Practitioner Perspective

Working with gender dysphoria in young people

By Sally O'Reilly

A workshop led by psychotherapist and author Stella O'Malley provided the 'most up-to-date thinking and understanding of how to best support gender-related distress in young people'. One attendee provides their review of the experience

Introduction

"The sharp rise in the number of young people questioning their gender has led to many professionals feeling unskilled in this area. This workshop will provide psychotherapists, counsellors, teachers, nurses and others with the most up-to-date thinking and understanding of how to best support gender-related distress in young people." This was the blurb circulated by Live Life Now, the event organisers who hosted a workshop led by Stella O'Malley, MA, psychotherapist, in Cork on the 26th November 2022.

The audience was comprised primarily, but not exclusively, of therapists with varying degrees of experience and from diverse schools of therapy – an interesting, eclectic mix. There was a certain sense of unease in the room, created by the fact that the original venue, UCC, had changed to an undisclosed new venue two weeks prior to the workshop. We all received an email the day before the event informing us that Hayfield Manor was the new location. It was a small gathering of professionals, with just 40 or so attendees, for three and a half hours. As a graduate of UCC I was disappointed, but also happy that at least the surroundings would be more comfy and the all-important coffee would surely be of better quality!

On a more serious note, and this is why I mention it, the curiosity around the venue change was a notable reflection of the contentiousness of the issues with which we are faced when working with clients who are gender questioning and/or self-identify as transgender. The issue has become increasingly adversarial, divisive, and with strong political and social ramifications. Some of us wondered if there was a political element to the venue change. Or was that paranoia? There is a lot of it about these days. It is easy to feel victimised, particularly when there is 'chat' online urging events – including this one – to be cancelled, and lists of attendees are sought. To what end we don't know, but it was not a warm, comfy, inclusive feeling, that's for sure.

The thing is, one needs to be on Twitter or Reddit to be fully cognisant of the division, anger and aggression out there when it comes to any discussion of 'The Trans Issue'. And while I applaud and indeed encourage frequent social media holidays or, indeed, abstinence, the result of not engaging in social media is that one is not privy to the social discourse that is influencing and, in some cases, overtaking the lives of many of our clients. As for professionals, it makes open discussion about working with gender-questioning minors difficult in a way that is unprecedented.

A new language

We live in a world with a growing and new lexicon. Words and phrases like cisgender (cis), cancel culture, ROGD, LGBTQI+ versus LGB, gender critical, non-binary, gender fluid, AFAB, AMAB, de-trans, desisting, pronouns, affirmation care, mis-gendering, dead-naming, exploratory therapy (isn't it all exploratory?), are part of the new common parlance. A new language has emerged and this language can be confusing for those not living in or familiar with the (virtual) reality of online life.

Those of us who work with children, teenagers and young adults know well that this is where *a lot* of time is spent. This world feels utterly real to many young people. For many, particularly those who have difficulty connecting socially IRL (in real life) it was their sole point of social contact during the darkest days of COVID-19. It was, and is, where they meet, discuss, find connection, acceptance and approval. Bread and butter stuff for all of us, but especially so for teenagers.

The threat of 'cancellation' is now so strong that people can and do feel misunderstood, silenced and bullied. Terms like conversion therapy are misused, sexuality and gender are incorrectly conflated and in the midst of all this confusion we – the therapists – are holding spaces with clients, while at times feeling utterly bamboozled ourselves. It is a difficult space for us to inhabit. Many of us simply avoid the conversation, perhaps even hoping it will all go away. It does not appear to be going anywhere for a while yet. It may never. What does this mean for the work we do as therapists? How can we continue to work ethically in such an evolving and changing social landscape?

Stella O'Malley

How can we feel competent?

It is my curiosity about these questions and my passion for working with young people that prompted me to attend this workshop. I had my first trans-identifying client back in 2016. I had no idea at the time what trans identifying even meant, what binders were (an elasticated garment to flatten and compress breast tissue), or how big the market for them would become. Despite my 20 years' experience working with teenagers, I felt suddenly unskilled and lacking in knowledge. There were new words, new ideas and what seemed like the beginning of a new social contagion – although I did not have the language for that either at that time. Reviewing my old notes recently I can see how troubled I was: eager to affirm my client, to not pathologise, to support her but also to support her relationship with her parents, which was fast deteriorating. Was binding a form of self-harm? What did we know about the effects? (not much at the time). What did we know about the process of transition? (again not much). What lay ahead for this client if she proceeded? Why did she suddenly not want to be a woman?

I saw the traits that I would later recognise as neurodivergent. I heard a history of trauma. These were all elements of what was emerging as a pattern for therapists all over the world, but we were as yet to connect the dots and, as yet, to connect with each other. It was a pattern I was soon to observe in my own practice – I was seeing common trajectories, common histories and common 'scripts'. I had no idea what was ahead.

Two years later Stella O'Malley made the film *Trans Kids;* later books like *Trans*, and *Irreversible Damage* were written. The new transgender 'movement' was ushered forth and it feels like so much has changed. Diversity is king. And yet we seem to have narrowed rather than widened our collective focus and sense of inclusivity.

In the meantime, what was happening to our vulnerable young clients and their parents? If we are to not panic and feel unskilled, how can we best support them without changing how we work, while staying faithful to our core beliefs

about what therapy is, irrespective of our training and background?

I can summarise in a few simple sentences how this workshop provided the answers to those questions. Stella took care to reassure us that there is nothing different we need to do with gender-questioning teenagers and clients. We simply continue to do the work of therapy. What we *would* benefit from is doing some homework – learn the new language. And as she said, that can be done in about 30 minutes, otherwise, pretty much keep doing what you are doing, folks.

The psychoeducation part

Stella began by taking us through some definitions to form the backdrop and give context to the meat of the workshop. Words and phrases like those I mentioned above were listed and explained. We were encouraged to think about gender, stereotypes and the evolution of diagnostic criteria according to the *DSM* for gender dysphoria, which was also defined for us. And while, as therapists, we are not in the business of diagnosis, this evolution is fascinating, useful and worth knowing for many reasons. But for me, one of the most salient reasons is that in this era of labels and self-diagnosing, teenagers are coming to us fully attached to and engaged with their own diagnosis from Dr Google and his colleagues Drs Twitter, Reddit and TikTok.

Our clients, she said, feel fully informed, but they are not. I have seen this too. A little exploration in the therapy room and the confusion becomes apparent. I recall asking a 14-year-old: “how can one be both non-binary and trans? Is the latter not dependent on the existence of a binary? How can we both ‘smash a binary’ and affirm a male or female gender identity?”

I wondered how this was settling on person-centred therapists and those among us who were unaccustomed to offering feedback

This mess of contradictions and dissonance is not new to those of us who work with teenagers. It is useful and can be used creatively to encourage the young person to explore and expand their own thoughts. Teenagers like to think critically, despite the oft-voiced assertion that they are incapable of doing so. They are in a sea of information and misinformation and are, as a result, often misinformed, or at best under-informed.

Listening to Stella I was reminded of the responsibility we have to our clients to be as informed as possible, and to engage critically with any information we might receive and encourage them to do the same, *if and when* that comes into the room. That point was also repeated – we are not to drive any agenda, but rather assist the exploration and facilitate our young clients in safely forming their own opinions.

How reliable are our own sources? What biasses might we ourselves have? We were prompted by the use of images and photographs from Stella’s own collection to ponder these thoughts. We know that today’s teenagers more than any other generation are bombarded by imagery and memes. We did not have to contend with this. It is dizzying when you think about it – and I like that we are prompted to think about it.

Gender identity theory

Next we dug a little deeper into gender identity theory as a way of formulating thoughts on what leads to gender dysphoria. We took a brief look at the biological model for gender dysphoria – a developmental model that theorises gender dysphoria as a maladaptive life strategy that can develop during the process of identity formation. We also looked at the biopsychosocial model, which views gender dysphoria as a result of a combination of factors. Of note, everything was referenced and evidence-based. It was clear that Stella is not sharing her opinion with us – she is imparting information, illustrating some points with examples from her practice and inviting our own thoughts and questions throughout. One of the things I appreciated was that disagreeing or challenging comments was not merely invited, but encouraged. While there were none, there was a sense of permission, for me at least, to challenge or disagree on all points.

The practice part

Where this all brought us was our options in the therapy room. It was outlined that the person with gender dysphoria is left with three clear(ish) paths:

- The individual’s sense of gender can be altered to align with their biological body;
- The individual’s ability to cope with and manage their distress can be improved with a range of different psychological approaches; and
- The individual’s body can be altered to align with their sense of gender (Stella O’Malley, 2022).

Each of these paths brings with it its own challenges and the latter, of course, brings a

heavy medical burden that will inevitably be lifelong. The issue of informed consent arose at this point and Stella facilitated our thoughts around what that means. The professional onus on us to engage in informed consent was floated – the consequent implication being that we need to be informed ourselves. What are the consequences of social transition, the side effects of hormone treatments, of surgery? How does testosterone affect the biologically female body? I think I can safely assume that none of the attendees had covered modules about transition and medical and psychosocial effects of same.

Next it was time to engage in some self-directed learning, and the responsibility to do so weighed heavily during this workshop, but not in an overwhelming way. I wondered how this was settling on person-centred therapists and those among us who were unaccustomed to offering feedback; there simply wasn't time to look at that – one of my few disappointments.

Before proceeding to have a look at what each option involves, Stella took care to address the issue of conversion 'therapy' as it applied to homosexuality and as it might apply to transgender clients. As an audience, we were left in no doubt as to her thoughts and feelings about the cruel and outdated practice. She is of the opinion that conversion therapy is in itself an oxymoron, preferring instead, as many of us do, to use the phrase 'conversion practices'.

Stella referenced the results of the most recent report on conversion "therapy", Minister O'Gorman's 2021 *LGBTI+ Youth in Ireland Europe: A two-phased Landscape and Research Gap Analysis*. The research reviewed all relevant research on LGBT+

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youth defined as under the age of 26) in Ireland and Europe between 2000 and Sept 2019. Happily, the review found no examples of conversion therapies in sexual and gender minority (SGM) youth in the literature since 2000 in Ireland or in Europe.

Throughout, Stella took care to clarify that we are not in the business of pushing our agenda on our clients. It's therapy 101, really – for example, would we assume that an unhappy spouse should leave their relationship? Or might we be more inclined to explore our client's relationship, the historical context, the family of origin? We would surely think of words like systems, constellations, patterns, dynamics, habits, adaptive and maladaptive, meaning, metaphor, repression and emotion. Our job is not to have a private agenda and to push it onto our clients and then deem them 'cured' or doing 'the right thing'. That is unethical practice. In the same way, there are issues to consider when working with trans-identified clients.

Stella introduced us to and summarised the most recent research around the new cohort of gender dysphoric youths, in particular. There has been a 4,000% increase in presentations to the now defunct Tavistock Gender Identity Disorder (GIDs) Clinic in the UK, which worked with clients from both the UK and Ireland. In Ireland we have a 4,000% increase in Irish female under-18 presentations and 65% to 90% of these have an autism diagnosis. There followed a well-referenced section on the historic development of gender dysphoria as contrasted with what we are witnessing today. We were then introduced to a brief but lively discussion of peoples' experiences with their own clients with autism and gender dysphoria.

An example that came to my mind was an experience I had with a client who is on the autistic spectrum and who said to me that she had decided that she would go ahead with "top surgery" once she turned 18 and started identifying as a man. Top surgery is common Internet parlance for double mastectomy – it sounds far less scary doesn't it? "As you know, Sally" she said with confidence, "my boobs will grow back if I change my mind later". This might sound shocking to you – to think that an intelligent teenager might believe this, but there are two things to consider: she had watched hours of TikTok videos telling her that breasts grow back and/or are easy to replace; and she is a literal thinker – meaning, if she identifies as a woman later in life, her breasts will grow back *because she will be a woman again*.

Stella gave other examples of how the cohort of clients can think with her own experiences, which is always helpful during a workshop like this. I could see in the room that some were reeling, but appreciating that education is essential here. In other words, when it comes to informed consent, we *might* be among the few evidence-based informers in the child's life. We don't live and practise in the US where this is a far more urgent and contentious matter as minors in some states

can legally access medicalisation, including surgery. In Ireland, gender dysphoric minors do not receive surgical intervention. Again, I wondered how this sat with others in the room? I wondered what exactly is the nature of the differences between gender dysphoric children, adolescents and adults with regard to medical treatment and access to same? I was saddened that we simply did not have time to discuss these questions, however, the references provided did lead me to answers to these complex questions later.

Rapid Onset Gender Dysphoria (ROGD), a phrase coined by Lisa Littman, was described and contrasted to the historical presentation in a way that illustrated clearly and in an evidence-based manner that what we are dealing with today is a new phenomenon. Other presenting issues such as body dysmorphia, transgender obsessive-compulsive disorder (OCD) and distorted body image were outlined, as well as their similarities with previous surges in presentations of anorexia, bulimia, and self-harming. Quite a few of us were 'long in the tooth' and remembered these clusters of behaviours appearing. We were gently walked through an array of presenting 'co-morbidities' (please forgive the phrase co-morbidities; I'm aware of the label, however, much of the language does originate in the world of psychiatry and the much lauded *DSM*) – autism being the most salient within this current cohort.

In the third and final section of the workshop, Stella spoke about the options for working therapeutically with this client population. Again, taking care to reference and emphasise 'back to basics' therapy that she spoke about earlier that morning. The

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three basic options for therapists pared down are:

- Gender identity affirmation: Encouraging the child to live in the gender that feels most comfortable right now, with or without medical intervention;
- The psychotherapeutic approach: Exploring the child's understanding of gender roles and self-acceptance; and
- Watchful waiting: Allowing time to pass before medical intervention or therapy is used.

Core principles

The workshop was for psychotherapists and so the psychotherapeutic approach was looked at as an alternative to the affirmation model – remembering that alternative is not conversion. Stella reiterated that regardless of our core training, we can assume that the following are core principles that we hold dear and are essential to ethical practice. They are and must remain:

- Compassion;
- Patience;
- Respect of the adolescent's defences;
- Awareness of the propensity to 'relapse'; awareness of the adolescents' vulnerability to social contagion;
- Awareness of developmental stages; and
- Awareness of up-to-date research. On this point, true suicide risk was outlined and again heavily referenced. There is much of panic and understandable fear around inflated and or misinterpreted statistical analyses out there. Again, I am reminded of how much we can miss if we do not keep ourselves informed. And difficult it can be to keep ourselves informed. If it is hard for us to trust sources, how daunting must it feel for our young clients and their parents?

There was a strong sense throughout of 'you've got this'; that, as experienced practitioners who already work with adolescents, much of the work of therapy is what it always was. However, there *is* an onus to educate ourselves in the language of gender – not just to illustrate to our client that we know what they are talking about, but that *we know*, as best we can, what we are talking about. To help allay that sense of flounder that so many of us feel in this new landscape of gender dysphoria and the rather vicious and, for some, genuinely frightening social backdrop against which it stands.

The final section of the workshop looked at de-transitioning and working with de-transitioners. This is a term used to describe those who socially and or medically transition, but then decide to reverse that decision. This growing cohort requires the same level of support, of course – and we were alerted with some case studies – to the fact that often the social rejection these people experience

as a result of changing their identities back can be excruciating. It was a profoundly moving and sad section of the workshop.

As a supervisor I am aware that many therapists are quite anxious around, or avoid completely, taking referrals of gender dysphoric, transgender or de-transitioning clients. A lot of that is driven by the toxic online environment where it has become quite contentious to align oneself with anything other than the affirmative model. Our collective sense of competence has been eroded, but perhaps this is an opportunity to look at what therapy is, and what it is not.

Collective responsibility

The discussion really brought home to me our collective responsibility and was an opportunity to look at our work as therapists: how we do it, and why we do it. We need to safeguard our profession, for example, from cries of 'conversion therapy'. The wording of the proposed bill to ban conversion therapy is an example of how we need to be clear on what we do. You may not be aware that in its current form the bill could criminalise any therapy that is not affirmative. This is deeply concerning. As therapists it is not our role to affirm or whatever the opposite of affirm is. There were many concerned conversations during the break about this very matter. I could certainly feel a sense of release as people spoke about these concerns openly with colleagues and, possibly, for the first time.

It is vital that we are protected by law and are allowed to work ethically with and support this vulnerable cohort in their decision to *either* transition or desist. We are told desistence figures for childhood onset gender dysphoria are quite high, with estimates running from 70% to 94%, depending on the study and severity of dysphoria. So for many, it seems, it resolves naturally during puberty or early adulthood. Again this was referenced for us. Therapy is exploration, not conversion, not coercion of any kind. This was oft and reassuringly repeated.

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We were also reminded in this workshop – or for some of us it new information – of the power of social contagion for adults. There are various trainings and seminars where information is being shared that is unhelpful and inaccurate. We were frequently encouraged to research ourselves after the workshop, and to source reputable academic studies with peer-reviewed and up-to-date research. The landscape is fast changing and more research is coming out all the time. In some ways, these are exciting times. In other ways, quite unnerving.

Stella finished up the morning by speaking about some of the various organisations that have come into being recently, including Genspect, GETA, and PITTs. Stats for Gender.org was a site she recommended for accessing studies on the subject. I am sure that if we had more time it would have been used enthusiastically. I wondered if there were other organisations to mention that might also be helpful or interesting to explore? There is so much more to learn, more case studies to share, more research to dig into, more questions to ask and answer or simply explore. We were a room full of curious listeners and I for one could have done with more, but this is not a complaint. I found the workshop valuable and enjoyable. Stella's presentation was clear, well-paced, moving and sometimes even entertaining. If there is a repeat workshop, I am happy to recommend.

The bottom line – psychotherapy is not conversion therapy and we know how to 'do' psychotherapy. We simply need to do some homework. Maybe a lot.

If your interest is piqued and you would like a full list of the workshop references, I can be contacted via the details below.

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Sally O'Reilly is a counselling psychologist, psychotherapist and supervisor and holds a BA (Psych), a MA CounsPsych, and the European Certificate of Psychotherapy. She also holds a Diploma in Integrative Supervision, a Diploma in Cyber Therapy, as well as a Practitioner's Certificate in EMDR from MTU. Sally is an accredited IAHIP therapist and supervisor and is a member of the British Person-Centred Association. She lives in Cork and works full-time in private practice and has a special interest in adolescence.

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