicians working within GIDS see a key aspect of their role as working with the wider network of professionals that are more local to the young person and their family (Maldonado-Page & Favier, 2018).

Child and adolescent mental health services (CAMHS) are often able to provide more local and frequent support, and GIDS and CAMHS therefore frequently work in partnership. With the rapid increase of referrals for transgender or gender non-conforming young people (TGNC) over the last ten years, clinicians working in generic CAMHS services have greater exposure to clinical work with this sector of the population.

Whilst there is a significant body of conceptual literature about therapeutic approaches to gender dysphoric presentations, there is a dearth of empirical research. Di Ceglie (1998) documents the therapeutic aims and management of young people presenting with 'Gender Identity Disorder'; however, in today's evolving social and political climate in which gender identity is a hotly contested topic, there is a need to understand how clinicians view the therapeutic space with these young people. Lament (2014) states that 'It is incumbent upon the child analytic community as stewards of what is developmental…to press for continuing dialogue about the transgender child'. (p.25)

1.1.2 Research Aims

My hope was that this research would promote a dialogue and go some way to providing a preliminary bridge between current conceptual frameworks around gender identity and how the clinicians that I interviewed are framing the therapeutic space that is offered to these young people. The central research question is:

What can we learn from interviewing clinicians about how they understand their roles when working with young people presenting with gender identity issues?

Broader **aims** will be to:

- *explore what the different therapeutic stances are when working with young people with gender identity cases*

- *consider the particular role Child Psychotherapy can have for gender identity cases*
- *examine what the challenges might be for clinicians working with this population of young people*

1.2 Literature Review

1.2.1 Introduction

In order to contextualise my small-scale project, this review intends to examine the last ten years of literature in the field of gender identity. Furthermore, to track the conceptual and clinical developments in this field, it will also examine historical psychoanalytic theories in this area. It was interesting to note that when I set out to complete the project there was very little written about clinical viewpoints around therapeutic interventions with TGNC young people. However, over the course of my completion of the study, there has been a surge of research in this field and many new articles have been published. This is undoubtedly a reflection of the increase in referrals of young people presenting to mental health services with gender identity issues and the subsequent increase in clinicians' experience of working in this area.

1.2.2 Methodology for review

I decided to use PsycINFO to conduct my literature search, given that it is the most comprehensive database for psychology and other related disciplines. I accessed this through the Tavistock and Portman library and followed the following links: 'Electronic Resources'- 'Databases'- 'PsychINFO' (via EBSCOhost).

As a starting point, I identified the key concepts within my research question which would make up each of my searches. Having deciphered as many words as I could per concept, I did one wide search per concept followed by an additional search combining all three concepts.

1.2.2.1 Search 1

My first search was centred around the key phrase 'gender dysphoric' (see Fig. 1). I brainstormed as many variations of this phrase as

possible, using a thesaurus to collate a comprehensive list of all the synonyms, plurals, verbs and nouns, as well as considering different spellings for each word, given that PsycINFO often uses the US spelling. I used the 'OR' boolean operator in order to find documents with any of the listed words or phrases within my search, and I ensured that for synonyms made up of more than one word (eg. 'gender fluid'), quotation marks were inserted so that the words were searched for simultaneously. Furthermore, I implemented the truncation symbol (*) to widen my search and to incorporate all the verbs, nouns, adjectives and plurals with the same prefix (eg. Transsexual* would search for transsexual, transsexualism, transsexuality and transsexuals).

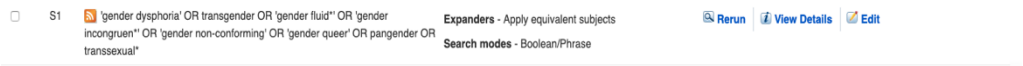

Figure 1. Concept 1 Search in PsycINFO

1.2.2.2 Search 2

My second search was centred around the word 'role' (see Fig. 2). As in my first search, I compiled an exhaustive list of synonyms using a thesaurus, used the 'OR' boolean operator, and truncated each word to also incorporate verbs and plurals.

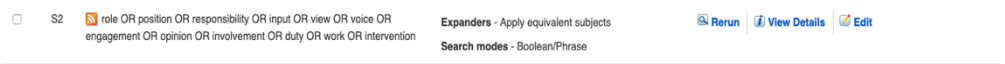

Figure 2. Concept 2 Search in PsycINFO

1.2.2.3 Search 3

My third search was centred around the word 'clinicians' (see Fig. 3). Again I created a comprehensive list of synonyms using a thesaurus, used the 'OR' boolean operator and truncated each word to also incorporate verbs and plurals.

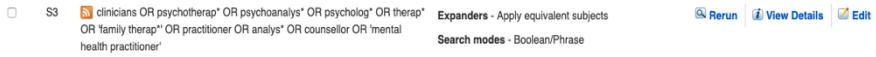

Figure 3. Concept 3 Search in PsycINFO

1.2.2.4 Search 4

Once I had the results for my three key concepts, I linked them by using the 'search with AND' tool to narrow my search by looking for documents with words or phrases from Searches 1, 2 and 3. This produced a high volume of results, with a total of 3,077 articles.

I was able to limit my search further using the 'refine results' section on the left-hand side of the PsycINFO search page (see figure 4). The first limiter I applied was the publication year, restricting my results to the past 10 years as I wanted current research. I specified ‘gender identity’ as my major subject, limited results to those written in English and identified young people (0-18) as the population I was interested in. Whilst I could have limited my search further, I felt that at this point 96 articles were a manageable amount to look through and further limit by hand.

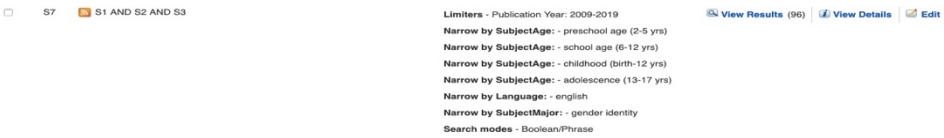

Figure 4. Concept 1, 2 & 3 with limiters in PsycINFO

It was evident that many of the articles were not relevant to my research question. I was able to exclude a further 66 articles, on the basis of their focus being about:

- Young people’s experiences of their gender dysphoria, including their experience of their gender identity transition; what they perceive will promote their wellbeing; considerations regarding puberty suppression and managing within the school setting
- Risk/protective factors in the lives of transgender and gender-non conforming young people

- Parents/carers' experiences of living with gender non-conforming offspring
- Outcomes for gender non-conforming young people, including psychological, social and health
- Sociodemographic factors of transgender populations
- Developments in diagnoses of gender dysphoria
- Links between gender identity issues and autism
- Aetiology of gender dysphoria
- Persistance/desistance of gender dysphoria into adolescence
- Prevalence of gender variance in particular populations
- Sexual orientation and gender dysphoria
- Links between gender identity and obesity
- Social work practice with gender dysphoric young people

The remaining 30 articles that were relevant to my central research question incorporated research about treatment models, including the gender-affirmative and liberation psychology approaches. Other articles centred around clinicians' psychoanalytic reflections on transgender identities, including the importance of reflecting on the counter-transference. A small number of papers focused on the psychologists' role and views on treatment, as well as psychiatric views on diagnosis, treatment and intervention. Assessment practices, parent work and network liaison around gender non-conforming youth were also covered.

For the purpose of this review, in addition to conducting a comprehensive literature review on PsychInfo, I also called upon literature that I was already aware of, particularly theoretical/conceptual psychoanalytic literature in the field of gender identity.

1.2.3 Gender Identity and Gender Dysphoria

Before 1955 there was no concept of 'gender identity'. The concept 'gender role' was introduced by John Money in 1955 (Money, Hampson

& Hampson, 1955), whilst Stoller (1968) coined 'gender identity' from a gender identity study group at the University of California. He identified three components in the formation of 'core gender identity' (an absolute sense of one's masculinity or femininity constructed by the age of two). These were i) biological and hormonal influences, ii) sex assignment at birth and iii) environmental and psychological influences

Gender Dysphoria (GD) (as stated in DSM-5, American Psychiatric Association, 2013) was previously named Gender Identity Disorder (GID) and was first included in the DSM-III (American Psychiatric Association, 1980). The clinical diagnosis of GID inherently pathologised gender variance and was understood as something to be corrected and directed towards a more gender-normative position. The change in nomenclature indicates the shifting landscape of thinking and formulating within this field of clinical work and shifts the focus to the clinically significant distress associated with GD, rather than the behavioural manifestations. A GD diagnosis is made on the grounds of there being distinct, persistent and articulated discrepancy between a young person's expressed and assigned gender that is causing clinically significant distress or impairment in functioning. Young people with GD express a wish to be treated as the other gender and to be rid of their biological sex characteristics (American Psychiatric Association, 2013). For the purposes of this report, I will refer to young people presenting with gender identity issues as 'transgender or gender non-conforming' (TGNC) youth. My intention is that this captures the very broad spectrum of young people presenting within this field of clinical work.

1.2.4 Psychoanalytic Perspectives on gender and gender identity

'It is important to understand clearly that the concepts of 'masculine' and 'feminine', whose meanings seems so unambiguous to ordinary people, are amongst the most confused that occur in science'
(Freud, *Three Essays on Sexuality, 1905 footnote, 1915, DE 7, p.219)*

For many years there was little interest in the origins of masculinity and femininity and they were assumed to correlate with the nature of biological sexes despite awareness of historical and cross-cultural variation (Person and Ovesey, 1983). It was Freud who can be credited with one of the earliest theories of personality development that accounted for the geneses of gender. From the birth of Psychoanalysis, it has been a clinical discipline with an enduring interest in gender, with it being one of the principal axes of early development. As Dess et al (2018) states, 'Freud was, paradoxically, both a man of his time and a man ahead of his time when it comes to sex and gender' (p.917) His theory encompassed a duality of perspective regarding gender. On the one hand, some would say he described an inevitable and fundamental biological basis to one's gender stating that '*the anatomical distinction between the sexes must, after all, leave its mark on mental life'* (Freud, 1937, p.160). Others interpreted his writing as revolutionary, stating that biology was not destiny and that our gender, male or female, is assembled over time and is somewhat independent of our biological sex. Breen (1993) understood this dichotomy as a manifestation of the inherent debate on the subject of gender that is still very much at play in today's world. According to Freud (1915), It was not purely a person's anatomy but the appraisal of their anatomy that shaped their masculinity or femininity, thus presenting the clear link he made between the mind and body in the formation of gender. He purported that men and women possessed both masculinity and femininity, passivity and activity and that humans were inherently psychically bisexual. Freud (1905) stated that 'In human beings pure masculinity or femininity is not to be found either in a psychological or biological sense'. He understood gender as developing from early childhood experience and that heterosexuality was not an inevitability but an indication of the Oedipus complex having been resolved. For boys this involved overcoming their fear of castration, the formation of a super-ego and identification with parental authority. Whilst for girls this encompassed an acceptance of not possessing a penis. Freud understood this as not only decisive for female sexual development but also for what he

saw as female character traits such as passivity. As stated by Person and Ovesey (1983) ‘femininity derived from the psychological ramifications of a single, momentous, and traumatic perception: the girl’s discovery of her anatomic difference from boys, a difference viewed as inadequacy’ (p. 208)

Freud’s (1915) early theory of gender received much criticism particularly from feminist and homosexual theorists. The assumption that maturity necessitated heterosexuality as well as the centrality of the penis in his theory were amongst some of the key criticisms (Chodorow, 1978, Benjamin, 1988). However, his theories were never entirely rejected and more reworked as his central interest in the formation of gender identity remained a fascinating enquiry for theorists, in particular how children identify and dis-identify with their parents.

Horney (1926) placed emphasis on societal forces rather than biology in terms of the development of one’s gender identity. She believed that penis envy was not a literal desire for male anatomy but for the power men held on a societal level. She proposed that men could also experience envy towards women’s capacity to bear children and that their perception of women as inferior was a way of raising their own standing in society.

Chodorow (1978) and Benjamin (1988) were both psychoanalysts as well as sociologists and were interested in both the origin of gender in the individual as well as on a wider societal level. Benjamin (1988) considered the social structures that were reliant on specific depictions of gender; women as primary carers being the most important figure to their children whilst devalued by society whilst men were elevated in society and held a position of power. With this in mind Chodorow (1978) questioned how boys and girls might connect and separate from their mothers in different ways. She proposed that it was perhaps a greater challenge for girls to separate and individuate from their mothers and that heterosexual relationships could be experienced as

unsatisfying in light of conflicts around closeness/separateness with their mothers. Their subsequent wish to become mothers themselves was felt to be a way of retuning to that primitive sense of closeness. In relation to this, Bleiberg et al (1986) explored the role of early object loss in gender variance and proposed the hypothesis that the wish for some young people to be the opposite sex is founded upon narcissistic defenses against early object loss, which evoke unbearable feelings of vulnerability. With that in mind, they suggested that young people may benefit from psychodynamic treatment aimed at resolving these pathological defenses, rather than responding in a literal way to their concrete wish to change their gender.

Early psychoanalytic ideas around gender were also criticised on the grounds that they assumed a heterosexual family constellation and implied that homosexuality was as a result of certain developmental challenges not being resolved. There were also criticisms about the universal experience of gender that they portrayed that did not account for the range of gendered experiences now seen in clinical settings (Dess et al, 2018).

From 1990 onwards more contemporary, post-oedipal experiences of gender were theorised. Dess et al (2018) understood these as 'neither rigidly experiencing gender in one objectively observable way nor experiencing gender fluidly only in a purely subjective way' (p.208) suggesting that we can experience gender in relation to opposing categories of gender as well as having freedom from any such demarcation. Early psychoanalytic categories of masculine/feminine, active/passive were now felt to limit peoples' subjective experience of gender (Butler, 2004, Salomon, 2010). Post-oedipal theorists such as Corbett (2011) and Goldner (2003) believed that arriving at ones' gender identity was neither purely about resolution of the oedipal constellation nor did it necessarily correspond with assigned sex at birth. They proposed that it is developmentally normal for a child to perceive more differentiated categories around gender and sex whilst acknowledging that these categories can become less clear as we

move into adulthood. In relation to this Dess et al (2018) states that arriving at a stable gender identity is a developmental achievement that requires processes of splitting and denial and that sometimes we can cut off from parts of ourselves as a defence against the complexity of such aspects of our identity. Breen (1993) states that *'understanding masculinity and femininity means understanding that interplay, means tolerating the out-of-focusness' (*p.38), highlighting the complexity of the term 'gender'. Post-oedipal theories around gender centre around the idea that we need to be able to tolerate the ambiguity and instability of gender and that we can occupy a range of categories; male/female, active/passive, penetrating/containing (Dess et al, 2018).

Within the body of literature of child and adolescent psychoanalytic psychotherapy, one of the seminal works has been Di Ceglie's *A Stranger in My Own Body* (Di Ceglie, 1998a). Di Ceglie discusses gender incongruence presentations in young people in relation to their rigidity-flexibility of thought. One of the therapeutic goals that DiCeglie states in terms of working with gender dysphoric young people is to 'enable symbol formation and symbolic thinking…' (Di Ceglie, 2018, p.15)suggesting that a young person's questioning of their gender identity should not always be taken literally and requires further exploration to understand what the confusion may represent on an internal, psychic level.

Current psychodynamic perspectives around gender identity maintain that there is no biological reason per se for gender variance but that our gender identification and presentation forms part of a complex journey of personality development (Bonfatto and Crasnow, 2018).

Trans and genderqueer movements have challenged traditional psychoanalytic thinking, stating that bodies and gender identities do not always correlate. As Dess et al (2018) states this has 'pushed psychoanalysis forward and back to its roots' (p. 211) and remains a contentious area of intellectual and clinical debate.

1.2.5 Sociological stance on gender

Contemporary sociologists understand sex and gender as conceptually distinct terms. Sex refers to physical or physiological differences between males and females, including both primary and secondary sex characteristics. Gender, on the other hand, indicates towards social or cultural norms associated with being male or female. Gender identity is understood as the degree to which one identifies as being either masculine or feminine (Diamond 2002). Transgender Studies started to develop as a field in the early 1990s and is a transdisciplinary project whose aim is to expose mechanisms of power that influence social norms. The Transgender studies readers (Stryker, 2006 & 2013) have collated scholarly articles within this field and serve to uncover, study, and challenge the prevailing social norms around sex and gender identity in different cultural contexts. Terms such as 'normal' or 'atypical' in relation to gender are explored in the context of a belief that we exist in binary-bound societies where sorting and classifying systems tend to be employed.

1.2.6 Therapeutic approaches to Gender Dysphoria

There is a severe lack of empirical research in the field of psychological therapies for young people presenting with gender identity issues. In 2003, Cohen-Kettenis and Pflafflin conducted a thorough review of treatments being offered for transgender children and youth. They stated that "despite the many treatment approaches, controlled studies do not exist" (p.129). Ehrensaft (2014) followed on from this, commenting that "we have not traversed much further in executing such studies" (p.338).

Much of the literature documents the key therapeutic approaches in this field, and Byne et al (2012) concludes that therapeutic intervention with cases of gender dysphoria in young people have the common goal of promoting psychological wellness. However, debates continue about what that entails and the literature indicates that this field of clinical

work is still fraught with disagreement and polarised perspectives on what, if any, therapeutic intervention is required. Much of the debate hinges upon the question of whether gender dysphoria should be considered pathological or variant. Drescher & Byne (2012) notes the *'current lack of consensus'* (p.296) regarding fundamental issues in treating TGNC youth, having drawn together a diverse range of clinical articles that outline clinical approaches to TGNC patients.

1.2.6.1 Traditional, reparative approach

Traditional psychoanalytic approaches to therapeutic work with young people experiencing gender dysphoria were reparative in nature, focusing on removing atypical gender identifications and promoting gender typical behaviours (Green, 1987). Historical psychoanalytic perspectives emphasising the role of intrapsychic conflict and early object loss as factors of gender non-conformity (Bleiberg et al, 1986) understood the role of psychotherapeutic treatment as resolving defences, thus reinstating young people on the path of growth and development. Documented rationales for this approach centred on the prevention of social ostracism (Green, 1987); however, more recent ethical questions have been raised in response to trying to manipulate a young person's gender identity and other approaches and viewpoints have developed.

1.2.6.2 Gender Affirmative Model (GAM)

Malpas (2011), writing from a psychology discipline standpoint, states that "contemporary approaches to gender nonconformity in childhood are moving towards an affirmative standpoint" (p.456) aimed at normalising and de-stigmatising their experiences, remaining open to fluidity and purposefully affirming the young person's gender variant preferences. TGNC identities are viewed as normal variants of human gender identity, and therefore TGNC youth are thought to be expressing their 'true' identities.

When conducting the literature search for this review, it was evident that much of the empirical research that has been conducted and literature written is from a GAM approach. Ehrensaft (2014), a developmental psychologist, proposes that psychoanalytic practitioners are ideally situated to help TGNC youth within the GAM, using techniques of listening, mirroring, play and interpretation. Singh & Dickey (2017) are explicit that the role of mental health providers is to hear the stories of TGNC youth and to advocate on their behalf, whilst critically examining existing research and assisting families with a child who is TGNC. Many other papers document gender-affirmative models of intervention (Alderson, 2013; Anderson, 2018; Beemyn, 2013; Coolhart, 2018; Hill et al, 2010; Ehrensaft, 2011; Keo-Meier & Ehrensaft, 2018; Olson, 2016), including multi-modal clinical applications of the GAM (Malpas et al, 2018), collaborative GAM of treatment across disciplines (Lev & Wolf-Gould, 2018) creating strong professional networks (Kaufman & Tishelman, 2018) and working with parental discord (McLaughlin & Sharp, 2018). Clinicians have also explored assessment protocols for TGNC youth and how clearly they align with GAM tenets (Berg & Edwards-Leeper, 2018).

1.2.6.3 De-pathologisation approach

Most recently the Informed Consent Model (Schulz, 2018) has been developed as an alternative to the diagnostic model for transgender health. This model provides access to medical and surgical intervention for gender dysphoric individuals without having to go through mental health services. Some consider this a promising step away from previous medical pathologisation of the gender-variant population, but others have raised questions about how much opportunity is given to fully explore and think about a person's understanding of their gender identity before irreversible medical intervention takes place.

1.2.6.4 Psychotherapeutic, developmental and gender-critical approaches

Wren (2014), a consultant psychologist working within a specialist

gender identity service, describes the therapeutic space with TGNC youth as 'a reflexive and thoughtful space to help clients explore the architecture and borders of their gendered world view' (p. 287) reflecting a more non-directive, exploratory psychotherapeutic perspective to the work. Exploration of the literature demonstrates the application of these approaches to single case studies (Ehrensaft, 2011); however, it would appear that the views of clinicians themselves is an under-researched area.

Lemma (2018), writing from a psychoanalytic perspective, presents a more developmental approach to the work with TGNC young people. She emphasises that the analyst's task is to explore the young person's feelings and thoughts in depth in order to establish the unique meaning of transgender to each individual. She presents the importance of *'questioning motivations, wishes, fantasies and fears from a position of equidistant curiosity'* (p.1093) in order to help young people find the optimum way to live in the knowledge of the emotional (and physical) costs and risks of their decisions. Lemma writes candidly, and in relation to case examples, about the challenges of today's external culture in which asking 'why' as well as 'how' questions can be perceived as pathologising. However, she concludes that '*this is the everyday work of psychoanalysis'* (p. 1104), and is imperative in understanding the multi-faceted meanings of a young person's understanding of their identity as a whole. *'Tolerating ambiguity and the undoing and reconstruction of identity narratives'* (p. 1094) is a key aspect, as well as challenge, of any clinicians' role in with this population, as Hakeem (2008) reiterates. Lemma also reflects on how essential, albeit challenging, it is for professionals to reflect on their own countertransference and notice their own prejudice/bias in their work with TGNC young people. She is unequivocal that a wide range of experience in this field is crucial if clinicians are going to maintain an unbiased internal position and be able to trust their own counter-transference when faced with the strength of feeling stirred up in this clinical work.

Barkai (2017) embellishes upon this, documenting the pitfalls of historic, reparative, psychoanalytic approaches to working with TGNC. She emphasises the importance that TGNC young people still have psychoanalytic psychotherapy available, but is clear that the treatment requires a *'suspension of gender focus'* (p.26), as well as a *'deep knowledge of one's gender biases'* (p.26). The traditional, non-neutral stance of having a goal towards same-gendered identification with TGNC patients, making the gender presentation the focus of the treatment and viewing gender as a pathological symptom are all viewed as outdated and inherently biased. She purports that '*psychoanalytic technical mainstays such as neutrality, curiosity, openness, and mirroring, as well as careful attention to countertransference phenomena ranging from gender bias to trans-phobia are crucial.'* (p.28) Much like Lemma (2018), Barkai stresses that the opportunity for TGNC young people to gain a deeper understanding of their unique circumstances and associated feelings should be at the heart of any psychoanalytic treatment.

Schwartz (2012), a clinical psychologist, in response to three differing clinical articles, notes that clinicians' varying theoretical assumptions about human nature imbues their decision-making, and therefore intervention. One significant assumption is where a clinician lies on the spectrum between viewing gender as an objective condition of every human and believing it is a subjective, inner condition. At the crux of Schwartz's discourse is a differentiation between clinicians who: a) perceive gender as an internal reality and will likely be determined to accept a literal hearing of a TGNC young person's story, and b) understand gender as comprised of symbolic and metaphoric representations and will be motivated to implement an interpretative process. Schwartz asserts that *'patients' communications always need some degree of interpretation; that is especially true for children, who, necessitated by their cognitive limitations, speak more symbolically'* (p. 471). In relation to this, the importance of being able to offer play therapy with younger TGNC children is stated. The benefits of sand play have also been documented in the literature (Ballantyne, 2017).

There is a candid acknowledgement in Schwartz's article that a more interpretative stance may appear to be a failure of respect for a young person's subjectivity. However, deeper, rather than literal, listening is presented as paying dividends and really enabling TGNC young peoples' stories to be heard.

Brunskell-Evans and Moore's new book *Transgender children and young people: born in your own body* (2018) explores the difficulties in adopting an affirmative standpoint and presents a range of opinions, including those of clinicians, that centre around a 'gender critical' position. Clinicians present their arguments as to why both social role transition and further medical intervention should be challenged by professionals, rather than inflexibly supporting the perspective that there are children born into the world who are innately transgender and should have this affirmed. This is a highly contentious area of clinical debate and the 'gender critical' approach is often understood as a 'transphobic' stance. In a recent review of this publication, Midgen (2018), a child and adolescent psychotherapist, is careful in teasing these two positions apart, describing the association between the two as a '*careless accusation levelled at those of us challenging the so called 'gender-affirmative' approach' (*p. 140).

1.2.7 Current UK Policy and Practice

1.2.7.1 Gender Identity Development Service

The Gender Identity Development Service (GIDS), located in the Tavistock and Portman NHS Foundation Trust with two locations in London and Leeds, was founded in 1989. It is a Tier 4 specialist service and is the UK's sole nationally commissioned assessment service supporting the emotional and physical needs of gender-diverse young people, and has seen a 100% increase in referrals between 2015-2016 (Maldonado-Page & Favier, 2018). The GIDS provides a multidisciplinary therapeutic assessment from a clinical team

composed of psychologists, social workers, psychotherapists, family therapists, endocrinologists and clinical nurse specialists. Maldonado-Page & Favier (2018) state that clinicians understand their roles as thinking with the wider systems around a young person and their family that are more local. This can often mean that local CAMHS teams provide ongoing therapeutic support, with frequent joint meetings with GIDS. It is very rare that weekly psychotherapy is offered at GIDS due to the long distances many families must travel and the huge demand for assessments (Bonfatto & Crasnow, 2018).

Di Ceglie, the founder and former director of GIDS, introduced the concept of atypical gender identity organization (AGIO) as a psychological entity that can be assessed under a range of factors pertinent to clinical intervention and management (Di Ceglie, 1998). Key factors include rigidity-flexibility of the AGIO, timing of the AGIO formation, traumatic events in childhood and the young person's position on the paranoid-schizoid-depressive continuum. The task of the therapeutic exploration is to evaluate each of these factors in depth in order to guide clinical management. Furthermore, he summarises the fundamental therapeutic aims of the GIDS as:

1. To foster recognition and non-judgemental acceptance of gender identity issues
2. To ameliorate associated behavioural, emotional and relationship difficulties
3. To break the cycle of secrecy
4. To activate interest and curiosity by exploring the impediments to them
5. To encourage exploration of the mind-body relationship by promoting close collaboration among professionals in different specialties, including paediatric endocrinology
6. To enable symbol formation and symbolic thinking
7. To promote separation and differentiation
8. To enable the child or adolescent and the family to tolerate uncertainty in gender identity development

9. To sustain hope

In a more recent publication, Di Ceglie (2018) states that a 'one size fits all' model cannot be applied to the TGNC population and that it is imperative that professionals offer different forms of help according to a range of diverse needs. He recognises that there is a risk in working with TGNC young people to become '*mechanical and too standardised'* (p.25), and that responding empathically and flexibly to the unique story of each individual is necessary in order to recognise the complexity and diversity of this population. Holding onto multiple perspectives and maintaining a certain level of ambiguity in situations where there may be a wish for certainty is at the heart of his clinical ethos.

1.2.7.2 Child Psychotherapists working in GIDS and CAMHS

McCann (2018) highlights the current challenges for clinicians working within CAMHS in the UK to define their roles in the contentious and complex area of work with gender-variant young people. Whilst there is lack of empirical research in the field, there has been a recent surge of academic writing in relation to the clinical case work of psychotherapists working with TGNC youth. Schwartz (2012) reflects on how psychotherapeutic responses to TGNC young people may have become falsely associated in the minds of some with the previously mentioned historical reparative approach. This can have the impact of true curiosity and exploration of a young person's emotional state being quickly discounted, making the work of psychoanalytically informed clinicians highly challenging (Lemma, 2018).

However, in the 2018 gender identity special issue of the Journal of Child Psychotherapy (JCP), Bonfatto and Crasnow's (2018) paper documents the current work of child psychotherapists working within GIDS. They make a '*plea for complexity, to counter the current intense focus on gender identity and the consequent reductionism this can lead to*' (Bonfatto and Crasnow (2018) p.29). They state the importance for

child psychotherapists, as part of a multi-disciplinary team thinking about gender variance, to focus on the unique journey of identity development for a particular young person and to move towards '*more processed and conscious appreciations of self*' (p.44). They assert that developing a therapeutic relationship that promotes exploration and thinking is what lies at the heart of psychotherapists' work within GIDS, widening the frame of thinking beyond a concrete view of just gender and promoting a capacity for symbolic thinking. Adopting a questioning stance, in which the complexity of development and spectrum of outcomes can be explored, is at the forefront of how psychotherapists in GIDS understand their role. Whilst the foundation of psychoanalytic treatment is to address and reintegrate painful aspects of self into the personality, to explore and investigate the complexity of identity development as a clinician can be a challenging process when the body and medical intervention is the primary focus for many families attending the service. The authors describe the use of transference interpretations via the service, as well as observation of the clinician's countertransference with families to understand the internal worlds of young people they are meeting. They reflect on how gender may have been too heavily focused upon over the past ten years and that a more holistic consideration of development and identity as a whole is important. The study concludes that it is the clinician's role to adopt a third position in order to promote a space to think, entertain all options and enhance a sense of playfulness. It is made clear that changing a young person's mind is not the task, rather to support and promote depressive thinking, as noted by Di Ceglie (1998), to foster informed decision-making.

Wright (2018), Ray (2018) and Tsoukala (2018) have all reflected on their work as child psychotherapists working with TGNC young people within CAMHS in the UK. Wright (2018) presents her work, with a young person experiencing gender dysphoria, as an exploration of the patient's thoughts in order to ensure that decisions around changing gender were fully informed. The work was non-directive and an opportunity to explore the patient's mind, without the intention of

moving towards a particular change. This case-study highlights the importance of psychotherapeutic work in promoting the movement from concrete to symbolic thinking, nurturing fluidity rather than rigidity of thought and tolerating a position of not-knowing. Ray (2018) impresses the value of being alongside and supporting a young person in their journey of self-discovery, in making sense of their position in the world, and integrating fragmented parts of the self, including their natal gender identity. Ray frames this in the context of a traumatic history, and the importance of facing an 'unthinkable' past is examined. Tsoukala (2018) purports that it is the psychotherapist's capacity to '…*bear the unknown, while gradually observing and mirroring the un-integrated inner self of the patient…'* (p.90) that can slowly help to piece the fragments of the personality together and assist a gender-variant young person to feel a sense of relief in terms of the trajectory they decide to pursue.

The importance of psychotherapists' awareness of their countertransference in order to inform the unfolding work (Pauley, 2014) and to be aware of a potential internal bias (Lemma, 2018) have also been discussed.

1.2.7.3 Clinical Psychologists in NHS

Much of the literature exploring the psychologist's role with TGNC youth focuses on supportive and affirming treatment approaches (Cousino et al, 2014, Tishelman et al, 2015), which includes the assessment of young people; diagnosis of GD if appropriate (Cousino et al, 2014; De Vries et al, 2012); 'watchful waiting' of how GD develops in the first stages of puberty (De Vries et al, 2012); supporting young people and their families to navigate challenging decisions regarding complex medical interventions; liaising with medics; and psychoeducation. Wren (2016), a clinician working with the GIDS service, has proposed a 'liberation psychology perspective' that is positioned towards social change and contesting conventional

discourses around gender.

McCann (2018) highlights the importance for clinicians working with gender variant young people to have fully examined their own relationship to gender and sexuality in order to build meaningful therapeutic relationships with the young people and their families. The British Psychological Society (2019) has documented guidelines to assist clinicians in adopting a non-judgmental stance, stating a clear need for practitioners to challenge their personal assumptions around gender identity.

1.2.7.4 Psychiatric intervention

Whilst the focus of this research is not on the role of psychiatry with TGNC youth, I believe it is important to briefly summarise the literature that arose from my search in order to provide a balanced overview of recent clinical approaches. Best practice with respect to psychiatric intervention for TGNC youth is an ongoing challenge given the comparative lack of existing empirical data (Leibowitz et al, 2016). It is also an area of clinical practice that is politically fraught, with medics possessing differing views over whether TGNC young people are appropriate referrals for today's UK psychiatric practice (Playdon, 2018, Turban, 2017). However, a range of professional organizations have created treatment guidelines, including understanding the multitude of biopsychosocial factors affecting identity (Kreukels et al, 2014), awareness of differential diagnoses (Singh & Sangganjanavanich, 2016), resisting premature interpretation (Daniolos & Cynthia, 2013) and thorough assessment protocols (Leibowitz et al, 2016). Treatment approaches in relation to TGNC youth presenting with co-morbid mental health difficulties have been explored and case reports have evidenced the benefits of a more holistic, rounded-approach to a young person's mental health needs rather than gender being the primary focus (Kilgus, 2014).

1.3 Methodology

1.3.1 Design

This is a small-scale exploratory study, in which I conducted semi-structured interviews with eight clinicians who had experience of working with young people presenting with gender identity issues.

1.3.2 Participants

I interviewed child and adolescent psychotherapists, clinical psychologists and family therapists for the purposes of this research, as they represent three of the key psychological therapies offered within child and adolescent mental health services within the UK. I recruited participants using a purposive sampling method, where participants were chosen in order to meet the objectives of the study. I gave a brief presentation of the research to the multi-disciplinary team meeting of the CAMHS service I was working in at the time and other potential participants from other NHS services within the same trust received written information via email about the study (see Appendix C). Twelve clinicians were directly approached for participation and eight gave their written informed consent to participate in the study. It is significant that a number of clinicians declined the offer to take part in the research on the grounds that they felt the topic is too controversial and that, despite being assured about anonymity, they still did not feel comfortable in sharing their views. This is something that is reflected upon further in the discussion chapter.

Inclusion criteria were clinicians (child and adolescent psychotherapists, clinical psychologists and family therapists) working within UK NHS mental health services, with experience of working with young people presenting with gender identity issues.

Eight clinicians (three child and adolescent psychotherapists, three

clinical psychologists and two family therapists) with experience of working with young people presenting with gender identity issues participated in this study. Participants were recruited from three NHS mental health services, two of which were generic CAMHS services and the other a specialist service. All clinicians were working within the same, large metropolitan area. In terms of the diversity of the sample, six were female and two were male. Of the eight participants there was a disproportionate percentage that were white (4 UK, 1 Southern European, 1 Latin American, 1 Australasian). One participant was Southern Asian. The majority of the clinicians had many years of experience whilst a couple had qualified within the past five years.

1.3.3 Procedure

1.3.3.1 Semi-structured Interviews

I conducted the semi-structured interviews using a flexible, semi-structured interview schedule (see Appendix D). Questions were based around the previously stated aims as well as background literature in the field. The interview covered: i) what the clinician felt their particular discipline could bring to this field of clinical work, ii) how the clinician understood their role when working clinically with young people presenting with gender identity issues, iii) how the clinician understood a young person's expression of gender dysphoria, and iv) how important they feel working with parents/ carers of the young people presenting with gender identity issues is. Questions were open-ended to allow the participants to direct the narrative, thus promoting the emergence of rich, organic data. Prompts were given to participants if required. Interviews took place in the clinics where the participants were currently working. Interviews took about one hour. I conducted all of the interviews to ensure consistency. I took audio recordings of all the interviews and transcribed them in full for analysis.

1.3.3.2 Data Analysis

I analysed interview transcriptions using thematic analysis (TA) outlined by Braun & Clarke (2006). TA is an appropriate approach when the aim

is to identify and analyse patterns of meaning across the data set. With this in mind, I implemented an inductive, as opposed to deductive, approach to the data (Frith & Gleeson, 2004), whereby the themes identified were entirely linked to the raw data itself rather than drawn from pre-determined theoretical ideas and a pre-determined coding frame applied. I considered inductive thematic analysis more appropriate due to the limited previous research gathering clinicians' voices and a desire to code in a 'bottom-up' manner rather than imposing pre-determined themes.

Whilst there is no specific guidance on sample sizes when conducting a TA (see Data Analysis), Braun and Clarke (2006) discuss the importance of having adequate data to answer one's research question. Furthermore, they acknowledge the pragmatic element of sample size choice. Given that this study was completed over a two-year period, there was scope to conduct eight interviews and have sufficient time to carry out a rigorous analysis of the data.

I undertook A TA in order to provide a more detailed and nuanced account of a group of themes within the data that related directly to my initial research question. This analysis was conducted on both a descriptive and latent level, gathering material into thematic categories, analysing and reporting patterns present within the dataset and comparing and contrasting viewpoints across participants. I considered other qualitative methods, including Grounded Theory (GT), Interpretative Phenomological Analysis (IPA) and Discourse Analysis (DA). I discounted GT on the grounds that the research was not intending to generate a theory. IPA, which seeks to generate an individual's lived experience of a phenomenon in intricate detail, did not correspond with the key research question. Whilst DA focuses on the interactional context of talk and may have supported the aim to understand how clinicians construct their roles discursively, I didn't think it was appropriate in the context of a semi-structured interview design. The aim of this research was to provide a rich thematic description of an entire dataset in the context of this being an under-

researched area. For that reason, I concluded that TA was the most appropriate analytic method. Claims have been made that TA can produce a surface level reading of participants' accounts. However, Braun and Clarke's (2006) guide to performing a rigorous and systematic TA incorporates the opportunity to analyse both the manifest and latent content of a dataset. To avoid a surface level, reductive account of the interviews, and in order to capture the richness and unique content of each clinician's dialogue, I have stated quotes verbatim and explored them in the results section.

I analysed the data following Braun and Clarke's (2006) six-phase guide to performing TA (see table 1). I will outline in detail the steps I took to analyse the data, as the literature stipulates the importance of transparency regarding decisions made in the process of analysis (Braun & Clarke, 2006).

Table.1 Phases of thematic analysis (Braun and Clarke, 2006)

Stage	Description of the process
1. Familiarising yourself with the data	Transcribing data, reading and re-reading the data, noting down initial ideas.
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set collating data relevant to each code.
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes	Checking if the themes work in relation to the coded extracts (level 1) and the entire data set (level 2),

	generating a thematic 'map' of the analysis.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. **Producing the report**	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis or selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

1.3.3.2.1 Phase 1- Familiarising yourself with the data

Following transcription of the interviews, I read and re-read the transcriptions and listened to the recordings again. This was crucial in order to become immersed in the data. At this stage, I noted down initial ideas and codes in a research journal.

1.3.3.2.2 Phase 2- Generating initial codes

'Codes are the building blocks of analysis" (Braun & Clarke, 2006). Being fully acquainted with the data, I began the process of coding by hand. This involved line-by-line coding (see Appendix E), with some sections being coded multiple times. Codes represent segments of meaning and related to perceptions, experiences and concepts. Sometimes codes were the words of the participant verbatim. Following coding of the first three interviews, I reviewed the codes to identify where certain codes were synonymous and could be reconceptualised. As stated by Braun and Clarke (2006), it is important that all codes are relevant to answering the research question. With this in mind and

considering the scope and time constraints of the study, I did not code certain parts of the interview transcripts, including the section in which participants spoke about their understanding about the rapid increase in referrals of young people presenting with gender identity issues. Throughout the process, I reviewed the codes to ensure that code names were reflective of the raw data.

Following coding of the first three interviews, I conducted more focused coding in which I applied previous codes to the following five interviews whilst also remaining open to new segments of meaning that I came across. I collated codes in a table in an ongoing way, ready for the next stage of clustering codes in order to produce themes.

1.3.3.2.3 Phase 3- Searching for themes

This stage of thematic analysis involved sorting codes into potential themes. In the current study this initially involved printing off and cutting up the code names and sorting them into '*theme piles'* (Braun & Clarke 2006, p.89) and later evolved into creating initial thematic maps (see Appendix F). Whilst I adopted a 'bottom-up' approach to data analysis, it is important to note the active role I had at this stage in terms of the decisions made about clustering of codes to make themes. What was crucial at this stage was that the identification of these should capture something important about the data in relation to the key research question (Braun & Clarke, 2006).

1.3.3.2.4 Phase 4- Reviewing themes

This phase involved refining potential themes by reviewing coded data extracts to ensure that themes were coherent and distinct (Braun & Clarke, 2006). Themes, sub-themes, codes and data extracts were reviewed a number of times until the researcher was confident they represented the data in a way that was meaningful for answering the research question. It is important to note that how 'key' a theme is does

not depend on quantifiable measures (Braun & Clarke, 2006), hence why frequencies of themes are not presented in this report.

There were some initial codes that did not serve to answer the research question about how clinicians understand their role when working with TGNC young people. The extraneous codes were put into a 'miscellaneous' category as recommended by Braun & Clarke (2006). Discarding coded material and provisional themes is expected during the process of inductive thematic analysis, however could be seen as a limitation of the study given that not all data is then represented in the final report. This will be further considered in the discussion.

1.3.3.2.5 Phase 5- Defining and naming themes

This phase involved defining and naming themes in order to identify what is unique and specific about each theme. This involved selecting extracts to present and analyse in order to tell the story of the data set.

1.3.3.2.6 Phase 6- Producing the report.

Braun & Clarke (2006) consider the writing of this report as the final phase of thematic analysis. This comprises the results and discussion sections of this paper.

1.3.4 Ethics

Given that data was only collected from clinicians, the research was considered as a 'clinical audit', and full approval by the NHS Ethics Committee was not required (see Appendix B). Local research and development ethical approval was required (see Appendix A), given that the research was part of an academic doctoral program. Further approval was required from the specialist service in order to recruit participants.

1.3.4.1 Informed consent and right to withdraw

All participants gave informed consent to participate in the study and were able to withdraw up to two weeks post-interview.

1.3.4.2 Confidentiality/anonymisation procedures

Any identifying data like names, professions or places were omitted prior to analysis. I stored recordings and transcriptions of interviews on a secure, encrypted device. I deleted recordings following transcription and all of the written data will be deleted following the final write up of the study.

1.3.4.3 Debriefing

Participants had the opportunity to ask questions following the interview and were advised to discuss ideas that may have arisen through the interview in their own clinical supervision.

1.4 Results

1.4.1 Thematic analysis

The in-depth and rigorous process of thematic analysis of the participants' interviews highlighted a variety of themes in terms of how clinicians understand their roles when working with young people presenting with gender identity issues. From the initial coding of the interviews, a total of 20 themes were considered relevant and were recorded. From these 20 themes, five superordinate themes were demarcated. The theme of 'Parent work' was initially amongst the superordinate themes but after closer reviewing of the data it was clear that this theme was relevant across four out of the five superordinate themes and therefore would not be a stand-alone superordinate theme.

1.4.2 Superordinate themes

This section will describe the five superordinate themes (Figures 5-9) that encapsulate the principal aspects of the data set as a whole. I will present each theme by addressing each sub-theme and relevant extracts from the interviews in order to bring them to life. For this study, superordinate themes were not organised in order to directly correlate to the interview schedule. Instead they were organised inductively from the data in order to answer the central research question: '*What can we learn from interviewing clinicians about how they understand their roles when working with young people presenting with gender identity issues?'* Understanding the different ways in which the psychotherapists, psychologists and family therapists understood their roles was also an important aspect of the study and this will be woven into the findings. Names and identifying data are anonymised when interview extracts are quoted to ensure anonymity.

1.4.2.1 Theme A- Finding Meaning

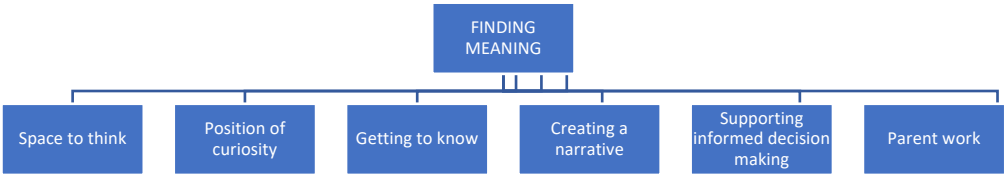

Figure 5. Superordinate theme 1

Clinicians understanding their role in terms of helping TGNC young people to find meaning was a dominant theme across all interviews and mental health disciplines (see Figure 5). This encompassed providing young people with a space to think in which taking a position of curiosity as a clinician was considered crucial. In doing so, clinicians spoke about this allowing one to get to know the young person and helping them to create their own, unique narrative. The aforementioned was also spoken about in relation to work with parents/carers.

1.4.2.1.1 Space to think

Providing a space to think was at the heart of how all three mental health disciplines understood their role when working with TGNC young people. One psychotherapist spoke about 'thinking' as the crux of their work:

"Our profession is about thinking and I think that we, what we provide is a thinking space rather than a jumping to action space without previously thinking. So there might be a time for action but we would hope to provide that thinking space before" (Psychotherapist 1, pg.17).

They embellished upon the importance of having *"an adult in your life who can help you….. to have the space to think… it's part of the equipment that is needed anyway in life, to have the capacity to think things through"* (Psychotherapist 1, pg.12). One psychologist corroborated this by stating that, *"anyone who comes to see a clinical psychologist has that non-judgmental space of acceptance to sort of*

explore and investigate and think about their identity, think about their mental health, think about their relationships" (Psychologist 1, pg.1) Providing a *"scaffolding"* (Psychologist 1, pg 2) for this thinking to take place was discussed. A family therapist spoke about their role in *"helping them (young people) think about it. We should be the ones saying hang on, let's go through it. I think we hold a huge responsibility*…" (Family Therapist 1, pg.15) Interestingly, the same family therapist spoke about the important role that they felt psychotherapy had to play in providing that space to think: *"I would always think that as a clinician from a MDT clinic approach I would of course want the child to get some individual child psychotherapy to think about what is going on and what is the expression of this confusion that this child is in"* (Family Therapist 1, pg.9)

1.4.2.1.2 Position of curiosity

I identified Taking a position of curiosity, linked with taking a position of 'not knowing', as a key sub-theme of the superordinate theme of 'Finding meaning'. Again this was represented across all three disciplines and incorporated broad ideas around being able to open things up to explore, question and seek understanding. The challenges of being able to take a position of curiosity were also discussed across the board.

One of the psychotherapists encapsulated both her intention to be curious in her work with TGNC young people and the challenges that come with that:

"I think that's what we take from our training, that we always come from the position of not knowing what we are facing and really being curious about it, and I think that is one of the challenges about dealing with gender specific problems, that sometimes there is a lot of resistance or anxiety around the diagnosis itself or trying to, to find an explanation for it too readily, that makes it quite difficult to ask questions around it I feel" (Psychotherapist 2, pg.2).

One of the family therapists reiterated the same point:

“I think the ‘not knowing’ position is a very wonderful position here in family therapy which is that I stay with the child to explore with and be curious about what the child is going through, you know what is it, what is their narrative, what is their discourse, what do they understand about it yeah, and um, how much do they understand it what is going on for them" (Family Therapist 1, pg.4).

However, she later discussed the resistance that she has experienced in young people and their families, of not wanting to be challenged or questioned:

"…it’s about them not wanting to be challenged, not wanting to be in a challenging position, it’s not wanting to take responsibility…I just feel the new generation don’t even know that that’s a kind of position you can take, the hardship of any issue" (Family Therapist 1, pg.15)

Interestingly one of the psychotherapists asked the question of *“are we trying to find meaning too quickly sometimes?”* in our therapeutic work, adding that *‘there may be times when there may be a need for some more just genuine exploration about what they are, who they are."* (Psychotherapist 2, pg.11) The promotion of exploration was considered to be *“no different to any other type of work we do"* (psychotherapist 2, pg 4)

Inherent to taking a position of curiosity as a clinician, both psychologists and psychotherapists felt that promoting a questioning stance was an important part of their role. One clinician spoke about their role being, *"to allow them [young people] to freely question how things are, how they feel and how they perceive how others perceive them, how they feel about others’ acceptance of them as they develop"* (Psychotherapist 2, pg.4). A psychologist stated that they felt they were there to *“ask kind of the harder questions"* (Psychologist 1, pg.16).

Through promoting exploration and questioning, ideas around gaining a deeper understanding and developing a sense of meaning with the TGNC young person was a key aspect of clinicians’ discourse. Psychotherapist 1 stated that *"The primary task is to open things up,*

um rather than think it's just to do with gender, well it is to do with gender but to open up the gender question in terms of their life and what that means to them" (pg.15). Psychotherapist 2 spoke about her intention *"to try and be led by the young person and try to understand where they are coming from with that feeling or with that view, that's how the exploration would begin anyway, where is this coming from? What it means to them, I guess basically questions, talking about meaning, how do they understand themselves"* (pg.4). This was reiterated by another clinician: *"I think that that's where I feel my responsibility is as a therapist…to help them to make more sense of it, it's a good thing but it might be a very bad thing if they have to make a drastic decision without having any understanding of it, or not, or maybe as we say it could a phase, but not knowing it's a phase, going with the trend, are they going with a trend? So we need to help them think about it make more sense about it…"* (Family Therapist 1, pg.11). One of the psychologists spoke about the importance of having a space to better understand a TGNC young person's situation but was careful to justify that their position was not one of trying to sway the course of events: "*So there is something about, you know creating a space early on to try and understand, and it's hard, I really am trying to hold onto neutrality when I say that because it's not that I'm saying 'get them in early and you'll talk them out of it', it's not about that at all"* Later they state that *"It's really having, again it's being quite sort of parental, having to really validate distress and to take that, to know that is completely real, and yeh, but to also to try and understand it."* (Psychologist 3, pg.6 and pg.12)

Challenges to having the space and time to be curious, ask questions and to develop a deeper understanding with TGNC young people was highlighted across the three disciplines. Some clinicians spoke about the challenges related to the context of modern day CAMHS clinics:

"A lot of it can be thought about and planned for but there's a whole area which is just about sort of having the time and space to work things out a little bit…...and there isn't In the sense that everyone's jobs

are a bit too much, a bit overwhelming in the current context" Psychotherapist 3, pg.12)

“Is the CAMHS as we know now prepared to work this way? Because there is more and more, with transformation and pathways, expectation to address symptoms” (Psychotherapist 2, pg.11)

Other clinicians discussed barriers in terms of young people and their families’ openness to this type of exploratory approach, which was particularly in relation to a parental wish for certainty:

"It’s not just about time but for me it’s about the openness of a system around a young person." (Family Therapist 2, pg.12)

"Things can become quite difficult, quite difficult to actually to, again to maintain that position of neutrality and curiosity and it doesn’t mean that I’m, by asking a certain question, trying to swing things to a different direction, I’m just trying to bring something else on the table to think about so that we can explore fully and exhaust all different possibilities, all different ways of looking at the problem." (Psychotherapist 2, pg.9)

“I found my stance of being very patient… not goal directed, directed by them in the room was very at odds with the parents wanting to know, kind of, wanting to know, seeing me as the expert and wanting me to say whether this was one way or the other or whether this would pass or this would remain, you know, they wanted to something black and white. That was their anxiety, they wanted to bring it back into something that they could understand.” (Psychologist 1, pg.9)

1.4.2.1.3 Getting to know

Getting to know a TGNC young person as a whole was something that was particularly spoken about amongst participants from the psychotherapy discipline. One psychotherapist spoke passionately

about *“being able to think, well what is this person’s life like, what kind of person are they, what kind of character do they have, and I think probably child psychotherapists and other disciplines too, but child psychotherapists really do bring that way of thinking about people in their entirety and not just the one specific diagnostic criteria, um so I think that is an important thing that they bring.”* (Psychotherapist 1, pg.3) Getting to know *“as widely as possible in terms of their character and their personality and their circumstances and their feelings"* (Psychotherapist 1, pg.5*)* was felt to be the primary task of this clinician. Promoting a TGNC young person to express themselves in order for them to get to know themselves better, to discover their authentic self and essence and reach a point of self-acceptance was felt to be important:

"I think the task for the younger one is to really give them the space to find their own voice, to express themselves.” (Psychotherapist 2, pg.10)

"I think something about holding onto authenticity for them, um, but it’s exploring it for long enough to make it a considered and most well-informed decision for them." (Psychotherapist 1, pg.16)

"but they can really have their own journey, and It brings in all of their life experiences and all of their innate kind of, or more, I don’t know what you’d say if it was innate, but what’s actually essential, what’s their essence within in them, that they can bring all of that together and then find the place where they want to be at the end of the day." (Psychotherapist 1, pg.5)

"It is important for them to be able to reach the stage where you know, you are, you feel that whatever you are you can accept yourself somehow warts and all, and be the person that you are and, but having somebody to help you with that task growing up is a really, really, is going to be helpful for both age groups." (Psychotherapist 1, pg.12)

Getting to know a TGNC young person was also spoken about in relation to work with the parents: *“Really, really getting to know what kind of child they love and is in their family, and in some ways they know very well… helping them to know their child and helping their child to know themselves I guess.”* (Psychotherapist 1, pg.12)

1.4.2.1.4 Creating a narrative

Taking a position of curiosity seemed directly linked to being able to help TGNC young people to formulate a narrative about themselves. This was mainly spoken about by psychotherapists and family therapists:

"[L]etting things emerge, letting the young person’s story really emerge um in their own time, within the therapy er is really important and I think again training as a child psychotherapist moves us in that direction." (Psychotherapist 2, pg.4)

"[C]reating a narrative about their life and an understanding about their own, what’ve they’ve made of their life, about what they’ve made of their life experiences, um, so I think with that as my primary task when I’m in the room.” (Psychotherapist 2, pg.5)

"[W]hat is their narrative, what is their discourse, what do they understand about it yeh, and um, how much do they understand it what is going on for them?" (Family Therapist 1, pg.4)

“[W]hat is the narrative behind their gender identity?" (Family Therapist 1, pg.2)

1.4.2.1.5 Supporting informed decision making

Through providing a space to think, taking on a position of curiosity in order to get to know a young person and helping them to create a narrative for themselves, clinicians from all disciplines discussed the idea of this process helping to support TGNC young people in making

informed decisions for themselves:

"If you aren't able to explore a little bit more with this child you might miss out. The child may not want to, there may be other issues or it may be a phase or maybe they don't want to go through the gender changes and just live in the LGBT+ kind of position." (Family Therapist 1, pg.15)

"[M]aybe the young people don't fully understand the weight of decisions and what gender identity means and we need to help them with that and be adults in that, and try our best to kind of scaffold them through that." (Psychologist 1, pg.20)

"[I]t's exploring it for long enough to make it a considered and most well-informed decision for them." (Psychotherapist 1, pg 16)

1.4.2.2 Theme B- Contextualising

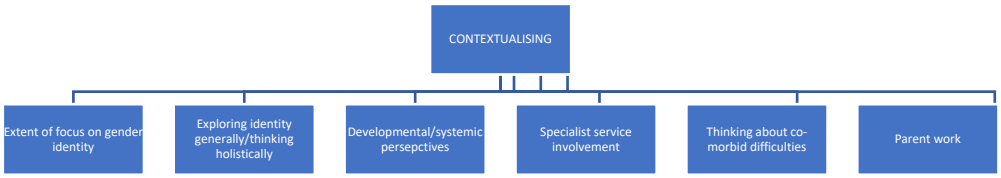

Figure 6. Superordinate theme 2

The second superordinate theme that emerged from the data set related to clinicians supporting TGNC young people to contextualise their difficulties (see Figure 6). Clinicians spoke in differing ways about the extent to which their clinical focus was on the gender identity presentation itself. Exploration of a young person's identity more generally was a pertinent sub-theme, thinking more holistically about their struggles, with certain clinicians adopting a more developmental perspective in some cases whilst systemic thinking being at the heart

of others' approaches. Direct focus on the gender identity issue itself was discussed, which stimulated talk about involvement with a specialist gender service. Considering co-morbid mental health difficulties was also linked to this theme.

1.4.2.2.1 Extent of focus on gender identity

The extent to which clinicians felt it was their role to focus specifically on gender identity with TGNC young people was spoken about across all three disciplines. One psychologist stated that, *"as a clinical psychologist you work very pragmatically, with what's in front of you, and someone who has , is going through transition or has gender issues, that may or may not be the thing to be spoken about and just because it's happening it doesn't mean that it's at the forefront of their mind, that in fact you might rarely touch on it in the work with them or it might be absolutely essential and they need to have space to explore it. So I think there is something very pragmatic about clinical psychology that allows one to be flexible."* (Psychologist 2, pg.2)

A family therapist reiterated the above point who said that "*the gender identity issues might not be at all relevant, so you know they might be flagged up by the referral process but then they are then not at all relevant."* (Family Therapist 2, pg.4)

Another psychotherapist felt that their primary task was to "*open things up, rather than think it's just to do with gender, well it is to do with gender but to open up the gender question in terms of their life and what that means to them."* (Psychotherapist 1, pg.5)

Over and above gender issues, getting to know someone, central to theme A, as well as considering a TGNC young person's feelings more generally and their wider context, was at the heart of how all three psychotherapists understood their role:

"[I]t's about getting to know them rather than thinking about them in terms of this is someone who's got gender identity issues, gender, you know body dysmorphia." (Psychotherapist 1, pg.5)

"[T]he gender is not the main aspect of the work to me, it's about the feelings, the feelings of the distress, trying to find the meaning, what we do normally in work with any other case." (Psychotherapist 2, pg.11)

"[I]t may be a whole range of other things that come up in the work which actually may or may not relate to gender." (Psychotherapist 3, pg.2)

There was a sense that clinicians, on the whole, were taking the lead from the young people coming to see them and that the focus of the work would be determined by the young person:

"*I think that our role in particular can be patient guided and what they do want help with irrespective of gender, that's just been my experience that they've brought a lot , that they don't always want to always come and talk about their gender and being able to provide a space for that…..there can be other difficulties that this population want to focus on as well, and sometimes, it's my view that clinical psychology has a role in addressing that." (*Psychologist 1, pg.3)

In relation to a particular patient one of the psychotherapists stated that *"he never wanted to talk in any detail about the gender identity issues"* (Psychotherapist 1, pg.7). Another psychotherapist spoke about the benefits of focusing on as well as not focusing on the gender issues themselves:

"There are things to gain from you sort of leading the conversation in that way because maybe the person is shying away from it, but there are also things to gain from just taking it where the young person takes you and if they don't mention it then maybe you'll never talk about it." (Psychotherapist 3, pg 10)

One of the family therapists stated that specific, explicit focus on the gender issues was important:

"[I]f they are able to safely explore some of these issues um dressing up the way they want to whether its gender issues or sexuality issues

you know, whether I want to be a female or a male or I'm non-binary or I'm not sure you know what it is, um, then there is a sense of they start feeling a bit more comfortable around what it is, it's a layer, its one layer peeled off if you know what I mean." (Family Therapist 1, pg.4)

However, the sense of there being multiple layers to a young person's presentation that need to be considered by a clinician was later acknowledged by the same therapist:

"*[I]t's layered with so many complexities, it may be layered by so many personal issues in their life that brings this about more, it can be a form of wanting to be someone different because of wanting to leave something that they don't want to face anymore, it's just not that, there are so many things that are connected to this presentation of depression and anxiety that they come to CAMHS with and then the gender issue becomes the big one."* (Family Therapist 1, pg.14)

This was reiterated by one of the psychotherapists: "*[I]t often turns out that there is actually a lot more beneath the surface going on and my limited experience with gender identity issues is that they may or may not fall into that sort of category, where actually there is a lot else going on under the surface as well and that what's explicitly brought is not necessarily the area that is important to work with.*" (Psychotherapist 3, pg.2)

One psychologist expressed their concerns that when the focus becomes so fixed on the gender identity issues, exploration of other, associated mental health difficulties can be inhibited:

"[T]he young person had a range of issues that would be affecting young people in general, or a person that meets the criteria for depression that wasn't being addressed because everything was seen in the context of their gender identity and I found quite a disillusioned young person coming in their view of what CAMHS could do and what CAMHS could help with, it was that everyone was just trying to make their family ok with their gender and everyone was trying to make sure that they were ok with their gender and they were, but they were incredibly depressed, and he just wanted to come and not talk about gender." (Psychologist 1, pg.4)

1.4.2.2.2 Exploring identity more generally /thinking holistically

*"Trying to flesh out their identity, making it as rich as possible, get them to language to let them create an image in my mind of something very , very meaningful and rich in their identity, um, and I think that's then a powerful experience for them…they can see themselves existing as quite a full human being as you explore identity…which is a very individualistic process…because its fleshing them out as a person." (*Psychologist 2, pg.4)

"Identity development in general" (Psychologist 1, pg.11) was identified by all eight clinicians as crucial to their role with TGNC young people. This involved clinicians' thoughts about being able to think holistically, as opposed to diagnostically about a TGNC young person:

*"I think there is also something about child psychotherapy helping people to think more holistically about young people. So not just thinking diagnostically, but being able to think well what is this person's life like, what kind of person are they, what kind of character do they have, and I think probably child psychotherapists and other disciplines too, but child psychotherapists really do bring that way of thinking about people in their entirety and not just the one specific diagnostic criteria, um so I think that is an important thing that they bring." (*Psychotherapist 1, pg.3)

This idea of widening ones field of understanding about a young person was substantiated by one of the psychologists: *"One needs to be willing and open with the difficulties that are associated with gender identity but not have that overtake just everything else that it is to be a young person in today's world, it's the same as , I kind of, I would kind of liken it to maybe, maybe not today, but maybe if someone was to come in and, who was on a different spectrum, having difficulties around sexuality, and things like that, I don't think I would suddenly drop all my other thinking about this person and say well right I need to see you in the context of this sexuality."* (Psychologist 1, pg.6)

In order to support TGNC young people in developing an understanding of their identities more generally, clinicians spoke about having the time to consider a young person's wider context:

"[T]he clinical task is to try and understand the child in context I would be trying to encourage the parents to do the same thing, so I think the clinical task doesn't differ in terms of what might be helpful in terms of understanding the child in context and you know knowing that child for really who they are." (Psychotherapist 1, pg.11)

One of the family therapists felt that understanding the home and school context were particularly important:

"[A]s a family therapist I would like to very curious….I mean about the context let's put it that way, it's the context I would explore the context, whether it would be school whether it be home." (Family Therapist 1, pg.9)

Another psychologist felt that a consideration of *"the wider socio-political context"* that the young person was living in was crucial (Psychologist 3, pg.8). Whilst careful thought about the wider context of TGNC young people felt pertinent in the minds of many of the clinicians interviewed, one of the interviewees was able to articulate an anxiety about how this stance could be perceived: *"I like thinking about things in a really general way and part of a bundle of things that make up a person. But I certainly think that where my anxiety is raising in talking to you about it is that I don't want it to come across that I'm minimizing gender identity issues or thinking of it as not something that's incredibly difficult and that this population faces quite a significant battle, and a significant amount of vulnerability. I don't want to take that away just because I think of it in this wider sense, I don't want that to come across."* (Psychologist 1, pg.14)

1.4.2.2.3 Developmental/systemic perspectives

Both psychotherapists and psychologists spoke about holding in mind a developmental perspective when working with TGNC young people. Having a clear developmental history of any TGNC young person they were working with was felt to be important, with consideration of the

young person's attachments to their primary carers, the impact of any adverse childhood events as well as their stage of sexual development. In particular, psychotherapists felt that their training equipped them well to think about TGNC from a developmental perspective:

"I think child psychotherapy can bring a high level of understanding in terms of child development. I think it is one of the professions which has a really thorough training in child development and I think that is really important as a backdrop to the young people who do have gender identity issues, that you understand them within the context of child development and where they are developmentally because I think some of the issues are specific to the diagnosis and some of the issues are related also to where they are developmentally." (Psychotherapist 1, pg.2)

This perspective was also captured by one of the psychologists: *"I guess kind of broadly speaking it's something about sort of facilitating the unfolding of gender identity as a, you know, as a sort of developmental and relational process"* (Psychologist 3, pg.2) The same clinician compared how, by adopting a developmental stance, one might understand differently the narratives of a pre-pubertal TGNC young person in comparison to an adolescent:

"*I suppose to be very concrete about it, you know, if a five year old says I want a willy or when am I going to have boobs…that does mean something different to when a 15 year old says the same thing."* (Psychologist 3, pg.4)

Another psychologist stated that "*I think I would be very conscious of the development, what stage they're where they're at in terms of not just physical development but the development of who they are, their attachments"* (Psychologist 1, pg.11). Psychotherapist 2 stated that they would want a *"solid developmental history"* (pg.2) in order to *"understand their inter personal relationships and from a child and adolescent psychotherapist point of view, thinking about their attachments…they're all different aspects to consider."*

More specifically, consideration of important developmental processes of separation between TGNC young people and their primary carers

was spoken about, as well as holding in mind a young person's stage of sexual development. Considering a young person's distress about their gender in relation to their pubertal, sexual development was also discussed: "*[H]ow much is about distress around pubertal development um, you know happening to somebody perhaps before they were ready to emotionally, you know, somebody whose physical development feels way out of step with their kind of social and emotional development."* (Psychologist 3, pg.4)

Enabling symbolic thinking as part of clinicians' role was discussed by three interviewees. This was particularly in relation to work with pre-pubescent TGNC young people and their parents/carers. This involved clinicians taking on a more challenging role in which the developmental stage of TGNC young person was very much held in mind and was felt to be important that their words and thoughts were not necessarily thought about in a literal sense:

"[T]he younger they are, there are so many factors to consider there…their developmental stage, how they think about the world in a more magical, ever changing way." (Psychotherapist 2, pg.11)

"[Y]oung people can get trapped in a world where things become very black and white and things become very non-symbolic, non-metaphorical, and you'd very much think that's the work of therapy would be to help them form relationships, have a more rounded experience that is less black and white, concrete one. And I suppose there's a way in which you could view grabbing onto gender, you know seeing it as very concrete…it's through the play, I think the play can develop and expand in a more sort of metaphorical way and can encourage that way of symbolic thinking." (Psychotherapist 3, pg.9)

"[S]hould parents be taking their child's words literally or is it being able to respond in a more reflective, attuned, developmental way to what the child might be trying to communicate?" (Psychologist 3, pg.7)

This linked with the above ideas around clinicians being able to provide a space to think, and slowing things down in order to fully understand the unique meaning of gender identity difficulties. Clinicians spoke about the challenges of introducing the idea of symbolic thought and the unconscious, phantasy world of young people, in particular the resistance in many parents/carers to take these ideas on board when there was a powerful wish for certainty.

Weighing up whether to think symbolically or concretely about a TGNC young person's presentation was felt to be important with a recognition that having the capacity and time to explore in depth was not always possible or appropriate:

"I guess what I was going to say about the person I saw yesterday in terms of symbolic and concrete thinking, is that you have to meet people where they are at and think about what opportunities people have had to…. I struggle with this ethically because I think, with this young person that I saw yesterday, I was thinking that they have had so little opportunity in their life to develop symbolic thinking about things and you think about how they are experiencing their body. There is such a significant history of trauma, if they were really helped to process that they may well arrive at a different understanding, they may arrive at a different understanding of themselves, or they may not, you don't know, but where are they going to get to do that thinking? You wonder whether the robustness or the concrete feeling of robustness and solidity achieved by an aspect of medical transition is actually what will hold them enough to do that thinking at some point later in their lives." (Psychologist 3, pg.5)

Developmental stage/age seemed to be key in whether clinicians felt their role was to think more symbolically/concretely about a TGNC young person's presentation:

"I suspect with a 16-year-old I would think I would do more thinking about the explicit level of, it would be clearer to a 16-year old in

comparison to an eight-year old, that would be a lot less clear and I'd be thinking a lot more about what does this represent, what else is going on in the young person's life." (Psychotherapist 3, pg.6)

Adopting a systemic perspective in relation to TGNC young people was spoken about mainly by family therapists:

"I would explore within the family around what are the narratives around gender, you know where is the child getting this idea pre-pubescently, because you know I think children don't have a very firm view on gender, I think gender is socially constructed for children, I don't think children grow up with a very, they don't understand what their body is or what they are to be. I think we start making a girl a girl by doing all the things we want to do; if there are two children that are brought up in a very equal gender way I don't think that children at that age understand what they want as a girl or a boy so I would try and understand more systemically what is happening in the context that the child lives around the preference around the other, the other identity and what is going on there and where its coming from. I'd be very curious about it, very, very curious about it." (Family Therapist 1, pg.9)

1.4.2.2.4 Specialist service involvement

Part of contextualising a TGNC young person's difficulties involved clinicians' discourse around when they might involve a specialist gender service. Some clinicians felt that a space for more general exploration (theme A) was required prior to any referral to a specialist service, whilst of course some TGNC young people would have attended a specialist service first and then be referred to CAMHS for ongoing intervention. Family Therapist 2 in particular spoke about their belief that referrals to a specialist gender service are often rushed, in many cases because of the sense of urgency in TGNC and their parents/carers to start thinking about physical transition. A number of clinicians relayed their feelings that they were the 'gatekeeper' for referrals to the specialist service and that therefore their involvement with a TGNC young person is solely a prerequisite for a specialist

service referral. Other clinicians (Psychologists 1 and 2) spoke about viewing the specialist service as the 'experts' and a safety net and reassurance in a field of work that is still relatively unchartered within general CAMHS services:

"I take responsibility for the work, I work with it as best I can but I've got this safety net, it doesn't matter if I muck up or if I say the wrong thing because there is the specialist service who are out there who will fix any mistakes I've made…it's quite reassuring for me as a clinician to know they are out there, that I don't have to know huge amounts or I don't have to get to a young person to a certain stage of understanding or acceptance." (Psychologist 2, pg.9)

"I suppose at a very practical level do they need/want a referral to the specialist service, so that's something in the back of my mind, and that is something that I know, that I hold in my mind as 'they are the experts on this thing' um, and then it's me making a decision as to is it appropriate, do they, is, what's my role in relation to the referral, am I the one who says, that needs to bring it up with them that there is this clinic out there for support? Do I, is it, or is that um there is I suppose, there is an anxiety in my mind, am I pushing them in a certain direction?" (Psychologist 1, pg.3)

1.4.2.2.5 Thinking about co-morbid difficulties

Part of clinicians' role in contextualising a young person's gender identity issues was about addressing, assessing, exploring and ruling-out any co-morbid mental health difficulties. It was psychologists and family therapists who spoke about the consideration of whether there might be underlying depression or anxiety that might need thinking about in advance of the gender identity issues:

"I think we have an important role, as opposed to other disciplines that might help in particular with the exploration around the gender identity itself. I think clinical psychology can be helpful in determining whether

there is an underlying depression or an underlying anxiety difficulty that is potentially associated with their gender identity or not…I think we have a role there, not to say that other disciplines don't have a role there, but I think our training is really quite specific in diagnostic assessments and understanding whether someone meets the criteria for another mental illness or mental health difficulty." (Psychologist 1, pg.3)

"[M]y understanding as a mental health clinician is that if I find that the depression and the anxiety lie elsewhere, it's not the gender identity that is the issue which is the problem that they came with, then I try to explore what the depression and anxiety are about." (Family Therapist 1, pg.5)

1.4.2.3 Theme C- Containment

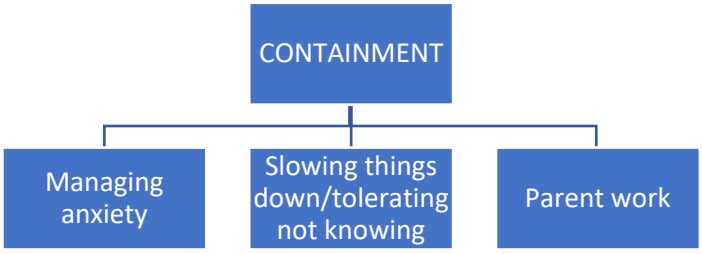

Figure 7. Superordinate theme 3

The containment of anxiety in TGNC young people and their parents/carers was the third superordinate theme to emerge from analysis of the eight interviews (see Figure. 7)

1.4.2.3.1 *Managing anxiety*

"[W]hen you are dealing with high levels of anxiety and there is something about anxiety itself that is quite paralysing, that makes thinking more difficult and you feel a bigger push for problem solving when you are under that sort of stress. Because it's like you know, 'I can't bear this level of stress so we need to do something about it', and that's usually when thinking goes and that's why I go back to what I said at the beginning. It's maintaining our professional stance kind of

not knowing, containing, bearing the anxiety and thinking about what is this communicating, what is this about, what is this anxiety about?" (Psychotherapist 2, pg.7)

This interview excerpt captures the importance, which some of the clinicians expressed, of being able to tolerate the high levels of anxiety that can get stirred up in this work in order to preserve a thinking space, but the clinical challenge of doing so. One of the other psychotherapists expressed ideas around containing anxiety:

"It's about helping to contain anxiety and not to panic. Um, so that they really can be available for whatever, because you know it's not sort of, growing up is not easy, so if you've got a container, an adult in your life who can help you that is going to be very important." (Psychotherapist 1, pg.12)

One psychologist felt that the containment of anxiety was often in the relation to the risk associated with TGNC young people: "*[I]n my own experience there are several factors that they, you know, suicidal ideation is higher in young people with gender identity difficulties so we do up the anti, but I think sometimes there is a real need the clinician to hold that."* (Psychologist 1, pg.6)

Through adequate containment, the exploration of anxieties was deemed vital. However, there were differing opinions about whether a clinician's role should always be to reduce the anxiety. One psychotherapist clearly stated that "*we want people to be free from crippling anxiety and depression" (Psychotherapist 3, pg.17).*
One of the psychologists explored the idea that raising anxiety to a certain extent, particularly with the parents/carers of TGNC young people, can be crucial in promoting deeper engagement with and exploration of a young person's situation and the decisions they are making:

"*[T]here's something about raising, from that position ideally of having*

built a relationship, parental anxiety often, but you know you sort of have to contain and then raise parental anxiety in terms of introducing the complexities of these decisions. I think that, I've realized that's something that I do a lot. Actually, giving them some of the anxieties, it often feels that there isn't a third position…that because there's not enough parental function in the family you're the parental function" (Psychologist 3, pg.11). This captures the importance of clinicians being able to balance both the containment as well as the raising of anxiety in some cases.

All three disciplines spoke about managing anxiety in direct relation to the parents/carers:

"[I]t's about trying to establish that therapeutic relationship in which the parent feels understood about where they're coming from with the anxiety." (Psychotherapist 2, pg.8)

"I think that parents who are, maybe, where there is an opportunity to kind of be contained, feel that they are talking to the experts, they can have something valuable and containing that kind of perhaps reduced anxiety." (Psychologist 3, pg.7)

"*[C]reating a narrative and a discourse to contain the parents' anxieties."* (Family Therapist 1, pg.15)

1.4.2.3.2 Slowing things down and tolerating not knowing

Part of containment involved clinicians speaking about being able to slow things down with TGNC young people and their parents in order to promote a space to think: *"I just think I would want to slow things down a lot more and have a lot more time to think about , kind of, everything that's going on"* (Psychologist 1, pg. 11). One of the family therapists felt that there were times when responding too quickly to the gender identity difficulty, and maybe making a referral to a specialist service, could provoke more anxiety in a TGNC young person and their

family. For that reason, taking things slowly was felt to be important: *"[T]here might be times when families are not ready to have these conversations about gender, like the family members around the young person….they might stop seeking help, and refuse to engage with CAMHS."* (Family Therapist 2, pg. 4) However, the same clinician reflected on the challenge of slowing things down in other cases where there is a sense of urgency to make decisions quickly. Providing a space to think, a key aspect of theme A, was very interlinked with clinicians' discourse around a desire to slow things down with TGNC young people.

Being able to tolerate feelings of uncertainty, ambiguity and of not knowing in relation to TGNC young people's situations was strongly linked to how clinicians understood their role of containment. The challenges of this were discussed in terms of TGNC and their parents/carers often wanting clear answers and a sense of certainty.

One family therapist considered an aspect of their role to be *"thinking about uncertainty, living with uncertainty…helping people to live and to bear this uncertainty. I think that has been part of the work at times when working with younger people with gender identity issues"* (Family Therapist 2, pg.12). This was reiterated by a psychotherapist who felt that, particularly with pre-pubescent TGNC young people, there was a need to engage the parents/carers with the idea of uncertainty rather than providing solid answers or solutions, One psychologist stated that "*the purpose of the space is for it to be just that space, a space where ambiguity is accepted and tolerated"* (Psychologist 1, pg.7). Another psychologist expressed the view that their role was to "*hold onto uncertainty a bit more. You know, that that then does genuinely provide a space for things to develop in different directions and that's not to say that some young people won't end up actually transitioning but it means that there is more likely to be a range of options*" (Psychologist 3, pg.7).

TGNC young people and their parents/carers' wishes for certainty were

felt by some clinicians to be at odds with their own wish to remain open to all options. One of the psychotherapists referred to a particular patient where this was the case:

"*[A]ny uncertainty about the certainty around gender he was very anxious about. That of course doesn't mean that the certainty wasn't right for him but there was a sort of anxiety about what if this wasn't so clear and certain?"* (Psychotherapist 3, pg 14).

They later stated that "*I suppose that's one reason why he ended the treatment, because I had fed back feelings of uncertainty and I think that had been very hard for him to hear."* (Psychotherapist 3, pg.16).

One of the psychologists referred to their own anxiety in tolerating a position of uncertainty with a particular TGNC young person: *"[A] bit of me is happy to work within that uncertainty but part of me struggles"* (psychologist 2, pg.10).

As a clinician, holding the position of 'not knowing' was spoken about by all eight interviewees. These are a few examples:

"I think child psychotherapists bring a capacity not to know, which I think is really important in all clinical work. I think child psychotherapists are particularly encouraged to be in that place and I think that is helpful actually, particularly helpful in this field. Partly because it's something quite new in terms of the clinical presentation, there are suddenly lots of young people coming forward, so there is something about us trying to work it out with the young people as we go along. I think being able to suspend one's own sense of well I've got to get a handle on this right away is quite helpful in this work." (Psychotherapist 1, pg.3)

"I think the 'not knowing' position is a very wonderful position here in family therapy." (Family Therapist 1, pg.4)

However, many difficulties in taking this position were discussed, including young peoples' and their parents'/carers' wish for certainty and clinicians being viewed as experts with clear answers:

"[H]olding a position of not knowing might be challenge because they might not be open to think about things. They think 'my son or daughter or whatever has finally found their true self and their true gender' and I felt with that process that they were very anxiety provoked…so don't ask me to think more, to raise more questions about fluidity." (Family Therapist 2, pg.10)

"[T]he parents wanting to know, kind of, wanting to know, seeing me as the expert and wanting me to say whether this was one way or the other or whether this would pass or this would remain, you know, they wanted to something black and white." (Psychologist 1, pg.9)

Managing and resisting the pressure to provide explanations and answers too readily was a key challenge: "*[S]ometimes there are too many anxious adults asking for answers when sometimes we haven't got that far that yet with the child."* (Psychotherapist 2, pg.10)

1.4.2.4 Theme D- Self-reflection

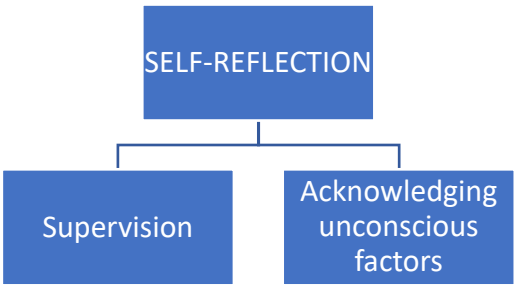

Figure 8. Superordinate theme 4

The superordinate theme of self-reflection incorporated clinicians' thoughts about being able to recognise and examine their own desires/bias/prejudice in their clinical work with TGNC young people and their parents (see Figure 8). In this field of clinical work, which stimulates strong opinions and reactions, it was the psychotherapists who emphasised the centrality of self-reflection in their roles,

particularly in the context of their own clinical supervision. It was interesting that most clinicians reflected on their desire to maintain a position of neutrality in their work with TGNC young people, entering sessions '*without memory or desire'* (Psychotherapist 3, pg.10), not investing in a particular outcome and remaining non-judgmental. However, it was notable that only two of the psychotherapists spoke about cases in which they had noticed they were adopting a particular stance or having a particular emotional response to the work.

1.4.2.4.1 Self-reflection and Supervision

Two psychotherapists in particular expressed how crucial it was to be able to reflect on their own bias:

"[O]ur task as a psychotherapist is to provide this space and to let people be who they are and to give them the space to discover that, and not to push them in one direction or another and to be aware of one's own desires, which may change in any one direction at any point." (Psychotherapist 1, pg.17)

"[T]hings can become very complicated, but I'm aware of that when it's happening and I'm constantly investigating what is what, what might be my own prejudice." (Psychotherapist 3, pg.15)

They spoke about supervision as a key forum for this to be able to take place:

"I think it is important to have supervision for these cases at whatever stage of development you are as a child psychotherapist. I think it is really helpful to have other minds to think about what's going on with these young people…I'm not quite sure how much a psychology perspective would be looking at things blow by blow, it's a different discipline so they do it differently but their supervision might cover more of 'what techniques are you using' with young people rather than thinking what is the young person actually bringing. So, I think that

child psychotherapy offers a kind of, a form of supervision that is particularly suited to thinking about intrapsychic and interpersonal, that kind of combination between both and I think that's seems to be at the nub of what is being brought to you in sessions with young people. I think supervision is really important." (Psychotherapist 1, pg.4)

1.4.2.4.2 Acknowledging unconscious factors

One of the psychotherapists spoke very candidly about considering one's own unconscious prejudice in order for it not to become a directing force in the clinical work:

"[W]here something in the work might not be your choice it might genuinely be the way the young person can be the most authentic person that they can be and not being unconsciously sexist or recognising that there is an unconscious element perhaps to racism, sexism, all of those things, within all of us, and just keeping on task. I think I'd recognise things would be there in myself, pushing and pulling you in different directions and just like we need to be recognising those unconscious processes in terms of racism, we also need to recognise them in ourselves In terms of gender and sex." (Psychotherapist 1, pg.16)

All three psychotherapists discussed observing their counter-transference. They felt that being able to examine it was a crucial way of teasing apart their own bias from potentially important communications about the states of mind of young people and families in their care:

"I think we are highly attuned to our own responses, to our counter transference, so I think we examine our counter transference, our responses to the patient thoroughly and I think that is a really important in this kind of work." (Psychotherapist 1, pg.3)

Another psychotherapist spoke about the centrality of the counter-

transference in relation to a particular case in which they experienced very powerful responses in clinical sessions:

"[M]y feeling with this young person is that I…. I just have to be honest because it sounds awful if I say this but, I feel very, what's the word, a little bit unnerved when I'm with him. At the start of sessions when I see him, or after a slight break I feel I'm seeing a girl who's telling me she wants to be boy and then perhaps at certain points in the session I think I'm with a boy. I don't know how much of it is about my prejudice, my bias…it's not simplistic, because in the room I'm with what appears to be a boy but it's not, he is, sorry, a girl, but he says he's a boy and I think that he talks a lot about body discomfort, having really bad acne, and not feeling in the right body, so maybe I have to experience something of that discomfort. It's slightly unnerving, I'm slightly on edge, and I don't know how much of that is about my own prejudice and how much is a projection of discomfort that I'm feeling." (Psychotherapist 3, pg.15)

Later in the interview, the same psychotherapist reflected that *"by thinking about this I will bear to differentiate between me having a bias and me identifying things like the confusion in my patient and bringing it up in the room"* (Psychotherapist 3, pg.17). Whilst felt to be so fundamental to the work, this clinician was honest in the challenge of constantly monitoring their own bias: "*[E]ven though the counter transference is a tool that psychotherapists use it's been difficult to then harness it and really bring it into the work"* (Psychotherapist 3, pg.16).

1.4.2.5 Theme E- Practical support

Figure 9. Superordinate theme 5

Providing TGNC young people and their parents/carers with practical support emerged as another superordinate theme through analysing the interviews.

1.4.2.5.1 Practical skills and managing risk

All three psychologists discussed equipping TGNC young people with resilience to manage the challenges they are likely to face in their day to day life: *"[I]t's about helping them to develop enough resilience facing a situation that may be there for the rest of their life, issues with um, acceptance, rejection, in social contexts"* (Psychologist 2, pg.4).

Psychologists and family therapists also discussed managing the associated risk with TGNC young people:

"[W]e also have a role in safeguarding the vulnerabilities this patient group come with." (Psychologist 1, pg.2)

"I think we have a role in safeguarding that population who in some cases have more vulnerabilities to their mental health and well-being than others, so we have a role to assess and pick up on those effectively." (Psychologist 2, pg.2)

"[C]reating a network around, for example in the CAMHS service setting around the child in order to be able to manage issues of risk which are very prevalent in these cases." (Family Therapist 2, pg.2)

A few clinicians spoke about how safeguarding issues could be quite disruptive to clinical thinking and exploration, central to theme A:

"[T]his population are vulnerable given the level of discrimination they go through, given the level of conflict they can be exposed to in their family around their gender identity, just given the distress of not feeling that your gender identity doesn't align with your biological sex, I think that there is so much vulnerability so there is a potential, in the service I worked for sometimes it feels as though we up the ante, which is appropriate we need to be on our guard to safeguard this population because we know that they're, they have more vulnerabilities than perhaps young people that don't have, but I think that causes us to up the ante…so there is an anxiety that gets stirred up…" (Psychologist 1, pg.6)

"[I]t's never straight forward, you know a lot of these YP are trying to kill themselves, a lot of children are full of risk and a lot of children have multiple secondary mental health issues so it's a very complex thing. So I may not be able to talk think about gender issues at all for a while…in one case I had to say 'if we are going to think about the gender issues you are bringing to me and making steps towards onwards thinking about changing your appearance, wearing clothes that you want to and opening up with your parents, then we need to get these issues under control'. So the child then suddenly realises that there is a certain kind of role I have to take on. So I've involved the psychiatrist if they present with risk and we say you know you either work on your eating and you cooperate with that or we can't progress with your gender issues." (Family Therapist 1, pg.7)

Another sub-theme of practical support was clinicians speaking about the importance of providing parents with psycho-education around their young person's difficulties:

"[W]hen they are very young you try to do something psycho-educational initially around development with the parents."

(Psychologist 3, pg.8)

"I think there was also a huge need in this case in working with the mum specifically to try and help her with basic understanding of thing." (Psychotherapist 2, pg.5)

"It's really important that parents are part of the conversation so I feel one of my goals is to help the family understand it more, about what is going on where that is possible." (Psychologist 2, pg.13)

1.4.3 Confusion about role

Braun and Clarke (2012) state that *'a theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set'* (pg.63). Whilst not spoken about so extensively by interviewees, it feels important to capture the sense of confusion that was expressed, if only briefly, by all three disciplines about how they understood their role when working with TGNC young people and their parents/carers. There was a sense that some clinicians felt that they were working towards an understanding of the work through doing it rather than entering into it with a clear idea about their role:

"I'm still very confused about what the work, what the work is about, where we're heading, my understanding this young person, it's still very much unclear to me." (Psychotherapist 3, pg.4)

"I think there's a lot of confusion clinically, at a service level, at a broader level, about what is the role of professionals and how much authority the professionals have or should have." (Psychologist 3, pg.12)

*"I think it would be not inappropriate to say that most clinicians are still really very novice to the idea of working with gender identity." (*Family Therapist 1, pg.1)

1.5 Discussion and conclusions

The aim of this study was to explore how clinicians understand and think about their roles when working with TGNC young people in NHS mental health clinics in the UK. In the context of a shifting landscape of gender discourse there is an ever-increasing body of theoretical writing about gender and the different therapeutic approaches to helping TGNC young people. However, whilst clinician-researchers have drawn upon their clinical work in journals and book chapters, there is still relatively little empirical research that captures how a range of clinicians are reflecting on this area of clinical work in the current climate. As Wren (2019) says, '*while the politicization of gender identity in children proceeds unabated and disputations on professional practice and principles are regularly news events, we rarely hear directly from the clinicians whose job it is to help young people grapple with the knowns and unknowns at the interface of sex and gender*' (p. 191). With this in mind, I felt it was important to be able to speak to and document what a small sample of clinicians understand about their roles with this group of young people.

I will now outline the findings that serve to answer the central research question:

What can we learn from interviewing clinicians about how they understand their roles when working with young people presenting with gender identity issues?

1.5.1 Summary of Overall themes

Across the eight interviews that I conducted for this study, I identified five overarching themes through the analysis of the data. It is important to note that a thematic analysis aims to capture the key aspects of meaning across a set of data and for that reason it was not possible for

everything discussed to be presented in the results. The aim of the study was to gather the predominant characteristics of clinicians' discourse around their work with TGNC young people, given that it is relatively unchartered territory in this field of clinical work.

Finding meaning through adopting a position of curiosity was a central theme that ran through all of the eight interviews. All of the clinicians felt they needed to gain a deeper understanding of a young person's situation and that getting to know a young person was key to the clinical work. It was the process of getting to know that allowed for a more coherent narrative to be formed with a young person. A number of clinicians raised the point that finding meaning would be part of their role when working with any young person, whether they were presenting with a gender identity issue or not.

Also key was being able to contextualise a TGNC young person's difficulties, and clinicians spoke in varying ways about the extent to which they would make gender the focus in clinical sessions. For many clinicians the focus lay elsewhere, with importance placed on exploring identity more generally, understanding co-morbid mental health difficulties and considering the developmental stage of young person as well as systemic issues. The role of containment, in order for meaning to be created and difficulties to be contextualised, was something discussed at length., Tolerating a position of not knowing as a way of slowing things down and allowing the organic development of a TGNC young person's trajectory to emerge was central. Despite the prominence of this idea across participants, it seemed to be the most challenging aspect of the clinical work, with the young person's or the family's desire for certainty often in opposition with clinicians' wishes to hold a position of not knowing. The psychotherapists spoke extensively about the cruciality of self-reflection in their work with TGNC young people, which linked closely with the role of their own supervision and being able to monitor/think about their own, sometimes unconscious, bias/prejudice. It was of note that no other discipline mentioned this. The final overarching theme was around practical support provided to TGNC who may be struggling in their day to day life, particularly in the school context. Interestingly, this was mainly discussed by the

psychologists.

An important aspect of clinicians' discourse was around a sense of confusion and bewilderment about being with TGNC young people, conveyed particularly by one of the psychotherapists in their description of the confusing and fluctuating nature of their counter-transference with a particular adolescent. Other clinicians spoke about their general confusion with regards to their role. It was apparent that some clinicians felt that they were working towards an understanding of the work through doing it, rather than entering into it with a clear idea about their role and the outcomes they were hoping for. Wren (2020) describes the idea of adopting a position of *'genuine therapeutic curiosity rather than expert knowingness about gender diverse children'* (p.195). With very little empirical research at this stage about the care and outcomes of TGNC young people, there is a sense that clinicians need to be able to tolerate the sense of confusion about what is the optimum way of intervening with TGNC young people and remain open to the unique situation of each young person in their care.

It is also interesting to think about what wasn't spoken about. No clinicians discussed historical, reparative clinical approaches, in which the aim might be to help a TGNC young person to realign with their assigned gender at birth. Traditional psychoanalytic treatments often aimed to resolve pathological defences, rather than responding to a young person's questioning of their gender in a concrete way (Bleiberg, 1986). Wren (2020) explores the now archaic nature of this kind of discourse, and it is interesting to note that one of the psychotherapists interviewed in the current study also expressed the idea that traditional psychoanalytic viewpoints on gender are somewhat outdated and need to be challenged in the current climate of NHS CAMHS.

1.5.2 Links to previous literature

In the analysis of the data, I formulated the themes as closely as

possible to the clinicians' accounts and in atheoretical language. To embed the results into the current literature related to how clinicians understand their roles when working with TGNC young people, we might draw parallels to some key articles. This study is the first of its kind in the published literature so there are no other published qualitative studies that directly enquire into how a range of clinicians understand their role with this clinical population. However, significant clinician-researchers have expressed their thoughts and opinions about clinical practice in journal articles and book chapters.

1.5.2.1 Theme A-finding meaning

Wren (2020) reflects that "*pressing questions arise for clinicians about how to find their feet with these young people, how to make sense of their unhappiness, their yearnings, their identifications, their convictions and how to address their struggles imaginatively, compassionately, effectively and safely"* (p.190).

This quote links closely with Theme A, Finding meaning, which was dominant across all eight interviews. This theme captured clinicians' views around looking beneath the surface of TGNC young peoples' presentations in order to gain a deeper understanding of their state of mind and identity. Central to 'Finding meaning' involved clinicians providing a space to think. This was discussed across the board, and barriers to thinking were highlighted in some cases. Bion's (1967) theory of thinking, in relation to the transformation of beta (unmetabolised affective experiences) into alpha elements (thoughts that can be thought by the thinker) is helpful in considering both Theme A, centred around 'Finding meaning', and Theme C, 'Containment'. A clinician's role and capacity to contain TGNC young people's anxiety, as well as their parents/carers' anxiety, seemed fundamental to whether thinking and exploration was actually able to take place.

The overarching essence of this theme is very much in line with Wren's

(2014) statement about clinicians being able to provide a '*reflexive and thoughtful space to help clients explore the architecture and borders of their gendered world view'* (p. 287). In order to do this, clinicians discussed adopting a position of curiosity, which links closely with Lemma's (2018) ideas about being able to question a TGNC young person's motivations, wishes, fantasies and fears for the purpose of exploring their unique, phenomenological experience of being gender-diverse. It is interesting that whilst Lemma (2018) writes from a psychoanalytic perspective, stating that taking a questioning approach is the '*everyday work of psychoanalysis'* (p.1104), this was something valued and explored by all three disciplines in the current study. My hypothesis prior to conducting the study was that psychotherapists may be uniquely suited to providing this kind of approach but, in fact, this was at the heart of what all of the clinicians interviewed had to say.

All three disciplines documented the challenges of taking a position of true curiosity. In particular, they centred around difficulties in taking an exploratory approach in the face of parents' and young peoples' pressure and urgency for certainty and clear solutions. Having a genuine opportunity to offer curiosity and exploration to a TGNC young person would appear not to be straightforward in the current climate. Schwartz (2012) has reflected on how psychotherapeutic interventions for gender-diverse young people can become falsely connected in peoples' minds with historical, reparative approaches. It begs the questions about whether, in the current climate, there is the space for clinicians to demonstrate genuine curiosity and ask important questions to the gender-diverse young people in their care without there being transphobic connotations or a sense that they are somehow underplaying what may sometimes be a genuine confusion around gender. Lemma (2018) clearly outlines the challenges for psychoanalytically informed clinicians working in this field. Clinicians' talk indicated that the anxiety stirred up (particularly in the parents/carers) by the uncertainty experienced by so many TGNC young people is such that clinicians' attempts to think, reflect and genuinely explore their situations can be met with intense resistance

and hostility. One might question whether accusations towards clinicians that they are transphobic or intending to direct a gender-diverse child away from the idea of transition might be more indicative of an anti-thinking campaign fuelled by a need to avoid intense anxiety. Bion (1967) theorised about the epistomophilic instinct (K) within all of us that is crucial for life in the face of uncertainty and relates to our inherent curiosity. He also felt that there can be negative forces (-K) operating that are the antithesis of healthy relating and curiosity, which serve to fragment potential creativity and can result in an impoverished psychic life. One could hypothesise that something of this is at play when genuine curiosity to explore a TGNC young person's mind is met with hostility.

All three disciplines referred to their responsibilities in promoting informed decision-making for the young people in their care. This relates to the writing of Wright (2018), Ray (2018) and Tsokoula (2018), who have all reflected on the centrality of exploring and finding meaning with gender-diverse young people to ensure that significant decisions around gender transitioning are fully considered. This is also at the heart of what Di Ceglie (1998) presents in his therapeutic aims for GIDS, stating that the promotion of depressive thinking in young people is crucial in order to foster informed decision making.

1.5.2.2 Theme B- contextualising

Wren (2020) reflects that, as clinicians, we should *'keep an awareness of situations where we sense that the gender distress may be secondary to trauma or emotional conflict, while not losing sight of the possibility of more unconflicted transgender experience'* (2019, p.193). This captures the complexity faced by clinicians about where we focus our therapeutic input with TGNC young people. Many clinicians highlighted the fact that, despite a young person initially presenting with gender identity difficulties, the focus of the intervention they were providing wouldn't necessarily be on gender. The focus was often on

other, co-morbid mental health difficulties or wider confusion around identity, which could beg the question about whether, for some young people, a TGNC presentation veils a legacy of other issues that require exploration. This again links to Wren (2020), who states that *'concurrent emotional difficulties need to be directly addressed, in collaboration with local mental health services, as experience has taught us to anticipate that severe problems may not be readily resolved just because the gender dysphoria is recognized and treated'* (p.193).

Looking beyond and beneath the gender identity presentation - at a young person's wider context, their development and the complex systems they may be existing in - seems to marry up with the more 'gender-critical' approach discussed in the literature review, in which clinicians want to ask questions and potentially challenge a young person's wish to not identify with their biological sex. This stance has raised much contention in the current climate, and Midgen (2018) wrote candidly about the label of being transphobic as a 'careless accusation' towards those clinicians trying to seek deeper understanding about a TGNC young person's situation. It was interesting that in the current study, one psychologist in particular expressed an anxiety about taking a questioning position for fear that they were somehow negating a young persons' struggle with their gender identity by doing so. This seems to powerfully highlight the difficulty, in some cases, of opening things up and questioning a young person's choices/situation without being quickly labelled as prejudice or transphobic. For a discipline whose cornerstone is to take a position of curiosity, it raises important challenges for psychoanalytic psychotherapists working in the current NHS.

There were divergent results in terms of how different participants and disciplines understood the idea of looking beyond and beneath a gender identity presentation. Psychologists spoke frequently about the importance of considering other co-morbid mental health difficulties with TGNC young people, whilst psychotherapists, on the whole, spoke

in more depth about grappling with the symbolic nature of what young people might be presenting with. The family therapists were more focused on holding in mind the systems that young people were living in, and the impact of this.

All clinicians reflected on being able to think with TGNC young people about their identity in a more general way, particularly with adolescent patients. This links to Lemma's (2018) ideas about the 'undoing and reconstruction of identity narratives' (p.1094), and Wren's (2020) statement that 'our role is both to provide the most open platform for identity exploration' (p.195). Both of these statements relate to promoting the examination of who TGNC young people feel they are more broadly, not confining it solely to their gender identity. We know that adolescence is a period of extreme emotional turbulence (Waddell, 2018) with extensive reconfiguration happening in the brain, the task of navigating puberty and the re-emergence of oedipal conflicts. It may be important to hold in mind, when thinking about the rapid increase in referrals of young people presenting with gender identity issues, that the availability of services now that can allow young people to physically transition may, for certain young people, serve as a kind of receptacle for the crisis of identity that is so often encountered in adolescence. With this in mind, providing a timely and honest platform for TGNC young people to examine themselves seems imperative, even if for some patients their gender identity issue persists and they make the decision to pursue physical intervention. Wren (2020) speaks to the challenge of trying to understand a TGNC young person's difficulties in terms of being able to *'disentangle the difficulties that are specifically gender-related from those that are associated with other developmental challenges, especially among those young people who present post-pubertally'* (p.192).

Holding in mind the symbolic nature of TGNC young people's discourse, which was reflected on by all of the psychotherapists and one of the psychologists, reflects previous writings documented in the literature review of this project. Schwartz (2012) asserts that *'patients'*

communications always need some degree of interpretation; that is especially true for children, who, necessitated by their cognitive limitations, speak more symbolically' (p.471). Wright (2018) encourages the importance of moving from concrete to symbolic thinking, and DiCeglie (1998) outlines the promotion of symbolic thinking as one of the fundamental therapeutic aims of GIDS. In the current study, one psychologist reflected on the difficulty in being able to promote symbolic thought in some young people who have a history of developmental trauma. They reflect that certain young people may experience more peace through the concrete changing of their body and that having the time to explore and think may come later.

There were important divergences of opinion to consider in terms of how clinicians viewed the specialist gender service in the context of their role with a TGNC young person. Specialist gender service clinicians being viewed as the 'experts' and a 'safety net' on the one hand, with other clinicians feeling that referrals could often be rushed on the other hand, seems to highlight the polarity of positions in clinicians; some wanting to explore the gender identity presentation very specifically and others wanting to slow the process down and carefully consider the appropriateness of a referral.

1.5.2.3 Theme C- Containment

Bion's (1962a) theory of containment stresses the importance of the mother being able to receive projections from her infant and transform them into something which is returned to the infant in a digestible form, allowing feelings and sensations to be thinkable. This experience of "reverie" or "alpha function" is reliant upon the parental object having the capacity to bear the mental pain which the infant cannot. An explicit or implicit understanding and use of this concept was at the heart of what many participants had to say about being privy to high levels of anxiety from both TGNC patients, their parents and the professional networks surrounding them. If this anxiety could be met, understood

and digested by the therapist then meaningful exploration and thinking was more likely to ensue.

1.5.2.3.1 Tolerating not knowing/uncertainty

Prior to conducting this research one of the questions in my mind was around whether psychotherapists might be uniquely equipped to work with TGNC young people, given that staying with uncertainty is a central premise of psychoanalytic training. In fact, all three disciplines spoke about how valuable the position of 'not knowing' was as a clinician in order to promote exploration and the task of seeking meaning. This links to Tsoukala (2018), who presents a psychotherapist's capacity to bear the unknown and Wren (2020) who purports that ***'****a very open exploration of future identity possibilities is advocated, promoting the need to tolerate uncertainty and live with complexity'* (p.193). The capacity to tolerate frustration and a position of not knowing can be thought about in light of Keats' (1817) concept of Negative Capability which he described in one of his letters as '*when a man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact & reason' (p.193-4)* Bion (1970) further developed this term to illustrate the quality that an analyst should possess; the ability to listen to their patient without looking too soon for meanings and without hurrying to offer a clear understanding. He felt that adopting this position would promote a state of mind in the analyst most likely to enable a true understanding of the patient's unconscious emotional experience. Rather than jumping to conclusions and adopting a position of omnipotent certainty, he promoted the idea of staying with the pain and confusion of not knowing. Whilst most clinicians expressed a need to tolerate uncertainty in their work with TGNC young people, the challenges of taking this position in the face of young peoples' and parents/carers' wish for certainty were also discussed. Wren (2019) states that '*the often-unconditional certainty and assertive support of parents and advocacy groups for social and physical transition are new and have led us into deep controversy'* (p.189). Clinicians have a demanding task of being able to bear the

anxiety in young people, their parents/carers and potentially in themselves, associated with wanting to know and to have clear answers and solutions. One of the psychologists spoke about the difficulty of maintaining a not-knowing stance when put in the position of the expert by parents/carers. Wren (2020) comments that '*our stance of reflective uncertainty can undermine our authority in a world of certain and committed voices'* (p.204), suggesting that as clinicians there is an inherent expectation for us to know. This study has indicated that it can be a real challenge for clinicians to maintain relationships with TGNC young people and their parents/carers if they aren't seen to have clear answers to questions. Wren (2020) in reference to Hodgkin and Metz (2015) suggests that *'the professional values that traditionally held sway in the public sphere at its best-uncertainty, reflection, dispassionate assessment, caution in response to evidence-are now pitted online against anecdote, anxiety, emotion and personal stories'* (p. 204) This draws stark awareness to the very different treatment landscape we are now working in and the challenges clinicians can have in adopting the concept of Negative capability into their practice with TGNC young people and their parents and professional networks.

Divergences between ideas of clinicians' role being either to reduce or raise parental anxiety were apparent in the data. The majority of clinicians felt it was their role to reduce anxiety however raising parental anxiety was an important aspect of one psychologist's discourse. This was thought about in the context of having already built a strong alliance, such that this might be possible. This is not something that has been widely considered in the literature but seemed to be an important and honest acknowledgement that sometimes there may be benefits in handing back anxieties to parents/carers in order for them to be able to fully grapple with the complexity and uncertainty of the situation their child is in.

1.5.2.4 Theme D- self-reflection as a clinician

In the current study, an important aspect of how the psychotherapists who were interviewed understood their role with TGNC young people was being able to adopt a self-reflective position in which observation of one's own prejudice/bias could take place. This links closely to previous literature by Lemma (2018) and Pauley (2014). They both stress the importance of interrogating one's own gender bias and examining one's counter transference in our clinical work with TGNC young people in order to stay open and not be swayed by personal prejudice.

Reflections on the centrality of clinical supervision was an aspect of the 'self-reflection' theme of this study but not something that was explored in great detail. Furthermore, ideas around supervision did not arise from the initial literature search around clinicians' roles with TGNC young people. It is interesting to consider the reasons why firstly, only a few psychotherapists discussed this briefly in the current study and secondly, there is a lack of empirical research/literature about supervision in this field of clinical work. In an area of clinical work that is contentious and provokes powerful responses in individuals, it would seem imperative that clinicians do receive rigorous supervision in order to think about the personal impact that working with TGNC young people can have. Future research into the role of supervision could help to illuminate, in more detail, how it may be used to inform clinical practice with TGNC young people.

Two psychotherapists highlighted being able to closely track one's counter-transference during sessions with TGNC young people as a critical aspect of how they understood their role. Barkai (2017) has written about the importance of monitoring *'counter-transference phenomena'* (p.28), and Bonfatto and Crasnow (2018) reflect on using the counter-transference to gain understanding of a TGNC young person's internal world. In this study, one psychotherapist particularly captured their sense of perplexity with a patient but reflected on the

importance of tuning into their counter-transference in order to grapple with the confusion. Being aware of one's own response to a TGNC patient was felt to be imperative in teasing apart what might be personal bias/prejudice or what may be a powerful communication about the young person's current state of mind. Tuning into unconscious communication through the clinicians' counter-transference is unique to psychoanalytic-psychotherapeutic technique. With this in mind, it may be that psychotherapists are particularly well suited to working with TGNC young people, given the level of emotional confusion and complexity that requires untangling.

It is important to note that neither clinicians from the psychology or family therapy disciplines discussed reflecting on their own responses to the clinical work with TGNC patients. This is particularly surprising given that reflexivity is considered a central tenet in contemporary family therapy practice (Flaskas, 2012).

1.5.2.5 Theme E-Practical support

Providing TGNC young people and their parents/carers with psychoeducation was a key sub-theme of *Practical Support,* more heavily discussed by clinical psychologists, and reiterated the literature of De Vries et al (2012). Whilst psychiatric input and the management of risk were not the focus of my literature review, what certain clinicians had to say about safeguarding and risk has been well documented in previous psychiatric literature around gender identity interventions (Kreukels et al, 2014, Leibowitz et al, 2016, Singh & Sangganjanavanich, 2016).

1.5.3 Strengths and limitations

There are some strengths and limitations to this study that need to be kept in mind when interpreting the results. As previously mentioned, this study may be the first of its kind. Whilst clinician-researchers have documented their views about what their roles might be with TGNC

patients, no published study has interviewed a range of clinicians. At the time this study was conducted, all of the clinicians interviewed were working in NHS clinics, and therefore making sense of what they had to say has validity in the current climate in which we are seeing a large increase in referrals of TGNC young people.

This study only interviewed those clinicians that agreed to be interviewed and audio-recorded. It is important to note that a number of clinicians declined the invitation to be interviewed, as they felt anxious about speaking on the subject given the level of contention about what is deemed the 'right' clinical intervention for TGNC young people at the current time. This in itself raises important issues around how able clinicians feel to speak their mind on the subject and have different clinical views in a climate where opinions seem to have become polarised. (Wren, 2020). It would have been interesting to gather the views of these clinicians to understand further what it might be about their particular clinical stance that feels too controversial to speak out-loud. One wonders whether a wider range of clinical opinions may have arisen if those who declined to be interviewed had taken part. Wren (2020) reflects on working within a specialist gender service and being '*exposed to attack on multiple fronts'* (p.191). She states that clinicians can be accused of being *'too rash or too cautious, too politically correct or too naive, too tentative or too arrogant; too neglectful of suffering or too responsive to demands for treatment; too conservative or too radical'* (p.190). With this in mind, it is maybe not a surprise that several clinicians declined my invitation to be interviewed on the grounds that speaking out loud might raise anxiety about opening themselves up to potential attack.

A number of clinicians reflected on how instructive and supportive the interviews had felt. In a climate where clinicians can feel wary about expressing their personal views, what might be the benefit of having the space to reflect on the work with someone else who is open, interested and curious? Nelson et al (2013) describe the 'therapeutic interview process', which serves to expand the meaning of a research

study for both the researcher and the participants. Whilst the purpose of the research project was to gather a better sense of how a range of clinicians understand their roles with TGNC patients, there was a sense that it may have been a therapeutic experience for some participants, who felt relieved to be able to discuss the complexity of the work.

Thematic analysis looks at themes across a data set, which means that it was inevitable that certain ideas that were discussed were not able to be fully captured in the results section. An important part of the process of thematic analysis is to be able to discard codes that do not clearly fit into the themes that emerge (Braun and Clarke, 2006). As psychotherapists, we are also interested in thinking about what it is that gets left out and is not spoken about, as much as what is. It is also concerned with individualities as well as commonalities. This therefore may be a potential limitation of the methodology chosen for this study. Whilst I took an inductive approach to my data analysis, drawing meaning from the data itself, it is importance to recognise the potential for my own bias and pre-conceived ideas that I may have brought to the process.

1.5.4 Future research

Whilst important views have been captured in the current study and are valid for the purpose of answering the key research question, the small sample size is such that the generalisability of the results is limited. However, findings could be built upon in the future if a larger number of clinicians from a wider range of services, covering a wider geographical area, were able to be interviewed. All clinicians interviewed for the current study were living and working in a large, metropolitan area and it would be interesting to compare views of those living in different parts of the UK.

A number of future avenues can be considered from the outcome of

the current study. Although it was beyond the scope of this project, it would be interesting to directly compare the support that generic CAMHS services feel they can provide in contrast to specialist services, as well as to look into how these services collaborate. It might also be beneficial to conduct this study on a larger scale in the future when there are more empirical, longitudinal studies published regarding the trajectories of TGNC young people. For the time being, there are no longitudinal studies to inform clinicians work.

Given that there has been research which evidences that there is a greater proportion of TGNC young people presenting to gender specialist services who are natally female and white (Chiniara et al, 2018) it would be interesting to explore how my own position as a white female might have had a role in how I engaged with and explored the subject.

1.5.5 Conclusions

My primary aim for this study was to learn more about how a range of clinicians understand their roles when working with TGNC young people. By interviewing child psychotherapists, psychologists and family therapists, I was able to collate key themes that emerged across all three disciplines as well as considering what child psychotherapy in particular may be able to contribute to this field of clinical work. It was evident that all clinicians highlighted the importance of thinking, exploring, seeking meaning and deeper understanding in the face of the complex presentations of TGNC young people in their care. The need to slow things down in order to have the time to contextualise TGNC young people's difficulties was discussed. Key to this involved clinicians' capacity to be able to contain anxieties within the young person, parents/carers and the wider professional networks. Child psychotherapists felt that close observation and monitoring of ones' own response to clinical work with TGNC young people was key to their role. This was considered imperative to being able to manage personal prejudice/bias in a field of work that can provoke strong opinions, but also using it as a potential communication that might

further our understanding of a TGNC young person's state of mind. Confusion about role was an important finding that demonstrates that, for many clinicians, they still feel that they have a lot to learn about the most helpful ways in which they can support young people questioning their gender identity.

Reflecting on the results section of the project it is evident that there was a high level of convergence and perhaps a sense of 'tidiness' where opinions and viewpoints of the clinicians I interviewed often correlated. This in itself is an interesting finding and perhaps alludes to a desire to tidy things up in a field of work fraught with controversy, confusion and polarity of opinion. It was evident that my sample of clinicians tended to adopt a middle ground with regards to their understanding of their roles, neither taking a strong, affirmative standpoint nor a more traditional, reparative approach. I believe it is important to consider this in the context of a fraught political climate where to adopt a more controversial position is felt to be too risky. With recent law suits being taken out against GIDS (Holt, 2020) regarding the clinical care that certain TGNC young people have received, it is unsurprising that clinicians may feel wary about expressing more radical, personal viewpoints on the subject. Furthermore, as a researcher working within this climate, I too may have been cautious about occupying a more controversial or radical position. It is also interesting to consider the impact of agreements such as the Memorandum of Understanding on Conversion therapy in the UK (2017) that has the purpose of protecting the public from the practice of 'conversion therapy'. This is described as *'an umbrella term for a therapeutic approach, or any model or individual viewpoint that demonstrates an assumption that any sexual orientation or gender identity is inherently preferable to any other' (p. 2)* This begs the question of whether this adds to a potential difficulty in mental health professionals being forthcoming with their own personal viewpoints that might lie outside of an agreement like this.

The process of interviewing clinicians evoked powerful feelings in me

as the researcher. At times, I found it nerve-wracking to probe clinicians to say more about their personal viewpoints and I wonder whether this anxiety was indicative of a much wider challenge for professionals to speak out about their views in the current context where viewpoints are often polarised and there is a difficulty in differences of opinion being tolerated. This study highlights the pressing need for continued dialogue amongst professionals and academics in order for us to remain open and curious about the unique situation of each TGNC young person who comes into our care.

My interest in this field of research was sparked by my own clinical experience of working with TGNC young people during my training as a child and adolescent psychotherapist. My personal difficulty in being able to articulate what I felt was the best way to intervene was the catalyst for wanting to hear about how other clinicians understood their roles with this clinical population. It is clear that there are no straightforward answers to this and it is evident that this research opens up more questions than perhaps it answers. Reflecting on the personal journey I have undertaken in doing this project I am aware that my personal views about this field of clinical work feel more confused than clarified. I feel it is important to hold onto this sense of confusion as it may well mirror something more realistic about a field of clinical work still full of unknowns.

However, what was clearly discussed was the need for time to get to know TGNC young people in order to put them in an informed position from which to make important and influential decisions about their lives moving forward. In the current political climate where there is a pressure for shorter-term interventions and greater throughput in mental health services, this will undoubtedly be a challenge but should not prevent us from making a case for careful and considered therapeutic support for this clinical population.

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1.7 Appendices

1.7.1 Appendix A- Ethics application

The Tavistock and Portman NHS
NHS Foundation Trust

Tavistock and Portman Trust Research Ethics Committee (TREC)

APPLICATION FOR ETHICAL REVIEW OF RESEARCH INVOLVING HUMAN PARTICIPANTS

This application should be submitted alongside copies of any supporting documentation which will be handed to participants, including a participant information sheet, consent form, self-completion survey or questionnaire.

Where a form is submitted and sections are incomplete, the form will not be considered by TREC and will be returned to the applicant for completion.

For further guidance please contact Paru Jeram (academicquality@tavi-port.nhs.uk)

PROJECT DETAILS

Current project title	Exploring Clinicians' views about their roles when working with young people presenting with gender identity issues.		
Proposed project start date	**01/05/18**	**Anticipated project end date**	**September 2019**

APPLICANT DETAILS

Name of Researcher	Kate Waltham
Email address	katewaltham@gmail.com
Contact telephone number	07878 874 543

CONFLICTS OF INTEREST

Will any of the researchers or their institutions receive any other benefits or incentives for taking part in this research over and above their normal salary package or the costs of undertaking the research? **YES NO x** If **YES**, please detail below:
Is there any further possibility for conflict of interest? YES NO x If **YES**, please detail below:

FOR ALL APPLICANTS

Is your research being conducted externally* to the Trust? (for example; within a Local Authority, Schools, Care Homes, other NHS Trusts or other organisations). *Please note that 'external' is defined as an organisation which is external to the Tavistock and Portman NHS Foundation Trust (Trust)	**YES x NO**

If **YES**, please supply details below:

Some of my sample of clinicians will be working within Central North West London (CNWL) NHS Trust where I currently have my clinical training placement.

Has external* ethics approval been sought for this research? **(i.e. submission via Integrated Research Application System (IRAS) to the Health Research Authority (HRA) or other external research ethics committee)** *Please note that 'external' is defined as an organisation/body which is external to the Tavistock and Portman Trust Research Ethics Committee (TREC) If **YES**, please supply details of the ethical approval bodies below **AND** include any letters of approval from the ethical approval bodies:	**YES x NO** **Noclor application made. Response received detailing I do not need ethical approval via Noclor or the NHS to proceed as it is not considered as research. Please see attached email.**
If your research is being undertaken externally to the Trust, please provide details of the sponsor of your research? N/A	
Do you have local approval (this includes R&D approval)?	**YES X NO**

COURSE LEAD
◆ Does the proposed research as detailed herein have your support to proceed? **YES x NO**

Signed	
Date	

APPLICANT DECLARATION

I confirm that:

- ◆ The information contained in this application is, to the best of my knowledge, correct and up to date.
- ◆ I have attempted to identify all risks related to the research.
- ◆ I acknowledge my obligations and commitment to upholding our University's Code of Practice for ethical research and observing the rights of the participants.
- I am aware that cases of proven misconduct, in line with our University's

policies, may result in formal disciplinary proceedings and/or the cancellation of the proposed research.

Applicant (print name)	Kate Waltham
Signed	
Date	13th February 2018

FOR RESEARCH DEGREE STUDENT APPLICANTS ONLY

Name and School of Supervisor/Director of Studies	Tavistock and Portman Clinic / University of Essex
Qualification for which research is being undertaken	Professional doctorate in psychoanalytic child and adolescent psychotherapy

Supervisor/Director of Studies –

- Does the student have the necessary skills to carry out the research?

  YES x NO

- Is the participant information sheet, consent form and any other documentation appropriate?

  YES x NO

- Are the procedures for recruitment of participants and obtaining informed consent suitable and sufficient?

  YES x NO

- Where required, does the researcher have current Disclosure and Barring Service (DBS) clearance?

  YES x NO

Signed	
Date	

DETAILS OF THE PROPOSED RESEARCH

1. **Provide a brief description of the proposed research, including the requirements of participants. This must be in lay terms and free from technical or discipline specific terminology or jargon. If such terms are required, please ensure they are adequately explained (Do not exceed 500 words)**
How do clinicians from two disciplines of child psychotherapy and psychology understand the nature of their task when working with young people presenting to mental health services with gender identity issues? By interviewing both child psychotherapists, clinical psychologists and family therapists in generic CAMHS teams as well as at a specialist gender identity service. I hope to explore how two key disciplines are framing their clinical work in the currently contentious climate in this field of mental health work. Over a period of 3-5 months, I will conduct a semi-structured interview(up to 2 hours I length) with 6-12 clinicians who are working routinely with young people presenting with gender identity issues. The sample will be comprised of Child and Adolescent Psychotherapists, Clinical Psychologists and family therapists as these represent three of the key psychological therapies offered within mental health teams within the UK. Following the interview stage, a debrief form will be given.
2. **Provide a statement on the aims and significance of the proposed research, including potential impact to knowledge and understanding in the field (where appropriate, indicate the associated hypothesis which will be tested). This should be a clear justification of the proposed research, why it should proceed and a statement on any anticipated benefits to the community. (Do not exceed 700 words)**

As a training child and adolescent psychotherapist, my clinical experience of working with young people with gender identity issues has fuelled my interest in this field of research. Exploring and developing my own therapeutic stance has evoked much personal perplexity in the context of the shifting sands around gender identity conceptualisation. This field has provoked increasing interest and debate in our modern world. With a sharp rise in the amount of referrals to mental health services for presentations within this sphere in recent years (Spack et al, 2012) important therapeutic and conceptual standpoints have been called into question. Quandaries about whether these young people should be eligible for treatment at all remain in the spotlight and, if so, further enquiries about the nature of the treatment they receive are being made (Lament, 2014). The recent changes to the 2013 Diagnostic and Statistical Manual of Mental Disorders-5(DSM-5), which replaced Gender Identity Disorder with Gender Dysphoria (Reisner et al, 2015) is indicative of this evolving conceptual landscape in this field.

Whilst there is a significant body of conceptual literature about therapeutic approaches to gender dysphoric presentations, there is a dearth of empirical research. Di Ceglie (1998) documents the therapeutic aims and management of young people presenting with 'Gender Identity Disorder', however in today's evolving social and political climate in which gender identity is a hotly contested topic, there is a need to scope how clinicians are currently viewing the clinical space with these young people. Lament (2014) states that 'It is incumbent upon the child analytic community as stewards of what is developmental…to press for continuing dialogue about the transgender child'(p.25)

My hope is that this research will promote this dialogue and that it will go some way to providing a preliminary bridge between current conceptual frameworks around gender identity and how the therapeutic space that is being offered to these young people is being framed by the clinicians that I will be interviewing. How do clinicians understand the expression of being uncomfortable with ones biological sex and how is this married with the therapeutic spaces they are offering?

The central research question will be:

What can we learn from interviewing clinicians about their roles when working with young people presenting with gender identity issues?

This will include:

-Exploring the different therapeutic stances when working with young people with gender identity issues and how this relates to clinicians' understanding of a young person questioning their gender identity

-Considering the particular role Child Psychotherapy can have with gender identity cases

-Exploring how important parent work is with gender identity cases

-Examining what the challenges are for the therapeutic space when working with this population of young people

3. **Provide an outline of the methodology for the proposed research, including proposed method of data collection, tasks assigned to participants of the research and the proposed method and duration of data analysis. If the proposed research makes use of pre-established and generally accepted techniques, please make this clear. (Do not exceed 500 words)**

Data collection

Audio recordings will be taken of all interviews and then transcribed for analysis. The semi-structured interviews will flexibly follow a schedule in which questions will be loosely based around the previously stated aims as well as background literature in the field. Questions will be open ended to allow the participants to direct the narrative, thus promoting the emergence of rich, organic data.

Feasibility

My aim is to recruit 12 participants in total, however, in the event of this not being possible I will interview 6-8 clinicians but conduct more than one interview per participant .The number of clinicians interviewed will depend on what is practically available given that I will be purposively recruiting from both a specialist gender identity service as well as clinicians from generic Child and Adolescent mental health teams. Formal permission has been granted for my research to take place from both the Tavistock gender identity service and Hillingdon CAMHS.

Data Analysis

After consideration about which qualitative method of data analysis to implement, I have decided that interview transcriptions will be analysed using Thematic analysis(TA). The epistemological paradigm adopted will be a constructionist one, in which the way participants make meaning of their experiences will be acknowledged as well as considering how these meanings are the effect of a range of social discourses (Braun and Clarke, 2006). The process of analysis will entail coding data, at a latent level, into thematic categories, analysing and reporting patterns present within the data set and comparing and contrasting viewpoints across participants. With this in mind, a 'bottom-up' approach to the data (Frith & Gleeson, 2004) will be implemented whereby the themes identified will be strongly linked to the data itself.

Other qualitative methods were considered, including Grounded Theory and Discourse analysis. Grounded theory was discounted on the grounds that this research is not wishing to move towards generating a theory and Discourse analysis, which focuses on the interactional context of talk was felt to be inappropriate in the context of a semi-structured interview design. The aim of this research is to provide a rich thematic description of an entire data set in the context of this being an under-researched area and for that reason TA was considered most suitable.

It is recognised that data analysis will be influenced by my own theoretical and epistemological presumptions. In order to ensure that the TA I undertake is rigorous, a 'transparent trail' (Harper and Thompson 2012) of how the data is analysed will be documented through keeping a field diary and an external coder will be recruited to check for inter-coding reliability. I am aware that my status as a psychotherapist trainee may affect the way in which I approach my data, however this will be discussed in the discussion section of the final write up.

4. Provide an explanation detailing how you will identify, approach and recruit the participants for the proposed research, including clarification on sample size and location. Please provide justification for the exclusion/inclusion criteria for this study (i.e. who will be allowed to / not allowed to participate) and explain briefly, in lay terms, why this criteria is in place. (Do not exceed 500 words)

My aim is to recruit 6-12 clinicians as my participants and they are still to be identified through my professional context and relationships. Potential participants will be given a participant information sheet which invites them to take part. They would then be given a consent and debrief form if they decide to proceed with the interview.

My inclusion criteria is:

- child and adolescent psychotherapist or clinical psychologist (2 key disciplines within mental health services in UK)
- working/has worked routinely with gender identity cases.

5. Will the participants be from any of the following groups?*(Tick as appropriate)*

x Students or staff of the Trust or the University.

x Adults (over the age of 18 years with mental capacity to give consent to participate in the research).

Children or legal minors (anyone under the age of 16 years)[1]

Adults who are unconscious, severely ill or have a terminal illness.

Adults who may lose mental capacity to consent during the course of the research.

Adults in emergency situations.

Adults[2] with mental illness - particularly those detained under the Mental Health Act (1983 & 2007).

Participants who may lack capacity to consent to participate in the research under the research requirements of the Mental Capacity Act (2005).

Prisoners, where ethical approval may be required from the National Offender Management Service (NOMS).

Young Offenders, where ethical approval may be required from the National Offender Management Service (NOMS).

Healthy volunteers (in high risk intervention studies).

Participants who may be considered to have a pre-existing and potentially dependent[3] relationship with the investigator (e.g. those in care homes, students, colleagues, service-users, patients).

Other vulnerable groups (see Question 6).

Adults who are in custody, custodial care, or for whom a court has assumed responsibility.

Participants who are members of the Armed Forces.

[1]If the proposed research involves children or adults who meet the Police Act (1997) definition of vulnerability[3], any researchers who will have contact with participants must have current Disclosure and Barring Service (DBS) clearance.

[2] 'Adults with a learning or physical disability, a physical or mental illness, or a reduction in physical or mental capacity, and living in a care home or home for people with learning difficulties or receiving care in their own home, or receiving hospital or social care services.' (Police Act, 1997)

[3] *Proposed research involving participants with whom the investigator or researcher(s) shares a dependent or unequal relationships (e.g. teacher/student, clinical therapist/service-user) may compromise the ability to give informed consent which is free from any form of pressure (real or implied) arising from this relationship. TREC recommends that, wherever practicable, investigators choose participants with whom they have no dependent relationship. Following due scrutiny, if the investigator is confident that the research involving participants in dependent relationships is vital and defensible, TREC will require additional information setting out the case and detailing how risks inherent in the dependent relationship will be managed. TREC will also need to be reassured that refusal to participate will not result in any discrimination or penalty.*

6. Will the study involve participants who are vulnerable? YES NO x

For the purposes of research, 'vulnerable' participants may be adults whose ability to protect their own interests are impaired or reduced in comparison to that of the broader population. Vulnerability may arise from the participant's personal characteristics (e.g. mental or physical impairment) or from their social environment, context and/or disadvantage (e.g. socio-economic mobility, educational attainment, resources, substance dependence, displacement or homelessness). Where prospective participants are at high risk of consenting under duress, or as a result of manipulation or coercion, they must also be considered as vulnerable.

Adults lacking mental capacity to consent to participate in research and children are automatically presumed to be vulnerable. Studies involving adults (over the age of 16) who lack mental capacity to consent in research must be submitted to a REC approved for that purpose.

6.1. If YES, what special arrangements are in place to protect vulnerable participants' interests?

If **YES**, the research activity proposed will require a DBS check. *(NOTE: information concerning activities which require DBS checks can be found via https://www.gov.uk/government/publications/dbs-check-eligible-positions-guidance)*

7. Do you propose to make any form of payment or incentive available to participants of the research? YES NO x If **YES**, please provide details taking into account that any payment or incentive should be representative of reasonable remuneration for participation and may not be of a value that could be coercive or exerting undue influence on potential participants' decision to take part in the research. Wherever possible, remuneration in a monetary form should be avoided and substituted with vouchers, coupons or equivalent. Any payment made to research participants may have benefit or HMRC implications and participants should be alerted to this in the participant information sheet as they may wish to choose to decline payment.
N/A
8. What special arrangements are in place for eliciting informed consent from participants who may not adequately understand verbal explanations or written information provided in English; where participants have special communication needs; where participants have limited literacy; or where children are involved in the research? (Do not exceed 200 words)
N/A

PARTICIPANT DETAILS

RISK ASSESSMENT AND RISK MANAGEMENT

9. Does the proposed research involve any of the following? *(Tick as appropriate)*

use of a questionnaire, self-completion survey or data-collection instrument (attach copy)
use of emails or the internet as a means of data collection
use of written or computerised tests
X interviews (attach interview questions)
diaries (attach diary record form)
participant observation
participant observation (in a non-public place) without their knowledge / covert research
X audio-recording interviewees or events
video-recording interviewees or events
access to personal and/or sensitive data (i.e. student, patient, client or service-user data) without the participant's informed consent for use of these data for research purposes
X administration of any questions, tasks, investigations, procedures or stimuli which may be experienced by participants as physically or mentally painful, stressful or unpleasant during or after the research process
performance of any acts which might diminish the self-esteem of participants or cause them to experience dis comfiture, regret or any other adverse emotional or psychological reaction
investigation of participants involved in illegal or illicit activities (e.g. use of illegal drugs)
procedures that involve the deception of participants
administration of any substance or agent
use of non-treatment of placebo control conditions
participation in a clinical trial
research undertaken at an off-campus location (risk assessment attached)
research overseas (copy of VCG overseas travel approval attached)

10. Does the proposed research involve any specific or anticipated risks (e.g. physical, psychological, social, legal or economic) to participants that are greater than those encountered in everyday life? YES NO x

If **YES**, please describe below including details of precautionary measures.

N/A

11. Where the procedures involve potential hazards and/or discomfort or distress for participants, please state what previous experience the investigator or researcher(s) have had in conducting this type of research.

N/A

12. Provide an explanation of any potential benefits to participants. Please ensure this is framed within the overall contribution of the proposed research to knowledge or practice. (Do not exceed 400 words)

NOTE: Where the proposed research involves students of our University, they should be assured that accepting the offer to participate or choosing to decline will have no impact on their assessments or learning experience. Similarly, it should be made clear to participants who are patients, service-users and/or receiving any form of treatment or medication that they are not invited to participate in the belief that participation in the research will result in some relief or improvement in their condition.

While there are no immediate benefits to participants, I hope that it will be a valuable opportunity for clinicians to be able to reflect on this area of their clinical work. Given that it is relatively uncharted research territory, I hope that the project will help to increase understanding of how a range of clinicians are understanding the clinical task of working with young people presenting with gender identity issues. I believe that exploring this area of clinical work in a local context will provide a starting point for understanding the current wider social position around gender identity and how clinicians' clinical and personal views on the subject are formed. I hope that the interview questions will stimulate participants' personal reflection as well as their thinking about their clinical work and the application of theory.

13. Provide an outline of any measures you have in place in the event of adverse or unexpected outcomes and the potential impact this may have on participants involved in the proposed research. (Do not exceed 300 words)

I think it is reasonable to say there are no known risks associated with participation in this study. However, giving clinicians the opportunity to talk about their professional and personal views on their work with gender identity cases may stir up emotions. Time will be offered at the end of the interview if needed, however all participants will be employed within an NHS clinical team and be receiving regular clinical supervision that should provide the necessary containment.

14. Provide an outline of your debriefing, support and feedback protocol for participants involved in the proposed research. This should include, for example, where participants may feel the need to discuss thoughts or feelings brought about following their participation in the research. This may involve referral to an external support or counseling service, where participation in the research has caused specific issues for participants. Where medical aftercare may be necessary, this should include details of the treatment available to participants. Debriefing may involve the disclosure of further information on the aims of the research, the participant's performance and/or the results of the research. (Do not exceed 500 words)

Time will be set aside at the end of the interview for any participant who feels they need the chance to debrief. An optional additional interview will also be offered to reflect on the process of the main interview and would be used as additional research data.

The results of the study will form the research element of my professional doctorate in child and adolescent psychotherapy and subsequently, it may be used in published academic papers and presentations. Participants will be able to request a summary of the results.

PARTICIPANT CONSENT AND WITHDRAWAL

15. **Have you attached a copy of your participant information sheet (this should be in *plain English*)? Where the research involves non-English speaking participants, please include translated materials. YES X NO**

If **NO**, please indicate what alternative arrangements are in place below:

16. **Have you attached a copy of your participant consent form (this should be in *plain English*)? Where the research involves non-English speaking participants, please include translated materials.**

YES X NO

If **NO**, please indicate what alternative arrangements are in place below:

17. The following is a participant information sheet checklist covering the various points that should be included in this document.

XClear identification of the sponsor for the research, the project title, the Researcher or Principal Investigator and other researchers along with relevant contact details.

XDetails of what involvement in the proposed research will require (e.g., participation in interviews, completion of questionnaire, audio/video-recording of events), estimated time commitment and any risks involved.

X A statement confirming that the research has received formal approval from TREC.

X If the sample size is small, advice to participants that this may have implications for confidentiality / anonymity.

A clear statement that where participants are in a dependent relationship with any of the researchers that participation in the research will have no impact on assessment / treatment / service-use or support.

XAssurance that involvement in the project is voluntary and that participants are free to withdraw consent at any time, and to withdraw any unprocessed data previously supplied.

X Advice as to arrangements to be made to protect confidentiality of data, including that confidentiality of information provided is subject to legal limitations.

X A statement that the data generated in the course of the research will be retained in accordance with the University's Data Protection Policy.

X Advice that if participants have any concerns about the conduct of the investigator, researcher(s) or any other aspect of this research project, they should contact Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk)

Confirmation on any limitations in confidentiality where disclosure of imminent harm to self and/or others may occur.

18. The following is a consent form checklist covering the various points that should be included in this document.

XUniversity or Trust letterhead or logo.

X Title of the project (with research degree projects this need not necessarily be the title of the thesis) and names of investigators.

XConfirmation that the project is research.

X Confirmation that involvement in the project is voluntary and that participants are free to withdraw at any time, or to withdraw any unprocessed data previously supplied.

X Confirmation of particular requirements of participants, including for example whether interviews are to be audio-/video-recorded, whether anonymised quotes will be used in publications advice of legal limitations to data confidentiality.

XIf the sample size is small, confirmation that this may have implications for anonymity any other relevant information.

XThe proposed method of publication or dissemination of the research findings.

X Details of any external contractors or partner institutions involved in the research.

Details of any funding bodies or research councils supporting the research.

Confirmation on any limitations in confidentiality where disclosure of imminent harm to self and/or others may occur.

CONFIDENTIALITY AND ANONYMITY

19. Below is a checklist covering key points relating to the confidentiality and anonymity of participants. Please indicate where relevant to the proposed research.

Participants will be completely anonymised and their identity will not be known by the investigator or researcher(s) (i.e. the participants are part of an anonymous randomised sample and return responses with no form of personal identification)?

The responses are anonymised or are an anonymised sample (i.e. a permanent process of coding has been carried out whereby direct and indirect identifiers have been removed from data and replaced by a code, with no record retained of how the code relates to the identifiers).

XThe samples and data are de-identified (i.e. direct and indirect identifiers have been removed and replaced by a code. The investigator or researchers are able to link the code to the original identifiers and isolate the participant to whom the sample or data relates).

Participants have the option of being identified in a publication that will arise from the research.

X Participants will be pseudo-anonymised in a publication that will arise from the research. (I.e. the researcher will endeavour to remove or alter details that would identify the participant.)

X The proposed research will make use of personal sensitive data.

Participants consent to be identified in the study and subsequent dissemination of research findings and/or publication.

20. **Participants must be made aware that the confidentiality of the information they provide is subject to legal limitations in data confidentiality (i.e. the data may be subject to a subpoena, a freedom of information request or mandated reporting by some professions). This only applies to named or de-identified data. If your participants are named or de-identified, please confirm that you will specifically state these limitations.**

YES X NO

If **NO**, please indicate why this is the case below:

NOTE: WHERE THE PROPOSED RESEARCH INVOLVES A SMALL SAMPLE OR FOCUS GROUP, PARTICIPANTS SHOULD BE ADVISED THAT THERE WILL BE DISTINCT LIMITATIONS IN THE LEVEL OF ANONYMITY THEY CAN BE AFFORDED.

DATA ACCESS, SECURITY AND MANAGEMENT

21. **Will the Researcher/Principal Investigator be responsible for the security of all data collected in connection with the proposed research? YES X NO**

If **NO**, please indicate what alternative arrangements are in place below:

22. **In line with the 5th principle of the Data Protection Act (1998), which states that personal data shall not be kept for longer than is necessary for that purpose or those purposes for which it was collected; please state how long data will be retained for.**

1-2 years 3-5 years **X** 6-10 years 10> years

NOTE: Research Councils UK (RCUK) guidance currently states that data should normally be preserved and accessible for 10 years, but for projects of clinical or

major social, environmental or heritage importance, for 20 years or longer. (http://www.rcuk.ac.uk/documents/reviews/grc/grcpoldraft.pdf)

23. Below is a checklist which relates to the management, storage and secure destruction of data for the purposes of the proposed research. Please indicate where relevant to your proposed arrangements.

X Research data, codes and all identifying information to be kept in separate locked filing cabinets.

X Access to computer files to be available to research team by password only.

Access to computer files to be available to individuals outside the research team by password only (See **23.1**).

X Research data will be encrypted and transferred electronically within the European Economic Area (EEA).

Research data will be encrypted and transferred electronically outside of the European Economic Area (EEA). (See **23.2**).

NOTE: Transfer of research data via third party commercial file sharing services, such as Google Docs and YouSendIt are not necessarily secure or permanent. These systems may also be located overseas and not covered by UK law. If the system is located outside the European Economic Area (EEA) or territories deemed to have sufficient standards of data protection, transfer may also breach the Data Protection Act (1998).

Use of personal addresses, postcodes, faxes, e-mails or telephone numbers.

X Use of personal data in the form of audio or video recordings.

Primary data gathered on encrypted mobile devices (i.e. laptops). **NOTE:** This should be transferred to secure UEL servers at the first opportunity.

X All electronic data will undergo secure disposal.

NOTE: For hard drives and magnetic storage devices (HDD or SSD), deleting files does not permanently erase the data on most systems, but only deletes the reference to the file. Files can be restored when deleted in this way. Research files must be overwritten to ensure they are completely irretrievable. Software is available for the secure erasing of files from hard drives which meet recognised standards to securely scramble sensitive data. Examples of this software are BC Wipe, Wipe File, DeleteOnClick and Eraser for Windows platforms. Mac users can use the standard 'secure empty trash' option; an alternative is Permanent eraser software.

X All hardcopy data will undergo secure disposal.

NOTE: For shredding research data stored in hardcopy (i.e. paper), adopting DIN 3 ensures files are cut into 2mm strips or confetti like cross-cut particles of 4x40mm. The UK government requires a minimum standard of DIN 4 for its material, which ensures cross cut particles of at least 2x15mm.

1.1. Please provide details of individuals outside the research team who will be given password protected access to encrypted data for the proposed research.
N/A
1.2. Please provide details on the regions and territories where research data will be electronically transferred that are external to the European Economic Area (EEA).
N/A

OVERSEAS TRAVEL FOR RESEARCH

24. Does the proposed research involve travel outside of the UK? YES NO X

1.1. Have you consulted the Foreign and Commonwealth Office website for guidance/travel advice? http://www.fco.gov.uk/en/travel-and-living-abroad/

YES NO N/A X

1.2. If you are a non-UK national, have you sought travel advice/guidance from the Foreign Office (or equivalent body) of your country? **YES NO N/A X**

1.3. Have you completed the overseas travel approval process and enclosed a copy of the document with this application? (For UEL students and staff only)

YES NO N/A X

Details on this process are available here http://www.uel.ac.uk/qa/research/fieldwork.htm

1.4. Is the research covered by your University's insurance and indemnity provision?

YES X NO

NOTE: Where research is undertaken **by UEL students and staff** at an off-campus location within the UK or overseas, the Risk Assessment policy must be consulted: http://dl-cfs-01.uel.ac.uk/hrservices/documents/hshandbook/risk_assess_policy.pdf.

For UEL students and staff conducting research where UEL is the sponsor, the Dean of School or Director of Service has overall responsibility for risk assessment regarding their health and safety.

1.5. Please evidence how compliance with all local research ethics and research governance requirements have been assessed for the country(ies) in which the research is taking place.

N/A

1.6. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

YES NO

N/A

PUBLICATION AND DISSEMINATION OF RESEARCH FINDINGS

25. How will the results of the research be reported and disseminated? *(Select all that apply)*

X Peer reviewed journal
X Conference presentation
Internal report
X Dissertation/Thesis
Other publication
Written feedback to research participants

Presentation to participants or relevant community groups

Other (Please specify below)

NB The research may be published in a peer reviewed journal or be presented at a conference having completed my thesis.

OTHER ETHICAL ISSUES

26. Are there any other ethical issues that have not been addressed which you would wish to bring to the attention of Tavistock Research Ethics Committee (TREC)?

N/A

CHECKLIST FOR ATTACHED DOCUMENTS

27. Please check that the following documents are attached to your application.

X Letters of approval from ethical approval bodies (where relevant)

X Recruitment advertisement

X Participant information sheets (including easy-read where relevant)

X Consent forms (including easy-read where relevant)

Assent form for children (where relevant)

X Evidence of any external approvals needed

Questionnaire

X Interview Schedule or topic guide

Risk Assessment (where applicable)

Overseas travel approval (where applicable)

1.1. Where it is not possible to attach the above materials, please provide an explanation below.

I am not using a questionnaire.

1.7.2 Appendix B-NOCLOR confirmation email

RE: Doctoral Research Project
NOCLOR, Contact (CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST)

Tue 14/11/2017 14:23

To:
WALTHAM, Kate (CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST);
Cc:
NOCLOR, Contact (CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST);

Flag for follow up. Start by 12 December 2017. Due by 12 December 2017.
You replied on 14/11/2017 14:27.

Dear Kate,

Following on to the outcome of the HRA toolkit which does not consider your project as research and based on the information we have received from you, we deem your study to be a Service Evaluation therefore you will not need to register with us, nor gain a Favourable Opinion from the National Research Ethics Service, nor seek our permission for commencement of this project and you may wish to discuss any dissemination plans. As discussed the approval of the service in which the study will be conducted is required prior to the study commencing. You will also have to inform the Information Governance Team in the Central North West London NHS Foundation Trust about your proposed project, particularly as your study involves the collection of data.

Please do not hesitate to contact me further for any clarification.

b/w

Mabel Saili
Research & Development Manager

1.7.3 Appendix C- Public facing documents

1.7.3.1 Recruitment advert

Research Project: Exploring clinicians' views about their roles when

working with young people presenting with gender identity issues.

Are you a psychotherapist, clinical psychologist or family therapist?

Have you had experience of working with young people presenting with gender identity issues?

Would you like to have the opportunity to share your views about this area of clinical work?

My name is Kate Waltham and I am a child and adolescent psychotherapist in doctoral training. I would like to invite you to take part in my doctoral research study which aims to explore clinicians' views about their roles when working with young people presenting with gender identity issues. I am

interested in finding out more about different therapeutic stances when working with young people with gender identity issues and how this relates to clinicians' understanding of a young person questioning their gender identity.

The study would involve you meeting me for an interview to talk about your views and experiences.

If you would like to learn more about this study, please email me on kate.waltham@nhs.net or telephone me on 07878 874 543

1.7.3.2 Participant information sheet

Participation Information Sheet

Research Project: Exploring clinicians' views about their roles when working with young people presenting with gender identity issues: A qualitative Inquiry

Are you a psychotherapist, clinical psychologist or family therapist?

Have you had experience of working with young people presenting with gender identity issues?

Would you like to share your views about this area of clinical work?

You have been given this information sheet because you are being invited to take part in a research study that has been formally approved by the Tavistock and Portman research ethics committee. This information sheet describes the study and explains what will be involved if you decide you would like to take part.

What is the purpose of this study?

In this study I want to explore clinicians' views about their roles in

working with young people presenting with gender identity issues.

You have been invited to take part in this study because you have worked with young people
presenting with gender identity issues. I hope to speak to around 8-10 clinicians about their
views on and experiences in this area of clinical work. During the interview, I will not be asking you to talk specifically about any young person and their family, but rather about how you perceive your clinical role and what contributes to that.

Who is conducting the study?

My name is Kate Waltham. I am a child and adolescent psychotherapist in doctoral
training employed by The Tavistock and Portman NHS Foundation Trust and validated
by the University of Essex. The research is being supervised by Dr. Margaret Lush (Child and
adolescent psychotherapist) at the Tavistock clinic.

What will my participation in this project involve?

If you agree to participate you will be invited to an interview. This will take place at a time and day convenient to you. It can take place either at your place of work or at the Tavistock clinic in Swiss Cottage. It will

last around an hour and will be audio recorded using a Dictaphone and then transcribed. This is to help me remember exactly what was said and means that I will not need to take notes during the interviews. None of these recordings would be available to anyone outside the research team. All participation information will remain anonymous.

Do I have to take part?

Your participation in this study is voluntary. This means that even though you have been invited to take part in this study, you can decide not to participate. You may also change your mind and withdraw your participation as well as any unprocessed data from the study at any time without giving me a reason for this. Any data that you have provided which has already been processed will be retained for data analysis. Your decision not to take part in this study, or to stop participating, will not affect you or your work in any way. If you do decide to stop taking part in this study, you should inform the researcher or your decision as soon as possible. All information collected prior to your withdrawal with your permission will be used, but no further data will be collected.

What will happen to any information I give?

All the information I have about you and everything you say during the interview will be kept confidential. The transcript of the interview as well as any extracts from what you say in the interview that are quoted in the research paper will be anonymised and pseudonyms used.

However, given that the sample size of the study is small, this may have implications regarding anonymity.

I will store information I receive from you during the interview securely and in keeping with the Data Protection Act 1998.

This research study may be subjected to audit checks and audit bodies may be granted access to your research information to check on study procedures and data. However, these data will not be made public. By signing the consent form, you will be authorizing that such access will be made available to external auditing bodies.

All digital recordings will be destroyed after the completion of the project and other data from the project will be retained, in a secure location, for 7 years. Once the project is completed, transcripts will be deposited in the UK data archive. These will remain available for 5 years.

What will happen to the results of the project?

The results of the study will form the research element of my professional doctorate in child and adolescent psychotherapy. Subsequently, it may be used in published academic papers and presentations. You can request to receive a summary of the results.

What are the possible benefits of taking part?

Whilst there are no immediate benefits to you, it may be valuable for you to be able to reflect on this area of your clinical work. Given that it is relatively uncharted research territory, by taking part you will help to increase our understanding of how clinicians from different disciplines are understanding the therapeutic task of working with young people presenting with gender identity issues.

Are there any risks?

I think it is reasonable to say that there are no known risks in agreeing to take part in this project. This interview invites you to talk about yourself and both your professional and personal views around clinical work with young people presenting with gender identity issues and this may stir up some emotions. If there are any questions that you do not wish to answer please discuss this with the researcher. You do not have to answer any questions you do not feel comfortable with. Time will be offered at the end of the interview if you require this.

Contact details

I am the main contact for the study. If you have any questions about the project, please don't hesitate to ask. My contact details are:

Kate Waltham
Child and Adolescent Psychotherapist in Doctoral Training

Email: kate.waltham@nhs.net

Tel: 07878 874543

You are welcome to contact the Tavistock and Portman NHS Foundation Trust if you have any concerns about this project. The contact details are:

Simon Carrington

Head of Academic Governance and Quality

Work address: Tavistock and Portman NHS trust, 120 Belsize Lane, NW3 5BA

Email: academicquality@tavi-port.nhs.uk

Tel: 0207 435 7111

Thank you for considering taking part in this study and taking the time to read this information. If you are willing to take part in a semi-structured interview for this research project, you will be asked to sign a consent form prior to interview.

1.7.3.3 Consent form

The Tavistock and Portman NHS
NHS Foundation Trust

January 2019

CONSENT FORM

Research Project : Exploring clinicians' views about their roles in working with young people presenting with gender identity issues.

Name of researcher: Kate Waltham, Child and adolescent psychotherapist in doctoral training.

I confirm that I have been provided with details of this research project (Participation Information sheet) and I have had an opportunity to consider the information, ask questions and have had these answered satisfactorily.

I confirm that I understand that the interviews will be audio recorded and then transcribed and analysed for the purposes of this research. I understand that any extracts from what I have said in the interviews that are quoted within the research will be anonymised.

I understand that any identifiable information linked to my participation in the research will be anonymised and held securely by the researcher.

I understand that information that I provide will form the research element of my doctorate in child and adolescent psychotherapy and may be used in published academic papers and in academic presentations.

I confirm and I have read and understood that my participation in this research is voluntary and that I can withdraw my participation up to one month post interview.

I confirm that I have understood all of the above and consent to participate in this research.

Name of participant (BLOCK CAPITALS) Name of researcher (BLOCK CAPITALS)

……

……

Signed Signed

……

……

Date Date

……

……

One copy to be given to the interviewee and one held by the researcher

Thank you for agreeing to take part in this research project.

1.7.4 Appendix D- Semi-structured Interview schedule

Draft 25/4/2018

Kate Waltham

Interview schedule

Exploring Clinicians' views about their roles when working with young people presenting with gender identity issues.

Introductory question:

Would you like to start by telling me briefly about your clinical role and where you work?

1. **What do you think child psychotherapy/psychology/family therapy can particularly bring to this field of clinical work?**

2. **How do you see your task when working clinically with a young person experiencing gender identity issues and how do you understand the purpose of the clinical space with you?**

Sub/probe questions:

- In your experience where does the expectation of the clinical work come from? (eg society, parents, service, young person)
- How would you see the differences in the clinical task with pre and post pubescent young people?
- How might being on hormone blockers change the nature of the clinical space?

3. How do you understand a young person's expression of wanting to be the opposite gender?

Sub/probe questions:

- How do you as a clinician regard what it is that leads young people with gender identity issues to seek help from you?
- Do you think your personal views around gender identity influence your professional practice and if so, how?
- How do you understand the rapid increase in referrals in this area of clinical work over the past 5 years?

4. Do you think work with parents/carers is important?

Sub/probe questions:

- Do you think the gender identity issue can be usefully explored in relation to family dynamics? In your experience has it been possible to explore this with parents/carers?
- How have you experienced your views around gender identity in relation to parent/carer views?

Concluding question:

Is there something that I have not asked you that you think I would need to know in order to better understand your views about this area of clinical work?

PROMPTS

"Would you tell me more about that"

"can you expand on what you've just said?'

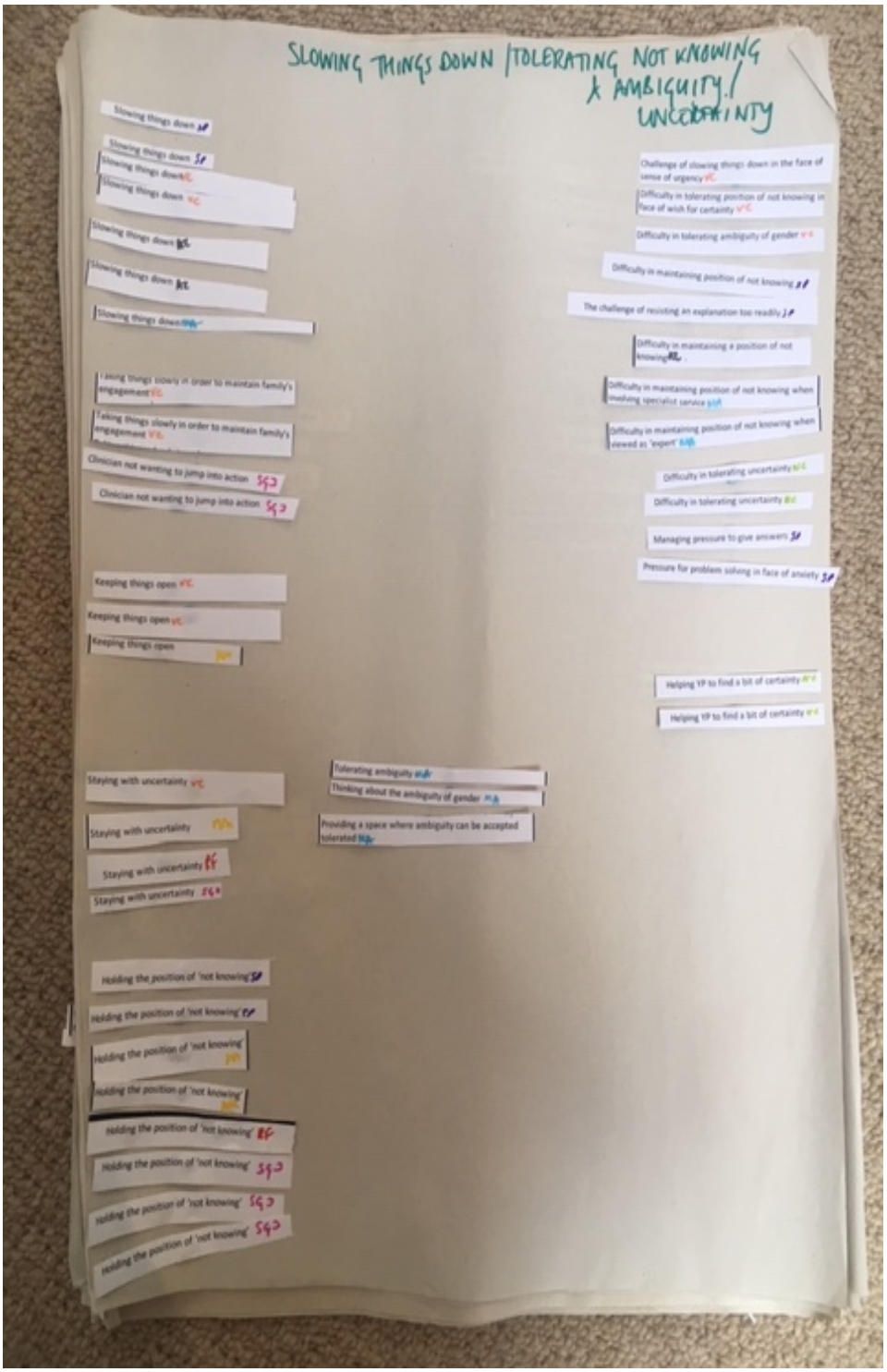
"What do you mean by that?"

“In what way?”
“How do you feel about that?”
“So what do you think that I need to know about this?”
“Is there anything else you would like to mention?”

“I now know what I need to know about this. I would like to move on and ask you…”

1.7.5 Appendix E- Initial coding excerpt

1.7.6 Appendix F- Thematic list excerpt



1.7.7 Appendix G- Data extracts table excerpt

CODES	EXTRACTS
Taking a position of curiosity (SP pg2 and 3, RF	*"I think that's what we take from our training, that we always come from the position of not knowing what we are facing and really being curious about it, and I think that is one of the challenges about dealing with gender specific problems, that sometimes there is a lot of resistance or anxiety around the diagnosis itself or trying to , to find an explanation for it too readily, that makes it quite difficult to ask questions around it I feel." (SP, pg 2)* *I put myself and I think the 'not knowing' position is a very wonderful position here in family therapy which is that I stay with the child to explore with and be curious about what the child is going through, you know what is it, what is their narrative, what is their discourse, what do they understand about it yeh, and um, how much do they understand it what is going on for them" (RF, pg 4)*
Intrapsychic and interpersonal exploration (SGJ	*"I think child psychotherapy looks at the intrapsychic and at the interpersonal um equally um and not focusing on one more than the other but genuinely looking at the inter play between intrapsychic and the interpersonal. So I think that is really important in all areas but particularly in the area of gender identity because the teasing out what is environmental and what actually comes from within is a, is something that will, is a question that is always in your mind" (SGJ, pf 3)*
Promoting individual exploration (MA, SGJ)	*"um rather than thinking about them in terms of this is someone who's got gender identity issues, gender , you know body dysmorphia, you know all those sorts of things, and actually think about them as widely as possible and to help them see that's what I'm doing and that's what I'm interested in. so I think it allows them to explore then what their feeling are....in a very individual way" (SGJ, pg.5)* *"providing a space for these young people to come and talk and and to have that sort of non-judgemental, as anyone who comes to see a clinical psychologist, um has that non-judgemental space of acceptance to sort of explore and investigate and think about their identity" (MA, pg 1)*
Promoting self-exploration in YP (SP)	*"are we trying to find meaning to quickly sometimes? Maybe not, maybe you know only the persistency and consistency will tell (laugh)with what they are presenting with, but there may be times when there maybe some more just genuine exploration about what they are, who they are." (SP, pg 11)*

2 Framing, Contextualising, Linking and Reflecting on the Clinical Research Portfolio

2.1 Introduction

My clinical research portfolio was comprised of two different forms of qualitative enquiry; a small-scale study reported in part 1 of this thesis and a single case study that was submitted for my qualifying paper.

In this paper, I intend to consider each component in terms of their respective evidence bases and empirical statuses as well as reflecting on potential methodological limitations. To contextualise my portfolio, I will begin by discussing some of the complexities, as well as the importance of conducting research in the field of psychoanalytic child psychotherapy.

2.2 Psychoanalytic child psychotherapy and research

'*Talking about research to psychotherapists can feel like selling deep freezes to eskimos'* (Fonagy, 2009)

Historically, research and psychoanalytic child psychotherapy were not often associated with one another, with academics purporting that psychotherapists circumscribe themselves to personal insight and *'the objective study of subjectivity'* (Fonagy, 2000) Fonagy articulates the resistance with which psychotherapists may have historically met the idea of empirical research relating this to the concept of *'cognitive asceticism'* (Whittle, 2000) which rests upon the idea that interpretation and theoretical constructions are *'temptations to be resisted'* (Fonagy, 2000). For child psychotherapists whose fundamental task is to seek meaning and create narratives through the use of interpretations, Fonagy comments on why it may be understandable that the concept or research in psychoanalytic psychotherapy has historically been felt to be jarring and unappealing amongst some clinicians. On the other hand, Rustin (2009) reflects on the paradigm of psychoanalysis, invented by Sigmund Freud, as having evolved as a *'productive*

research programme' in which '*its primary research method has been clinical, its main laboratory has been the consulting room'* (pg 36) With this in mind, he discusses more specifically the importance of the single-case study as a form of research despite its lowly position in the hierarchy of research methodologies.

Qualitative research more generally aims to '*study things in their natural setting, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them' (*Denzin & Lincoln, 2002)*,* using *'a holistic perspective which preserves the complexities of human behaviour'* (Green & Britten, 1998). Much has been written about the strengths of quantitative research in terms of its reliability (repeatability)- that is the same procedure should produce the same results over and over. However, qualitative research has historically prided itself regarding its validity (closeness to the truth) and its ability to penetrate to the crux of what is going on rather than providing a superficial overview. Building upon this, much of the literature states that the validity of qualitative research is greatly improved by the use of more than one method (triangulation) as well as the researcher thinking carefully about the part they might have to play in influencing the data (reflexivity)(Greenhalgh, 2010).

There are few comprehensive reviews of outcome studies of psychodynamic approaches to child and adolescent mental health difficulties (Fonagy, 2000) Kennedy and Midgley (2007) conducted a thematic review to scrutinise outcomes, assessment and evaluation tools in psychoanalytic treatment. This provoked statements about the poor evidence base for child psychotherapy in relation to concerns around methodology. Whilst empirical literature on psychodynamic treatments does exist, there are important limitations that have to be considered. Shedler (2010) outlines these limitations stating that *'patient samples have been too loosely specified, treatment methods have been inadequately specified and monitored, and control conditions have not been optimal'* (p.106) Very few randomised controlled trial research studies(RCTs) exist in relation to child

psychotherapy and the number of RCTs for other variations of psychotherapy (eg CBT) are significantly greater. Because the goals of psychoanalytic psychotherapy encompass more than simply the reduction of symptoms and are also interested in the development of internal resources, typically symptom-orientated outcome measures (eg Beck Depression inventory) implemented in research studies can prove problematic. In light of this, Shedler (2010) states that the poor reputation of psychoanalytic treatment in the research world reflects '*a failure of researchers, psychodynamic and nonpsychodynamic, to adequately assess the range of phenomena that can change in psychotherapy'* (p. 105) Further research is required to address this issue.

However, the recent IMPACT study (Goodyer et al, 2016) has been a key piece of evidence for the efficacy of child psychotherapy as an approach. Furthermore, it demonstrated a greater 'sleeper effect', indicating that psychoanalytic treatment may have a longer lasting impact in comparison to cognitive behavioural therapy. This, amongst other more recent empirical findings, makes it more difficult now for academics to make blanket statements about the lack of scientific support for psychodynamic approaches (Shedler, 2010).

2.3 The single case study

Part of my clinical research portfolio included a single case study in which I told the story of a two-year piece of therapeutic work with an adopted girl who was five years old when we began. Throughout the paper, I explored how a young girl's primary experiences during her first year of life had imprisoned her into a haunting and cruel internal world in which she was grappling with unpredictable and frightening adult figures. I intended to demonstrate how through intensive psychoanalytic work, along with the unwavering support of this young person's parents, she was able to begin to introject a different kind of

experience such that her internal objects could develop qualities of safety, love and trust.

The single case study has a long history within the psychoanalytic psychotherapy field and the wider field of research. The work of Sigmund Freud, the founder of psychoanalysis, was often written in the form of the clinical case study, with *Little Hans* as a prime example. Although it has been recognised as crucial to the development of clinical practice, new ideas and teaching, it has also received heavy criticism as a research method (Midgley, 2006). With this in mind, Midgley (2006) proposed three potential weaknesses of the single case study from which one can gauge empirical status; the '*data problem*', the '*data analysis problem'* and the '*generalisability problem'*. He advocates that if these can be addressed systemically then the single-case study should be able to re-establish itself at the crux of psychoanalytic research.

As Rustin (2003) purported, the consulting room should be considered as the primary 'laboratory' in which psychoanalytic research takes place, given that it is the sole method that is suited to the psychoanalytic study of the unconscious and the inner world. This statement was to rebuff Fonagy's (2003) belief that single case studies do not count as 'scientific evidence' and places psychoanalysis in an inferior position in the hierarchy of research evidence within psychological therapies. Although Rustin and Fonagy would appear in opposition, Rustin (2003) also recognises the vulnerability of the child psychotherapy profession if the consulting room is the chosen methodology for their research. To remedy this, he suggests the implementation of systems, for example of audio recordings of sessions.

It is important for the aforementioned to be considered in relation to the single case study I submitted for my clinical research portfolio. Whist I believe that my case study was clinically meaningful in terms of portraying the complexity of the therapeutic relationship between

myself and the young girl described, It is crucial that the rigour of my paper as a form of research is reflected upon.

The composition of my single case study was the culmination of a piece of intensive psychoanalytic psychotherapeutic work and was an opportunity for me to bring to life my qualitative experience of being with this young person and seeing her development over an extended period of time. Furthermore, it was an opportunity to exhibit my own learning and growth during my clinical training as a child and adolescent psychotherapist. On reflection, this piece of the research portfolio served as the showcase for my clinical training, taking the reader on the same turbulent journey that I felt I went through as a trainee learning through my own experiences. In that sense, it was not a description of a perfect, polished therapeutic intervention but a truthful portrayal of the struggle of trying to make contact with a young person with very little trust in the adult world. In my conclusion, I reflected on how this piece of work served as an advertisement for long-term psychoanalytic intervention for looked-after young people with histories of developmental trauma. In light of this, in the future I hope that It may serve as an important piece of qualitative research for other clinicians in the field working with similar types of cases.

I will now use Midgley's (2006) three 'problems' as a structure from which to highlight and respond to the potential methodological concerns of my single case study.

Midgley's '*data problem'* refers to the potentially unreliable nature of data collected In order to present a psychoanalytic single case paper. As psychotherapists, the writing up of process notes following a session is a crucial aspect of our work and typically make up the data that forms a single case study. Research has recently been conducted to address questions about the nature and reliability of process notes. Creaser (2015) has demonstrated that significant discrepancies exist between process notes and the audio recordings of psychoanalytic psychotherapy sessions. My single case study relied solely on the data of my process notes that were collated over a period of two years. I

therefore recognise that the data I was drawing upon is unlikely to be a direct reflection of what happened during the individual sessions with the young girl being discussed. Whilst Creaser's finding could be interpreted as a pitfall of using process notes as research data, she argues that the process notes of psychoanalytic sessions serve to represent something about the therapist's conscious and unconscious processing of any given session as well as the internal and external nature of the therapeutic relationships and I would reiterate that what was recounted in my process notes were important reflections of the therapeutic relationship in question. With the discrepancies that Creaser identified, she proposed that for process notes to hold more gravitas in the field of psychological research, they should be accompanied by audio recordings in order for important and informative comparisons to be made. In future, it would therefore be interesting to compile a single case study drawing upon both process notes and audio recordings to provide an even richer, fuller and more reliable account of the internal and external processes at play.

Midgley's (2006) '*data analysis problem'* relates to what data is selected by the researcher-clinician from the process notes of psychoanalytic therapy sessions. Tuckett (1993) refers to the potentially seductive nature of psychoanalytic single case studies, suggesting that they often tell a pleasingly coherent narrative about a case, with clinical vignettes that helpfully exemplify the chosen theoretical basis of any given paper. Whilst it is impossible to capture all of the nuances of a clinical case in a short case study, I would like to think that my single case study captured the struggle and messy aspects of the work, particularly in the early interactions with this young girl. That is not to deny the fact that certain aspects of the work were not included given the scope of the paper. I also recognise that the process notes that I drew upon represent a co-creation of the analytic relationship established between myself and the young girl. My intention was not to support or refute a specific hypothesis, but was to describe a unique therapeutic journey and explore both the

development of the young girl as well as my own learning as a trainee psychotherapist.

More recently, researchers in the field of psychoanalysis have implemented more systematic approaches to data analysis for single case studies, using methods such as grounded theory (Reid, 2003), thematic analysis (Meier and Boivin, 2000), and discourse analysis (Madill and Barkham, 1997). It could be interesting for me to apply a more orderly analysis with future single case studies, or to set out with an intention to either support or refute a particular hypothesis, through a rigorous and systematic analysis of all process notes.

Midgley's (2006) final problem is the '*generalisability problem'.* He asks the question '*if the findings of each study are only able to tell us something about this one particular patient, we might doubt whether the effort expended has been worthwhile? In other words, if the study is not in some way generalisable, is it really of value?'* (p. 136.) In response to this central criticism made about the single case study as a form of research, researchers have stated that studying a group rather than an individual enhances generalisability. However, even when researching a group, or comparing two groups, criticisms have been made about the 'representativeness' of a wider population given people's inherent individuality (Midgley, 2006). In the grand scheme of research within psychological therapies, my single case study would likely come up against significant criticism regarding its generalisability. However, it nonetheless represents an important piece of clinical work that studies a particular case in depth and I hope that it could serve as an important resource for clinicians working with similar types of cases in the future.

It would seem that the validity of the single-case study comes down to the purpose of the research. Is one's expectation as a researcher to be able to generalise one's findings to a much wider population or is it about honing in on the complexity of a particular clinical encounter? The latter expectation is important in terms of fostering the development of new ideas and continuing the dialogue about

psychoanalytic intervention in a climate where long-term psychoanalytic treatment may be under threat.

2.4 Small-scale study

Greenhalgh (2010) states that '*qualitative methods really come into their own when researching unchartered territory-that is where the variables of greatest concern are poorly understood, ill-defined and cannot be controlled' (p 166)* Because of this, qualitative studies often do not start with a hypothesis but rather allow it to evolve through the process of researching. With this in mind, it is imperative that the researcher has identified a clear focus of research as well as highlighting a specific question to attempt to answer (Greenhalgh, 2010) There is a dearth of research in the field of gender identity which was the topic of my small-scale study. However, it was apparent that over the course of completing the project, a lot more literature was published, particularly in terms of case studies. Whilst many clinician-researchers have documented their personal viewpoints about therapeutic intervention for TGNC young people, I found no empirical papers that qualitatively analysed a range of clinical views. For this reason, I kept my research question broad in order to scope the current landscape of clinical viewpoints.

Because Qualitative research intends to gain an in-depth understanding of the experience of particularly individuals of groups, participants tend to be deliberately sought out who meet the criteria for the study. It is recognised that this gives us 'biased' samples as qualitative researchers, however this is the intention! Greenhalgh (2010) highlights the potential downfalls of samples recruited '*on the basis of convenience'* (*p. 169)* given that the data obtained is not always the most relevant and therefore helpful. In my small-scale study, participants were recruited from clinics that were convenient to me as the researcher, however all of the participants met my recruitment criteria that stated that participants should be working

routinely with young people presenting with gender-identity issues.

Recognising ones' own position as the researcher is another crucial aspect of any qualitative study. As a child psychotherapist, it may have been expected for this study to have solely focused on the views of child psychotherapists. However, I felt that it was important that a range of disciplines were interviewed in order to be able to compare and contrast the way in which clinicians are thinking about their work with TGNC young people. Furthermore, I felt this would enable me to identify more clearly what child psychotherapists may particularly have to bring to this field of clinical work.

It feels important to reflect on my particular identity as a white, female child and adolescent psychotherapist and how that may have impacted on my small-scale study. As highlighted by potential participants (all of whom were child and adolescent psychotherapists) declining the invitation to be interviewed, this is a contentious area of clinical practice at present and one in which psychoanalytic practitioners perhaps feel that their views are not fully welcomed or it is too risky to speak up. For those who did agree to speak to me, how might my own position have influenced the way in which they approached their interviews? Given that the majority of my sample were white and female perhaps I could identify with their standpoints more easily and that this had a part to play in the evident cohesion of my results. If my sample had been more diverse would I have seen greater divergence of opinion? Furthermore, I am aware that my position as a psychoanalytic psychotherapist trainee may have impacted the way in which participants approached their interviews. With child and adolescent psychotherapists perhaps associated with adopting a more reflective position of curiosity, might this have impacted the way clinicians felt they should speak on the subject? What may have gone some way to offset the bias of my own position and how this will have undoubtedly impacted the data is the fact that I had a research supervisor who had an oversight of my data analysis and emerging themes. Nonetheless, it is important to acknowledge that research does not exist in a vacuum and results are

impacted by the idea that any researcher writes from a position of somewhere rather than nowhere.

Research methodology is important to reflect upon when considering empirical status. Greenhalgh (2010) poses the question '*are these methods a sensible and adequate way of addressing the research question? (p. 170)* It is also important to reflect upon the method of data analysis and the rigour of it. Greenhalgh (2010) states that the researcher must '*seek to detect and interpret items of data that appear to contradict or challenge the theories derived from the majority'* (p.171) As mentioned in the discussion part of my small-scale study, thematic analysis was the method of analysing the data for my small-scale study. Whilst It is common these days to conduct qualitative analysis with the assistance of computer programmes such as ATLAST-TI or NVIVO, Greenhalgh (2010) impresses that '*excellent qualitative data analysis can occur using the VLDRT (very large dining room table) method'* (p. 172) in which printouts of interviews are annotated manually by the researcher. Indeed, this was the method of analysis implemented in my small-scale study. Whilst a long and sometimes painful, iterative experience, I believe that it allowed for a deeper engagement with the qualitative accounts and immersed me in the emerging themes.

Given the small-scale nature of my qualitative study, there was no additional researcher to independently code extracts of the data to ensure inter-rater reliability. Whilst inter-rater reliability is important in qualitative research it is also acknowledged that '*just because the data has been analysed by more than one researcher does not necessarily assure rigour'* (Greenhalgh, 2010, p.172). What is more crucial is the capacity to expose and resolve disagreements between individuals. In the future, it would be interesting for a larger version of my study to be conducted in which this could be implemented.

Key to the method of thematic analysis is being able to discard themes that lie outside of key clusters of meaning. Therefore, it was impossible

to capture all that was discussed by participants and there may have been aspects of clinicians' discourse that was not able to be addressed. On reflection, this is a limitation of the method chosen which was mentioned in the discussion section of my thesis.

Another important question to be asked in relation to the rigour of qualitative research is about whether the results are credible. Key to this is whether actual verbatim data is cited to demonstrate the findings and quotes and examples are indexed so that they can be tracked back to the original source of data. For both components of my clinical research portfolio, verbatim data lay at the heart of my results and I believe that I provided a rich and powerful portrayal of the individuals (either the case of the young person or the clinicians interviewed) being discussed. If anything, it was a struggle to limit the amount of verbatim data I included.

As mentioned in the main body of my qualitative study, the generalisability of my small-scale study cannot be guaranteed. The sample was taken from a large, metropolitan area only and it would therefore be interesting to know what results would be obtained if, in the future, interviews were conducted in other parts of the UK in the future.

2.5 Conclusion

As a newly qualified child psychotherapist, I feel passionately that the discipline continues to thrive within the NHS and that it is widely recognised as a crucial part of any multi-disciplinary mental health team. For this to happen, I believe that the continued development of a research evidence-base for psychoanalytic psychotherapy is imperative in order to demonstrate the efficacy of the approach. As discussed in this paper, this is a challenging task where clinical observations are the data and cannot be replicated in a laboratory (Fonagy, 2009). However, these observations are hugely rich and can be used to develop clinical thinking, ideas and practice. It has been

documented by many academics that if in-depth clinical observations from the child psychotherapy discipline can join up with other disciplines, such as neuroscience (Fonagy,2004) this could strengthen and develop important insights about the importance of psychotherapy as a treatment modality. Completing a single-case study as well small-scale qualitative study for the purposes of my training as a child and adolescent psychotherapist has been an enriching and challenging experience and has felt like a small contribution to a wider drive for research in the field of psychoanalytic psychotherapy.

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