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Towards a Gender Exploratory Model: slowing things down, opening things up and exploring identity development



*Anastassis Spiliadis*¹

Throughout the western world, the care of children and adolescents whose sexed corporeality is at odds with their gender-related feelings raises medical, psychological, and ethical dilemmas. There are currently differing views around what constitutes responsive and timely support for these young people and how professionals can operate within a rapidly shifting and contested field, in which evidence-base is scarce. In this article I aim to reposition the theoretical framework away from 'affirmative' or 'reparative' polarities, arguing that both can be problematic, and to invite the reader into a Gender Exploratory Model (GEM) grounded in a systemic-developmental framework; such a model acknowledges and often embraces the notion of uncertainty with regards to young people's developmental trajectories and clinician's 'unknown unknowns' and exploratory responsibilities. A short introduction to the service (GIDS), as well as a presentation of the current theoretical and clinical debates, will offer a contextual base for clinicians supporting young people experiencing gender dysphoria. This is not an attempt to explore the multifactorial aetiology of gender dysphoria but rather one to add on the theoretical underpinning of therapeutic approaches in supporting these young people.

One is perpetually telling one's story to oneself and others, trying to shape things so that the next step fits with what has gone before, ceaselessly claiming significance for one's experience and actions and the question always is, in what language can or must one do these things?

Boyd White (1984:277)

I write this article in my capacity as a systemic and family psychotherapist in the highly specialist Gender Identity Development Service (GIDS) at the Tavistock Centre, in London. In GIDS, I occupy simultaneously multiple positions; I am a clinician and therefore, a supervisee but also a supervisor and a trainer. I am aware of my responsibility to provide ethical care to young people and families who experience distress with their developing bodies, whilst holding in mind the multiplicity of the potential outcomes in young people's physiological and psychological development, as well as the potential affordances and constraints that medical / hormonal interventions offer to people who decide to change their bodies. Holding on to my systemic training,

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I connect with the conceptualisation of gender identity as socially constructed but equally acknowledge the sexed reality of our bodies and their boundaries and limitations, irrespective of whether these are chromosomal or relating to external genitalia or internal reproductive organs.

Therefore, practicing systemically, I am not focusing on linear aetiologies with regards to someone's experience of gender dysphoria. I am rather interested in practicing from an idiosyncratic approach and position that would allow for an open dialogue among health care professionals and service users to develop, so as the meaning-making of embodied and gender(ed) experiences can be explored. At the same time, I am interested in further developing my capacity to be self-reflective. This is supported through on-going individual and group-based systemic supervision and through reflecting on my own experiences of gender identity development. My ultimate aim is to support the families I work with to be curious about the diverse narratives, lived experiences and developmental outcomes of those who have experienced gender dysphoria and therefore often highlight 'the danger of a single story' (Adichie, 2009) in this specialist, often highly contested, field.

In my clinical practice, I often reflect on the 'blind spots' and the 'unknown unknowns' that both clinicians and families can be faced with when supporting gender questioning or gender non-conforming children and adolescents. As we operate within a field where evidence is scarce, we often rely on evolving practice-based evidence and clinical experience, as well as international standards of care (Coleman et al., 2012). In the current article, I will present the clinical context in which I operate as a systemically trained clinician; I will then present the current theoretical polarities with regards to supporting young people whose gender identity feelings are at odds with their sexed corporeality. I will aim to present a modified theoretical and therapeutic approach working with gender questioning young people with reference to a specific case study and clinical reflections, connecting to my own clinical experience as a systemically trained psychotherapist. That theoretical underpinning aligns tightly with how I tend to practice in GIDS, whilst holding in mind that other clinicians might approach exploration through a different lens. I am also not claiming the application of such an approach as fitting with all young people who present to the service; rather I am interested in enriching the narratives available to young people who experience an incongruence between their gender identity and their bodily reality (and to their families) and make an addition to the wider debate in the field of gender identity development.

The clinical context

The Gender Identity Development Service (GIDS) at the Tavistock Centre in England is a highly specialist child and adolescent service, part of the wider National Health Service (NHS). It supports young people up to the age of 18 years old, who experience difficulties with their gender identity. The service was founded in 1989 by Domenico Di Ceglie, child and adolescent psychiatrist, with the aim, among others, to encourage exploration of the mind-body relationship and challenges for gender non-conforming young people through a holistic multidisciplinary approach.

Some of the young people presenting to GIDS identify as trans. Other young people do not connect with this 'umbrella' term or other labels, which they might often describe as 'limiting'.

The team at the Tavistock Centre consists of systemic and family psychotherapists, clinical psychologists, child and adolescent psychotherapists, social workers, and a child and adolescent psychiatrist. Paediatric endocrinologists and clinical nurse specialists are part of the team and usually tend to meet, if relevant, with young people and families following a psychosocial assessment. The current service protocol suggests 3-6 assessment sessions over 3-6 months, although the length of the assessment can be flexible and is often longer depending on the complexity of a young person's gender identity development or the associated difficulties. Whilst the service's initial exploratory approach was aligned with a psychodynamic understanding although parents and carers were involved at different phases), current therapeutic exploration has a stronger systemic focus, as most young people are encouraged to be seen together with their significant system; in most cases with their parents or carers, siblings or even extended family members and any significant others. Family days and parents groups are an integral part of the psychosocial pathway. Family therapy is not currently part of the routine GIDS pathways or assessment; however a small number of families have been seen in the Family Therapy & Consultation Service in London that was established in 2017.

At a broader-systems level, GIDS has adopted the network model approach (Davidson & Eracleous, 2009), which can be conceptualised as an adaptation of Seikkula & Olson's (2003) open dialogue framework. Developed on dialogical and Batesonian (Bateson, 1963) ethos and tradition, the approach advocates for the 'tolerance of uncertainty,' 'dialogism' and 'polyphony' as guiding principles in multiagency work in the community and with relevant stakeholders. Specifically, even though the GIDS operates as a highly specialist service with a strong focus on assessment of young people's gender identity development, any decision-making in relation to children's and adolescents' gender identity, their embodied identities (Spiliadis, in press) and their on-going psychological support, requires multiagency coordination, cooperation and communication. This is in line with the complexity of the clinical presentation of some of the young people attending GIDS (Holt, Skagerberg & Dunsford, 2016) and gender identity services in other countries, such as in Finland (Kaltiala-Heino et al., 2015), in Canada (Bechard, VandeLaan, Wood, Wasserman & Zucker, 2017) and in the Netherlands (de Vries, Doreleijers, Steensma & Cohen-Kettenis, 2011). Such observations perhaps signify the need to move away from linear and simplistic explanations around the aetiology of gender dysphoria but also the 'thin narratives'² with

² *Editors' Comment:* Michael White defines as "thin narratives," "thin descriptions" and "thin outcomes" concerning someone's identity, those that are not based on a dialectic process leading to some interpretation but simplified processes. Alternatively, he proposes the dialogue and the interaction between the person (IP), the Mental Health professional, and the community leading to more secure / or complex narratives, descriptions (thick descriptions) and outcomes (White, M. (1997). *Narratives of therapists' lives*. Dulwich Centre Publications).

regards to possible developmental trajectories for young people experiencing embodied distress, and the relevance and value of clinicians' interventions.

Clinicians working in the field of child and adolescent gender identity development have to navigate through differing and competing narratives and beliefs that professionals, families, third sector organisations or even the media might have, in terms of persistence and desistance of gender dysphoria across the lifespan and the relevance of any clinical intervention. There is ongoing debate about whether professionals supporting gender questioning young people (and their families) can predict with confidence which young people will 'persist' in their gender identification and/or their wish for medical/hormonal interventions and which will 'desist'; in the case of 'desistance' it could either mean that young people come to understand their gender identity (and possible associated distress) in different ways or cease wishing to pursue hormonal interventions (Churcher Clarke & Spiliadis, 2019).

There is some evidence that medical interventions can, for some young people, alleviate gender dysphoria (Kreukels & Cohen-Kettenis, 2011). However, there is anecdotal agreement among some clinicians working in this field that different outcomes are possible and that gender-related distress (or gender dysphoria) is not always alleviated through medical, hormonal or surgical, interventions (Dhejne, Oberg, Arver & Landen, 2014; Levine, 2018). In some cases, presentations of broader identity confusion indicate a need for exploration beyond the gender identity narrative (Marcus, Marcus, Yaxte & Marcus, 2015). These questions extend easily to wider moral and clinical debates; in any case, they signify the need to ask ourselves 'do symptoms of gender dysphoria always predict a transgender identity'? And also 'what type of interventions should we offer to young people experiencing symptoms consistent with a GD diagnosis'?

Current theoretical polarities

Clinicians working in GIDS are constantly faced with clinical and ethical dilemmas. Equally training clinicians wanting to gain experience in the field of gender identity are often puzzled by the rarity of a theoretical base that would inform clinical practice and would allow trainees and newly appointed clinicians to follow a well-defined theoretical framework. In the last five years, gender identity services throughout the western world have experienced an unprecedented increase in referrals; contrary to historical figures and referral profiles, there has been a significant rise in the numbers of younger (often prepubertal) children, as well as female-bodied adolescents being referred (de Graaf & Carmichael, 2019), as well as the development of strong online communities. These phenomena raise important questions around the need to possibly revisit current clinical approaches within a fast-evolving field and highlight the importance of a carefully developed clinical formulation when

Perhaps it should be added that the terms «thin» and «thick description» were first introduced by the 20th-century philosopher Gilbert Ryle. Later on, Clifford Geertz, the cultural anthropologist, who influenced the practice of symbolic anthropology, in *The Interpretations of Cultures* (1973), described the practice of "thick description" as a way of providing cultural context and meaning that people place on actions, words, things, etc. Thick descriptions provide enough context so that a person outside the culture can make meaning of the behaviour. "Thin description," by contrast, is stating facts without such meaning or significance. <https://cognitive-edge.com/blog/the-thick-and-thin-of-it/>

working with complexity and with uncertainty around possible developmental trajectories (Hutchinson, Midgen & Spiliadis, in press).

There have been some attempts to review the differing clinical/therapeutic approaches when working with young people with GD. Interestingly more detailed accounts of these have focused on younger / prepubertal children and the dilemma of early social transition (Zucker, 2019), or adults rather than adolescents. Broadly speaking, we can conceptualise competing theoretical approaches in working with young people with GD, as loosely connecting to two different polarities: one that would affirm (often perhaps confirm) a young person's subjective gender(ed) experience and related hopes (for instance, for medical interventions) in the context of 'authentic self-knowledge' (Lopez, Marinkovic, Eimicke, Rosenthal, & Olshan, 2017) or on the basis of their 'privileged access' (Wren, 2014); and, on the other hand, one that would posit that offering active therapeutic intervention will effect a change / desistance in the young person's identification and therefore lead to congruence with their natal sex. The first position can be understood as the gender affirmative model of care (Hidalgo et al., 2013), which initially developed in the USA and was later adopted by different teams and clinicians throughout the western world (Keo-Meier, & Ehrensaft, 2018; Lopez, Marinkovic, Eimicke, Rosenthal, & Olshan, 2017) and is often criticised for its hypothesised underpinning in neurobiology. An affirmative approach to therapy with people of diverse sexualities has been well established. However, an affirmative approach to working with gender questioning young people raises controversy. Clinicians practicing from such an approach often affirm, perhaps actively confirm, young people's wishes for early hormonal (irreversible) and in some cases surgical interventions in otherwise healthy bodies.

The second approach can be understood as Dreger's (2009) 'therapeutic approach' involving quite radical interventions that can lead to it being described as 'conversion or reparative therapy.' Such therapeutic interventions, which in the past have been used as an active attempt to alter people's sexual orientation, have been officially described as unethical and harmful, in the Memorandum of Understanding (MoU) against conversion therapy, which was signed by many leading UK organisations, such as NHS England and the UK Council for Psychotherapy (UKCP) among others (Keogh et al, 2016). It can thus be hypothesised that the description of any psychological or indeed psychotherapeutic intervention as 'therapeutic' for young people with GD can easily raise concerns with regards to possibly practicing conversion therapy. The launch of the Memorandum triggered much debate and some anxiety among clinicians working in the field around what would be the remit of ethical clinical practice, psychosocial assessment, and therapeutic exploration. However, the MoU (Keogh et al., 2016) clearly states:

For people who are unhappy about their sexual orientation or their transgender status, there may be grounds for exploring therapeutic options to help them live more comfortably with it, reduce their distress and reach a greater degree of self-acceptance. Some people may benefit from the challenge of psychotherapy and counselling to help them manage dysphoria and to clarify their sense of themselves. Clients make healthy choices when they understand themselves better (p.2).

Therefore, it can be inferred that a psychotherapeutic intervention for gender questioning young people does not necessarily align with a conversion approach, as long as the therapist practices from a curious stance, aiming to support people explore the meaning they make of their symptoms of gender dysphoria rather than actively 'guide' them to a different identification. The question of 'what would such a psychotherapeutic intervention entail' is a valid one.

Contrary to the discussed theoretical polarities, a third framework or approach to supporting young people's gender identity development operates within the domain of exploration; in that domain, the therapist(s) could actively acknowledge and respect the young person's gender identity and subjective experiences (without attempting to alter these) and at the same time invite them into an exploratory therapeutic or 'assessment' process, in order to better understand the meaning-making of their gender(ed) and broader selves. This aligns closely with Di Ceglie's (2009) psychodynamic - developmental approach; the founder of GIDS proposed a developmental approach to working with young people experiencing gender-related distress, where acceptance, curiosity, unconscious meaning, and projective identification would be at the core of the therapeutic journey.

While acknowledging Di Ceglie's psychodynamic approach, I tend to privilege a relational and systemic framework when working in GIDS; I view people and therefore their challenges as developing between relationships, contexts, and multi-layered narratives. I also attend to young people's developmental needs and processes; this means I work differently with the family of a 5-year-old, where I might take up a rather structural systemic approach, as opposed to working systemically with the family of a 17-year-old service user. I do not view gender variance as a mental illness; however, I am mindful of the diverse presentations (and also co-occurring difficulties alongside gender dysphoria) that some young people present with at GIDS. Through my clinical experience with gender questioning children, adolescents and adults in the NHS, I have come to appreciate how therapeutic exploration should be taking place before as well as through (Wren, 2019) and potentially after any relevant medical decision-making, and that this could happen within a developmentally informed systemic framework. What I often call the 'Gender Exploratory Model (GEM)' is an integration of systemic practice with a dynamic developmental lens (Fausto-Sterling, 2012) -the one that a clinician can develop experience in through years of practicing within a developmental child an adolescent service like GIDS. Such an approach can offer a framework through which the young person's identity status at a particular moment in time could be acknowledged; and yet through a process of exploration, the young person could be invited into a collaborative exploration of their stories lived and told (Pearce, 2007), through reflective conversations around their embedded and embodied context (Hardham, 1995) and intergenerational narratives, as well as future hopes around intimacy which often intersect with both gender identity and sexuality. It is also important to hold in mind that there is currently no consensus among thoughtful and committed professionals working in the field of gender identity development with children and adolescents on whether the administration of the GnRH analogue (the 'hormone blocker') potentially offers all young people the opportunity to 'buy time' and explore or, conversely, serves as a radical

intervention that could arrest wide-ranging physical and emotional development (Giovanardi, 2017).

The below diagram is an attempt for a brief presentation of different theoretical approaches:

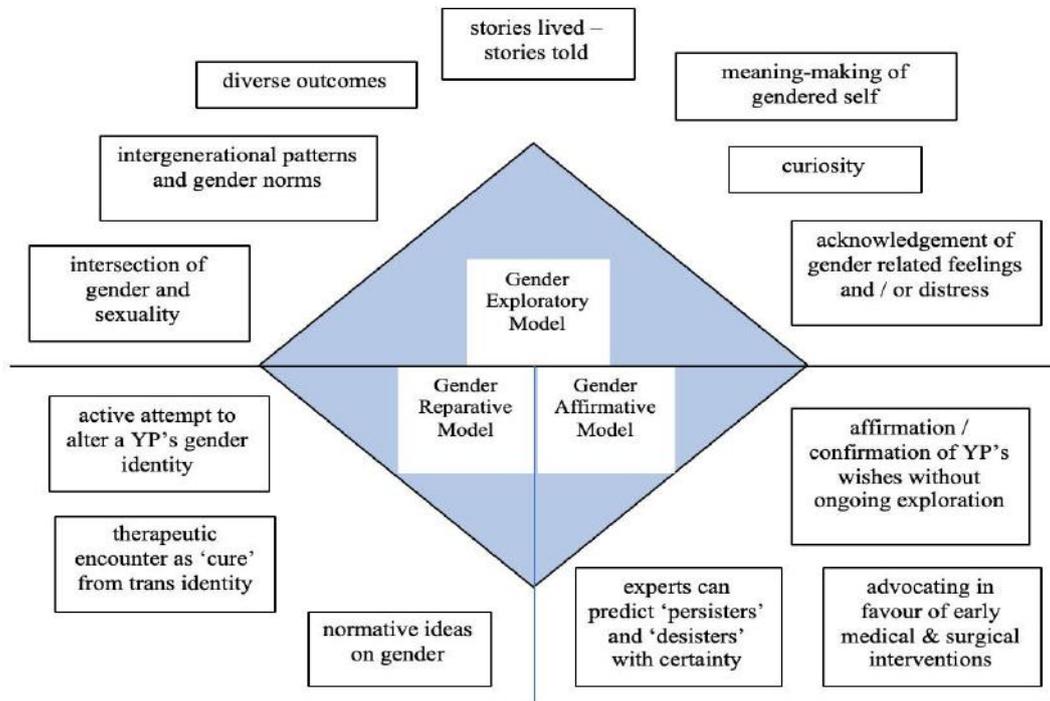


Diagram 1. Brief presentation of theoretical approaches in working with gender questioning young people

The above diagram is an attempt to position a systemically informed Gender Exploratory Model (GEM) away from 'affirmative' or 'reparative' extremes into a ground where young people and their significant systems will be invited to explore broader, as well as gender(ed) identity development within a collaborative framework. I argue that such an exploration can take place through different domains of action: production, explanation/exploration, and aesthetics. Such a distinction can be useful to clinicians wanting to gain experience in this specialist area, as well as trainees being part of the team, aiming to link theory to practice.

Domains of action in gender identity work

The Domain of Action theory, as developed by Lang, Little & Cronen (1990) and based on Maturana's (1988) theory of human act and existence, serves as a helpful framework in supporting clinicians and mental health professionals interested in systemic practice with gender questioning young people and families to reflect on their clinical responsibilities, acts, moral postures and their relationship with the notions of neutrality and curiosity (Cecchin, 1987). It might be helpful to reflect on how this could apply to 'action' within a Gender Identity Service.

Production. The domain of production relates to rules, processes, and ‘realities’ that emerge contextually at any particular time. In GIDS, clinicians are expected to work in line with the service protocol and to focus on providing ethical care for young people experiencing gender-related distress. Quite often, families expect an assessment period between 3-6 sessions and at the end of this, a report, which includes an agreed care plan. Operating in a domain of production, clinicians often find questions within a landscape of action helpful (Bruner, 1986; White, 2007) in order to elicit information and connect with the young people’s gender narratives. It’s important that clinicians maintain a curious stance in relation to when the young person started questioning their gender, how they managed this, whom they shared their thoughts and feelings with, how their significant others found out and what they have done (or not done) ahead of their first appointment. The landscape of action questions can provide information about preferred names and pronouns and parents’ or carers’ reactions. Within a domain of production, we can often situate young people’s wishes in relation to medical transitioning. It is often felt that some service users in GIDS view this specific domain of action as a stepping-stone to hormonal interventions. Any clinician working in such a context should acknowledge the importance of that domain for gender questioning young people and its relevance to good standards of care, in that it supports young people’s narrative and personal journey.

Explanation. The domain of explanation relates to the exploration of meaning making in lived experiences, rather than with the search for absolute truths or aetiologies. In this domain, Cecchin’s (1987) ‘curiosity’ is privileged, as well as ideas around alternative narratives and the possibility for these. In GIDS, it can be hypothesised that such a domain offers the opportunity to explore ideas around diverse gender identity pathways and developmental outcomes (Churcher Clarke & Spiliadis, 2019), which are not uncommon within a child and adolescent gender identity service. Within a wider social constructionist approach, clinicians should continuously reflect on their own relationship to medical interventions and perhaps challenge dominant narratives around their necessity.

Questions within a landscape of consciousness (Bruner, 1986; White, 2007) can help explore young people’s subjective gender identity and experiences. Inviting the young people to reflect on how they understand their experienced gender dysphoria, what is the meaning they give to their lived and told experiences and how these influence others (and are influenced by others) are of primary importance.

Exploration of key developmental processes, such as intimacy/closeness, masturbation, meaning making of developing sexuality, is crucial as they offer the platform through which identity development in broader terms can be explored. Exploration of cultural influences, religious beliefs, and societal pressures around gender expression and norms are paramount. As a clinician who was born and raised in Greece but having lived as an adult in the United Kingdom, I often locate myself as a person (and as a clinician) within often-contradictive social realities, where ideas around femininity and masculinity had their own culturally embedded fixity. Such interventions, within this domain of action, are not intended to challenge the young person’s gender identity.

However, as aligned with the MoU, they are rather intended to invite young people (and families where relevant) into a collaborative exploration so they can better understand their lived experiences and make informed choices.

Aesthetics. The domain of aesthetics relates to how clinicians do what they do – how they attempt to explore. Attending to the systemic tradition, clinicians often rely on social constructionist ideas around the co-creation of people’s subjective experiences. At the same time, by paying close attention to language, clinicians can embrace the tentativeness that relates to exploring behaviours and identities in young and still developing children. For instance, when talking to the parents of a five-year-old child that has been referred to GIDS, clinicians might prefer to move away from ascribing the identity ‘trans’ to a minor. They rather might privilege phrases such as ‘gender questioning’ or ‘gender non-conforming,’ which offer multiple developmental possibilities. In any case, clinicians should practice in line with their professional standards, attending to difference and diversity and use ongoing clinical supervision to reflect on how they attempt theory and practice links ethically, while gracefully attempting to invite ideas around safe uncertainty in systemic conversations (Mason, 1993).

Beyond the single gender(ed) narrative

The following case, vignette serves as a representative example of exploratory work in GIDS, grounded in the Gender Exploratory Model. The vignette has been anonymised and identifying information changed to preserve confidentiality. Oral and written consent was obtained from both the young person and the family. The pronouns used to reflect the young person’s preference at the end of the exploratory work.

Referral. Peter -known then as ‘Louise’-, a 15-year-old white male-bodied young person, was referred to GIDS by the school counsellor. The referral included information about Peter’s female identification and his wish to medically transition so that ‘(s)he could be (her) his true self’. The referral posited that Peter had done a lot of thinking while growing up in a very supportive family, in which parents would support him in ‘any decision (s)he might take.’ The counsellor referred Peter to GIDS formulated that Peter had always felt different while growing up and that his certainty around his subjective gender identity had intensified in the last year.

Peter (then Louise) presented as a tall, strong-built young person. He would usually choose to dress in what he described as ‘stereotypically female clothes’ and wore his hair long. Peter would talk in length about his experimentation with make-up, in an attempt to be ‘perceived as more female’.

Exploratory intervention. The work consisted of eleven assessment sessions (eight family-based; three individual) over a period of twelve months. At the end of this period, an assessment report was shared with the family and further exploratory work in GIDS was recommended. This consisted of seven individual face-to-face sessions over a period of eight months. Peter’s certainty around his female gender identity was communicated openly at the start and throughout the assessment. Peter had already pursued a social role transition

and was known as 'Louise' in school, at home, and in GIDS. Parents had consented to an official / legal name change, which the young person had achieved through a deed poll.

Early on in work, Peter shared with confidence that he wanted to transition medically through oestrogen and hoped to pursue surgery to alter his secondary sex characteristics as an adult. He was initially upset about the lengthy assessment process and struggled to understand the need for a holistic psychosocial assessment in the context of getting to know him better and therefore developing a relevant care plan. Most appointments were attended by Peter and his mother, Maria, who could be described as having occupied a one-down position (Minuchin, 1974), thus suggesting that she would support Peter in any decision he took and that she did not feel able to express her own view.

Peter lived at home with his biological parents and two older sisters. All were supportive of Peter's wishes and felt that he had finally 'found his authentic self'. Peter was initially focused on the domain of production with regards to his transition into a female role. He spoke about his realisation at the age of 14 that he must be trans, which he connected to his lived experience of 'always feeling different'. Peter was well into puberty and had acknowledged that his voice had already got deeper. However, he was clear that he was experiencing significant distress due to body-hair growth, as he felt this did not align with his female identification. Peter was complaining about his body image and his dislike of his broad shoulders. I was struck by Peter's account of his coming out process. He initially shared his body-related distress online, initially with a trans-affirmative community-based in the USA. He spoke about how the community quickly affirmed with experienced distress as signifying that 'he must be trans.' I expressed my surprise by reflecting on the fact that the diagnosis of gender dysphoria was initially given by these other young people that Peter had never met in his 'offline' life, rather than an experienced professional. By doing so, I was aware I was communicating an 'expert' positioning for myself; expertise not in relation to Peter's gender identity or communicated distress but rather an expertise in relation to having worked with similar presentations in the NHS.

By focusing on questions within a landscape of action, I was able to elicit information on the timing of his coming out, as well as the length of what was described as gender dysphoria. It soon transpired that Peter had been given this diagnosis a few years after his onset of puberty and that his realisation that he should be trans connected with some linear hypotheses mainly around his gender expression and relational challenges in school, mainly in the context of being bullied or feeling excluded.

There were times when I felt that Peter might disengage from the exploratory process, mainly due to him insisting on starting hormonal treatment as soon as possible. I attended to his wishes by reflecting on how challenging it must be for him perceiving me as wanting to support him to 'think more,' whilst for him 'acting on his wishes to transition medically' was of primary importance. Locating myself openly as a white, male, cisgender, non-native speaker clinician and attending to the power dynamics relating to myself as the

gatekeeper of Peter's medical intervention, opened up more space for relational reflexivity and impacted positively on the therapeutic alliance.

I invited Peter to reflect on different aspects of his embodied distress. I noticed that Peter focused on his fixation with body hair and we thought together how there might be alternative ways for him to manage this while continuing with an explorative assessment. These conversations led to Peter trying out laser treatment, which eventually alleviated part of his experienced dysphoria and opened up space for further exploration. It was felt that this allowed for Peter's urgency to medically transition slow down and gradually opened up space for further exploration.

Within a domain of explanation, I expressed my curiosity around Peter's meaning making around his sexuality. These conversations took place over a number of sessions, and it was through revisiting them often that Peter gradually became more interested in these. His initial avoidance to explore sexuality was understood in the context of his past experience of bullying. Peter was able to share how, from a young age, he enjoyed trying out his older sisters' clothes and playing with make-up. While this was supported at home, he reflected on regularly experiencing homophobic bullying and teasing in school. It soon transpired that Peter had decided not to share this with his family, as he connected it to a sense of shame and hopelessness. I wondered about the impact of this on Peter's psychosexual development and meaning making of his embodied identity; through reflective conversations, I was struck by the impact of societal pressures and stereotypes on his gender(ed) self. Peter was reflective about how different levels and contexts of his daily reality interacted in a dynamic and how he often experienced oppression with regards to his freedom to live comfortably in his body. People in his neighbourhood would openly disapprove of his gender fluidity as a developing adolescent, while he would struggle to develop friendships with males in his local youth centre, as he was never interested in rough and tumble activities. Peter soon reflected on how contact with the trans-affirmative online community had given him a sense of safety and felt supported by 'other young people who felt different from the norm'. Through deconstructing these narratives, it gradually became apparent that Peter's distress mainly connected to the disempowerment he had felt as a young adolescent.

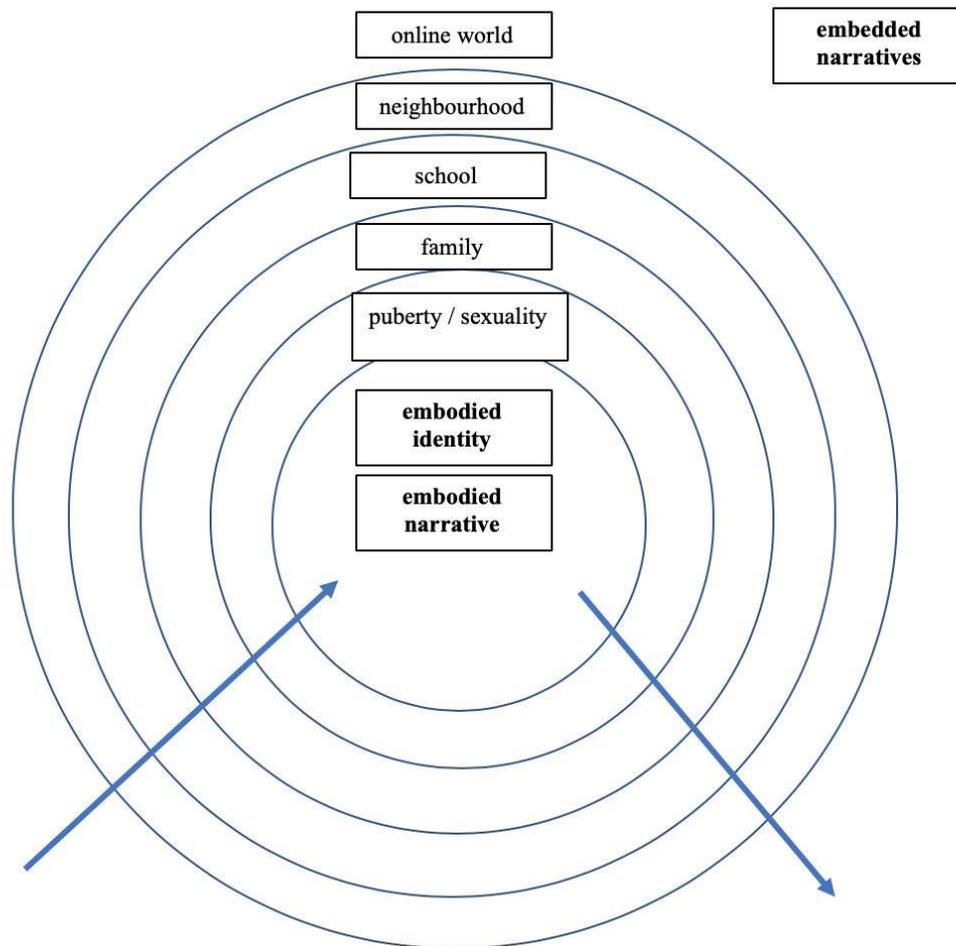


Diagram 2. Peter's embedded and embodied narratives as intersected with different contexts

I sought permission (Aggett, Swainson & Tapsell, 2015) to ask 'landscape of consciousness' questions around Peter's experience of puberty and relationship to genitalia and masturbation. Peter reflected on how he found pleasure in masturbation and ejaculation and gradually started talking more openly about his sexual fantasies. Having not had any intimate experiences, Peter felt that the only way for him to find relational / intimate pleasure in the future would only be possible after a medical transition. He described how he thought this would be the only way possible for him to take up a more feminine role; this was understood to serve as a thin narrative in relation to his gender identity development and how this was perhaps (at times) conflated with his emerging sexuality (White, 2001). While acknowledging Peter's subjective gender(ed) status and attending to Peter's wishes around preferred pronouns and name, I aimed to enrich the narratives available to him and shared experiences of male-bodied young people starting of GnRH analogue treatment. I shared how this treatment often suppresses young people's libido and how there are still many 'unknown unknowns' on how this might affect young people's intimate experiences. During the later phase of the exploratory work, therapeutic alliance improved significantly. Peter would come in with ideas around which aspects of his identity development he would like to explore and would often reflect on how his confidence had improved, and his

experienced dysphoria had weakened. It was during this phase that I noticed Peter not referring to medical intervention and his wish to transition.

Soon after his 17th birthday, Peter presented to GIDS having cut his hair short and without wearing make-up. Peter shared that he had had his first intimate experience with another male-bodied young person, in what he described as a consensual sexual act. He reflected on how this had served as an important developmental process for him in that he allowed him to connect with another aspect of his identity, namely his sexuality, which he felt he had ignored throughout the years. Peter spoke confidently about his wish to start experimenting with a more fluid, rather than a stereotypically female, identity and asked to put a pause to a referral for hormonal interventions.

When asked what enabled him to understand himself in a different way to how he initially presented to GIDS, Peter spoke about the invitation from the GIDS to explore the meaning of his multi-layered identities. He was able to share how his initial frustration around the staged approach of our interventions was gradually alleviated by him feeling understood and listened in the consulting room. During the last session, Peter asked me to start using his birth name and male (he/him) or gender neutral (they/them) pronouns. It was agreed that a review session would take place after six months in order to revisit Peter's care plan and to potentially agree on his discharge from the service, as Peter no longer wished to pursue hormonal interventions.

Conclusion

In this paper, I attempted to move away from current theoretical polarities around psychosocial support for gender questioning young people and invite the reader to a different approach, the Gender Exploratory Model. Drawing on systemic and developmental theories, clinicians working with gender identity can invite service users into a process of collaborative exploration, whilst being mindful of the different domains of their action and the intersection with different contexts of the embodied and narrated distress. Such a model offers more possibilities with regards to assessment outcomes and young people's developmental trajectories. I do not claim the universal application of such an approach, as it is well documented that different countries have different regulations and protocols on the treatment of gender dysphoria in childhood and adolescence.

However, this theoretical underpinning seems pertinent to the current UK clinical context, the ever-shifting landscape in the consulting room, as well as systemic training and approaches. Clinicians ought to respect the young person's identity and gender expression, acknowledge the communicated embodied distress, and simultaneously invite service users into a process of exploration which can safely and respectfully shed light into the meaning-making of the lived experiences.

Finally, the dynamic intersection of gender identity with other markers of broader identity and psychosexual development is important, as is the acknowledgement that the notion of uncertainty is central in exploratory work with gender questioning or trans-identified young people. Systematic research into the different theoretical approaches utilised in different gender services

can offer important qualitative and quantitative data and can serve as a base for future developments of clinical practice and service delivery.

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The views, thoughts, and opinions expressed in this article belong solely to the author and don't necessarily express the views of the author's employer, organisation, committee, or other groups and individuals.

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