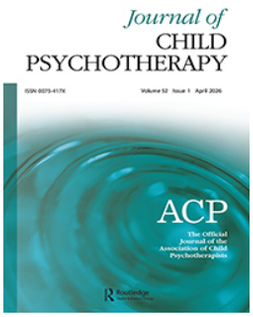

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Group psychotherapy for young people with gender-related distress

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ABSTRACT

This paper describes the evolution, learning and key components of a group psychotherapy provision for adolescents experiencing gender-related distress (GRD). It suggests that this approach has much to contribute to current consideration of what help for this population could include. In the context of rapidly increasing numbers and a changing demographic of young people referred with gender incongruence over the past 15 years, the Cass Review was commissioned to make recommendations about their NHS care. Concluding in 2024, it found relevant research to be limited and emphasised the importance of gaining a much better understanding of those presenting for help, their support needs and the potential treatment options. While the diverse antecedents and manifestations of adolescent GRD indicate that no one model will fit all, this paper offers a rationale for considering group psychotherapy as a meaningful support. It describes a provision that originated as a CAMHS and third sector partnership initiative, and has been maintained in a third sector community setting across this 15-year period with a mix of NHS, local authority and charitable funding. Informed by psychoanalytic, group analytic, mentalization-based and art therapy approaches, the model used has been shaped through trial, error and collaborative endeavour with affected young people. Service developments and current research plans are outlined. Process examples as well as photographs of artwork illustrate the discussion.

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Introduction

In line with similar patterns outside the UK (Kaltiala et al., 2020; Respaut & Terhune, 2022), the national Gender Identity Development Service (GIDS) for children and young people at the Tavistock and Portman NHS Trust saw its referrals increase from a baseline of approximately 50 per year in 2009 (Cass, 2022, p. 32) to over 5000 in 2021/22 (Cass, 2024, p. 85). Also notable has been a

> change in the case-mix from predominantly birth-registered males presenting with gender incongruence from an early age to predominantly birth-registered females presenting with later onset of reported gender incongruence in early teen years. (Cass, 2022, p. 32)

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Since GIDS' closure in 2024, new referral systems have become established and the set-up of regional specialist services is in progress, but the number awaiting help has continued to rise (Thomas & Fox, 2025).

Adolescents seeking help with gender-related distress (GRD) often experience complex difficulties that include 'higher than expected' levels of co-existing mental health issues (anxiety, depression, eating disorders, suicidality, self-harm), adverse childhood experience and neurodevelopmental conditions (Taylor et al., 2024). In a context of legal challenge such as *Bell v. Tavistock And Portman NHS Foundation Trust* (2021) and significant concern about the effectiveness and ethical implications of early medical intervention (Evans, 2025; Giordano, 2025; Heneghan & Jefferson, 2019; Latham, 2022; Levine et al., 2022), the question of what psychotherapy can offer has been highlighted (D'Angelo et al., 2021; Gay Men's Network, 2024; Heathcote et al., 2024; Schwartz, 2021). The Cass Review found that while 'for the majority of young people a medical pathway may not be the best way' (Cass, 2024, p. 30) to address their difficulties, there remains very limited evidence of *what is*. It concluded that 'information about provision of psychological care and consideration of how this should be delivered is urgently needed' (Cass, 2024, Appendix 2, p. 7).

Cass (2024, p. 13) suggests that the 'toxicity of the debate' surrounding the meaning of gender incongruence and the consequent care pathways negatively impacts both the young people concerned and research in this field. While her final report (Cass, 2024) was widely acknowledged to be a 'comprehensive and evidence-based' (Royal College of Psychiatrists, 2024) study that 'employed the highest clinical and research standards' (Association of Clinical Psychologists, 2024), dispute about its findings (British Medical Association, 2024; Cheung et al., 2025) and about the appropriate response of professionals to this subject persists. For example, opinion among many psychological therapists remains divided as to whether an 'affirmative' or an 'exploratory' stance represents best ethical practice (Ashley, 2023; Jenkins, 2023).

This paper discusses a psychoanalytically informed psychotherapy group for young people experiencing GRD and what such an approach can offer this population. It explains the origins of the service and characteristics of the young people referred, going on to discuss the running of the group, its culture, structure, therapeutic aims and systemic features. Key therapeutic components and their rationale are then explored, with reference to underpinning theoretical ideas. Process examples are given and artwork from sessions reproduced with permission from the young people involved. Finally, current research is outlined and concluding thoughts are offered.

Beginnings and context

In 2010, as GIDS was beginning to observe the rise in referrals that would gather pace and become exponential over the following decade, a regional adolescent mental health conference was considering unmet need. Two of the agencies present – Southampton Child & Adolescent Mental Health Services (CAMHS) and Yellow Door (a local third sector service for those at risk from or impacted by sexual/domestic abuse) – discussed the small but increasing number of young people requesting their help with gender incongruence. A representative of each – myself on behalf of Yellow Door and a manager from CAMHS – subsequently met to consider the potential for

a partnership response. We both had some previous experience of providing therapeutic groups and, based on our initial understanding of the young people concerned, wondered about the viability and potential benefit of this option. In August 2010, with a small allocation of CAMHS pilot funding we opened to referrals and began meeting the young people seeking help. They described significant distress in connection with gender-related ideas and perceptions (their own and those of others) and limited opportunity or capacity for dialogue with trusted others about these concerns. Other than a higher prevalence of gender non-conformity and autistic traits, in the range of psychological difficulties and/or problematic histories that the young people reported, they were not dissimilar from other adolescents accessing both partner services. In any combination, their 'differences' were seemingly contributing to interpersonal problems in school, social or family settings as well as to low self-esteem and/or acute body-consciousness. An apparent struggle to put words to the experience of GRD indicated that play and art making might be helpful, and those we met expressed cautious interest in a group, suggesting to us that their adolescent drive for peer connection was still alive, if not quite kicking.

Unable to find much written about related clinical work, we flagged our 'not knowing' through professional networks, hoping someone else might. A GIDS psychologist was encouraging and reported that their occasional summer holiday get-togethers for young people, while not therapy, had seemed beneficial in reducing isolation. A group analyst at the Portman Clinic, who had conducted both adolescent therapy groups for other presentations and a group for gender dysphoric adults, offered valuable insights, highlighting the benefits of having male and female co-therapists when working with gender-related themes. Local colleagues with relevant experience were equally generous with their time and expertise.

Although a 12–18 age range would include all those referred, the developmental differences this encompassed sat among our many apprehensions, and we found ourselves seeking reassurance from the illusory certainty of a carefully written activity plan. We co-conducted the first therapy group session in June 2011 with eight adolescents. Initially under the umbrella of CAMHS, the feedback and observed outcomes after two pilot years led to the service becoming established within Yellow Door under grant agreements with CAMHS and the local authority. It has been maintained since as a free-to-access provision with (often 'hard to reach') funding from NHS, local government and charitable sources.

We looked for, but did not come across, then or since, any similar psychotherapy groups in the UK or elsewhere for gender distressed youth, so were keen to learn of interventions with common features. Hakeem (2012) reported on what seemed the closest parallel – an NHS group therapy for adults with gender identity difficulties that offered a similarly modified fusion of mentalization-based and group-analytic approaches but without an art therapy component. Resonating with our own intentions and developing model, Hakeem's group encouraged openness to a range of potential routes for managing gender dysphoria and aimed 'to give the patient a greater understanding of the meaning they afford to gender' (p. 19). More recently, Evans and Evans (2021) and Lemma (2022), among others, have made further important contributions (unfortunately too extensive to do justice to in this paper) to a growing psychoanalytic discourse in this area.

The therapy group

Young people referred to the group

CAMHS have made the highest number of referrals (48%) to this psychotherapy group, followed by Children's Services, then Education, G.P.s and the third sector. Of the 160 young people who were referred between August 2010 and July 2025:

- 88% were given some form of support
- 41% had a diagnosis of or were awaiting assessment for autism
- 13% had a diagnosis of or were awaiting assessment for ADHD
- 12% were care-experienced
- 30% presented with emotionally based school avoidance
- 24% had experienced domestic abuse or neglect
- 18% had experienced sexual abuse
- 122 (76%) attended an initial meeting to consider their suitability for group therapy. Of these, 84 went on to attend the group and three were awaiting a space.

Over this period, 75% of those referred were natal females and 25% were natal males. Originally the group comprised a fairly even mix in terms of natal sex but by 2015 we were mostly seeing natal females, mirroring national trends. Since the start of 2024 we have noticed a resurgence in natal male referrals and will be interested to see whether this continues.

Initial contact

Depending on the young person's age and other details provided, initial phone contact is made post-referral with a parent/carer, professional or the adolescent as appropriate. One-off support, information and/or signposting at this stage can be sufficient, particularly when there is questioning of gender rather than associated distress. A face-to-face meeting is otherwise offered to the young person, parent/carer(s) and, at times, involved professionals so that from the start, presenting difficulties can be considered in a relational context. General wellbeing, previous experience in groups (including at school and in families), hopes, fears and expectations regarding therapy and any risk or safeguarding concerns are also discussed.

Information about how the group operates and the challenges it can present have always been offered to support collaborative decision-making about potential participation, but expectations have shifted over the lifetime of this service about what help for GRD should look like. We have found it increasingly important to make it clear at early contact that while group psychotherapy can be supportive and rewarding, it may also give rise to painful or unsettling emotions that may be understood less as negative effects and more as indications of areas to be attended to. We explain that this provision offers no silver bullets and may not be the right help for everybody. Emphasis is placed on the need for regular attendance and for sign-up to a group agreement about issues such as confidentiality. We discuss the normally 6–12 month wait – at which point a further check-in takes place to consider any changes before a group space is offered.

Group framework

The group meets weekly for one and a half hours during the early evening to help support educational engagement. Operating only within school terms enables planned breaks for all from what can be an intense and demanding process. Prior to our introducing a waiting list (from 2017), young people were offered up to seven terms if we had space, but they can now stay for a maximum of six.[1] This is an unusual length of provision in the current climate, but an approach that can involve a 'major restructuring of the child's way of relating to the world' is 'itself dependent on making it first safe enough to do so' (Kegerris & Midgley, 2014, p. 41). In our experience with this population, establishing this safety often takes time. Length of stay has been an average 3.7 terms with each term comprising about 12 sessions. How much is 'enough' is discussed in the group, with recognition that this will be different for each adolescent.

We ask for no out-of-session contact between group members, sharing our learning from difficult experience that this reduces the risk that sub-groups, splits or boundary breaches may undo hard won progress towards trust-building and cohesion. There is significant variability among group members in terms of stability, functioning and support systems. For many, the group can be enough. Some, in attempting to manage their difficulties, may engage in risky behaviours, and time must be spent, both in and out of the group, addressing safeguarding concerns. Others may require a referral, signposting or support to access additional help, or may already be receiving input from CAMHS, Mental Health in Schools Team, Children's Services or other local youth providers. Disclosures in the course of therapy may require information to be shared with parents/carers and/or professionals. Dilemmas about what can or should be held or processed within or outside of the therapeutic space and what information can or should be shared with other group members are common. We are open with young people that these predicaments exist, and invite the views of group participants whenever possible – even where we cannot share detail. While our aim is to process as much as we can within the group, sometimes a meeting is arranged with family members and/or involved professionals to provide additional containment, address risk concerns or support systemic care.

Structure and culture

Adolescents with GRD are a heterogeneous population and the difficulties of those who attend the group are often complex and multifactorial. It seems fitting then that a therapy for them has evolved not from one group membership, clinician or theoretical framework but from several, in combination and over time. Feedback given by group participants verbally or in writing, at mid-way and ending points, anonymously or not, has influenced our therapeutic stance, the design of sessions, the activities we offer and the content we discuss. My own training and experience in group analytic and mentalization-based approaches has been complemented by that of my co-therapists – initially a male CAMHS manager/mental health nurse and then, for the majority of its lifetime, male art therapists. In being male and female co-conductors who bring differing skill sets and sometimes offer contrasting views, we have tried to

model how alternative positions can be taken up within one space without conflicting, cancelling each other out or having that space unravel.

The balance we try to strike between structure and flexibility has been important for this cohort as a whole but may be particularly so for young people, as Blackwell et al. (2021) suggest, whose resistance to change is linked to neurodiversity. A slow-open approach aims to offer stability without the group becoming static. New young people join at term start and endings are planned for term close so that the security of a known membership is balanced by periodic exposure to change and uncertainty. This appears to help foster a degree of resilience and to encourage reflection about how the fear or fantasy of something or someone new matches with realities or confounds expectations over time.

The broad age range does present significant challenges, but we talk about these within sessions and they tend to become 'self-managed' by group members in playful ways. Panto-style collective booing, for example, amplified in response to language or content perceived to be less appropriate for younger members, has brought both some laughs and some sharing of boundary controls. The attempt is to forge a group culture that takes the experience of its members seriously without taking itself too seriously. Therapist self-mockery is helpful because for young people, an approach that acknowledges unconscious process and recognises all 'outputs' (behavioural, verbal, creative) as potentially meaningful, can take some getting used to.

There is no manual or set format to this therapy, but each session or sequence of sessions is thought about, and adaptable plans are made in both the reflective time we ringfence before and after each session and in clinical supervision with an art therapist who has extensive CAMHS and group experience. These thinking spaces have been crucial to our staying attuned to the ebb and flow of the group's needs and those of each young person within it. This can be a tenuous balance and we attempt to work collaboratively – offering and inviting ideas for activities and encouraging participants to make individual and collective choices that help steer the direction of sessions. More structured activity is required during periods of greater turbulence or when surfacing themes need additional 'scaffolding'. At these times the therapists are more active and more tightly 'hold the reins'. In periods of greater stability or as groups settle and mature, these reins can be shared and, in some aspects, handed over; at such times we may plan to have no plan at all other than to put out creative resources, step back, hold the boundaries and see what young people make of the therapeutic space.

Therapeutic aims

Initially informed by a combination of co-therapists' training backgrounds and discussions with both young people and colleagues, our stated aims have been updated periodically but not fundamentally altered. These are to help young people:

- Express thoughts and feelings that may be hard to put into words.
- Build social skills and confidence through exchange with others and participation in group activities.
- Explore thoughts and feelings about gender and related distress – considering the many possible contributing factors.

- Recognise and manage uncertainties about the future, holding in mind the many possible ways in which GRD can develop, resolve or change over time.
- Look at things from different perspectives.
- Explore ways of coping with challenging thoughts, experiences or emotions.

While the gender-related difficulties that adolescents experience exist along a continuum, their impact for those who tend to seek our help can be significant, far-reaching and sometimes navigated without key support frameworks. We have seen the group's role as enabling gender-related distress – along with the many other inextricable aspects of the young person who attends – to be seen, heard and thought about. Not all, but most of those referred express their intention to pursue some form of medical intervention in the hope or belief that this will resolve or at least ameliorate their difficulties. While puberty blockers are no longer an option for most, cross-sex hormones and/or surgeries continue to be very present in the thoughts and discussions of many. Where gender-related disturbance is felt to be intolerable, there can be an urgency for and insistence on such action. In high-affect or in disconnected mind states, the health risks of (Cass, 2022, p. 36; NHS, 2025), and potential to regret (Bell, 2021; Littman, 2021) medical intervention can be hard to talk, think or allow mixed feelings about. Imagined outcomes may be idealised and the possibility that such actions may not bring resolution can be disavowed. Engaging in therapy signifies hope for psychic change, but the idea of getting to know a self that is perceived to be an anathema can feel counterintuitive and the thought of showing that self to others can meet significant internal resistance. It may seem pointless to focus on the mind if, as is often the case, the primary difficulty is conceived of as physical at source. Yet in any group there will inevitably be at least one 'other' position, opening up opportunity for dialogue and symbolising a capacity for ambivalence. It is in this recurring dynamic, that thinking, feeling, the group interaction of ideas and the exploration of mind states, can all become gradually less threatening, more tolerable, of use, of interest, perhaps at times even enjoyable. The central therapeutic aim is to strengthen reflective ability and agility that can be utilised beyond the group, to the benefit of (among other things) the young person's future relationships, self-care and decision making.

Working with families

Parents and carers of adolescents with GRD can feel isolated. The wish to help their young person is shared, but they may be confused or have very different ideas about how best to do so. While more information has become available on this subject, the often conflicting messages found online and elsewhere can exacerbate anxieties and tensions within families. The idea of getting potentially life-changing decisions wrong can become as unbearable for the parent/carer as for the young person, bringing a risk that the GRD may become managed unconsciously through the maintenance of a collusive foreclosure.

Historically, we offered family sessions where needs arose and resources allowed, but from 2018 we have provided a termly parent/carer group in which questions, thoughts and experiences can be exchanged. This has been well used and welcomed by its attendees, and young people have also expressed relief that their family members are

receiving some help of their own. There is less creative activity and more talking, but the parent/carer group otherwise has a similar format to the adolescent group – demystifying and allowing a joined-up experience of the approach that we use. Occasionally we have held a multi-family session where parents/carers and young people come together to discuss a particular theme.

In 2022, following professional requests for help for younger children and feedback from some adolescents and parents/carers about how earlier support may have been helpful, we sourced funding to offer brief family interventions for those of primary school age. The aim was to give early-stage thinking space to gender-related questions and difficulties and to the potential implications of any decision-making, both short and longer term.

Group therapeutic factors

The therapy group approach we use is rooted in psychoanalytic, group analytic, mentalization-based and art/play therapy models. This section discusses why we have considered these relevant to the young people and the subject we are working with.

Group thinking

> Being a respected and effective member of the group, being accepted … belongs to the basic constructive experiences of human life. Health is inconceivable without this. (Foulkes, 1990, pp. 155–6)

The transmission of gender-role expectations to children begins early (Endendijk et al., 2019; Portengen et al., 2024; Sullivan et al., 2018) and by adolescence can have detrimental impact on those who don't conform (DeLay et al., 2017; Tankersley et al., 2021). A House of Commons Health and Social Care Committee (2023) reported that young people and individuals identified as 'LGBT' were among those most negatively affected by increasing exposure to idealised body types through social media or advertising. 'Pressure to conform to stereotypes and gender constructs' (p. 12) was cited as a particular cause of distress. Merino et al. (2024, p. 25) similarly found the struggle to meet 'gender-specific ideals' to be 'a critical risk factor for various mental health challenges'.

Group analytic theory recognises such pressures to be psychologically formative. According to Foulkes and Anthony (1965, p. 27), 'the culture and values of a community' are 'inescapably transferred to the growing infant … verbally or nonverbally, instinctively and emotionally, twenty-four hours a day'. In this sense, 'the disturbed individual is' seen as 'a symptom of a disturbed group' (Foulkes, 1975, p. 60) and gender-related distress can be understood as stemming, not from dissonance *within* the individual, but from dissonance *between* the individual and their social group. Through this lens, and borne out by the stories of our group members, the discomfort that an unconventional gender presentation arouses in the majority, becomes projected into and taken up by the individual as *their problem* to resolve.

Overlapping and interweaving with the gender non-conformity that is common among young people with GRD are 'high levels of neurodiversity and/or co-occurring

mental health issues and a higher prevalence than in the general population of adverse childhood experiences and looked after children' (Cass, 2024, p. 26). Attendant attachment disruptions and interpersonal frictions populate the themes that surface and resurface in this therapy group. Manifest in multiple and various ways, these features, in constellations unique to every individual, can fuel a sense of mis-fit with, or exclusion from, their 'group' (family, peers, external world). This 'not belonging' may elicit primitive fear responses: withdrawal from school, social world or painful realities (flight); combative, punitive or retaliatory reactions towards self or others (fight); or a desire to halt the puberty that symbolises lost control or is seen to catalyse social or internal disconnect (freeze).

Psychoanalysis has long recognised the unconscious, fundamentally constructive impulse to replicate unbearable or unfathomable experience that has formerly been split-off or suppressed – 'not as a memory but as an action' (Freud, 1914, p. 150) – in the search for recalibration. Freud's (1920) concept of repetition compulsion describes this urge to 'work over in the mind some overpowering experience so as to make oneself master of it' (p. 16). This helps us understand how experiences of alienation or estrangement, in coming to dominate the psyche, might re-enact internally (in perhaps the safest-seeming space for processing), in the form of mind rejecting body, or in the young person developing a discordant, even hostile relationship with themselves. Yet the longing for belonging propels a quest for 'solutions'. Attempts to manage the perceptions of others or to hide, suppress, eject or eradicate those aspects of self perceived as *un-acceptable*, materialise (or 'repeat') in the behaviours, dialogue or creations of those affected, as relief is sought from the internal pressure they generate (see Figure 1).

Attending to the interface between the adolescent and the social world, a group-analytic therapy, interpersonal at its core, attempts instead to *integrate* 'otherness' – to

Figure 1. 'Hiding' (image created by young person in group session – felt pen on paper).

invite *in* the strange(r), the unknown, unwanted or even abhorrent – without pretending this is easy. In this way, it operates antidotally – bringing 'back the problems to where they belong' (Foulkes, 1990, p. 155) – in other words to a relational field in which concomitant conflicts, inevitably stimulated, become available for a more communal 'remembering, repeating' and 'working through' (Freud, 1914).

For adolescents who are neurodiverse and/or have experienced poor quality interpersonal 'reception', communication with others or with otherness can present particular challenges. Some prefer more explicit and literal exchange, but for others conversation is more accessible and manageable when they can tune in and out through the less concrete wavelengths of symbolism and metaphor. For example, when we talk about the many ways in which the interactive 'body' of the therapy group can be inhabited and responded to, there is much that is analogous to the mind-body relationship for young people to reflect on – or not. How does what is happening on the outside affect how it feels from the inside? Can the discomfiting aspects be tolerated, or contained by the boundaried framework? Do the relationships within it change over time? Will the urge to reject rather than stay in the space be followed or resisted? What or who do we want to include or exclude, protect or assimilate, attack or dis-member, and why? In the comings and goings, how does a change to one part affect another? How might conflicting or seemingly incompatible parts find ways to co-exist?

Mentalizing

> Being in uncertainties, mysteries, doubts … (Keats, 1899/2008, p. 277)

Mentalization-based therapy or MBT (Bateman & Fonagy, 2004, 2012) was originally developed and shown to help adults with borderline personality disorder reduce self-harming behaviours and better understand their emotional responses. Its clinical adaptations, including in groups, have since found much wider reach and become effectively integrated within a spectrum of adolescent therapeutic interventions (Midgley & Vrouva, 2012; Midgley et al., 2021; Sharp & Rossouw, 2024).

Fonagy et al. (2017), describe the process by which children learn to mentalize (consider and begin to make sense of their own and other people's minds), as emerging from 'early interactional experiences in which the infant finds himself reasonably accurately represented by the other' (p. 177). This attachment security facilitates the building of 'epistemic trust', or in other words 'trust in the authenticity and personal relevance of interpersonally transmitted knowledge about how the social environment works and how best to navigate it' (p. 177).

Cass (2024, p. 292) suggests that 'gender questioning requires an open-minded approach, in which no outcome is presumed or predetermined and where an individual is given space (and time) to reflect on – and understand – what questioning means for them and their bodies'. Yet our experience has been that many young people affected by gender incongruence have, for a variety of reasons, had limited access to, or experience of, such space and time to mentalize – that is, opportunity to develop an understanding of gender-related thoughts, feelings, wishes, fears, beliefs and behaviours (their own and other people's), or to

consider how they link. Their psychosocial experience may have led to the development of 'epistemic mistrust' – described by Fonagy et al. (2017) as an 'adaptive response to a hostile or threatening social environment' (p. 178). This can inhibit a perception of other minds as benevolent, or at least benign – impeding openness to new interactions and with it, to new information. For professionals, amid dwindling healthcare resources, finding time to look beyond quick fixes and work at the adolescent's own developmental pace, can also present a significant challenge. According to Adichie (2022), young people's immersion in a contemporary culture of 'social censure' (5:44) stifles discourse and can leave them 'afraid to ask questions for fear of asking the wrong kind of questions' (7:45). Growing up at a time when 'no debate' was widely promoted as the apposite response to gender self-identification (Summerskill, 2025), appears to have had a chilling effect on the internal dialogue of young people and on the potential for exploration with those they normally turn to. When there are 'few other areas of healthcare where professionals are so afraid to openly discuss their views' (Cass, 2024, p. 13), it can be no surprise that some young people with GRD internalise a sense that their difficulties are almost unspeakable.

It is in this context that a mentalizing group, alongside 'similar enough' others, may offer new, potentially reparative experiences of recognition, resonance and belonging. The relief at finding common ground can allow for more confident differentiation. Self-esteem can grow as young people find themselves of use in contributing to one another's therapy. This helps re-build the epistemic trust that can lower barriers to new perspectives as adolescents revisit 'a process that was derailed, and begin to develop secure relationships' (Fonagy et al., 2017, p. 200).

Upholding the principle of 'negative capability' – a term introduced by Keats (1899/2008, p. 277) and developed by Bion (1967, 1970) – MBT assigns value to the struggle to 'not know' and holds an 'attitude of curiosity' (Bateman & Fonagy, 2012, p. 138) at the centre of its practice. The mentalizing approach normalises, de-stigmatises and makes therapeutic use of our innate human propensity for relational misalignment. There is consistent exposure to the idea that what may be 'wrong' from one angle or for one person may be 'right' from or for another. Fostering a culture that questions norms and ideals and that finds value in difference rather than seeing it as a problem has important connotations for young people who are prone to considering themselves 'mistakes'. Alternative perspectives are recognised as helpful in both making sense of such experience and in regulating strong emotion that can otherwise impair reflective functioning. These differing positions are inherent in the very structure of a group (see process example 1), where there are always more than two minds to reduce the potential for polarisation and to help plasticise thinking.

Process example 1. What is a boy?

(a) *So, when you started talking, did you tell her you're not a real boy?*
(b) *But … I AM a real boy!*
(c) *Disrespectful! (laughs)*

(a) *Yeah … sorry … I know … well … you're not pretending … but I mean … you're not a real boy YET …*
(b) *(Silent, looking unhappy)*
(c) *I suppose it depends what you mean by real doesn't it … I just think … I don't know … I mean, whatever I do, however much I want to be, I'm not going to be the same as someone who was born a boy.*
(d) *I think you should tell her anyway. It's not fair on her really if she finds out you're not what she thinks you are.*
(e) *She must have an idea already though, mustn't she?*
(b) *Do you think?*
(d) *I don't know … I feel like she'd be able to tell … girls aren't stupid.*
(b) *You think I don't pass … is that what you're saying?*

Silence for a moment

(f) *I think you do! 100%!*
(c) *Well you're lucky if you do because I don't think I do … I mean, I want to … I wish I did … but I just don't think anyone really sees me that way.*
(d) *Look she must like you anyway – as a person – so maybe it doesn't matter that much. Maybe you just need to talk to her. She might be ok about it?*
(e) *Or she might not!*

Making and playing

> There are things that are not sayable. That's why we have art.
> (Leonora Carrington, as quoted by Sopinka, 2012)

Art therapies have been found to have positive outcomes for young people with autism in terms of social interaction (Bernier et al., 2022), emotional regulation and opportunities for the safe expression of thoughts and feelings in indirect ways (Schweizer et al., 2019). Space for young people with GRD to create and play together is a third key feature of this group, and particularly important when opportunities to do so have been limited by school avoidance or social withdrawal. Available in sessions are a range of resources – pencils, wire, glitter, model magic, sand-tray, figurines, textile scraps – that can, like conversation threads, be picked up or not. These materials can alleviate pressure to make unwelcome eye contact and, in their tangible, malleable and sensory qualities, help young people to self-soothe and stabilise.

In the therapy room, we sit around a large table and have a sink that allows mess to be made (for example with paint, clay, papier mâché or glue) and later emerged from. Whole-group activities (in which therapists normally participate), can help counter fragmentation (pairings, side conversations, cliques, isolated members). In making models or playing games, exchanging ideas or sharing resources, space, process, body and mind are interactive; there is movement to offset any stuckness or rigidity.

Shame or anxiety is often linked to being seen or heard, but in artwork meaning can be simultaneously communicated and disguised, affording a degree of protection. The group format and resources combine to offer choices: to come in and out of view as defences allow; to speak or not speak; to play a form of hide-and-seek between landscape and foreground that facilitates self-guided, gradual exposure. When new

members arrive, we might play jenga with a tower that has 'getting to know you' questions, (sometimes funny, sometimes more serious), written by group members on each brick. Or 'cat's cradle' where different coloured wool is passed from one person to another when they find something in common such as a pet snake or a mum called Debbie. When enough wool connections form a 'matrix', objects from the room or from young people's pockets, or some artwork they have made, is put onto the 'cradle' to see what can be held or bounced around between us and how high. Setting the group culture in this way appears to reduce pressure in establishing that not everything has to be about gender and that things said or done in each session do not need to have obvious meaning or outcome.

Central to psychoanalytic psychotherapy and the ethos of this provision is to 'enable the patient to speak of everything, including that which is forbidden elsewhere' (Woods, 2007, p. 204). For this, many alternative communication routes are needed to support group members who struggle to verbally articulate their experience. While some are 'noisy', others do not speak at all or do so only under specific conditions. Social (and internal) censure plays its part but young people can also struggle to find and use their voice when they perceive that voice itself to be shameful or 'wrong'. Games and art projects can encourage exploration of themes that feel too 'stuck' or 'heavy' to just 'put on the table' (see process example 2). Through what can seem the safer medium of abstract images or concepts, toes can be dipped into hotter water – helping young people gauge their peers' responses and gradually feel their way towards going further 'in'.

Process example 2: the washing line

A piece of wool is stretched across the room. Two images or objects (often comical and highly stereotypical) are made or found (for example in magazines) by group members to represent 'male' at one end and 'female' at the other. We talk about what these terms mean while each young person creates a self- representation, either freehand or using a template that can be decorated with pens, glitter, felt, feathers, stickers or junk materials. Someone might cut into the template, re-shape it entirely or, having created an image, then scrunch up, damage or throw it away (see Figure 2).

Figure 2. 'Ripped' (image created by young person in group session – felt pen on paper).

The images or objects are pegged onto the wool line. The therapists ask questions and encourage group members to do the same: 'Does anyone want to say where they have put themselves and why?'; 'How are you affected by each other's positioning?'. If one young person does not put up their image, another may take theirs off the line to put it next to the isolated image or say 'Come on . . . we want you up here with us'. Sometimes the line itself is re-worked with new threads hung from the wool to create 'sub-threads' that a few images will then cling to – creating a 'mobile' effect. We wonder out loud: 'What is happening here?'. The line is stored away, but after six months or so a group member or a therapist might suggest we put it up again. We might ask: 'What is it like for group members to look at "themselves" six months on?'; 'Does anybody want to change or move their figure and, if so, what is motivating this?' Like most of our activities, there is no set formula; what happens in the session takes on a life of its own and any number of discussions or decisions might ensue. In this sense, the 'washing line' becomes 'an active line on a walk, moving freely, without goal' (Klee, 1953, p. 16). For example, when we retrieve it from the cupboard it could be tangled. One group member might suggest it 'needs surgery' but another may argue that: 'We should leave it as it is'. Others may ask: 'Shall we keep trying to untangle it?'; 'Should we cut out the knotty, difficult bits and put it back together?'; 'If we do that, won't it change the whole thing?'

Such relevant questions!

Adichie's (2022, 9:48) view is that to enable creativity 'one needs a kind of formless roving of the mind to go nowhere and anywhere and everywhere'. When sessions are less structured, space can be created for free associative paintings, sculptures or doodles, individually or as a group (see Figure 3).

The absorbing yet liberating process of this free art-making can offer containment or expression of more contemplative or fantastical ideas. Meaning matters and is always on the table, but it is equally important that the space allows for outputs to be meaning*less* or *not* understood. In this way, the 'nonsense that belongs to the mental state of the individual at rest' (Winnicott, 1971, p. 65) or what may have long been hidden or suppressed, can come up for the

Figure 3. 'Free associating in paint' (unstructured art-making in group session – paint on paper).

fresh air of others' input, before going back again, though rarely to the same position. The aim is not to interpret or attribute meaning but to recognise, for example, that artwork can communicate at multiple levels and sometimes 'speak for itself' (see Figure 4) – articulating thoughts, emotions or something important but intangible for which words cannot be found.

We sometimes get the dressing up box out. Feather boas, stilettos, wigs, moustaches, handbags, tiaras and suits inevitably stimulate gender-related conversations. Flitting between funny/silly and meaningful/serious, we talk about what is considered appealing or repugnant, real or fake, masculine or feminine and how we tell the difference. The activity offers 'opportunities for safe play, that is, for trying on and taking off various gloves of identity without serious consequences' (Hopper, 2001, p. 144). Participants wonder aloud: 'Why does changing how I look change how I feel?' Young people both look into the real 'mirror' that we haul into the therapy room, and also receive one another's 'reflections'.

Collage can be accessible for those who worry they can't draw or paint and can help us think about seemingly disparate parts. We might make portraits where everyone contributes to an image of everyone else, stimulating myriad ideas and emotions as each young person gets 'to know himself – and this is a fundamental process in ego-development – by the effect he has upon others and the picture they form of him' (Foulkes, 1964, p. 110). The resources, too, hold communicative potential. Clay can be attacked or smoothed gently, broken into parts and put back together, shaped and reshaped. This can help us think about what is hard and what is soft, and about

Figure 4. 'Body parts' (image created by young person in group session – found objects on paper).

permanent or reversible change: 'Does it have to look perfect?'; 'I liked it last week but now it looks rubbish!'; 'Shall I keep it or throw it away?'.

In a process that activates mentalizing, space is ring-fenced at the end of a session to reflect on and value what has been made. Perspectives shift and free associations cross-fertilise, generating multiple meanings. There is always more than one way to look at something. The assumption that things *are* as they seem is gently and repeatedly questioned in ways that are relatable to gender norms.

Relational phenomena

Interspersed with many funny, joyful, integrated moments, the group can be riven with attempts to close down thinking or to split off or denigrate therapists, peers or 'otherness'. On the receiving end of young people's projections, we can find ourselves as therapists teetering on eggshells and scrutinised to see how *we* will cope with hostility, rejection or the shame of being or getting things 'wrong', as we inevitably do. The swirl of (sometimes frequently changing) names and pronouns can generate dysphoria in *us*. Attacks on what or who is seen as male or female can erupt as if from nowhere. Cass speaks of 'young people caught in the middle of a stormy social discourse' (2024, p. 13) and it has been imperative to consider in our clinical supervision how this backdrop permeates the therapeutic process and our own responses. In an attempt to retain the group's 'identity', we have had to work hard (not always successfully), to keep an open mind, to collaborate with the systems that surround each adolescent and to listen to different voices and perspectives including those we ourselves find alien or 'other'. The integrated model of this provision does not 'fit' within any instantly recognisable frame and, very much like Gaffney & Reyes' 'countertransference to process' when working with gender incongruent young people, we can 'feel ourselves to be "a bit of this and a bit of that", leading us at times to question our experience and whether we are proper psychotherapists' (Gaffney & Reyes, 1999, p. 383).

External visitors, returning members and ongoing contact

Once or twice a year, we invite a visitor in response to young people's questions or expressed interests. For example, a Q and A session with a paediatrician about hormones and a visit from a music therapist to orchestrate a jam session have generated rich conversation and brought different parts of young people to the fore. Group members who have been reserved or non-verbal in sessions have sometimes, to everyone's surprise (including their own), become joyously loud and expressive when given the chance to use musical instruments. For the first time we have been able to 'hear' from them and they have engaged in a different kind of reciprocal interplay with peers.

In the last five years, former group members have had the option to be on a contact list for an annual 'large group' garden event at the end of the summer term. There is music, food, and a chance for them to catch up with one another, talk with current group members and touch base with us as therapists. A few who ended some years before, following discussion about their readiness to do so, have volunteered to attend

the young people and parent/carer groups to share their experiences since. Through this, both sets of group members hear from those who describe positive effects of medical intervention, and those who speak of negative impact, regret and/or de-transition. These personal stories offer a longer-term view, fostering insight into the potential for perspectives – including those fixed and long-standing – to change over time.

Research

Midgley et al. (2021) discuss the growing evidence for the efficacy of psychoanalytically oriented psychotherapies for young people presenting with a range of neurodevelopmental and mental health difficulties, identifying an 'increasing need to pay attention to the findings of qualitative research, including studies of client experience' that position 'the needs and experiences of children, young people and families at the heart of evidence-based practice' (p. 14). With positive ethical reviews from the NHS Health Research Authority, University of Essex and Yellow Door Trustees, a research project is underway exploring how this provision is received by young people and utilised in practice. Adolescents who have engaged in this therapy have been interviewed. Using Reflexive Thematic Analysis (Braun & Clarke, 2019), the research aims to provide a detailed understanding of how this service design translates into user experience, including its benefits, limitations and potential to contribute to meaningful change.

Concluding remarks

> Group psychotherapy has the possibility of freeing one from being stuck in one discourse, one experience of self and world, and opens up the possibility of connecting with other discourses, other ways of being and experiencing that one did not have previous access to . . . . there is no definitive health here, just flexibility, which perhaps is health enough. (Dalal, 1998, p. 177)

As an adaptation, or coming together, of widely used art, group analytic, psychoanalytic and mentalization-based therapy approaches, this model recognises the many possible pathways into and out of gender-related distress, and offers no simple solutions. Instead, it aims to encourage the expression, exploration and understanding of this distress by providing an empathic, collaborative, curious space that holds alternative perspectives and both current and future wellbeing in mind. The hope is not that this is an endpoint, nor that it is all those attending will need, but that it offers a generative experience through which these components can be internalised, transferable and of lasting use to young people in navigating their future decision-making, their interactions with others and their relationships with themselves. The approach also intends to support adolescents' recognition that the problem of gender-related distress does not belong within them, as their sole responsibility to carry and find answers to, but is instead – as safeguarding has been recognised to be – everyone's business. Former England football manager Sir Gareth Southgate – experienced more than most in the benefits of working as a team – speaks of culture as 'made up of hundreds of small behaviours and

actions that shape the overall environment' (Southgate, 2025, 28:12). This offers a reminder of the part we can all play in the gender-related difficulties experienced by this group of young people, and of our associated, collective potential to contribute to change that may, longer term, reduce harm and need for therapies such as this one.

Note

1. The typical UK school year is split into three terms separated by holiday periods at Christmas, Easter, and Summer. Each term is also split by a one-week half-term holiday.

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Patient anonymisation statement

Potentially personally identifying information presented in this article that relates directly or indirectly to an individual, or individuals, has been changed to disguise and safeguard the confidentiality, privacy and data protection rights of those concerned, in accordance with the journal's anonymisation policy.

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