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Clinical Child Psychology and Psychiatry

Gender Dysphoria in looked-after and adopted young people: a gender identity development service

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Abstract

This research investigated the prevalence of looked-after and adopted young people in a case file review of 185 young people referred to a UK gender identity development service over a 2-year period (1 April 2009 to 1 April 2011). Data were extracted from referral clinical notes and clinician letters. Looked-after young people were found to represent 10.3% of referrals in this cohort, which is significantly higher than within the English general population (0.58%). Adopted young people represented 3.8% of referrals. In addition, findings showed that looked-after young people were less likely to receive a diagnosis of gender dysphoria compared with young people living within their birth family. There were no statistically significant differences in the gender ratio or age of first gender dysphoric experience between groups. Looked-after and adopted young people were also not found to be experiencing greater impairment in overall functioning compared to other young people referred to the gender identity development service. In conclusion, there is a substantial proportion of referrals pertaining to looked-after or adopted young people, and it appears

referral route and process through the service may be distinct, particularly for looked-after young people. This may be understood by considering the possible complexities in the presentation of these groups, alongside the established higher levels of complexity generally for those experiencing feelings of gender dysphoria.

Keywords

[Gender dysphoria](#), [gender identity](#), [gender identity development](#), [looked-after](#), [adopt](#)

Introduction

Gender dysphoria

Young people with gender dysphoria are defined as experiencing a difference between gender assigned to them and the gender that they identify as and/or express ([American Psychiatric Association, 2013](#)). This incongruence commonly results in distress and impairment for the young person across multiple domains in their life, such as in education, family life, and in the community. While the experience of gender dysphoria is personal to each young person, it usually includes a wish to be seen and treated as another gender and to undertake physical interventions to align their physical appearance with that of the experienced gender. To receive a diagnosis of Gender Dysphoria based upon the *DSM-5*, a young person is required to have had significant distress or social impairment associated with their experience of gender dysphoria, which has lasted greater than 6 months ([American Psychiatric Association, 2013](#)). This is distinguished from young people who express gender diverse behaviours, which would not be considered as meeting the criteria for a diagnosis of gender dysphoria ([Parekh, 2016](#)). The term 'gender diverse' can be used to refer to aspects of an individual, such as physical features and behaviour, that deviate from gender norms within their society for the gender that individual is assigned to at birth. A significant proportion of the referrals to gender identity services are for young people who, during exploration of their gender identity, do not continue to identify as transgender ([Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011](#); [Steensma, McGuire, Kreuker, & Beekman, & Cohen-Kettenis, 2013](#)). These young people initially present with an experience of distress in relation to their gender and may express gender diverse behaviours. Through the process of their assessment, however, their experience of the

gender progresses to a point where they are no longer significantly distressed or socially impaired. For some, they may no longer experience gender dysphoria and may return to living in their assigned gender. For others, they may continue to identify as gender diverse; however, at this point they and their family decide they no longer require support from gender identity service (Steensma et al., 2011; Steensma et al., 2013). For many, this may be due to this process leading to greater acceptance of their transgender identity and a reduction in their feelings of gender dysphoria. Within this paper, to be clear about the distinction in experiences, 'gender dysphoria' will be used to describe the diagnosis, 'feelings of gender dysphoria' will be used to acknowledge the experience more broadly.

The Standards of Care (E. Coleman et al., 2012), set out by the World Professional Association for Transgender Health (WPATH), provide guidelines which underpin the practice of most professionals and specialist services who support young people that are currently experiencing feelings of gender dysphoria and their families. Within these guidelines, psychological support is recommended to assist young people and their families to explore their gender identity and its expression, work to promote their resilience and develop a support network, and peer support, improve the young person's perception of their body image and counter the stigma and negative impact often associated with feelings of gender dysphoria, with a focus on reducing internalised transphobia. Such support is important as young people who experience gender dysphoria have been identified as being more likely to have negative psychosocial outcomes compared to their gender-conforming peers (Peterson, Matthews, Coppins, Smith, & Conrad, 2016).

Transphobia refers to a disgust or dislike towards a person who does not conform to gender norms (Hill & Willoughby, 2005). Internalised transphobia refers to an experience of distress or discomfort by a person due to their possession of a transgender identity, which results from the internalisation of societal gender norms (Bockting, 2015). A prolonged experience of internalised transphobia can lead to shame and self-hate in young people and alongside transphobic abuse, has been associated with negative psychological outcomes (Lev, 2004).

Identity and gender identity development

Identity as a psychological construct is defined as a person's sense of who they are, 'I'. Identity is theorised to be both a conscious and unconscious construct, which can be used by individuals as a way of understanding what they mean, both to themselves and

others ([Erikson, 1977](#)).

Adolescence has been described within normative theories as a period of exploration and experimentation for young people, during which exploration of identity is a core task ([Erikson, 1968](#)). Following this period, a person's identity is described as being stable and consolidated. It can therefore be suggested that individuals possess a conceptual view of themselves as a person with a differentiated and distinct identity from that held by others ([Erikson, 1968](#); [Kroger, 2004](#)). Once a person's identity is experienced as stable, this identity is then used as a reference point for predicting about the self in the future ([Kroger, 2004](#)).

Within identity theories, greater exploration of gender identity is hypothesised as occurring largely as a result of physical pubertal changes which need to be consolidated into a person's understanding of self ([Erikson, 1968](#); [Kroger, 2007](#)). Gender identity formation is theorised to begin in early childhood, with a young person beginning to develop an understanding of their identity which incorporates an understanding of their gender. As pubertal changes occur, the currently held understanding of gender identity can be challenged, with the resultant understanding of gender and sexual identity requiring consolidation with the previously held identity ([Kroger, 2007](#)). For some young people, this process can involve large changes to their identity, as their new understanding of their gender cannot be easily accommodated into their previously held identity ([Cobb, 1999](#)).

The idea of a stable identity following a precisely bound process of identity exploration during adolescence is, however, challenged by many (e.g., [T. Matthews, 2016](#); [Meeus, 2011](#)). [Meeus \(2011\)](#) concludes that while longitudinal research is supportive of progression in identity formation during adolescence, longitudinal data and research on adults suggest that this can continue beyond these years and is a lifelong process, and for some is a defining feature of their adolescent years. This may, therefore, offer insight into why difficulties with gender identity can emerge at different points in a person's life and also why some people continue to experience fluidity in their gender beyond adolescence and throughout life.

Gender identity development in context

Identity development occurs within an interpersonal and societal context, with the young person's sense of themselves being impacted by those around them and their interactions within the world ([J. C. Coleman, 1974](#); [Lerner, 1991](#); [Lerner & Kauffman, 1985](#)). The

WPATH guidelines ([E. Coleman et al., 2012](#)) references the influence of context when considering a young person's feelings of gender dysphoria and their associated distress. These guidelines emphasise the importance of understanding a young person and their family's context when supporting them. The need for contextual understanding is further supported by research demonstrating young people who experience feelings of gender dysphoria develop within a wide range of socioeconomic, racial, and cultural backgrounds ([Grossman & D'Augelli, 2006](#)).

Young people who present to gender identity services can be developing within particularly complex contexts. For instance, young people who are gender and sexually diverse have also been found to be overrepresented in the youth population who become homeless and live on the streets in the United Kingdom ([Albert Kennedy Trust, 2015](#)) and the United States ([Cunningham et al., 2014](#)). Of the population of young people who live on the streets, those identifying as gender and sexually diverse were also found to be less likely to receive support than their peers who are also homeless (Albert Kennedy Trust).

Generally, the acceptance of individuals with feelings of gender dysphoria has largely increased over time ([Steensma et al., 2013](#)), which has been associated with an increase in the available options to facilitate both social transition and physical intervention. Acceptance of gender diverse identities, however, continues to vary widely within different societies and the environment an individual resides in being cited by young people as potentially exacerbating the distress they experience ([Grossman & D'Augelli, 2006](#)). It is therefore important to consider the social, emotional and developmental context within which young people who attend gender identity services are developing ([Edwards-Leeper, Leibow, Sangganjanavanich, 2016](#)). This service evaluation was conducted within the United Kingdom, which in comparison to other societies may be deemed to have a higher level of acceptance of feelings of gender dysphoria in young people, and where physical intervention is available free of charge to young people during puberty via the National Health Service (NHS).

Associated difficulties

Alongside feelings of gender dysphoria, it has been established in the literature that it is common for young people to also be experiencing associated difficulties, particularly the internalisation of difficulties such as low mood and anxiety ([E. Coleman et al., 2012](#)). [Bechard, VanderLaan, Wood, Wasserman, and Zucker \(2016\)](#), for instance, in their study

of adolescents experiencing gender dysphoria described that over half of the sample or more psychosocial and psychological vulnerability factors present out of a possible 10. The mean number of vulnerability factors across the sample was 5.56. These vulnerability factors included current and historical outpatient mental health treatment, school refusal, self-harm, and abuse. This study, unfortunately, lacked a control group to allow compare the prevalence of vulnerability factors in this population with those found in clinical or non-clinical adolescent samples. [Holt et al., 2016](#) found the most common associated difficulties in a sample of young people (aged 5–17 years) accessing a gender identity development service (GIDS) to be bullying, low mood and self-harm. A consistent finding is that features of Autistic Spectrum Conditions are more frequently prevalent in young people experiencing gender dysphoria than would be expected based upon general population estimates of prevalence of such diagnoses ([de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010](#); [Holt et al., 2016](#)).

While studies have considered the associated difficulties that are commonly present alongside feelings of gender dysphoria, the developmental trajectory of these difficulties has given limited exploration. [Kaltiala-Heino, Sumia, Työlajärvi, and Lindberg \(2015\)](#), however, offer data which allowed consideration of the developmental path of these associated difficulties within their adolescent sample of referrals ($M = 16.35$ years) who attend a gender identity service in Finland. It was reported that of the 47 referrals, 75% of the sample had been or were currently undergoing psychiatric treatment for reasons other than gender dysphoria when they sought referral for assessment in relation to their gender identity. It was also reported that 68% of the adolescents had their first contact with psychiatric services due to other reasons than gender identity issues. The data reported by [Kaltiala-Heino et al.](#) support a hypothesis that a proportion of young people who experience gender dysphoria may have a history of associated difficulties which are documented prior to the presence of gender dysphoria. [Kaltiala-Heino et al.](#), similarly to [Holt et al. \(2016\)](#) and [Bechard et al. \(2016\)](#), however, employed a retrospective design, thus these studies do not allow for a full exploration of the trajectory of the associated difficulties which were identified. It is therefore unclear if these difficulties predated, developed alongside, or emerged following the onset of gender dysphoria. The use of this design limits the possible conclusions that can be drawn, particularly in relation to causality or the proportion of young people with identified associated difficulties for who these experiences may predate or are secondary to the feelings of gender dysphoria.

The associated difficulties which are present in those with feelings of gender dysphoria add complexity to the work undertaken by services supporting young people experiencing gender dysphoria. Such complexity makes formulating a treatment plan more difficult and can delay the process for the young person. [De Vries, Steensma, Doreleijers, and Cooijer \(2011\)](#) compared young people accessing a gender development service with both parents (including two adoptive parents) with other living arrangements, which included young people in foster care, and those living with a single parent. It was found that the increased complexity of not living with both parents led to an increased proportion of young people being delayed in accessing puberty suppression. This decision was found to take longer than 1.5 years from the start of assessment to physical intervention, compared with those living with both parents who were more likely to be eligible in less than 1.5 years. Such long assessment processes suggest a need for space and time within the process for treatment decisions to be made. It could be argued that young people who present with complexities alongside their feelings of gender dysphoria require a lengthier assessment process so that a plan about their future trajectory can be reached. For those who do proceed with a medical transition, however, it may be important to consider the path to this decision and the need for adaptation in the process. Without adaptation, unnecessary delay in their assessment process may occur and it could be argued that such young people experience discrimination due to either their past or presenting complexities. To do this, the impact of additional complexity such as being adopted or looked-after needs to be better understood, so to illuminate the location in which adaptation could be best applied.

Looked-after and adopted young people

Looked-after was introduced as a term by [the Children's Act \(1989\)](#) to describe children in statutory care, including those in foster care and residential homes, and those residing with their biological family but subject to care orders ([Richardson & Lelliott, 2003](#)). The age range of looked-after young people is 0–18. It has been established that outcomes for this population in relation to their mental and physical health can be negative compared to their peers in the general population. In their national study of the mental health needs of looked-after young people in England, [Meltzer et al., 2003](#) reported that 45% of looked-after young people were assessed as having a mental health diagnosis rising to 72% of those in residential care. This compares to around 10% of the general population aged 5–15 ([Department for Children, Schools, and Families, 2009](#)). These rates of identifiable mental health needs rise as young people age in care, with older young people having a

comparatively higher prevalence of such diagnoses. It is possible that for some young people, these complexities contributed to their journey into the care system. The literature however, has also demonstrated that certain experiences within the care system, such as multiple placement moves (e.g., [Fisher, 2015](#)), can contribute to further negative outcomes.

Being adopted has also been associated with poorer outcomes, with adopted young people being established as having a higher prevalence of mental health difficulties and distress compared to the general population ([Rushton, 2004](#)). Though adopted young people are typically living in a more stable and emotionally secure setting, both looked-after and adopted young people may share similar early life histories, which could include abuse, neglect, loss and multiple caregivers prior to adoption. While there is evidence that both adoptive and local authority placements that offer stability and responsive care can moderate these outcomes, they have generally been found to be worse for those adopted later in their childhood (between 5 and 11 years) when compared with the general population and those adopted at a younger age ([Rushton & Dance, 2004](#)).

In response to the higher levels of complexity and associated difficulties with being a looked-after or adopted young person, it has been suggested that specialist services and approaches are required to support the needs, including general mental health, of these populations ([Golding, 2010](#)). Golding argues that a lack of parental advocacy, increased instability, and the ways that services traditionally work, such as referral processes and discharge policies can act as barriers to looked-after young people accessing support. For adopted young people, it is a lack of understanding about the impact of adoption that has been suggested as a barrier to being well supported by services. Parents of adopted children, for example, have reported that they feared being blamed rather than being understood due to the challenges parenting an adopted child can present ([Rushton, 2004](#)). It is therefore suggested that services need to offer increased flexibility when working with these populations and to endeavour to try and engage and understand the complexities that looked-after and adopted young people may present with.

Looked-after and adopted young people and gender dysphoria

Looked-after and adopted young people have been anecdotally recognised by clinicians at the GIDS as possibly overrepresented within the amount of people referred compared to their prevalence in the general population. Research exploring the prevalence of looked-after young people as a sub-population within specialist gender identity services is limited.

absent, with much research lacking specificity in reporting of the care status of participants within their sample. For example, [Kaltiala-Heino et al. \(2015\)](#) reported 13% of referrals in their Finnish sample were either in foster care or living independently. Similarly, [de Vries, Steensma, Doreleijers, and Cohen-Kettenis \(2011\)](#) coded anyone not living with two biological parents as their 'other' group. While these studies enabled interpretation of data in relation to those who live with their biological family and those who do not, they encompassed a range of distinct care statuses and groups, each with idiosyncratic complexities due to their potentially very distinct contexts. For instance, while adopted young people may have had similar early care experiences to looked-after young people, research has established that, even when compared to their looked-after peers in long-term stable foster placements, adopted young people have greater emotional stability, psychological and general wellbeing and feelings of belonging ([Triseliotis, 2002](#)).

[Holt et al. \(2016\)](#), in their study of associated difficulties in young people accessing a gender identity service, suggest that 4.6% of referrals were within local authority care, an additional 1.8% were supported or independent accommodation or their care status was not stated. 0.9% of the sample was adopted. [DeJong, Hodges, and Malik \(2015\)](#) explored the psychological wellbeing of adopted children and reported that within their sample, 3% met the criteria for gender dysphoria. Due to the small sample size (34 cases), this represented a single case. Together these provide some idea about the prevalence of looked-after and adopted young people within referrals to a gender identity service. These studies, however, did not cover the progression of these populations through services, and the outcomes of contact with gender identity services for these groups. Instead, the above research focused on associated difficulties more generally. Further investigation is required to be able to report on the outcomes and trajectories of both looked-after and adopted young people who access a GIDS.

Summary and the present study

Looked-after and adopted young people develop in a context which differs from that of the general population ([Matthews, 2016](#)), and thus differs from the majority of other referrals to a gender identity service. Looked-after and adopted young people are highlighted in the literature as a population who are at a greater risk of emotional distress and other negative outcomes, independent of their gender identity, due to their background and current circumstances in which they reside. While it would be expected that GIDSs would support young people

from these groups, if looked-after and adopted young people are an overrepresented subgroup in referrals to GIDSs, it may be important to consider the frequency of this to justify consideration of more specialist support pathways for these populations.

This study aimed to explore the prevalence of looked-after and adopted young people referrals to a specialist GIDS to establish if there is, as hypothesised, a higher than expected number of referrals in regard to these populations. The service evaluation also aimed to begin to explore if there are any difference in the process or outcomes for this group in comparison both to each other and to young people living with their birth families (YPBF) who are referred to the service.

Method

Participants

The participants were 185 young people who were referred to the Tavistock and Portico GIDS in London, UK (mean age at referral = 13.70 years, $SD = 3.35$, range = 3–17 years). Of these referrals, 52.4% were assigned males at birth (mean age at referral = 13.03 years, $SD = 3.88$) while 47.6% were assigned females at birth (mean age at referral = 14.44 years, $SD = 2.45$).

The GIDS is a nationally commissioned highly specialised gender service covering this area as part of the NHS. It is set up to work with children and young people up to 18 years who either have gender dysphoria or are the children of a transgender parent. It is a multidisciplinary service consisting of clinical psychologists, child and adolescent psychiatrists, social workers, child and adolescent psychotherapists, systemic and family therapists, and trainees across these disciplines. The service works alongside paediatric endocrinology colleagues who offer appointments to consider medical intervention, which is delivered with GIDS clinicians, to young people following a period of assessment.

Data collected

Data were collected from all the referrals for young people (aged less than 18 years) to the GIDS for an assessment of gender dysphoria during a 2-year period (1 January 2009 to 31 January 2011). In all, 232 referrals were made during this sampling period. Data were collected from 185 cases, as 2 cases were excluded due to being referred for counselling only.

relation to having a transgender parent and 45 cases were excluded either for not attending their first appointment or for being lost to follow up. Information was not available for cases who were excluded and so comment cannot be made on whether they differ from the sampled group.

The data collected recorded the following variables: gender assigned at birth, age of young person at referral, whether gender dysphoria was diagnosed, whether they were referred to the paediatric endocrinology clinic for treatment, their score on the Child and Adolescent Global Assessment Scale (CGAS, [Shaffer et al., 1983](#)) their care status (with biological family, in foster care, other local authority care, or adopted), and any noted associated difficulties.

A looked-after young person was defined as a person fostered or reside under local authority care, including residential care, while adopted referred to young people who have been legally adopted into the setting in which they currently live and not cared for by biological relative. Looked-after and adopted young people were considered separately to the distinctions in their current context, while acknowledging possible historical similarities. We defined young people cared by their biological family (YPBF) as those with their biological relatives. In our sample, this was generally a parent, parents or grandparents.

Measures

The CGAS ([Shaffer et al., 1983](#)) is a scale which is clinician rated to provide a single score in relation to the general functioning of young people aged under 18 years. The scale is scored from 1 to 100 with higher scores reflecting better overall functioning by the young person. The measure considers the young person's functioning at home, school and with friends, with lower scores reflecting impairment across a greater range of domains. Scores under 70 are interpreted as within the clinical range, while scores of 71 and above indicate normal functioning ([Bird, Canino, Rubio-Stipec, & Ribera, 1987](#); [Shaffer et al., 1983](#)).

Procedure

The service evaluation was agreed by the GIDS Research Team as a service evaluation. Once a list of eligible cases was generated, data were extracted from their referral letters, clinical letters and clinical notes by the research team (consultant psychiatrist and co-

psychiatry trainee). A conservative approach to data collection was undertaken in which data was only recorded when it was clearly stated in the file. All data were anonymised to ensure the confidentiality of the individuals. After completion, the data were converted to SPSS and analysed.

Consent and ethical approval

Consent was gathered for the use of data for research purposes at the point that the person attended the service from which the sample was collected. When the project was presented to the departmental research meeting at GIDS, based on NHS research guidelines, the project was deemed as service evaluation and so ethical approval was required.

Results

Proportion of referrals who were looked-after and adopted young people

Within the 185 cases, 4.9% were looked-after young people ($n = 9$), while 3.8% were adopted ($n = 7$), together representing 8.6% of all referrals received by the service. In the looked-after sample, 77.8% of the looked-after sample were assigned male at birth ($n = 7$) while 22.2% were assigned female at birth ($n = 2$). In the adopted sample, 71.4% of young people were assigned male at birth ($n = 5$) and 28.6% were assigned females at birth ($n = 2$). Comparatively, the 169 YPBF 50.3% were assigned males at birth ($n = 85$), while 49.7% were assigned female at birth ($n = 84$). A chi-square test revealed that there was not a statistically significant difference ($p > .05$) between either the proportions of looked-after nor adopted young people's gender assigned at birth in comparison with the YPBF sample.

Within the general population of England in 2011, there were 65,520 looked-after young people ([Department for Education, 2011](#)) which represented 0.58% of the overall uncensored population in England based upon the 2011 census data ([Office for National Statistics, 2013](#)). When compared with the proportion of looked-after young people within the referral sample, the increased proportion was statistically significant ($\chi^2(1) = 59.86, p < .000$). Data describing the total number of adopted young people living in England is not available in the same way it is for looked-after young people. An estimate was therefore calculated based upon the available data about the number of adoptions in England between 2005 and 2011 ([Department for Education, 2011](#)). The estimated number of adopted young people

Diagnoses of gender dysphoria and referral to paediatric endocrinology ser

Within the whole sample, 84.3% ($n = 156$) met the criteria for a diagnosis of gender dysphoria. A chi-square test showed that there was a statistically significant difference between the proportion of looked-after young people who met the criteria for a diagnosis of gender dysphoria in comparison to the YPBF group ($\chi^2(1) = 5.84, p < .05$) but not in comparison to the adopted group ($p > .05$). The difference between diagnosis of gender dysphoria in the adopted group and YPBF was also not significant ($p > .05$). [Table 3](#) provides details of this report by the care status of the young person, alongside the percentage of those who met the diagnostic criteria for gender dysphoria who were referred to the paediatric endocrinology clinic.

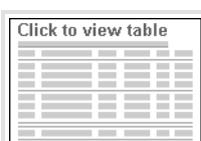


Table 3. Percentage of those with diagnosis of GD and who are referred to Paediatric Endocrinology Clinic by care status.

A proportion of the referrals in both the adopted group and YPBF group were referred to adult gender services at age 18, prior to completion of a full assessment, as the young person became too old to access paediatric services. It was therefore not possible to conclude the proportion of each group for whom physical intervention was ultimately accessed, as this would have occurred within the adult service.

Associated difficulties

There was evidence of associated difficulties across the sample, with complexity in the young people's presentation other than possible gender dysphoria being evident in all sample groups, irrelevant of care status. Examples include diagnoses of autistic spectrum conditions, attention deficit hyperactivity disorder, eating difficulties, low mood, self-harm, suicidal ideation, and bullying. The percentage of cases with a reported comorbidity for the looked-after, adopted, and YPBF groups is presented in [Table 4](#), alongside the mean CGAS score. Comorbidity with other diagnoses were recorded for 55.6% of the looked-after young people, 28.6% of the adopted young people, and 41.4% of the YPBF. There were CGAS scores available for five of the looked-after young people ($M = 48.60, SD = 4.98, \text{range} = 43-55$), for five of the adopted sample ($M = 58.20, SD = 12.87, \text{range} = 43-72$) and for 12 of the YPBF group ($M = 61.24, SD = 12.72, \text{range} = 49-85$). The differences in CGAS scores



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Table 1

Table 1. Mean age at referral by care status.

Age of referral by care status	Looked-after mean age	Adopted mean age	YPBF mean age
Total	12.44 (SD = 3.49)	13.86 (SD = 3.13)	13.76 (SD = 3.36)
Assigned male at birth	12.29 (SD = 3.59)	13.40 (SD = 3.65)	13.07 (SD = 3.96)
Assigned female at birth	13.00 (SD = 4.24)	15.00 (SD = 1.41)	14.46 (SD = 2.45)

YPBF: young people living with their birth family.

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Discussion

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Looked-after young people were referred at a significantly higher frequency than would be predicted based upon the prevalence of young people who are looked-after within the general population of under 18-year-olds and, alongside adopted young people, represent a proportion of the referral population to the GID service. This finding is what would be predicted based upon clinical anecdotes and available estimates in the literature, such as Holt et al. (2016). This research is unique, however, due to the more thorough focus on these populations to explore the treatment process for these groups. Looked-after and adopted young people's distribution of their gender assigned at birth, age at referral, and age of first gender dysphoric experience are not significantly distinct from their YPBF counterparts, though these conclusions are tentative due to the group sizes sampled.

Young people who are looked-after were significantly less likely to meet the criteria for a diagnosis of gender dysphoria than YPBF, but not less likely than those young people who are adopted, and were therefore less likely to be put forward for physical intervention given the diagnosis of gender dysphoria, both looked-after and adopted young people were referred to paediatric services at an equivalent level compared to the YPBF sample. This difference in diagnosis rate may reflect an actual lack of identifiable features in these young people. It may also represent the difficulty of reaching conclusions and a need for caution due to additional complexities and difficulties. De Vries et al. (2011) found that complex family situations can lead to delays in young people being viewed as eligible for treatment. Both looked-after and adopted young people did not present with significantly different CGAS scores than the YPBF group, with all groups' average being within the clinical range. Thus, distress and associated reductions in general functioning are a feature across the population who are referred to gender identity services, suggesting elements of complexity in the looked-after population which are external to the young people and their individual functioning may be important in understanding differences in their progress through

services.

The UK Gender Identity Development Service Specification ([NHS England, 2016a](#)), based upon the WPATH Standards of Care guidelines ([E. Coleman et al., 2012](#)), cite a range of inclusion criteria for treatment. The guidelines cite a need for support from parents or carers throughout the process, with the person or people who hold parental responsibility being central in decision-making. They also require that there is not an intense or chronic psychological condition that could interfere with decision making. There is not a requirement for placement or caregiver stability, with the focus instead being on personal stability and support to resolve any social difficulties that may be a barrier to treatment adherence ([Coleman et al., 2012](#)). In the case of looked-after young people, this includes consulting with the local authority to ensure that there is social support for the young person to assist them in managing their physical transition and any associated effects of this ([NHS England, 2016b](#)). Based on the above, the developmental context of being looked-after and adopted young people, and their potentially complex history, should not prevent these populations from accessing medical interventions in a timely manner.

Looked-after young people develop in a context and with a developmental history which may be unique when compared to the general population ([Matthews, 2016](#)). Theories of development suggest that development occurs in a context, such as developmental contextualism ([Bronfenbrenner, 1991](#); [Lerner & Kauffman, 1985](#)), argue that the context and individual have an influence on each other, with context and society being central in theories of gender and gender identity development (e.g., [Zucker & Bradley, 1995](#)). Being looked-after may, therefore be, an important part of understanding the context in which young people who are experiencing gender dysphoria are developing.

Identity development, identity confusion and trauma

Abuse and neglect is a common feature in the histories of looked-after and adopted young people, with 62% of young people being cited as entering care for this reason ([Vicker, 2014](#)). A high prevalence of traumatic early experiences has also been reported in young people experiencing gender dysphoria, with reports of rates including 17.4% ([Holt et al., 2016](#)) and 45.8% ([Colizzi, Costa, & Todarello, 2015](#)). Such experiences of childhood have been associated with difficulties forming a coherent identity in young people and identity confusion generally, with a sense of change and fluctuation in a young person's identity being reported ([Bailey, Moran, & Pederson, 2007](#); [Cole & Putnam, 1992](#); [van](#)

[Kolk, 1996](#)). This literature and hypothesis is referring to a person's general identity, of which gender identity is a part. It may therefore be that early experiences of trauma influence gender identity development, which could assist in the understanding of the greater prevalence of looked-after and adopted young people in the referrals than would be expected. Feelings of gender dysphoria have been theorised to possibly emerge due to a young person experiencing difficulty consolidating a novel understanding of their gender with the identity which was previously held ([Kroger, 2007](#)). For looked-after and adopted young people, a hypothesis may therefore be that as this 'previously held' identity is less coherent due to their experiences; this limits the young person's ability to develop a coherent gender identity during adolescence without support. It may, therefore, be that young people with traumatic early experiences may struggle with discussions about their future and their future gender as a result of difficulties imagining who they may become, leading to confusion about one's current identity.

Of the sampled young people referred to the service, a diversity of trajectories emerged and this seemed to particularly be the case for those who were looked-after or adopted. There were a number of young people who were referred with feelings of gender dysphoria who did not go on to pursue medical intervention. For some, it may be that they did not possess an ongoing transgender identity following their engagement with the service despite their experience of distress about their gender at the point of referral. For others, however, they may have continued to identify as transgender but chosen to not access medical interventions at the current time. This could be because: they do not believe interventions are needed; they do not feel ready yet, or; they prefer to wait for a referral to an adult gender identity clinic to access medical intervention. Based on these possibilities, this indicates the importance of psychological exploration prior to provision of a medical intervention. This may lead to a 'delay' to accessing medical intervention if a standard protocol is applied, as more sessions may be required. The importance, however, of the process being undertaken is clear so that young people are supported to consider whether gender dysphoria and associated medical intervention is indicated.

[Colizzi et al. \(2015\)](#) put forward a possible association between early trauma and gender development based on establishing comorbidity with experiences that have been most strongly associated with trauma, such as dissociative identity disorder. The literature on the involvement of trauma in gender identity development, however, remains sparse and theoretical exploration of this hypothesis is underdeveloped. While mindful of the need

further empirical and theoretical exploration in relation to this hypothesis, it may be that a sense of fluctuation and difficulties with identity becomes established as a relevant clinical consideration when working with both looked-after and adopted young people in relation to their gender.

Clinical implications

Gender identity services supporting young people need to be equipped to manage the possibly increased complexity associated with being a looked-after or adopted young person due to the increased proportion of these groups in the referral population. One of the ways of better supporting these groups may be to appreciate the impact that the context in which they are developing may have on their gender and their progress through the service. Possible clinical implications based on their developmental history and context will need to be offered.

Looked-after and adopted young people have been established, in the literature, as generally experiencing a greater range of negative outcomes in relation to their peers who are not looked-after. These experiences include an increased prevalence of mental health difficulties, not being in education or employment, and having less stability in their residential context (e.g., [Dixon, Wade, Byford, Weatherly, & Lee, 2006](#); [Golding, 2010](#); [Meltzer et al., 2003](#)). While the difference between scores on the CGAS were not significant in this research, the trend for poorer functioning in looked-after young people, with slightly better functioning for the adopted group and the best functioning in the YPBF group was keeping with expectations from previous literature. It may be that clinicians working with looked-after young people, and other groups and families presenting with complexity, need to evaluate their typical working practice to accommodate the additional needs of the person to conduct a timely assessment. For instance, if assessments take a greater number of sessions to complete, an option may be more frequent appointments than is standard working practice for the GID service. This would allow the additional required appointments to be conducted, while undertaking the assessment with looked-after and adopted young people in a similar timeframe to their YPBF peers. If services are unable to offer flexibility to this group then the support offered may not meet their needs with their progress through service being inequitable in comparison to peers developing in less complex situations ([Golding, 2010](#)).

Available treatments to attempt to reduce gender dysphoria present new ethical and

challenges, particularly around consent (Cohen-Kettenis et al., 2008). Looked-after young people may have intricate parental responsibility arrangements, with a range of adults having legal responsibility or at least an influence in decisions about the young person. Vries et al. (2008) suggest that the role of a parent is to consent and participate in the intervention in relation to a young person, for instance, in social or physical transition. For looked-after young people, there may be a range of people from whom participation is required to live in their preferred gender role, which may include foster carers and foster family, residential staff and biological family, and so this may be a source of further complexity. It may be important to find ways of hearing the young person's voice in systems in which the need to hear a number of adult voices could make their perspective have prominence, particularly as there are a potentially large number of people who could influence a young person to conform and suppress their preferred gender.

Limitations

The sample was relatively small, meaning that there may have been an insufficient sample size to have the necessary power to acknowledge differences that exist. This may have therefore led to a type II error occurring, when with a larger sample, any true differences that exist may have been established. For example, this may have been the case when comparing the proportion of referrals by assigned gender across the three groups, which was found to be not statistically significant. This was despite an observable difference between both looked-after and adopted young people in comparison with the YPBF sample.

As data were sampled from referral letters, clinician letters and clinical notes they may have been lacking in the information which was being sought, meaning not all categories could be accurately populated, as if information was missing or partially present then the information was not recorded. The data were also gathered retrospectively rather than clinicians being prompted to ensure data relating to looked-after and adopted young people was clearly recorded. It was also not recorded if the diagnosis of gender dysphoria and the assessment for referral to paediatric endocrinology services was not met or if the process was ongoing, thus representing a delayed assessment process rather than lack of diagnosis. It may be that a proportion of the young people went on to receive a diagnosis of gender dysphoria but this point had not been reached in the assessment due to the additional complexities discussed. An additional component could be to approach clinicians to ask them if there is information from which missing data could be populated, or a more nuanced status of

diagnosis could be recorded.

A further limitation of the research using a retrospective data collection approach was that it was not possible to report the order in which experiences developed, for instance, if the experience of gender dysphoria preceded the reported experience of other associated difficulties. It was also not recorded, and thus was not reported, whether the experience of gender dysphoria preceded becoming looked-after and/or adopted. A further research design may be indicated in which the emergence and trajectory of the various experiences reported in this article are temporally recorded and compared. To collect this extra information to respond to the above limitations, a design which employs a live data collection method rather than using a retrospective case file review design, is indicated.

Future research

While the data set covered a 2-year period, this did not provide a sample which was sufficient in size to reliably undertake possible comparisons, therefore a need for a future study with a larger sample is indicated. This would be anticipated to allow conclusions that are tentatively offered by this research to be reported with confidence in their reliability.

It would also be useful for further research to record time from referral to beginning of psychological intervention, so this could be compared across groups alongside information about the proportion who receive the diagnosis and proceed to physical treatment. This would allow for comparisons of the length of the assessment process to be reported and compared across groups. In addition, a further piece of research could involve following a group of looked-after and adopted young people more closely, and undertaking qualitative data collection from the young people, carers and clinicians to provide an insight into their experience of the process, including the process of clinical decision making when faced with complex issues. A more detailed analysis would also allow for the impact of differences that may exist between looked-after and adopted young people, and between such as abuse history, age of referral, permanence, and number of placements.

It would also be of interest for research to focus on the trajectory of other groups through the gender identity service, so to consider similarities and differences in trajectory based on other features of complexity. It would be particularly interesting to compare young people with abuse histories and early developmental adversity who continue to live within their family, so to consider the similarities and differences between this group and looked-after-

and adopted young people. From a systemic perspective, this would also allow the consideration of any additional impacts of being in local authority care for looked-after people, over and above the complexity of having early adverse experiences.

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