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Abstract

This article presents the findings from a cross-sectional study on demographic variables and associated difficulties in 218 children and adolescents (Mean age = 14 years, $SD = 3.08$, range = 5–17 years), with features of gender dysphoria, referred to the Gender Identity Development Service (GIDS) in London during a 1-year period (1 January 2012–31 December 2012). Data were extracted from patient files (i.e. referral letters, clinical notes and clinician reports). The most commonly reported associated difficulties were bullying, low mood/depression and self-harming. There was a gender difference on some of the associated difficulties with reports of self-harm being significantly more common in the natal females and autism spectrum conditions being significantly more common in the natal males. The findings also showed that many of the difficulties increased with age. Findings regarding demographic variables, gender dysphoria, sexual orientation and family features are reported, and limitations and implications of the cross-sectional study are discussed. In conclusion, young people with gender dysphoria often present with a wide range of associated difficulties which clinicians need to take into account, and our article highlights the often complex presentations of these young people.

Keywords

Gender dysphoria, associated difficulties, demographics, bullying, self-harm

Introduction

Gender dysphoria

Children and adolescents with gender dysphoria (GD) experience ‘a marked incongruence between their experienced/expressed gender and assigned gender’ (American Psychiatric Association, 2013). GD, in itself, often results in profound distress to the individual, namely an intense, often unbearable feeling of being ‘in the wrong body’. This often causes the young people to struggle in a number of different areas in their lives. The distress and feeling of being in the wrong body often

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increases at the onset of puberty due to an intensification of feelings of incongruence between self-perception and the body (e.g. Steensma, Biemond, De Boer, & Cohen-Kettenis, 2011). The constant conflicting relationship with their natal gender and the often unbearable pubertal changes often result in young people with GD withdrawing socially and feeling depressed and low in self-esteem. At times this results in self-harm and/or suicidal feelings (e.g. Skagerberg, Parkinson, & Carmichael, 2013).

Associated difficulties

An audit by Di Ceglie, Freedman, McPherson, and Richardson (2002), looking at 124 young gender dysphoric people in the United Kingdom, showed that more than half of the young people experienced relationship difficulties with peers and/or parents/carers and that 42% experienced depression. Several other papers confirm that children and adolescents with GD often present with a number of associated difficulties. De Vries, Doreleijers, Steensma, and Cohen-Kettenis (2011) looked at psychiatric comorbidity in 105 gender dysphoric adolescents in Holland and found that 10% of the young people suffered with social phobia, 21% with anxiety disorders, 12.4% with mood disorders and 11.4% with disruptive disorders. Skagerberg, Davidson, and Carmichael (2013) examined externalising (e.g. 'acting out') and internalising (e.g. withdrawn, depressed) behaviours in a sample of 141 gender dysphoric adolescents who had attended an assessment of 4–6 sessions at the Gender Identity Development Service (GIDS). They found that overall the adolescents showed significantly higher levels of internalising than externalising behaviours. Moreover, the natal males presented with significantly more internalising behaviours than the natal females, thus, scoring more in line with their perceived rather than natal gender.

Several other studies have looked at internalising and externalising behaviours in children and adolescents with GD. Zucker and Bradley (1995) examined parent reports (Child Behaviour Checklist (CBCL)) of 161 boys with GD between the age of 4 and 11 years and 90 male siblings. They found that the boys with GD had significantly more behavioural problems compared to their male siblings and that they also had significantly more internalising than externalising behaviours. Also, Steensma et al. (2014) looked at behavioural and emotional difficulties and peer relations using the Teacher's Report Form in a sample of 728 young people referred to gender identity clinics in the Netherlands and Canada. They found that internalising behaviours were more common than externalising behaviours and that the children were better functioning than the adolescents, thus highlighting the increased distress around the onset of puberty. In line with the findings by Skagerberg, Davidson, and Carmichael (2013), the natal males showed more internalising behaviours than the natal females. Furthermore, more emotional and behavioural difficulties were found in Canada than in the Netherlands, and this was found to be partly attributable to poorer peer relations.

The incongruence between self-perception and the body is not likely to be the sole contributing factor to the distress often experienced in this group of young people. Young people with GD frequently suffer with discrimination and prejudice which can itself result in fear, distress and other associated difficulties (Grant et al., 2011). Zucker et al. (2012), for example, found that the majority of the gender dysphoric youth in their study had difficulties with peer relations, and Cohen-Kettenis, Owen, Kaijser, Bradley, and Zucker (2003) examined demographic characteristics, social competence and behavioural difficulties in 488 children referred to gender identity clinics in Toronto and Utrecht and found that poor peer relations were the strongest predictor of behavioural difficulties.

Whereas some of the aforementioned associated difficulties are likely to be linked to the GD itself, other associated difficulties are likely to be related to the effects of the discrimination and

prejudice often experienced in young people with GD. Therefore, gaining a better understanding of what the associated difficulties are, and being able to work with young people and their families by trying to help ameliorate some of these difficulties alongside the GD, will be of benefit. A good understanding of the associated difficulties is also important in the assessment, formulation and clinical management, taking into account the complexities and specific needs of these young people.

The present study

This cross-sectional study intended to provide an overview of demographic characteristics and associated difficulties in young gender dysphoric people. It follows on from a 2002 audit by Di Ceglie et al. conducted at the same gender identity service in London and includes a larger sample and a different focus. We wanted to get a snapshot of the lives of gender dysphoric young people and the challenges they face, and so we examined a number of different variables from the age of first gender dysphoric feelings and sexual orientation to associated difficulties such as self-harm, suicidality, low mood/depression, psychosis and eating difficulties. We also recorded family makeup, looking specifically at divorce rates, siblings, living arrangements and other familial difficulties. We thought it might be helpful to have a greater understanding of the sexual orientation of the young people referred as well as school attendance and bullying. By being more aware of the range of difficulties young people with GD experience, clinicians can provide them with better and more appropriate support and care.

Method

Participants

The participants were 218 children and adolescents (Mean age at referral=14 years, standard deviation (*SD*)=3.08, range=5–17 years) with features of GD attending the GIDS in London. A total of 37.2% of the young people referred were natal males (Mean age at referral=13.15 years, *SD*=3.76) and 62.8% were natal females (Mean age at referral=14.51 years, *SD*=2.47). Information regarding ethnicity was not available for 18.8% (*N*=41) of the young people. The ethnicity of the remaining 177 young people was 88.7% White British, 2.2% Black Caribbean, 2.2% any other mixed background, 2.2% any other White background, 1.1% mixed Black Caribbean and White, 0.6% mixed Black, 0.6% Asian-Pakistani, 0.6% Asian-Indian, 0.6% Asian-Chinese, 0.6% mixed White and Asian and 0.6% White Irish.

The GIDS is a national highly specialist gender service covering the United Kingdom, as part of the National Health Service (NHS). Many of the young people attending the service frequently present with a number of associated difficulties. The GIDS is a multidisciplinary service consisting of child and adolescent psychotherapists, child and adolescent psychiatrists, clinical psychologists, social workers, researchers and trainees.

Data collected

Data were collected for all new referrals to the GIDS in London during a 1-year period (1 January 2012–31 December 2012). The age inclusion criterion was 0–18 years. During this period, 303 children and adolescents were referred to the GIDS. A total of 85 cases were excluded from the study due to being children who received counselling in relation to having a transsexual parent (as the children themselves were not gender dysphoric), cases that were referred to the GIDS Leeds

base (i.e. our second centre in Leeds) which the researchers therefore did not have easy access to or cases that did not result in a first appointment. So data were collected from a total of 218 cases.

The data collected comprised 25 variables: the natal gender, the age of the young person at the time of the referral, ethnicity, whether they were in education, whether they were living in their chosen gender, whether they preferred to be referred to by a name different from the name given to them at birth, sexual orientation, age of first gender dysphoric feelings, family variables (e.g. who the young people lived with, number of biological siblings, parental depression and alcohol use, domestic violence, migration) and associated difficulties. The associated difficulties included non-suicidal self-harm, suicidal ideation, suicide attempts, autism spectrum conditions (ASCs), attention deficit hyperactivity disorder (ADHD), symptoms of anxiety, psychosis, eating difficulties, bullying and abuse (i.e. physical, psychological/emotional, sexual abuse and neglect). We were interested in the challenges that young people face before coming to the service, and so the data were ascertained from referral letters but also from clinical notes and clinician reports mentioning any information about the young people before they attended the GIDS. All data were anonymised in order to ensure the confidentiality of the individuals.

Procedure

The research was carried out by the GIDS consultant child and adolescent psychiatrist, GIDS research psychologist and GIDS assistant psychologist. Once a list of patients who were referred to the GIDS between January 2012 and January 2013 had been made and the 85 cases had been removed (see the above section on data collected), the referral letters and GIDS clinician notes/reports from each of the 218 remaining case files were systematically read by one of the three GIDS members. Any reference to associated difficulties prior to attendance at the service, or other information collected, was recorded on an excel spreadsheet. Data were only recorded when it was clearly stated in the file. After completion, the data were transferred to SPSS and analysed by the research psychologist. The research was then written up jointly by the consultant child and adolescent psychiatrist, the research psychologist and the assistant psychologist.

Results

GD and sexual orientation

Information regarding the age of the first gender dysphoric feelings was not available for 4.6% of the cases ($N=10$). For the remaining 208 people, 42.7% reported having their first gender dysphoric feelings between 0 and 6 years of age, 34.9% between 7 and 12 years of age and 17.9% between 13 and 18 years of age. Statistically, no significant difference was found regarding the age of first gender dysphoric feelings between the genders ($\chi^2(2)=4.97, p>.05$, see Table 1 for more information).

Overall, 47.8% of the young people preferred to be referred to by a different name from their birth name, and this percentage differed significantly between the genders ($\chi^2(1)=41.76, p<.001$) with 67.2% of the natal females and 20.8% of the natal males preferring to be referred to by a name different to that given to them at birth. Data regarding whether the young people were living in their chosen gender was not available for 6.4% of the cases ($N=14$). For the remaining 205 people, 54.6% were living in their chosen gender full-time, 9.8% part-time and 35.6% were not living in their chosen gender. A chi-square test revealed that there was a significant difference in the frequency of natal males and natal females living in their chosen gender (full-time or part-time) with the natal females more often living in their chosen gender than the natal males ($\chi^2(1)=18.73$,

Table 1. The percentage of natal females ($N=129$) and males ($N=79$) having their first gender dysphoric feelings between ages 0–6, 7–12 and 13–18 years.

Age of first gender dysphoric feelings	Natal males	Natal females
0–6 years	54.4% ($N=43$)	38.3% ($N=50$)
7–12 years	29.1% ($N=23$)	41.1% ($N=53$)
13–18 years	16.5% ($N=13$)	20.2% ($N=26$)

Table 2. The sexual orientation of the natal males and females over the age of 12 years for whom data were available ($N=97$, 71 natal females and 26 natal males).

Sexual orientation	Natal males	Natal females
Attracted to females	19.2% ($N=5$)	67.6% ($N=48$)
Attracted to males	42.3% ($N=11$)	8.5% ($N=6$)
Bisexual	38.5% ($N=10$)	21.1% ($N=15$)
Asexual	0% ($N=0$)	2.8% ($N=2$)

$p<.001$). If we separate the percentages by those who live in their chosen gender full-time and part-time, we find that 69.2% of the natal females were living in their chosen gender full-time and 6.2% part-time whereas 29.3% of the natal males were living in their chosen gender full-time and 16% part-time. It is, however, important to remember that the natal males in this study were, on average, slightly younger (Mean age at referral = 13.15 years, $SD=3.76$) than the natal females (Mean age at referral = 14.51 years, $SD=2.47$) and this may have influenced the results.

Information regarding sexual orientation was available for 56.7% ($N=97$) of the young people 12 years of age and above (see Table 2 for more details).

Family: features and composition

The mean number of biological siblings was 1.39 ($SD=1.31$, range = 0–8). A total of 58.3% of the young people had parents who had separated, and domestic violence was indicated in 9.2% of the cases. Maternal depression was indicated in 19.3% of the cases (4.1% post natal) and paternal depression in 5% of the cases. Parental alcohol/drug abuse was indicated in 7.3% of the cases. Table 3 shows the living arrangements at the time of referral for all 218 participants.

Associated difficulties

Overall, the three most common associated difficulties were bullying (47%), low mood/depression (42%) and self-harming (39%). Table 4 shows the percentage of associated difficulties for the natal males and females separately. For the natal females, self-harm and bullying were the two most common difficulties whereas for the natal males it was bullying and low mood/depression. Chi-square tests showed that reports of actual self-harm ($\chi^2(1)=8.65$, $p<.01$) were significantly more common in the natal females than the natal males. This finding supports those by Skagerberg, Parkinson, and Carmichael (2013) looking at self-harming thoughts and behaviours in young people with GD. ASC diagnoses and queries were found to be significantly more common in the natal males ($\chi^2(1)=7.33$, $p<.01$). No significant difference was found between the genders in terms of

Table 3. The living arrangements at the time of referral for all participants ($N=218$).

Living with	Percentage	N
Both biological parents	36.7%	80
Mother	31.2%	68
Mother and step father	11.9%	26
Foster care	4.1%	9
Father	3.2%	7
Father and step mother	3.2%	7
Alternated between separated parents	1.8%	4
Independently	1.8%	3
Grandparents	1.4%	3
Adoptive parents	0.9%	2
Partner's family	0.9%	2
Boarding school	0.5%	1
Aunt	0.5%	1
Supported accommodation	0.5%	1
Children's home	0.5%	1
Mother and grandparents	0.5%	1
Unknown	0.9%	2

Table 4. The percentage of associated difficulties in natal males and females ($N=218$, 137 natal females and 81 natal males).

Associated difficulties	Natal males	Natal females
Self-harm	25.9% ($n=21$) (+ thoughts in 4.9%)	46% ($N=63$) (+ thoughts in 3.6%)
Suicidal ideation	38.3% ($N=31$)	32.8% ($N=45$)
Suicidal attempts	12.3% ($N=10$)	13.9% ($N=19$)
Low mood/depression	45.7% ($N=37$)	39.4% ($N=54$)
ASC	18.5% ($N=15$) (+ query in 7.4%)	10.2% ($N=14$) (+ query in 1.5%)
ADHD	12.3% ($N=10$)	5.8% ($N=8$)
Symptoms of anxiety	21.0% ($N=17$)	23.4% ($N=32$)
Psychosis	3.7% ($N=3$)	5.8% ($N=8$)
Eating difficulties	12.3% ($N=10$)	13.9% ($N=19$)
Bullying	49.4% ($N=40$)	45.3% ($N=62$)
Abuse	11.1% ($N=9$)	21.2% ($N=29$)

ASC: autism spectrum conditions; ADHD: attention deficit hyperactivity disorder.

reports on suicidal ideation, suicide attempts, low mood/depression, abuse, ADHD, anxiety, psychosis, eating difficulties and bullying.

Table 5 shows that, overall, many of the associated difficulties increased with age. Chi-squared tests showed that there was a significant relationship between age and self-harm ($\chi^2(1)=12.18$, $p<.001$), suicidal ideation ($\chi^2(1)=9.1$, $p<.01$), suicidal attempts ($\chi^2(1)=5.17$, $p<.05$), low mood/depression ($\chi^2(1)=24.61$, $p<.001$) and eating difficulties ($\chi^2(1)=7.75$, $p<.01$). There was no significant relationship between age and bullying, ASC, ADHD, symptoms of anxiety, psychosis and abuse (all $ps>.05$). If we look at, for example, self-harm we can see that there were reports of self-harm in 14.6% of the 5- to 11-year-olds and 44.1% of the 12- to 18-year-olds. Similarly, 7.3% of

Table 5. The percentage of young people with associated difficulties in the different age categories.

Associated difficulties	5–11 years (N=41)	12–18 years (N=177)
Self-harm	14.6% (+ thoughts in 4.9%)	44.1% (+ thoughts in 4%)
Suicidal ideation	14.6%	39.5%
Suicidal attempts	2.4%	15.8%
Low mood/depression	7.3%	49.7%
ASC	12.2% (+ query in 4.9%)	13.6% (+ query in 3.4%)
ADHD	14.6%	6.8%
Symptoms of anxiety	17.1%	23.7%
Psychosis	2.4%	5.7%
Eating difficulties	0%	16.4%
Bullying	36.6%	49.2%
Abuse	9.8%	19.2%

ASC: autism spectrum conditions; ADHD: attention deficit hyperactivity disorder.

the 5- to 11-year-olds reported feeling low in mood whereas 49.7% of the 12- to 18-year-olds reported feeling low in mood. These findings highlight that puberty is often a time of increased distress for young people with GD.

Discussion

Most common associated difficulties and comparisons with previous studies

The findings from this cross-sectional study showed that, overall, the three most common associated difficulties were: bullying (47%), low mood/depression (42%) and self-harming (39%). If we compare these findings to those of Di Ceglie et al. (2002), we find that the percentage of young people who were depressed/low in mood was the same (42%) whereas the percentage of young people who were harassed/bullied was lower in their study (33%) as was the number of young people who were involved in self-injurious behaviours (18%). The percentage of people who were involved in self-harming in the current study was higher than in a study by Skagerberg, Parkinson, and Carmichael (2013) where, overall, 24% of the children and adolescents with GD were reported to self-harm. It is possible that the higher percentage of young people self-harming in the current study compared to those in earlier studies simply reflect trends in the general population (see Muehlenkamp, Claes, Havertape, & Plener, 2012).

Comparisons between natal females and natal males

Our findings showed that there was a significant difference in the occurrence of self-harming and ASC in the natal males and natal females with self-harming being indicated more often in the natal females and ASC being indicated more often in the natal males. The higher occurrence of self-harm in the natal females in this study concurs with, for example, Skagerberg, Parkinson, and Carmichael (2013) who looked at self-harming thoughts and behaviours in 125 gender dysphoric children and adolescents, and with Fox and Hawton (2004) and recent figures from the Health & Social Care Information Centre (2013) in the United Kingdom looking at self-harming in adolescents in the general population. The higher occurrence of ASC in the natal males accords with a study by De Vries et al. (2011) looking at ASC in children and adolescents referred to the Gender Identity Clinic in Amsterdam. However, whereas they found an incidence of ASC in 7.8% of their

sample of 204 children and adolescents, in the current study we found that ASC was indicated in 13.3% of the young people. It is important to note, though, that the Dutch team used the Diagnostic Interview for Social and Communication Disorders (DISCO) to assess ASC, while the young people in our sample may not all have been formerly diagnosed.

Interestingly, natal females presented to our services more frequently than natal males; this shift opposes historical trends where more natal males were referred. Also, significantly more natal females than natal males were living in their chosen gender and/or were referred to by a name different from that given to them at birth. It is important for clinicians to be aware of the gender difference on some of the associated difficulties as well as the difference between natal males and females in terms of living in their chosen gender and changing their name. Natal males and females may, thus, need to be thought about separately and may require different interventions. As already mentioned in the results, however, it is important to remember that the natal males in this study were, on average, 1 year younger than the natal females and this may have influenced the results.

Distress around puberty

Our findings showed that puberty seemed to be a time of increased distress for many of the gender dysphoric young people. A total of 14.6% of the 5- to 11-year-olds and 39.5% of the 12- to 18-year-olds reported feeling suicidal. Similar patterns emerged for low mood/depression and self-harm. This finding accords with the literature on gender dysphoric young people (e.g. Di Ceglie et al., 2002; Skagerberg, Parkinson, & Carmichael, 2013) and on the general population (e.g. 'Truth Hurts', 2006), which suggests an average age of onset of 12 years for distress associated with pubertal changes.

Sexuality

Many of the natal females and natal males described being attracted to the opposite sex (to the gender they identified as). This information is useful as it further informs our understanding of young people's sexual identity. Negotiating one's sexual orientation is an important developmental task for all adolescents and may be more complex for young people with GD and professionals must, thus, be sensitive to the sexual identity of their patients.

Clinical implications

The findings highlight the importance for clinicians to be mindful of the associated difficulties linked to GD and to consider what factors are important in increasing these young people's strength and resilience (see Grossman, D'Augelli, & Frank, 2011). Clinically young people may present with GD but also with a number of other psychological difficulties, and one difficulty may precipitate another. High levels of bullying, harassment and abuse were reported and so all services must ensure that any child protection concerns are responded to urgently. GD in a heteronormative society undoubtedly predisposes a young person to a number of other difficulties ranging from social isolation, stigma and shame to psychological issues such as depression, anxiety, self-harm and eating disorders.

Our findings stress the need for services to work collaboratively in order to support a young person with GD. General Practitioners, Child and Adolescent Mental Health Services (CAMHS), education and specialist services each have important roles in ensuring that young people with GD are provided with support in a number of areas of their lives. It is, for example, evident that there are high levels of deliberate self-harm and suicidal ideation which require frequent and ongoing

support from CAMHS alongside the input from specialist gender services in order to alleviate the distress. Clinicians therefore need to be particularly aware of signs of low mood and depression and regularly screen for suicidal ideation and self-harming. This is especially important around puberty which is often an extremely distressing time for young people with GD.

It is also important for the families to receive support, and a young person may require a number of different interventions ranging from psychological support and/or medication for mental health difficulties such as depression, school intervention to help reduce bullying and support regarding which toilet or changing area to use. This may be alongside a young person being referred for the hypothalamic blocker in order for the pubertal process to be halted in a reversible manner, allowing the young person more time and space to explore their gender identity without the often devastating effects of puberty.

Links with ASC

Our findings show that a significant proportion of cases also have some social and communication difficulties and are on the autistic spectrum. These young people may require support from more specialist services, and an understanding of how this may relate to their gender identity is important. For example, some young people with a comorbid diagnosis of GD and an ASC may hold more rigid views of what it is to be male or female. Helping them to explore gender in a less stereotypical way may alleviate some of their distress and may deconstruct the gender binary. Conversely, their perhaps more rigid views and more black and white style of thinking may make their gender identity less fluid and more fixed (Di Ceglie, 2009; Di Ceglie, Skagerberg, Baron-Cohen, & Auyeung, 2014).

Future research

More research is undoubtedly needed into links with associated difficulties. In some cases, for example when a young person with GD is significantly depressed, it is important that the depression is understood and treated alongside the management of the GD. Undoubtedly, GD can lead to low mood, but conversely depression can lead to doubts about ones identity in general, and clinicians need to take all of this information into account when working with children and adolescents with GD and ensure that individualised multidisciplinary support is provided. Moreover, as this cross-sectional study was done at the initial point of referral, it would be useful to follow it up once the young people have received psychological and/or physical intervention (such as hormone blockers and cross-sex hormones) to help us understand what factors might lead to amelioration of the difficulties. Further research is also required to better understand which difficulties are a result of the GD itself and which are a result of social shaming and stigmatisation of these young people by society.

Limitations

This study has several limitations. First, the figures presented are likely to be an underestimate as they were based on referral letters and clinician notes/reports. The referrers and clinicians may not have asked about demographic variables and associated difficulties and/or may not have included the information in their letters, notes or reports. Thus, if there was no mention of, for example, self-harm, then it was assumed that the young person did not engage in this behaviour. It is perhaps especially likely that more 'internalising' behaviours, such as low mood and anxiety, were under-reported. Second, letters from referrers were sometimes very brief, and even though the GIDS has

a standard referral form enquiring about many of the variables in this study, not all referrers had completed this form. Finally, numbers were sometimes low, such as in the 5–11 age group, and further research with a larger sample is needed in order for generalisations to be made from these findings.

Conclusion

Young people with GD frequently present with associated difficulties. This cross-sectional study has shown that some of the most common difficulties are bullying, self-harm and low mood/depression. The findings presented are important as they will inform the management and understanding of young people with GD and they highlight the importance for clinicians to regularly screen for associated difficulties in this group of young people and for them to keep in mind their often complex presentations.

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