

# Balancing in the margins of gender

How clinical psychologists relate to puberty suppression when  
working with gender variant youth

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*What an enormous number of swathings!  
Isn't the kernel soon coming to light?  
I'm blest if it is! To the innermost centre,  
It's nothing but swathings – each smaller and smaller. –*

From “Peer Gynt. A Dramatic Poem”, Henrik Ibsen, 1867

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# Abstract

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**Title:** Balancing in the margins of gender: How clinical psychologists relate to puberty suppression when working with gender variant youth

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The purpose of the present study is to explore how clinical psychologists work psychotherapeutically with gender variant youth. Gender variant refers to people who do not identify with the gender they were assigned at birth. Over the past 15 years, a prevailing management of gender variant youth has been to clinically suppress puberty, in order to gain time for determining if a full transition is necessary. Research within the gender binary tradition has demonstrated that a carefully selected group of gender variant youth benefit from physical treatment and a transition to the other gender, but little is known about the underlying processes behind the decisions regarding puberty suppression and the psychotherapeutic processes clinical psychologists aim for. Besides, there has not been much focus on the clients that seek treatment, but are not selected. The overarching research question guiding the present study is: *How do clinical psychologists relate to puberty suppression in their work with gender variant youth?* To explore the research question, five semi-structured interviews were conducted with clinical psychologists working at a European clinic. The data were analysed through thematic analysis. The results indicated that the participants deploy facilitative and explorative therapeutic strategies in their work, in order to enable clients to make informed decisions regarding puberty suppression. Participants explained that important outcomes for the clients included enhanced abilities to negotiate identity with cultural discourses and integration of thoughts and feelings within social contexts. The use of puberty suppression can be an advantage in order to create space for reflection. A potential pitfall can be that it provides the signal to clients that the management is going to be only medical, at the expense of exploration of gender identity and different ways of managing gender variance and distress related to it. The present study aims to contribute to the current research on clinical work with gender variant youth, because it encourages clinical psychologists to focus more on the processes behind decisions regarding puberty suppression, instead of predictors of future gender identity. In addition, it suggests that clinicians should be open for a variety of gender identities and expressions. Thus, it

challenges heteronormative assumptions within prevailing treatment and suggests more openness in terms of treatment outcome.



# Preface

It has been a privilege to be offered free education the last six years and time to delve into queer theory, psychotherapy, psychodynamic theories and other topics that have interested me throughout the years.

First and foremost, I want to thank the participants for sharing their clinical experiences with me. I am impressed by the work you are doing, and it is with the deepest respect that I have attempted to convey some of your psychotherapeutic strategies.

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Reidar Schei Jessen

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*Yes, of course it hurts when buds are breaking.  
Why else would the springtime falter?  
Why would all our ardent longing  
bind itself in frozen, bitter pallor?  
After all, the bud was covered all the winter.  
What new thing is it that bursts and wears?  
Yes, of course it hurts when buds are breaking,  
hurts for that which grows  
and that which bars.*

*Yes, it is hard when drops are falling.  
Trembling with fear, and heavy hanging,  
cleaving to the twig, and swelling, sliding –  
weight draws them down, though they go on clinging.  
Hard to be uncertain, afraid and divided,  
hard to feel the depths attract and call,  
yet sit fast and merely tremble –  
hard to want to stay  
and want to fall.*

*Then, when things are worst and nothing helps  
the three's buds break as in rejoicing,  
then, when no fear holds back any longer,  
down in glitter go the twig's drops plunging,  
forget that they were frightened by the new,  
forget their fear before the flight unfurled –  
feel for a second their greatest safety,  
rest in that trust  
that creates the world.*

“Yes, of Course It Hurts”, Karin Boye, 1935, translated by David McDuff.

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# 1 Introduction

Some youth present with a gender expression, or identify with a gender that is different from what they were ascribed at birth, hereby referred to as gender variant youth. Since the advent of sophisticated physical treatment like hormonal therapy and surgical techniques, capable of removing certain characteristics of the sexual body, an increasing number of clinics globally have started to offer puberty suppression, in order to allow more time before making decisions regarding gender identity. Many countries have established special clinics, which focus on development of treatment programs. This research has focused on the medical effects of puberty suppression, and how to predict a successful outcome in terms of mental health (Wren, 2000). The rationale for puberty suppression is that one can buy time for thinking, before making decisions regarding gender. However, there is a lack of knowledge about the developmental consequences of breaking gender norms, and the psychotherapeutic processes behind decisions regarding puberty suppression (Drescher & Byne, 2012).

In order to receive physical treatment, gender variant youth are required by mental health professionals to receive the diagnosis of Gender Identity Disorder (GID) F64.0 (DSM-IV, 1994). One is dependent on a medical professional assessment and judgement, but the hallmark has since the DSM-IV been whether one demands to be transformed into the other gender or not. Hence, it is a diagnosis with criteria that depend on how strongly convinced and persistent the client is when it comes to expressing the mismatch between the gender assigned at birth and how one identifies (Lev, 2006) Although the aetiological evidence when it comes to biological measures is limited, GID is a diagnosis that relies on early experiences of gender dysphoria and a wish for physical treatment. The idea of GID as a medical disorder and a biological condition appeals to many clinicians and clients. The prevailing management has therefore been to identify clients with a credible assurance of being the other gender, which should be offered physical treatment (Wren, 2000).

There has been raised critique from a poststructural and discursive perspective towards the prevailing clinical management of gender variant youth. The GID diagnosis and the use of physical treatment in order to transform clients to the other gender rely on cisnormative assumptions and a binary view of gender. Binary gender norms refer to the assumption that there exists only two genders, male and female. Cisnormative refers to the assumption that one should identify with the gender one was ascribed at birth, based on the

classification of genitals (Roen, 2011). According to a cisnormative perspective, those who identify with the opposite gender are disordered, and a physical intervention is then a sort of correction. Another consequence of cisnormative discourses is that clients should present as convinced and certain, in order to receive treatment. This does not leave much space for clients who identify as neither male nor female, or have a non-normative gender expression.

In addition to the poststructural and discursive critique, Drescher and Byne (2012) have addressed the need for more research on the psychosocial work that needs to be done in relation to treatment of gender variant youth. A majority of the research on clinical management has focused on the use of puberty suppression as a way of buying time for reflection and preparation for subsequent physical treatment. There is therefore a lack of knowledge about the processes behind decision making regarding puberty suppression, the effects of that treatment on the complex nature of gender identity development in relation to social discourses around gender and internal psychological processes. Hence, Drescher and Byne (2012) have called for research that can challenge and complement the existing research from a poststructural perspective, with a non-binary view on gender.

Because of the political nature of gender, clinicians like Ehrensaft (2012) and Menvielle (2012) have called for therapeutic approaches to gender variant youth that incorporate an understanding of how heteronormative values discriminate people who deviate from the gender they were assigned at birth, and the impact this could have on the youth. Queer theory provides a useful framework to analyse how society is permeated by heteronormative assumptions about gender as binary. According to this perspective, gender dysphoria arises from a world that treats gender as fixed by biology, and hence misgender young people who identify with a gender that is different from the one they were assigned at birth (Roen, 2011). Psychodynamic models of personality can offer a conceptualization of how gender is discursively produced and internalized on a psychological and relational level (Layton, 2004).

There is a lack of knowledge in the research literature on how clinical psychologists work psychotherapeutically with gender variant and relate to puberty suppression. Therefore, the present study aims to explore how clinical psychologists at a specialized gender identity clinic in Europe are working, and what therapeutic processes they are aiming for when relating to puberty suppression.

## **1.1 Thesis structure**

In the following chapter I will elaborate on how gender dysphoria is treated psychologically and medically, followed by an introduction to the theoretical framework of the present study, and end with the research questions. In chapter two, the methodological and epistemological approaches will be presented. The results are going to be presented and analysed in chapter three, followed by a theoretically informed discussion in chapter four and concluding remarks in chapter five.

## **1.2 Gender variant children and youth**

People with cross-gender identification have been met with various degrees of tolerance throughout history and across cultures (Wren, 2000). The prevalence of gender variant youth depends on how it is measured and what kind of behaviour is being classified as cross-gender. Studies have indicated that 3,8% of the boys between 4 to 11 years in a normative sample were rated as sometimes behaving like the opposite gender by their mothers, as compared with 8,3% of the girls. 1% of boys and 2,8% of girls wished to be of the opposite gender (Zucker, Bradley, & Sanikhani, 1997). These numbers vary across studies of normative sample, but there is more prevalent to find cross-gender behaviour among girls than among boys (Moller, Schreier, Li, & Romer, 2009). There is therefore interesting to note that between three to six times more boys than girls are referred to a mental health counsellor for gender identity concerns. Research has indicated that a majority of the children and youth with GID will not remain gender dysphoric after puberty. A majority of those who not remain gender dysphoric will become homosexual (Moller et al., 2009). However, one should be cautious to draw any linkage between these indications and the outcome of future generations. Besides, there are no ways of predicting which of the children with GID will go on to be transgendered adults (Moller et al., 2009).

There has not been done much research on the process of diagnosing GID (Paap et al., 2011). There are two main criteria in DSM4 and ICD-10. Criteria A is “strong and persistent cross-gender identification”, and criteria B is “persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex” (DSM-IV, 1994; ICD-10, 1993). However, as Paap et al. (2011, p. 181) states: “it is practically impossible to diagnose transsexualism on the basis of objective criteria (...) the criteria as stated in DSM4 and ICD-10 leave ample room for interpretation”. Hence, the diagnostic process of GID relies on how convinced the client is. This has been criticized, because it excludes clients that are uncertain and present as non-binary or not stereotypical in relation to gender. In DSM5, the name has

changed from GID to Gender Dysphoria (Lev, 2006). The diagnosis has kept many of the criteria from DSM4, but an important difference is that the gender identity is not per se a disorder, because the individual must also report distress in relation to it (DSM-V, 2014). For children, an important change in terminology is that they use the formulation “assigned gender at birth” instead of “sex”, which indicates that gender is something one is ascribed at birth and not innate. This is more in line with poststructural perspectives on gender as discursively produced rather than natural and self-evident. In addition to the subjective nature of the diagnosis, it has been described as a paradox that gender variant people are forced to receive a psychiatric diagnosis that states them as mentally ill, in order to get access to physical treatment. There is the consideration of gender variance as mentally ill that reinforces the stigma associated with it. According to Lev (2006, p. 57), “being labelled with GID can serve to ameliorate symptoms and suffering by getting access to physical treatment, and concurrently increase the same human suffering, by ensuring a definition and experience of one’s gender experience as pathological and mentally deranged”. Thus, there is important to be aware of the complex nature of GID, and that the diagnosis relies on gender binary norms and evaluations of the clients’ gender expression. In the present study I have included research that draws on different perspectives on gender. There has not been done much research with the new diagnostic criteria, because the DSM5 was published as late as 2013. Therefore, I have not distinguished between studies that use different criteria.

### **1.2.1 Clinical management of gender variant youth**

The treatment of gender variant youth has shifted over the years. Up to 20-30 years ago, cross-gender identification was understood as a response to psychological problems, and the clinical work focused on how to persuade the clients to identify with the gender they were assigned at birth, so-called reparative therapy. Today, GID is understood as a condition that can be solved with physical treatment that changes the body more in accordance with the experienced gender (Wren, 2000). According to the Endocrine Society’s guidelines, the first of the treatment steps is to put youth who fulfil criteria for gender reassignment on treatment to suppress puberty, in order to stop the development of secondary sex characteristics, and reduce the pressure the youth are experiencing when the body is developing in a way that creates a lot of distress. The next step is to put them on cross-sex hormones, and the final step is gender reassignment surgery (Hembree et al., 2009). Studies from specialized clinics have provided empirical evidence showing that carefully selected gender variant youth diagnosed with GID no longer suffered from gender dysphoria after receiving puberty-blocking

hormones, cross-sex hormones and gender reassignment surgery. One to five years after surgery, they were functioning psychosocially as well as their peers (Moller et al., 2009).

Due to the absence of randomized controlled treatment outcome studies (RCT) of gender dysphoric youth, the American Psychiatric Association's (APA) Task Force of Gender Identity concluded that the highest level of evidence available for treatment recommendations for these youth best could be characterized as expert opinions (Byne et al., 2012). A problem with this evaluation is that APA considers RCT as the gold standard for treatment research. Furthermore, an RCT study would be unethical, because it requires clinicians to withhold certain forms of treatment to clients in the control groups. In addition, there is a challenge that the expert clinicians within the field disagree on what constitutes the best treatment. According to Drescher and Pula (2014), there are two clinics who have done extensive and systematic research on management of youth with GID, and therefore can be regarded as expert opinions. These are the Canadian model from the Gender Identity Service in Toronto and the Dutch model from the VU University Medical Centre in Amsterdam.

Kenneth Zucker (2008) at the Gender Identity Service in Toronto suggests that GID can be the result if a combination of biological and psychosocial factors like trauma or parents reinforcing cross-gender behaviour, but emphasizes that the aetiology remains unknown. Despite being supportive of hormonal interventions for carefully selected gender variant youth, Zucker primarily recommends therapeutic strategies that help children with gender dysphoria to become more comfortable with the gender they were assigned at birth. This includes encouraging gender nonconforming children to play with peers who were assigned the same gender at birth, and discouraging behaviour associated with the opposite gender. An example of this practice is encouraging parents to remove toys associated with the other gender little by little. Since research has indicated that a majority of the children who are cross-dressing will desist and most probably become gay or lesbian, he does not support a transition, because the children will most probably transition back at a later stage. However, if the cross-gender behaviour persists until adolescence, the Canadian model opens up for puberty suppression and a transition to the other gender. However, the first choice is to await a transition, and encourage stereotypical behaviour (Zucker, 2008). The Canadian model is problematic and has been highly criticized by activists, researchers and clinicians, because the approach has elements that are associated with reparative therapy (Moller et al., 2009).

The Dutch Model has provided several studies on the benefit of puberty suppression at an early stage, in cases where the youth are without additional mental health problems, have presented with a consistent cross-gender identification for many years and have

supportive families (Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005). In the therapeutic work with gender variant children, they attempt to elucidate all possible factors that could play a role in gender dysphoria and advise clients not to transition their gender. However, if the gender dysphoria remains, they are more positive than the Canadian model to intervene physically with puberty suppression when the youth reach adolescence (de Vries & Cohen-Kettenis, 2012). The argument is that “despite the understandable concern about potential harm that could be done by early physical medical interventions, it seems currently that withholding intervention is even more harmful for the adolescents’ wellbeing during adolescence and in adulthood” (de Vries & Cohen-Kettenis, 2012, p. 315). Hence, according to the Dutch model, the potential negative consequences of not intervening makes initiating puberty suppression urgent for a selected group of clients. Similar to the Canadian model, they wait as long as possible before they encourage a gender transition. They encourage physical treatment to youth who they think are going to persist with GID until adulthood, but not those clients they believe are going to desist before they reach adulthood. Clients that are considered as candidates for puberty suppression should be supported throughout the treatment with psychological care (de Vries & Cohen-Kettenis, 2012). Clients who are not considered as candidates, either because they have too many additional problems or they do not present as persistent and convinced enough, are referred to other mental health workers.

An important research paradigm within the Dutch model is therefore to search for factors that can predict whether the gender dysphoria will persist into puberty and adulthood, or desist. Their studies indicate that if the gender dysphoria desists, the children most likely become homosexual or bisexual, and they will probably identify as the gender they were assigned at birth. If it persists, the young people will probably identify as the opposite gender (Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013). This is considered important knowledge, because it enables the clinicians to decide whether a child should receive puberty suppression in order to prepare for a gender reassignment procedure and early transition. Retrospective qualitative studies have indicated that those clients who persisted experienced a more severe dysphoria and a stronger notion of being the other gender when they were young (Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011). However, the quantitative follow-up studies have not been able to find predictors (Steensma et al., 2013). Thus, studies from the Dutch model have provided some evidence that hormonal and surgical interventions can be efficient in ameliorating gender dysphoria in carefully selected clients, who identify with the opposite gender (Smith et al., 2005). Despite some differences, both the Dutch and the Canadian models rely on binary norms. In addition,

both models understand gender as a feature that is waiting to be discovered. Therefore, they search for early predictors of persistence and desistance. They also share a preoccupation with early transitions, but the Canadian model is more eager to discourage behaviour associated with the opposite gender.

According to Möller et al. (2009), questions remain unresolved regarding the treatment of GID. The complex relation between additional mental health problems and the gender dysphoria should be investigated more. Furthermore, the societal and cultural assumptions about gender as binary and the consequences of breaking gender norms should be investigated in relation to treatment of GID (Drescher & Pula, 2014; Moller et al., 2009). The nature of gender identity development in childhood is complex and the subjective beliefs can be held with extreme conviction, compared with more fluidity in later stages of life (Wren, 2000). In contrast to the Dutch studies, that have proven evidence that carefully selected clients with GID benefit from hormonal and surgical interventions (Smith et al., 2005), follow-up-studies from Finland showed that the majority of the young clients with gender dysphoria did not benefit from physical interventions (Kaltiala-Heino, Sumia, Työläjäarvi, & Lindberg, 2015). The clients' psychosocial situation did not improve and the psychiatric symptoms did not ameliorate, especially for those with additional psychopathology. The researchers hypothesized that one reason for the Dutch success is the fact that they only accept a highly selected group of clients, in contrast to the their own study. The Finnish researchers concluded with the need for an open discussion about the variety of pathways when it comes to treatment for gender variant youth, in addition to the persistence-desistance paradigm. Others have called for more research and clinical attention towards clients that present as uncertain, regarding both physical treatment and how they want to express themselves in relation to gender (Moller et al., 2009; Roen, 2016). These researchers are concerned that a considerable amount of clients fall outside of the treatment programs, because the Dutch and Canadian clinicians require them to fulfil the criteria for GID. As a consequence, clients have to be certain and present with a binary and stereotypical gender expression. In addition, the GID criteria require that clients do not have additional psychiatric problems. In this way, the criteria for GID excludes many clients who could benefit from treatment programs more adjusted to their needs, and not perceiving uncertainty and non-binary identification as pathological.

Recently, clinicians have challenged the Dutch and Canadian approaches to treatment of youth, calling for a therapy that consider gender nonconforming and non-binary youth as healthy (Menvielle, 2012). According to this perspective, there is the negative judgement and

marginalization of gender variant youth that produces the psychiatric symptoms. Building on theories from the psychoanalyst Donald Winnicott, Ehrensaft (2012) has developed what she refers to as “true gender self therapy”, which is an approach that aims to help gender variant youth to be able to express themselves in the way they prefer, regardless of what gender they were assigned at birth. Hill et al. (2010) focus on the importance of working with parents and families, in order to foster understanding for the gender nonconforming children. Studies have demonstrated that psychosocial symptoms ameliorate when the family and school become less judgmental (Hill et al., 2010). This indicates that nonconforming and non-binary gender expressions are not unhealthy per se, but breaking gender norms provoke negative reactions that make them vulnerable for secondary mental health problems. The therapeutic strategies, according to both Ehrensaft (2009) and Hill et al. (2010), are therefore to foster non-judgmental recognition and acceptance, to encourage early gender transition and to prescribe puberty suppression when clients reach adolescence.

Di Ceglie (2009b) calls for a clinical practice that focuses more on a non-judgemental exploration of gender variant clients’ identification and motives, and an open attitude towards a variety of outcomes in terms of gender identity and expression. He supports puberty suppression, and emphasizes the importance of exploration of psychological problems that could have contributed to the development of atypical gender identity. In his developmental model, Di Ceglie distinguishes between desistance and persistence, similar to the Dutch and Canadian models. But he does not attempt to predict the development. His aim is rather to formulate some processes that can guide the therapeutic work, in order to foster exploration. He uses the psychodynamic concepts of symbol formation and symbolic thinking, meaning the ability to verbalize and represent psychological needs and motivations, as a framework of understanding of the young clients’ unique atypical gender identity development. The goal is to continually evaluate how gender identity is organized on an individual psychic level, and how it develops in relation to social discourses. Di Ceglie emphasizes the importance of not aiming to change gender identities, but rather to focus on the developmental processes and getting in touch with unconscious thoughts, feelings and identifications that are not symbolized. In line with this, Lemma (2012) proposes that many gender variant clients have been victims of stereotypical gender expectations, at the expense of mirroring and acceptance of their unique personal characteristic. Her therapeutic focus is therefore initially aimed to mirror the clients’ experienced gender identity. According to Saketopoulou (2014), many gender variant youth have internalized gender norms that cause distress, in addition to the traumatic experience of being misgendered. Hence, clinicians should be non-judgemental and

open for physical treatment. However, in Saketopoulou's view, mirroring of experienced gender identity is not enough, because the clients may have developed negative feelings towards themselves. They should therefore explore the clients' thoughts and feelings in relation to their bodies. These therapeutic strategies are aimed to help clients symbolize their hatred towards the body, combined with exploring new ways of doing gender, in order to foster embodiment and an increased ability to live with the body as it is.

### **1.2.2 Gender identity development**

Identity is defined as the link between self and society, and points to the individual engagement with ideologies and discourses, made manifest in personal narratives that are reorganized throughout life (Hammack, 2008). A central concern is how people on the one hand engage with master narratives that structure social discourses, and on the other hand deviate from them and therefore have to construct their personal narrative. Social discourses are systems of meaning which structure how people construct reality and experience the world. Individuals are depending on these discourses in order to make sense of themselves, in relation to themselves and others. Social structures are reproduced, and dominant discourses are manifested in individual subjectivity through the relationship between the master narrative and the personal narrative (Hammack, 2008). In Egan and Perry's view (2001), gender identity is a core element of human identity, and a multidimensional construct, consisting of (a) knowledge of membership in a gender category, (b) feelings of contentment with one's gender, (c) felt pressure for gender conformity, and (d) attitudes towards gender groups. Egan and Perry examined the relationship between the components of gender identity and psychosocial adjustment. They found that low contentment with one's gender was predictive of psychosocial problems when children felt strong pressure for gender conformity, and concluded that "children who wish they were the other sex or who desire to engage in cross-sex activities, then, are at risk for problematic development mainly when they perceive their social environment to be telling them that they cannot" (Egan & Perry, 2001, p. 460). Hence, it appears to be the felt pressure to be gender conforming, and not low gender contentedness per se, that predicts psychosocial problems.

In her research on gender identity development, Fausto-Sterling (2012) draws on modern infant research on how representations of the self and the world develop. Gender identity is not static, but a continuous development of representations of oneself in relation to the world. According to Fausto-Sterling (2012), the sense of oneself and other people as male or female, and the development of representations of femininity and masculinity, result from

the moment-to-moment interplay between infant and caregiver. Representations are the result of embodied thoughts and emotions, and social discourses around gender permeate all these processes. Fausto-Sterling suggests that the transition from presymbolic representations of gender, that are physiologically embodied memories, to symbolic and verbalized representations, are central to the internalization of a sense of gender. Each individual's gender identity is the result of an ongoing interaction between presymbolic and symbolic representations of gender. Even the apparently most spontaneous features of gender identity, like for example which colours a child prefers, are the result of the continuous interaction between presymbolic representations and more deliberate negotiation with gender stereotypes and social discourses. Fausto-Sterling (2012) criticizes the Dutch and Canadian models for treating gender identity as an innate feature that can be predicted. In her view, gender identity is rather continually developing in relation to social discourses.

### **1.3 Queer critique**

Judith Butler is critical towards the notion that there exists a subjectivity prior to social discourses (1990). She argues that human subjectivity is constituted by the available discourses. The discourses function as a framework of understanding, in order to communicate with others and make sense of oneself. According to Butler, gender is constituted by repeated performative acts, as a way of expressing oneself within heteronormative discourses. The idea of heteronormativity consists of two main notions. Firstly, that there are only two sexes, male and female, and that the two gender identities, man and woman, align innately and unwaveringly with their physical counterparts. Secondly, that one is supposed to fall in love and have sex with someone of the other gender. Heteronormative values function as laws that structure how people develop a sense of themselves in relation to gender and how they behave. One consequence of the understanding of gender as prediscursive is the common notion that behaviour and expression mirror a gender identity that is innate. However, according to Butler, it should be understood the other way around. The gender identity that is expressed at the outside does not mirror an inner feature, but is rather the result of gender norms and expectations. People have to rely on social discourses, in order to make sense of themselves and become subjects. There is no doer behind the deed, Butler states, because the doer is constructed in and through the deed. There is difficult to express oneself outside of heteronormative discourses without being sanctioned and lose privileges (Butler, 1990).

A widespread interpretation of Butler's theory of gender as performative and discursively produced, is that subjects can just choose their gender identity and decide on a daily basis what kind of expression they prefer. Others interpret the subject as fully determined by the discourse. Subjects have no predetermined gender, because they are constituted solely by heteronormative discourses (Käll, 2015). Käll argues that there is a possible middle way between these two interpretations. Performative acts that people do all the time, rest on already established forms of doing gender. Individuals are prone to repeat their actions, but at the same time, every act also opens up for new ways of doing gender. The act of breaking with the expected gender norms is not just a matter of will or choice. On the contrary, it can be really difficult. The point is that the individual's subjectivity and the outer social discourses do not exist separate, but are mutually dependent and impossible to separate. Butler's main contribution is to demonstrate that people depend on discourses in order to make sense of themselves. According to Butler (1990), the belief in a subject that exists prior to discourses legitimizes an essentialist view on gender. Gender is not determined by sexual characteristics, but by heteronormative discourses that force people to internalize binary gender identities and stereotypical ways of doing gender (Butler, 1990). Butler has contributed heavily to the development of queer theory, a poststructural and discursive tradition that challenges binary and stereotypical norms regarding gender and sexuality. These norms marginalize people that do not conform to them. From a queer perspective, the focus is on how identities are constructed discursively, and the subversive potential of deconstructing gender, in order to discover new ways of doing gender.

There is a potential conflict between poststructural perspectives on gender identities as fluid and discursively produced on the one hand, and gender variant clients on the other hand. Clinicians have reported that many gender variant clients present with a need for a coherent self that is not in flux, and an appreciation of their gender identity as innate and unchangeable (Wren, 2014). This is relevant in relation to the opportunities for physical treatment. According to clinicians working with gender variant youth, physical treatment can be interpreted by clients as a confirmation of their experience of gender identity as innate and unchangeable, and not the subject of deconstruction. At the same time, clinicians attempt to highlight the continuous development and negotiation of gender identity. The clinical work with gender variant youth confronts clinicians with an epistemological challenge. The clinicians want to open for new and more flexible ways of performing gender, for example non-binary identities. Many clients, on the other hand, only want physical treatment that can confirm their experience of being born in the wrong body, and their experience of gender as

unchangeable and innate. Roen (2016) is concerned that the GID diagnosis legitimizes an exclusive focus on puberty suppression as the dominant approach within clinical practice, because the diagnosis pathologizes gender variant youth that present as uncertain and non-binary. In Roen's view, physical treatment is in risk of reproducing heteronorms, by "fixing" gender variant youth into binary identities, instead of opening up for uncertainty and gender nonconformity. Roen (2016) calls for a queer bioethics that questions heteronormative assumptions that underlie much of the prevailing treatment of gender variance. She focuses on a queer concept of embodiment, that defines the body as an integrated part of the individual's process of becoming a person, and not as an object independent of the self, that can be fixed separately.

## **1.4 Psychodynamic models of personality**

Several clinicians working with gender variant clients draw on psychodynamic models of personality, for example Di Ceglie (2009b), Lemma (2012) and Saketopoulou (2014). Psychoanalysis is a broad theoretical tradition with a wide spectrum of perspectives. A central notion is that human psyche is constituted by more or less unconscious processes. Layton (2004) attempts to combine poststructural and psychodynamic perspectives in her clinical work. She focuses on how the psychodynamic conceptualization of unconscious processes can shed light on the internalization of oppressive gender norms, and elaborates on ideas developed by Jessica Benjamin (1988) Nancy Chodorow (1978). An example is how men's needs for dependency and connectedness with other people are not mirrored or accepted as tolerable, and therefore split off from the conscious psychic structure.

In addition, Layton draws on Kohut's concept of pathological narcissism, which means the incapacity to experience self and other as separate centers of awareness. This is the result of developmental traumas in the family. Layton expands this idea of developmental trauma, and includes societal factors like homophobia, racism and strict gender norms as origins. The pathological-narcissistic incapacity to perceive the ambiguity and fluidity is not constant, but restricted to certain areas, for example when it comes to gender or race. Layton refers to this as gender trauma. Such traumas are caused when cultural and familial gender expectations constrain the many ways one can be in either normative femininity or normative masculinity. In Layton's view, oppressive gender norms are internalized and experienced on a psychic level, and create experiences of being coherent selves. But the experience of being coherent can be at the expense of more flexible ways of performing gender, and thus create

psychological problems. On the one hand, there is insufficient to have a poststructural perspective on mental illness, because oppressive discourses and norms do always operate through psychological mechanisms. On the other hand, there is insufficient to have a psychodynamic and psychological perspective on gender problems, because one have to look at how heteronormative discourses marginalize clients that are breaking gender. (Layton, 2004). Layton proposes that poststructural theories can be relevant in relation to psychodynamic concepts. The psychodynamic conceptualization of psychological processes as unconscious can shed light on the internalization of gender norms. Psychodynamic models of personality can also conceptualize the relationship between cultural levels of meaning, and how these are related to the relational history and structured on a psychological level of meaning. Gullestad and Killingmo (2013) conceptualizes psychodynamic therapy as a way of improving the clients' insight into unconscious processes, in order to explore new ways of relating to oneself and foster autonomy. This can be seen as lying parallel with Di Ceglie (2009b), and his focus on symbolic thinking as a therapeutic strategy to explore how unconscious processes and identification structure gender identity.

## 1.5 Research questions

The overarching research question guiding this study is: How do clinical psychologists relate to puberty suppression in their psychotherapeutic work with gender variant youth? The research question is approached through semi-structured interviewing of clinical psychologists working at a special clinic for gender variant youth in a city in Europe. The method of analysis is thematic, followed by a theoretical analysis informed by queer theory and relational psychoanalysis. Based on the thematic analysis of the semi-structured interviewing, three more specific research questions are addressed:

- What psychotherapeutic processes do the clinicians aim for, when they relate to puberty suppression?
- How do they articulate their approach in relation to the more binary approaches that dominate the research field, represented most prominently by the Dutch and the Canadian models?
- Based on the exploration of how the clinicians' work, is it possible to formulate some therapeutic principles regarding how clinicians should meet gender variant youth, in order to counteract heteronormativity in clinical practice?

## 2 Methodology

In this chapter I will describe how and argue why the semi-structured interview design was used to explore how clinical psychologists work with gender variant youth.

### 2.1 Qualitative method

Most of the research that has been done on the treatment of gender variant youth is quantitative (Drescher & Byne, 2012). It has consisted of self-report questionnaires from the clients and information from parents and teachers, investigating symptoms and psychosocial functioning. The research has shown that carefully selected clients benefit from physical treatment and experience a significant improvement of general mental health (Drescher & Byne, 2012). Hence, the research on treatment has focused mostly on predictors of good outcome, and not much on the processes behind and how clients and clinicians have made decisions. This is consistent with McLeod (2013), when he summarizes different research traditions in clinical psychology. Quantitative methodologies are preferred when the aim is to produce general knowledge of client characteristics and treatment outcome, and knowledge that seeks to explain events in terms of abstract laws. He refers to quantitative methodologies as paradigmatic ways of knowing. Qualitative methodologies are on the other hand preferred when the aim is to give voice to therapists and clients, and to explore the processes behind the treatment outcome and give a more nuanced picture. He refers to qualitative methodologies as narrative ways of knowing. The present study aims to complement the paradigmatic ways of knowing of treatment of gender variant youth with narrative ways of knowing, in line with the importance of methodological pluralism within psychological treatment research (McLeod, 2013).

Central to qualitative research is the emphasis on process over outcome, and the interest in meaning making and peoples' experiences (Willig, 2008). For the purpose of studying how therapists are working psychotherapeutically with gender variant youth and the processes that are behind the outcome, a qualitative approach is to prefer. A qualitative approach is also required in order to complement quantitative research, especially when there has been done much research on the outcome of treatment of gender variant youth, but less on the processes behind. According to McLeod (2013), quantitative outcome studies should be complemented with qualitative approaches that are closer to the lived experience, and vice versa. This is especially important when the client population is diverse in terms of age,

psychiatric symptoms and psychosocial factors, as is the case with the group of gender variant youth seeking help.

An other advantage of qualitative research is the possibility to evaluate how values and different ideological perspectives and power affects the treatment (McLeod, 2013). This is relevant when doing research on the clinical work with gender variant youth, because gender binary assumptions are often marginalizing the clients' life in general. Therapists that are not aware of this could influence the therapeutic process and use their own gender norms as a framework. Thus, a qualitative approach is chosen in order to complement the quantitative research on treatment of gender variant. In the present study I am using semi-structured interviewing in order to explore how therapists work psychotherapeutically with gender variant youth and how they relate to puberty suppression.

## **2.2 Semi-structured interviewing**

According to Willig (2008, p. 24) , the semi-structured interview “provides an opportunity for the researcher to hear the participant talk about a particular aspect of their life or experience”. An advantage of semi-structured interviewing is the compatibility with several methods of analysis. The interviewer must maintain the balance between control and openness, which means that one should allow the interviewee the space to redefine the themes under investigations, on order to produce new knowledge. At the same time, the interviewer must ensure that they focus on the overarching research questions. In addition, there is recommended that the interviewer has a naïve approach, which means to express ignorance and encourage the interviewee to state the obvious. This does also include incorporating the interviewee's own terminology (Kvale & Brinkmann, 2009). During the interview, there is recommended to check whether the interviewer has empathized with the interviewee and understood correctly. Good research and knowledge about the interviewee's milieu is also a prerequisite to semi-structured interviewing of good quality (Willig, 2008).

### **2.2.1 Choice of method**

McLeod (2013) distinguishes between three levels of qualitative research within clinical psychology: macro, mid-range- and micro level. The macro level focuses on the context of the therapy and how cultural and societal factors influence on the therapeutic processes. The mid-range level focuses on the experiences of therapy, while micro level research investigates moment-to-moment-processes. Observational methods are suited to produce knowledge on the moment-to-moment-processes. Knowledge on how clinical psychologists work psychotherapeutically with gender variant youth could be produced

through observation of therapy sessions, but this method is not necessarily good at exploring the experiences of therapy. The present study is mostly focusing on the mid-range level, and for this purpose semi-structured interviewing is considered suitable to encourage participants to talk about their own experiences as therapists (Kvale & Brinkmann, 2009).

Kvale and Brinkmann (2009) categorize interviewing based on how directive they are. Open-ended interviewing is non-directive, while structured interviewing follows an interview guide strictly. An advantage of open-ended interviewing is that it follows the participants' perspectives closely and opens up for a range of topics to be addressed. The main disadvantage is that if the topic under investigation is too open, the data can be very diverse. An advantage of structured interviewing is that it ensures that the participants talk about the topics under investigation, but a disadvantage can be that the questions are not very close to the participants' lived experiences. Semi-structured interviewing is between open-ended and structured, because it includes some important themes that make it easier for the interviewer to focus on some of the topics. At the same time, a semi-structured design allows the interviewer to be flexible and let the participants talk about topics that they consider as relevant (Kvale & Brinkmann, 2009). This is an advantage for the topic of the present study, because the aim to explore therapists' experiences. The interview guide should therefore be flexible enough to encourage the participants to talk about topics they themselves consider as important. Focus group method could also be suitable in order to explore how clinicians work psychotherapeutically with gender variant youth, because it resembles closely to everyday discussions about experiences (Willig, 2008). However, a requirement is that the participants should not know each other well or be in a position where they could meet each other in other settings. There is therefore reason to believe that a focus group setting in the present study had not offered a secure space for reflection, and that the participants had not been very open about their own experiences, because they are colleagues.

## **2.3 Procedure**

### **2.3.1 Recruitment**

The main criterion for participation was that the participants work on daily basis with gender variant youth. My supervisor, Katrina Roen, helped recruit the participants through a network of clinicians that share ideas. The participants did not receive any compensation.

### **2.3.2 Participants**

I interviewed five clinical psychologists separately. Two of them had worked with gender variant youth for more than five years, while three of them had between two to three

years of experience with this work. They worked at the same gender identity clinic in Europe and were colleagues. The shortest interview lasted 50 minutes, while the longest interview lasted 1 hour and 35 minutes. The total amount of recorded data was 6 hours and 35 minutes.

### **2.3.3 Semi-structured interviewing**

I developed the semi-structured interview guide with assistance from Roen, and I alone accomplished the interviews (see appendix 3). Initially, I did a literature research. Based on this work, I developed a project description together with Roen, where we teased out possible topics for the interview guide. I started every interview with information about the project and the purpose of the study. In line with advices for the development of semi-structured interview (Kvale & Brinkmann, 2009), I ended up with four topics to be addressed. However, in the introduction I made it clear for the participants that I was interested in topics that they found important when working with gender variant youth, in order to make the interview closer to their lived experiences and open up for a flexible approach. I did also give the participants information about anonymity and storing of the data in the introduction. The ethical approval by the Norwegian Social Science Data Services (NSD) was received the 23th of June 2015 (see appendix 1). In addition, I gave an impression of the theoretical approach of the project. I explained that my goal was to produce knowledge that differs from the quantitative and gender binary approach that dominates the research. Thus, I encouraged them to focus on the complexity of the work with gender variant youth. This was not done to set limits for what the participants could talk about, but rather to focus the interviews and explore processes behind the treatment outcome, in line with the research question.

The interviews were done during two days. After each interview I evaluated the process and I asked for feedback from the participants. The feedback was used to improve the interview guide for the following interviews, and as an attempt to keep the questions open. I tried to maintain an informal environment, that was as close as possible to a normal professional conversation between colleagues. Initially I noted down some topics that the participants said they wanted to discuss at a later stage. This can be seen as lying parallel with the role of the interviewer that Kvale and Brinkmann (2009) describes, in order to accomplish a dynamic and flexible semi-structured interview that opens up for new knowledge to be produced. Kvale and Brinkmann (2009) emphasize the importance of considering one's own role as a researcher in relation to the participants. This resembles Willig (2008) and her focus on reflexivity and how the interviewers social and cultural identity and values can influence on the participants. In the beginning of the interview I

emphasized that my role was not to be a clinical psychology student and a future colleague evaluating the participants' work, but rather a curious researcher aiming to explore therapeutic processes. This was a message I tried to repeat during the interview. The awareness of the power relations that Kvale and Brinkmann (2009) emphasize has been especially important in the present study, because I possess the role of the researcher, but I am also a clinician and a colleague of the participants.

### **2.3.4 Transcription**

I transcribed all the interviews myself. I first transcribed the entire material. Then I listened through the data again, in order to ensure that I had not forgotten any sentences. This was also an opportunity to get familiar with the material. I noted down thoughts and reflections as analytic memos while transcribing, and these were used in the beginning of the analytic process. Before ending the process, I read through the transcribed material to correct for type errors and other orthographic errors. Thematic analysis does not require the same level of detail in the transcript as conversation or discourse analysis (Braun & Clarke, 2006), but I included pauses, hesitations and stuttering. My comments were written in parenthesis.

## **2.4 Analysis**

Several methods for analysing the qualitative data could be used, but I have chosen thematic analysis as the fundament of analysis, because it is both a suitable method for identifying patterns within data and a convenient tool to get an overview of the data corpus. It is an analysis that is applicable across a range of different methods, theoretical frameworks and epistemological stances (Braun & Clarke, 2006). This is in line with Kvale and Brinkmann (2008), who recommend that interviews should be theoretically analysed after a meaning condensation. Meaning condensation is an analytic tool that resembles thematic analysis, because the aim is to organize the material on a content level. Another advantage of thematic analysis is that it is suitable to look for patterns across the participants. This is important for the present study, because the focus is more on themes across the participants. Thematic analysis enables a focus on how the participants are impinged by the broader cultural and social context, while maintaining a focus on the processes and experiences that are described (Braun & Clarke, 2006). I followed Watts' (2014) recommendations for skilful use of qualitative methods, distinguishing between first-person and third-person perspective during the analytic process, in order to obtain as much closeness to the participants' experiences as possible. First-person perspective implies an attempt to discuss the results without bringing external knowledge, while third-person allows theoretical analysis of the data. The results

will therefore be discussed in first-person perspective in chapter three, followed by a more theoretically informed third-person perspective in the discussion in chapter four.

Braun and Clarke (2006) divide the analytic process into six phases, but emphasize that the analysis goes back and forward until the final report is written. The first phase is familiarization with the data. This starts already during the interviewing and the transcribing, and includes reading and re-reading of the data. The second phase is about generating codes. The third phase is searching for themes and the fourth phase is reviewing the themes. The reviewing involves two steps. The first step is to check if the coded extracts seem to be integrated by the theme. The second step is to consider how the themes are related to each other and whether they overlap or not. The fifth phase includes naming the themes and writing short summaries of each theme. The sixth phase is to produce the report, which involves relating the finding to relevant literature and argue why certain conclusions have been drawn. These steps are not a fixed recipe to a thematic analysis, but rather an attempt to conceptualize the analytic process. I have used the phases as guidelines during the analytic process and the entire project, in addition to relevant method literature when necessary. The first analytic step was done during the interviewing, when I made notes in order to evaluate the interviews and refine the semi-structured interview manual. During this process, I got the impression that important topics would be potential mismatch between clients' and clinicians' expectations toward treatment and the diversity among gender variant youth. I continued this process when I transcribed, and wrote notes in a separate notebook. But I started to get an impression of the data as a whole when I listened through the entire data corpus, in order to make sure that I had transcribed everything correct. I read the transcribed interviews several times, and wrote notes in the margin. I suggested 25 codes, based on the notes I had written in the margins and the separate notebook, and the literature research. Before I coded the data more systematically, I reduced the codes from a number of 25 to 21.

After refining the list of codes, I coded the entire dataset twice, by highlighting extracts in the transcribed material. During this process I continued to make notes in the separate codebook, in line with Bazeley's recommendations (2013). I refined the definition of each code and the distinctions between them throughout the coding process. I soon realized that many of the codes applied to the same or overlapping passages of text. However, the same extracts could be understood differently, depending on the perspective each code offered. I followed the advices from Bazeley (2013) and coded inclusively, in order to look for associations between codes. The second time I coded the entire material, I tried to be aware of my own biases and test the coding I had done during the first round. Furthermore, I

read the initial memos that I had written down in the codebook to maintain an open attitude towards the coding throughout the process. After having coded the entire dataset twice, I created separate word files for each code with the extracts from the transcribed interviews, and read them. Based on the reading I wrote a summary for each code. According to Braune and Clarke (2006), one of the hallmarks that can indicate good validity of the code is that the researcher is able to explain the main points using only some few sentences. First, I reduced the 21 codes to seven, based on the summaries. Then I tested the seven codes with the transcripts to ensure they were representative of the data. Based on the seven themes, I developed three themes that form the basis for the result chapter. This was again tested with the transcripts and the summaries of each code. I ended up with three themes.

I have left out some data, in order to anonymize. Furthermore, the interviews focused on clients with additional problems, that make participants concerned that physical treatment and a transition to an other gender will not be sufficient. According to the participants, there exists a group of gender variant clients that present as more straight forward. The purpose was not initially to focus the interviews this way. Perhaps it reflects my emphasis initially on the complexity. However, this has implications on the generalization of the results.

## **2.5 Epistemological and hermeneutical considerations**

Epistemology concerns the nature of knowledge (Kvale & Brinkmann, 2009). The current study is based on a poststructural stance, rejecting the data material understood as natural, but focusing on how it is discursively produced, and made understandable through language (Youdell, 2006). The empirical material of the present study is the experiences of clinical psychologists working with gender variant youth. A challenge during the analysis and the interpretation of the data has been that the participants in many ways present experiences that have already been interpreted by them. Anthony Giddens (1996) developed the concept of “double hermeneutic” to describe that social scientists are interpreting experiences that have already been interpreted by the participants themselves. This concept is relevant for the present study, because the analysis should take into consideration that the experiences from the participants’ work are not necessarily reflecting what actually happens, but how they understand it. However, many of the experiences that the participants shared have already been analysed by themselves through their professional approach to therapy. It has therefore been a challenge to interpret the data they are experiences without relying too much on their own theoretical analysis. One way to overcome this challenge has been to focus more on the lived experiences they have presented, and less on their theoretical analysis.

## **3 Results and analysis**

In this chapter I will present the results from the thematic analysis, based on the themes that emerged. The first theme deals with the initial assessment process, and the professional and ideological starting point for the participants. The second theme explores how the participants intervene therapeutically. The third theme is about what participants consider as desired outcomes of the psychotherapeutic work.

Before presenting the analysis of the results, there is important to understand what kind of data the participants offered. When I started coding the data, it soon became clear to me that many of the topics that emerged where themes that involve reflections on the clients, for example identity development and expectations they have. This was in line with the aim of the study, namely to understand how clinical psychologists work psychotherapeutically with gender variant youth and relate to puberty suppression. There is therefore important to bear in mind that the data reflect the participants' construction of what is happening, and not the clients' experiences. Having said that, I believe that the interviews and the results can shed light on some of the processes that the clients are experiencing.

The division of the data into three themes emerged as a convenient way of presenting the data, and is not a reflection on how the work progress in real life. Although every therapeutic course starts with a broad assessment of what clients bring to therapy, the participants' perception of the clients and their main problems are changing as the psychotherapeutic work progress. There is often said that the relationship between theory and data is cyclical in qualitative research, and that the analytic process moves backwards and forwards. The same metaphor can be used to describe the relationship between how the participants understand what the clients bring, the therapeutic strategies they use and the outcome they aim for.

### **3.1 The therapists' construction of the clients**

Clients bring a wide range of challenges to the first consultation. According to the participants, one common factor is that either the clients or someone in their surroundings experience trouble related to gender. These challenges can be of internal or external character. Examples of internal challenges are hatreds towards ones own body, self-harming, anxiety or depression. Examples of external challenges are problems with peer relations or

lack of social acceptance. The structure of this section will be the following: First, I describe the framework of understanding that the participants have. Second, I give a short summary of what symptoms and challenges that clients are struggling with. Third, I give an account of which expectations the clients and their families have and the discourses they draw on and implications these aspects have for the therapeutic work, according to the participants.

### **3.1.1 Framework of understanding**

According to the participants, one important goal of the clinical work is to know more about how to intervene in the best possible way. The work starts with a broad assessment, that aims to survey the clients' life situation and psychological symptoms, with a special emphasis on gender.

#### **Participant A**

One aim is to develop an understanding of how they came to make sense of their gender identity. Was it in relation, you know, I suppose, what other things that made them think about gender. And how did that happen. How did they develop a sense of self that is kind of more male or more female or more, you know, someone else. What has that process been like.

As will be elaborated more in the section on therapeutic strategies, the participants encourage reflection. Initially, the participants attempt to get an impression of how clients and their families understand their gender dysphoria and gender identity.

#### **Participant C**

I would try not to put words into their, into their mouth, in terms about how they speak about their gender, so I would be listening very careful how they are speaking about gender and what kind of discourse is they draw on (mhm). And sometimes it's like born in the wrong body or sometimes they speak about "it" (mhm), and its almost they can't quit name it, "it" referring to transgenderism.

C explains how they try to get along as therapists and build a working alliance. C tries to locate the clients in their social contexts, and understand them in relation to their family and local community. This work can be directed towards the clients' understanding of gender, as C explains, but also look at more practical aspects that can impede their development and prevent them from grappling with challenges that peers at their same age usually meet.

The participants shared a poststructural understanding of gender and psychotherapy. This is manifested in their focus on language and discourse and a general scepticism towards essentialist beliefs. They focus on how clients give meaning to different phenomena.

#### **Participant A**

It is just worth randomly noting that, over... although I see positive things thinking theoretically in a positivist framework and ehm (...) and theoretical ehm models that developed as useful and I draw on them I don't believe in truths and ehm (...) and things as fixed yeah so that's bit of the context how I think of things and if I use ideas from psychoanalytic ideas from or whatever it is I don't believe it's a truth, it's a helpful way of thinking.

Here, A expresses view that is in line with a poststructural approach that focuses on identities and categories as discursively produced and always in change. I will in the following highlight some aspects of the participants' framework. I will focus on the critical attitude they expressed towards the existing research on treatment of gender variant youth, the relational aspects of gender they emphasized, and their developmental approach to treatment therapy.

The mismatch between the Canadian and Dutch research on treatment of gender variant youth and the clinical reality the participants experience emerged as a central topic.

**Participant B**

No, yes, I think, I think that's I think that's a difficult, I mean if you look at the look at the research literature I mean it is often very ehm (...) it's it feels it feels so ehm tidy, when you read the research papers. You get the ehm this group, who's ehm ehm who desist. And you get this group who persist.

According to B, the literature is often not helpful in the clinical work, because the existing research gives an impression of the stereotypical client as less complex than what the participants experience. The participants emphasized that the clinician's underlying assumption regarding gender will influence on how they meet clients and understand the clinical picture. For example, clinicians with a stereotypical and binary view on gender will favour clear interventions that can discover the clients' "true" gender identity, and these clinicians can therefore be seen as more in line with the literature that attempt to discover whether the clients are going to be desisters or persisters. According to the participants, the Canadian and Dutch research literature can be pathologizing of gender variant youth with a non-binary expression, because they frame certainty as a sign of maturity and uncertainty as unhealthy. This clinical framework is in line with the participants' poststructural approach.

In contrast to the research on predictors of good outcome and a focus on whether gender variant clients are going to persist or desist, the participants emphasized the diversity among the young people they meet in the clinic.

**Participant A**

We are in a particular ehm context at a particular moment in time (okay) and it gets so easy for things to become simplified and the complexity to be lost. (...) I guess it is it's really ehm it's really complicated and I just think about the people that I am working with, and they are all so unique and different.

A emphasizes the importance of giving priority to the specificity of each person, at the expense of the general knowledge that the research literature has generated. The client population at the clinic ranges from young people with a nonconforming gender expression to those who have experienced an intense hatred towards own body since childhood and the way other people misgender them. Some of the clients have expressed explicitly that they

want to be referred to the clinic, while others are referred by parents, teachers or mental health workers that believe they have gender related problems. The clients that are referred to the clinic are between 6 – 18 years old. As a consequence, their intelligence and ability to think abstract varies, depending on the age. This has implications on the clients' ability to articulate their gendered feelings and experiences, and how they should be approached therapeutically. As mentioned earlier in this section, the participants have a contextual approach, and they pay attention to the clients' families and local communities. Some clients have supportive parents and a school that is working actively to help them, while others are fighting with their family and struggling to receive acceptance and recognition of their problems. The clients do also differ in terms of how they relate to others. Some have already transitioned to another gender, some are partial open and present as another gender in certain situations, while others keep their gender variance and gender identity completely secret.

A topic that emerged repeatedly was how the participants relate to additional difficulties, which means symptoms and challenges that are not directly related to the gender dysphoria. In practice, it can be difficult to differentiate between problems that are the consequences of gender variant and what is not. According to the participants, many gender variant clients have more problems and adversities, compared to others on their same age. Although problematic to clearly distinguish between gender-related difficulties and additional problems, there is important to have an impression on the young person's general life situation. The additional difficulties can be in relation to the clients' life circumstances, for example are some clients out of school or they are being bullied. Other clients experience a more general feeling of isolation or lack of belonging.

**Participant B**

(...) this kind of adolescent group, where typically what what happens is that they ehm they started to question them selves, within a broader kind of like identity developing questioning and like (mhm). Where do I fit, where do I belong? And typically... ehm there has been a long history of them not really belonging or fitting in anyway.

Here, B describes clients that seem to have been struggling for many years in relation to other people, before they started to think about gender dysphoria and being transgender. According to B, a consequence of feelings of isolation can be that clients have difficulties with intimacy and in forming relationships. This can prevent them from exploring themselves in relation to others. Additional problems can also be more internally rooted. Some clients are struggling with depression and anxiety that are not necessarily related to gender dysphoria. They may have problems with emotional regulation or they have experienced traumatic events or losses. According to the participants, clients experience a wide range of additional difficulties that

may be related to the gender dysphoria, or reinforce it. As will be discussed later, these additional problems can pose dilemmas regarding the therapeutic interventions.

The way clients relate to their body emerged as a central topic. According to the participants, some clients may experience an intense hatred towards it, while others are more comfortable. As a consequence, the participants try to form an impression of how distressed the clients are, how this has evolved over time, and how they attach meaning to the body.

**Participant C**

I would also try and find out what's the relationship to their body in general (...) but also I guess to... especially the you know, the female or male biological aspects of their bodies.

C tries to move from the often very stereotypical views that the clients may have about their body, to more differentiated experiences. C does also focus on what discourses clients draw on in order to make sense of their body. The body is often central to how clients understand gender, and the site of interventions and change. This points forward to the more explorative approach that is being discussed in the section on therapeutic strategies

### **3.1.2 Expectations**

The participants do often experience a mismatch between the therapeutic processes they aim for and what the clients and their families expect. Many clients and their families wish to change the body, and physical treatment is therefore central to the solutions they ask for. Some expect that the treatment is going to happen quick, for example that they are going to start straight on cross-sex hormones, without puberty suppression first.

**Participant A**

(...) and he was devastated because he hadn't realized he couldn't have a penis that would just work like someone who is assigned male at birth (mhm) or, born with an anatomical male body, as we classify it (mhm). Ehm, and he was absolutely devastated.

In this quote, A talks about a client that has expectations that are not going to be met with the physical treatment. According to the participants, there is often a mismatch between the expectations that clients and families have to the results that physical treatment is going to deliver, and what it can offer. For example, some clients believe that the cross-sex hormones are going to make them taller or that it is going to give them menstruation. In addition, participants and clients do sometimes have different expectations about therapeutic strategies.

**Participant C**

Another challenging aspect is just families, ehm... that they want, yeah, or lot of the young people come here and they just want ehm... physical interventions (mhm), and that's what they are focused on.

According to C, some clients and their families are only motivated for the physical treatments, and have not considered other therapeutic strategies. A gives an other example.

**Participant A**

And sometimes understandably people come and think that the young person is the only focus Ehm, if you just give them (mhm) testosterone this very minute everything will be perfectly fine (yeah). And I am not saying that testosterone won't be helpful (...) so I am I don't think just doing this will be helpful, unless we are also thinking... so it's the both and I suppose.

In A's view, some families believe that the treatment is going to focus on physical treatment for the young person. These families can be surprised by the contextual approach that focuses on the network around the client, and the focus on alternative strategies.

**Participant D**

So we do get some of these families who want to come and think, but more typically we get families who have really (...) to keep uncertainty done ehm have have have bought into an idea that there is a... a problem... a correct diagnosis (mhm) or... atypical you are atypical ehm (mhm) and then a treatment (mhm). And then good, hopefully, good outcomes.

D experiences that many clients and families understand gender variance as a diagnosis that should be treated with a physical solution, and that good outcome includes changing the gender expression to be more like the opposite gender. In relation to this, the participants experience that some clients and families hope that the treatment can make them less gender-nonconforming. Sometimes is it the clients themselves who want to transition, but it can also be the families or others in their surroundings that aim for it.

**Participant A**

There are children who very much expresses a sense of them selves being the other "gender", but also some times I see children who very much particularly assigned male at birth, small children, that when they, ehm, are expressing preferences that are stereotypically associated with females in terms of play, friendships and clothing (...) often, the wish can be, to just let them be a girl... ehm... I wonder are we kind of reducing the possibilities for their ehm unique ehm gender expression.

A talks about clients assigned male at birth, that are considered by others to have a very feminine gender expression. The threshold is low before they are referred to the clinic, even if the clients themselves have not asked for it. Participant A has the impression that sometimes the school or family expect these young boys to transition into girls, because they do not want them to be feminine boys. These clients illustrate how difficult it can be sometimes to understand which expectations belong to whom, and how gender nonconforming youth often become referred to the clinic because the environment hold the opinion that they are atypical. The participants were concerned that sometimes the binary gender norms force gender variant youth to become "the opposite gender", instead of exploring their unique gender expression. In this way, many clients and families believe that gender is binary, and that there exists only two identities. These expectations do often influence on their expectations towards possible outcome, and support physical treatment at

the expense of explorative work. The participants talked about clients that were referred to them, because either their school or family had been concerned for their well-being. Though, when the participants met with the clients, they realized that the clients were completely fine with their gender expression.

The participants do not always take what the clients or their families say for granted, but attempt to frame it within a broader societal context and understand what discourses they draw on. They do also try to be aware of how they talk about gender variance when clients.

**Participant D**

That how we talk about gender dysphoria, how we, how we construct an idea of the gender nonconforming child (mhm), is a big responsibility (mhm), because... how we shape it up (mhm), will influence what children feel about them self.

According to D, gender dysphoria is co-created during therapy and in relation to binary discourses, and not an unchangeable feature. There is therefore important to be aware of how one frames it. In addition, the participants aim to open up for more than two genders.

**Participant C**

(...) if a family comes to me and they are very certain, and you know all they want is physical interventions and. That's it, it's very, the discourse is very you know ehm... female born in the wrong male body (mhm). (...) I wouldn't introduce something that's where the difference is too great (mhm), but I think over time... what I might just pay really attention to how I use language (mhm) and sometimes I might just say "well... female bodied, male bodied, ehm... gender queer people".

According to C, the social discourses around gender nonconforming people and ideas around gender have an impact on how clients themselves experience gender and gender dysphoria. These views create a lot of pressure towards being conform to gender stereotypes. Because these discourses marginalize nonconforming gender expressions and gender identities, the participants were concerned that the discourses favour physical treatment at the expense of exploration of the unique gender identity. This awareness of how one frames different topics in therapy is in line with a poststructural approach. Negotiation of identity in relation to discourses emerged as a central foci of the therapeutic work. This means the ability to understand oneself in relation to others, to accept similarities and differences, and draw on available identities in order to make sense of ones own experiences. According to the participants, clients often have problems negotiating their experiences regarding gender.

**Participant A**

You could to understand how they impact peoples understanding of themselves, so ehm... So trying I guess to help (...) think about how people want be effected about that... how did their child reach their conclusion about identity. And how could they have reached this conclusion. But that's not a fixed conclusion. But it's kind of a conclusion at a moment in time.

Here, A conceptualizes identity as something that is continuously developing in relation to social discourses, and a topic that should be explored. According to the participants, the mismatch between how the clients' experience and identify themselves regarding gender and how the society views them is often challenging in relation to identity development.

Sometimes participants get the impression that clients have bought into binary identities and draw on discourses about being born in the wrong body, apparently without much reflection.

**Participant B**

That's very different from adolescents who have come across the concept ehm... and kind of like self-defined that, I fit there (mhm). That's more of a conscious kind of like thing (mhm). And I think what then alarms me is that (...) They have effectively kind of like self-diagnosed them (mhm). I fulfil this category.

B talks about clients that present as certain when it comes to how they identify. Nevertheless, when B asks them what made them think that the identity of the "opposite gender" fits them, they struggle to articulate it. B takes this a sign that they have invested a lot in an identity without exploring alternative options. The participants were concerned that binary gender norms and expectations from the family or local community put pressure on clients to identify as either male or female in a stereotypical way, at the expense of exploration of other identities.

**Participant E**

It's really hard for people to have to be in an uncertain position (mhm), and it's really hard to have to be in an uncertain position when you in a society that demands some level, you know, there is a society that demands certainty around especially things like our gender (...) where there are those expectations (mhm) and they are having themselves to negotiate the wider world (mhm), they have to negotiate their families, they have to negotiate their local areas, they have to negotiate the school (mhm), so actually you know... to kind of really... ehm recognize how hard it can be for families I think, and to, and young people.

In E's view, there is important to understand the relation between heteronormative social discourses around gender that demand certainty, and how clients have internalized binary identities. The preceding examples demonstrate how the participants pay attention to how social expectations create a lot of pressure. They are concerned that the pressure encourages clients and their families to embrace dominating identity categories and ways of expressing gender, without considering other options. According to the participants, gender is in itself very complex. If the clients are experiencing additional problems or challenges, this can further increase the pressure towards conformation to a more privileged binary identity. The problems arise on the other hand if the transition to the opposite gender, or what can be defined as a normalizing process, does not reflect how clients feel and think. According to the participants, it can also be problematic if the clients and their families believe that a physical

treatment and a transition can be the solution to all the problems they are experiencing, without paying attention to additional challenges and negotiation of identity.

**Participant D**

And so they are struggling with... ehm.. social integration, peer, friendships ehm.. sexuality perhaps... ehm, or fear of sexuality (...) the solution presents it self. Turns of “ah”, this is because my body is wrong (mhm). I am not seen rather, and that that then they are just gonna kind of go tarrying down that road and... launch them self into that and that’s the answer.

D is concerned that some clients too early reach the conclusion that they struggle because they are born in the wrong body and have GID. The solution is therefore puberty suppression and physical treatment, in order to alter the body. D is worried that is this solution overshadows other challenges, for example negotiation of identity or other additional challenges. According to D, it exists a lot of pressure from both parents and social discourses around gender variance to reduce the complexity around gender and the additional problems.

The participants experience that they easily can be perceived as gatekeepers or even transphobic by clients and families, if they do not meet the expectations that have been described. Especially if they do not accept the demands for puberty suppression immediately.

**Participant D**

But actually we are seen as (mhm) withholding (...) what the clients want, what the family wants, what the young person wants should dictate what happens, so why are we bringing our own considerations (mhm), there is not much, some times not much respect for... the ideas of professionals (mhm) who might... be saying... well, lets take our time here. You know that’s regarded as... perhaps... in the worst situations, that can be seen as a kind of transphobia.

D has the impression some clients and families experience that they do not acknowledge their gender identities, if the therapists opt for explorative work. However, if the therapists support too early that the clients are going to begin on puberty suppression, D experiences that this can make clients and families less minded for explorative work.

The participants experience a mismatch between the research on treatment of gender variant youth and the search for predictors of persistence and desistance, and the diversity among the clients they meet. In addition, they stressed how important it is to validate gender variance as healthy, and encourage clients to discover their unique gender identity. Physical treatment can be a way of affirming the clients’ unique gender identity and delay puberty. Nevertheless, the participants were concerned that physical treatment and puberty suppression discourage the clients from exploring alternative solutions to their problems. The participants were therefore concerned that many clients and their families have internalized binary gender identities and the understanding of being born in the wrong body, at the expense of negotiation of identity with discourses. This understanding can be seen as lying parallel with their poststructuralist views on gender as discursively produced and

psychotherapy as a continuous co-creation of meaning between clients and therapists. The participants also emphasized the importance of being affirmative towards how clients identify and their unique gender expression, in order to avoid being positioned as transphobic. There is a potential tension between the need to affirm the clients' unique gender identity and at the same time encourage clients to relate to gender identity as discursively produced.

## **3.2 Therapeutic strategies**

An important part of the present study is to investigate how the participants work with gender variant youth, in order to obtain the goals the participants have for the treatment. As written in the method section, an aim of the semi-structured interviewing was to encourage the participants to focus on their experiences from the therapeutic work. In this section I will therefore focus on how the participants work therapeutically with clients and the processes they strive for, before I describe what outcome they aim for in the next section. Two main therapeutic strategies emerged from the analysis. The first strategy is facilitation, in order to foster recognition of gender identity and related distress. The second strategy is exploration of how clients manage distress and deconstruction of the clients' fundamental assumptions regarding gender. In addition, puberty suppression emerged as a topic that the participants have to relate to in both the facilitative and explorative work. Firstly, I will give an account of the facilitative and explorative work, and how the two therapeutic main strategies are related to each other. Secondly, I will discuss how puberty suppression, according to participants, can be both beneficial and pose challenges to the process.

### **3.2.1 Facilitation**

According to the participants, there is important to remove barriers that impede the clients' psychological development, in order to be able to relate to puberty suppression and gender identity in an explorative way.

#### **Participant B**

I mean very broadly, I mean, I think, ehm, in a nutshell what we are aimed to do, is that we aim to enable children to live well. We want them to be... to live well. (...) And to be resilient, and to have a, you know, to have a childhood that that where possible I suppose (mhm), is, is not too different from any other teenagers life.

In B's view, an overarching goal of the psychotherapeutic work is to help clients to thrive well, and this is something they focus on already during the assessment. For example, if the participants during the assessment get the impression that the school environment is an obstacle to the explorative work the considered as required for identity development, they

aim to change this. The quote does also demonstrate how facilitation is characterized by a developmental approach, because the clients are evaluated in comparison to others at their same age and the challenges they should meet according to knowledge from developmental psychology.

**Participant A**

So our assessment I suppose on the one hand is really about trying to understand the gender identity, but it's also really about trying to understand the context (yeah) and what do we need to focus on, to ensure that the young person can continue to navigate and negotiate (mhm) their evolving developing gender identity so what are the barriers that we have to remove.

A demonstrates how the focus of attention during the assessment is on both internal and external factors that pose challenges to the clients, in order to intervene therapeutically in a way that can create space for exploration and negotiation of identity. The interventions A talks about are on a practical level, for example that the therapists talk with staff at school and argue for gender neutral toilets and less division between boys and girls, or that they give information to parents about how being gender nonconforming is a challenge for the client that can create tensions and problems. The facilitative interventions that the participants aim for do often involve goodwill from people in the young persons' network.

**Participant A**

(...) and actually that's also some of the work we do, and it might be joining the course of our assessment, if there is ongoing bullying in relation to gender or other difficulties, we relate, we work with the parents, and relates with the school, and sometimes during the assessment period, and we go out to the local environment where the child lives. To think with the school and the local services (...) they don't have, ehm... they don't have barriers that shouldn't be there, because ultimately they have the rights to be supported and their needs to be dealt with.

In this quote, participant A draws on what can be considered a human right discourse, and argues that clients have a right to receive support on their own premises. There is unknown whether the participants use the framework of rights when they meet families or schools, but there is worthwhile to notice that the A in this case draws on a discourse about rights that normally characterizes activists. On the other hand, the participants described how they adjust their facilitative interventions based on how tolerant they perceive the network to be.

**Participant E**

What is... going to feel far beyond their understanding, so for example a family today...s we were talking about (...) the parents really, the idea of... physical interventions or, it is just beyond their zone of proximal development to talk about... physical intervention... what steps can we take that are going to feel manageable for them within their... kind of understanding and where they feel able to... go at the moment (mhm). And how can we help them to kind of you know, to to to ehm... to things to broaden out or open up a bit.

This demonstrates how E cautiously attempts to introduce nuances in the family's thinking, in order to facilitate understanding between the client and the network. Yet, in order to foster

recognition and acceptance for gender variance and the clients' problems and openness to different solutions, the participants emphasized the importance of affirming how frustrating and painful it can be to live with the distress related to uncertainty regarding gender identity.

In addition to removing barriers and fostering acceptance, the facilitative work is aimed to help clients and their families to tolerate the gender dysphoria related distress they are facing.

#### **Participant A**

Ehm, and I think he is really helpful in terms of thinking actually about the container and the contained... how a family are able to respond and contain a young persons distress and frustrations. Because ehm you know life in general is distressing and frustrating. And kind of gender variance can pose up an additional pose additional challenges that needs kind of support from people around them. So I often think about how parents appear to be able to tolerate and work with and manage difficult feelings and then think about what support can I give them. Ehm, and actually I really like the idea of container and contained, because actually if we can bare what a person is bringing and give it back in a digestible form, then it enables the possibility to ehm to think about other things. Imagine other possibilities.

In this quote, A refers directly to the work of the British psychoanalyst Wilfred Bion and his work on how parents are helping their children to understand their thoughts and feelings better by mirroring their experiences. The caregivers are containers of the little child's internal world, and the child is being contained. A aims to enable parents to contain their children's distress, in order to facilitate exploration. This is in line with E's emphasis on the importance of adjusting the facilitative interventions to what kind of ideas the families are able to cope with at that moment, so that the therapists cautiously can introduce nuances. Initially, the participants aim to be containers of both the young person's thoughts and feelings about gender and the families' concerns, by offering a therapeutic space where the distress can be talked about. The participants' aim is to enable parents to talk about gender, so the parents themselves can support the gender variant youth in the exploration of gender. This demonstrates also the mutual dependency between facilitative and explorative strategies.

### **3.2.2 Exploration and deconstruction**

A common factor that encourages many gender variant youth to seek help is that their psychological functioning and the way they have organized their life create tension and mental health problems. The explorative work do often start during the assessment and continues throughout the treatment. It is often directed towards developing alternative ways of coping with distress.

#### **Participant B**

So, ehm, what I now recently have been doing I suppose in order to kind of activate (mhm) the exploration ehm, process, ehm, ehm, is is to kind of like say why don't you (...) sort of, ehm, experience, what is like... to live as... let's say a girl. Or a boy. Let's do it as a trial

period. Because, because you know you have made this commitment to this idea, but I suppose what is not quit clear to me is that how much you have tested it out really. (...) So, so let's test it out (mhm), let's try and do that... if you come across as very determined, so, so, it might well, then, then, maybe it might stay. Maybe it won't (mhm). And I would use again, introducing the idea of kind of, ehm... possibility for things to change.

In B's view, an important part of the therapeutic work is to encourage the clients to explore why they have reached their conclusions regarding gender, and how they are going to express their gender identity in relation to others. In relation to exploration, B emphasises to the clients that things can change and that being uncertain can be positive. Similar to what was discussed in the section about expectations, B describes how some clients find the idea of being transgender meaningful, and that they need physical treatment, apparently without having explored other possibilities. An important therapeutic focus is therefore to explore how clients give meaning to certain concepts.

#### **Participant E**

And it means various things, I think, and I will say that, quit often, I will say that, there might seem a really obvious question... but... dysphoria, gender dysphoria, can mean different things for different people and I will think with them about... what that means. And part of the work I think is about thinking about what it means for them, and the result of what it means for them what might be helpful, and what might be helpful in terms of going forward.

E aims to break down important ideas about what it means to have gender dysphoria, in order to make it more comprehensible and to be able to think about other possibilities. E emphasizes the importance of understanding how clients and their families arrived at certain conclusions and how they construct meaning. D formulates a similar explorative approach.

#### **Participant D**

But yeah, but ideas (yeah), yes, ehm... possible pathways... and, you know, that some of they sort of do a spectrum of gender... and and a sexuality is on a different axes... you know, you can draw these things, map them in pictures (...) you know most people don't feel a 100 % female or male (mhm), so... how do how does anybody know that they are (mhm) a boy or a girl, you know what are the things that tell you... if I talk to myself about being (mhm), what, you know, so you may... you kind of what are the things are... or I am a boy for these reasons, but I am not a boy for these reasons. And you just make everything more complicated, I suppose, is part of what you are doing.

If D gets the impression that the clients have arrived at rigid solutions regarding gender, that may have created tensions and problems, a strategy is to engage the clients in a conversation around gender that encourages them to reflect on their specific way of doing gender. A further result of this work can be that it challenges normative discourses around gender that some clients may have internalized. Participants are generally concerned when they get the impression that clients and families present with certain solutions regarding how to handle gender dysphoria.

### **Participant C**

I feel like there is, with the earlier example is like... there is the safe certainty, like everything is sorted, it's fixed (mhm), transitioned... and I think I almost wanted to introduce a little bit of uncertainty and (yeah) conflict, because ehm, I guess... it isn't, from my experience (yeah) it isn't as simple in, yeah, I hope that makes sense.

C is sceptical towards certain and fixed solutions to gender identity problems. An example on this can be a child that transitions early to the opposite gender. As emphasized in the section about the facilitative work, the participants initially attempt to affirm the clients' and their families' thoughts and feelings around gender, in order to facilitate their way of managing gender dysphoria. However, as C states, they cautiously attempt to introduce some complexity, in order to stimulate exploration. It seems like the participants refuse to take for granted what clients say and how they identify, in order to open up for new meanings. This is a strategy that can be seen in line with their poststructural approach to psychotherapy.

The participants shared poststructural perspectives on psychotherapy as starting points for the explorative work, in particular the concept of deconstruction and the approach to gender as discursively produced. Some of them used ideas about deconstruction as a way of challenging norms that, according to participants, constrain the clients in their ability to negotiate with social discourses. However, it can be challenging to make abstract ideas about gender as discursively produced available for children and youth.

### **Participant A**

So if I talk to a seven year old I do in a very simplistic way and I would talk about the gender police (okay) and how the gender police thinks for example that their, you know, if you ehm if you like these things or look this particular way then you are a girl and girls can only like this, and if you like these things and like to wear particular clothes then you are a boy (...) I might also start asking them, and if they say "oh, no, only a boy can do this, or only a girl can do this". Then I say "where do you think those ideas come from? Who told us that?"

This quote demonstrates how A attempts to engage the clients in dialogues around gender. It gives an impression of how the deconstructive interventions can serve various purposes. It can for example give information about where the stress lies in the environment and how the clients have arrived at certain conclusions regarding gender that create problems. The deconstructive interventions that A describes can also enable the client to think different about being gender variant and explore other solutions. The aim of the deconstructive interventions is to engage clients in a dialogue that can open up for different possibilities about gender identity and expression, instead of taking for granted common ideas about gender. In order to create awareness about how the clients' experiences of gender are related to social discourses, the participants attempt to help clients to differentiate between their own thoughts and feelings regarding gender and opinions held by the media or people in their

environment. In line with the poststructural and deconstructive approach, the participants emphasized the use of language in the therapeutic work. By introducing new and subtle nuances, this can create awareness and open possibilities.

**Participant C**

I wouldn't introduce something that's where the difference is too great.. I might just pay really attention to how I use language (...) just say "well... female bodied, male bodied, ehm... gender queer people". I might just slowly introduce nuances of... different experiences or different ways of performing... gender (...) I think when I speak to the family as, so what are your preferred pronouns, is it he, she, they (...) and suddenly they are like "oh, what, what, what, they or". So, so even though they might don't want to identify in that way, I think they might go away and just... hopefully would have broadened the... options that are available (mhm) to explore things and experiment how they want to do gender.

C suggests the gender neutral pronoun "they" as alternatives to the binary pronouns "he" and "she", but without pushing the clients and their families. In line with other participants, C emphasizes the importance of exploring cautiously. The deconstructive interventions and the use of language that C describes can be seen as lying parallel with the poststructural focus on how discourses and language influence on how people do gender and experience themselves in relation to others, and how discourses both restrict and open possibilities.

It has been discussed earlier that many clients are referred to the clinic because they experience distress. The facilitative work aim to create space for reflection, by appreciating how painful it is for clients and families to experience uncertainty regarding gender, and the problems this can lead to. The explorative work can also be aimed to handle distress.

**Participant D**

Owes a feeling, they are angry with their friends... they are... really disappointed in their father. They really hate their sibling, they... feel the loneliest person in the world, they got no friends, everybody else has got a boyfriend or a girlfriend, or they are let down (mhm) by a... partner or something, and a... and it's unbearable, the pain of it, and the disappointment the sadness is unbearable. And you are trying to help them to believe that they can bear it (mhm), that's the work in supporting adolescents, its that they can bear it (mhm). Life is bearable.

Here, D describes elemental psychotherapeutic interventions directed towards new ways of experiencing feelings and thoughts, in order to increase the clients' ability to regulate themselves. According to D, clients and their families do often experience stress and frustration that needs to be tolerated, before they are able to explore gender and identity. This demonstrates how the facilitative work is often a prerequisite for the explorative work. In addition, exploration of other ways of managing gender dysphoria can also help clients to tolerate distress resulting from being gender nonconforming. Hence, the relation between facilitation and exploration is mutual dependent. They depend on each other.

There are various reasons why the participants encourage exploration. One reason can be that since the clients and their families seek help, they most probably suffer in one or the

other way. Such problems indicate that some of their certain beliefs and conclusions can be maladaptive. Furthermore, as mentioned earlier, the participants get often preoccupied if clients are certain when it comes to gender identification and ways of doing gender.

**Participant B**

And I think what then alarms me is that (mhm)... If you want to use medical terms (mhm). They have effectively kind of like self-diagnosed them (mhm). I fulfil this category and I fulfil this criteria (...) what made you think that yes this fits me? (mhm, yeah). And then sometimes ehm that is also a struggle (mhm). So then I start to go worry then is it that you know inevitably I am going to worry is this perhaps, you know, they prematurely committed to... an identity category without sort of really fully exploring it.

If the clients present as certain when it comes to gender identification, but appear to relate to identity in a rigid manner without having explored other options, B sometimes gets concerned that the commitment to an identity category is seen as the solution to other problems. In line with the deconstructive therapeutic strategy, an important focus during both assessment and throughout therapy is therefore to understand more of how the clients have reached certain conclusions around identity and whether they have explored alternatives. Another reason why the participants choose to explore instead of just support a decision, is to prevent future problems. This can happen if they get the impression that the social transition has happened too quickly.

**Participant C**

Maybe it's the emotional conflicts I am looking for... And their emotional process of engaging with the social transition or... so it might all present as very, it's all very happening very... quickly and easily and and there might be certain things... that come up that that are sticking points, or like somehow they might slip out with pronouns, say he instead of she (yeah), and you kind of pay attention a bit to that and say, oh, like what has it been like for you to use those pronouns, what has it been like for you to change the name (yeah), use a different name and, you kind of as a parent gave that name, and suddenly... so often... I think you can pick up small details often (mhm) in to action and then... can almost be a hook into exploring... I think the complexity of feelings, that's really often what I try and get.

C talks about clinical hunches that indicate emotional conflicts, for example if the parents use the wrong pronoun. C attempts to explore how it has been for the parents that their child suddenly just changed name and pronoun. According to the participants, it is common that families have both negative and positive feelings towards the social transition, but some parents are afraid of insulting their child if they are open about that. In these cases it can be useful to explore the ambiguity and appreciate that these decisions can be difficult.

The explorative work can also be used as an attempt to prevent future problems in relation to what the participants consider as unrealistic expectations about what physical treatment can offer, that some clients and families might have. For example, one girl assigned male at birth asked her father when she would get her period, because her teenage sister had

just got her first menstruation. Another example is a teenage boy assigned female at birth, who asked one of the participants if the physical treatment could make him taller. Neither puberty suppression nor cross-sex hormones can give clients menstruation or make them taller. In both cases, the psychotherapeutic work was therefore centred around problematization of gender stereotypes.

**Participant A**

So I suppose starting to really think about actually the differences (mhm) and the diversity, ehm within ehm gender categories ehm, and you know it's huge variation, but also thinking a lot about ideas and stories that perpetuates (mhm) about gender binaries and how to be a girl and how to be a boy, and so just trying to get into some conversations about those ideas.

This quote demonstrates that the explorative work can be aimed to help the clients to accept the potential mismatch between their own body and the social norms for female and male bodies. A's attempt to encourage awareness of how social norms and discourses have an influence on the clients' well-being and their relation to their body can also prevent future problems. An increased awareness of social discourses and norms can also encourage exploration of other ways of doing gender. In addition, some participants were concerned that the gender binary approach towards treatment of gender variant clients does not take into account that not everyone will be able to pass as the other gender, as long as the gender norms are as rigid as they are today. Although the female client assigned male at birth is going through physical treatment, she will never have menstruation. According to A, an important goal of the explorative work is therefore to deconstruct rigid and stereotypical discourses around gender views on gender that clients might have internalized. The participants do also encourage exploration, if they are concerned that a sudden social transition closes down other possibilities too early and reduces the clients' opportunities for a more authentic gender expression or way of living.

**Participant A**

And some times I wonder this, ehm, to reduce the complexity of allowing this child to just be, so one child that I saw was at school with his hair, did all what they wanted, and then as they were getting older, the other kids were becoming increasingly ehm confused, and less accepting of this child's gender expression. So kind of kind of happy to be ehm a boy as long as they could do all the things they want to do, wear whatever they wanted have long hair, play with the girls. But actually the people around them found this very difficult. And what then happened was a very sudden social transition. So I guess there is, sometimes I have that worry that because the environment isn't tolerant, isn't tolerant enough, what is the impact of that in terms of limiting or creating opportunities in terms of peoples gender identities.

A reflects about a specific case where the client, a child assigned male at birth and identifying as male, was referred to the clinic by his parents, who thought he had to be transgendered because he was behaving in a very stereotypical female way. This is an example of how both

internal pressure, like psychological symptoms, and external pressure from society and local community, often affect each other and encourage clients and their families to search for gender-normative solutions and early transitions. The participants are concerned that some clients and their families have bought into heteronormative identities, without exploring other options, and the explorative strategies are therefore aimed to find better solutions.

### **3.2.3 Puberty suppression in relation to facilitation and exploration**

Puberty suppression is interlinked with the facilitative and explorative work, and emerged as a central topic to the therapeutic processes. According to the participants, clients and their families have to relate to decisions regarding puberty suppression throughout the treatment process. This is a complicated decision with both advantages and disadvantages.

#### **Participant E**

But I think in a way the... idea of starting on a hormone blocker enables that ehm... space to kind of reflect and think and explore without the pressure of the body changing. I do think of as a treatment of it's right (mhm). I think there can be a worry that actually... most young persons on a hormone blockers (...) the outcome it means that they won't be less likelihood of them... ehm... being able to think about other possibilities, especially for the younger children. Trying to make sure that space is open for exploration.

According to E, puberty suppression can reduce the pressure, because the body stops developing for some time. In this sense, puberty suppression is a therapeutic strategy that can create some space for reflection. E is on the other hand concerned that a disadvantage with puberty suppression is that it can provide the message to clients and families that physical treatment is the only way to handle gender dysphoria, instead of exploring other solutions.

#### **Participant D**

Ehm... we can say it, to young people who are self-harming, because self-harming is clearly not a good solution and everybody would agree with that, mostly (...) and we work with them to work out, what are the kind of things that help you bear it (mhm). And of course there are really ordinary things, suddenly you found a friend... maybe you have a bath, you go for a walk (mhm), you take the dog out, you listen to your favourite music (mhm). You know, comforting things that help you bear emotions ehm... but that seems wrong... when we have a physical intervention that can be brought on straight and why use these psychological things (mhm) ehm, when you have something that is sort of, seems to be more available.

According to D, the act of giving puberty suppression can provide the message that the gender dysphoria and psychological pain and suffering like depression, anxiety and self-harming require a physical solution, at the expense of psychological work.

#### **Participant B**

If that's where there they are at. So if I think that's where they are at, the either they are sort of diffused, kind of like really stuck I don't know who I really am or, they are really strongly committed to ehm an identity perhaps prematurely... so foreclosed I suppose the route out of that is to engage with the identity task (mhm) of exploring oneself and grapple with it. If I then say to them "okay but give you the blockers" (mhm). But for then to kind of like say "ah, ehm, let's provide you the blockers anyway (mhm), and maybe as a later stage, you would be

ready”. My worry is that I, I am, what the family and perhaps the young person would read from that, is that going the medical way is gonna is gonna be the way forward.

E, D, and B are concerned that puberty suppression draw the attention from psychological ways of handling pain and suffering, and that it can impede the explorative work. While E emphasizes that puberty suppression can be a way to manage distress and self-harming in order to create reflection, B is concerned that offering puberty suppression for some clients that experience a lot of distress and problems with exploration of identity can actually be counterproductive. The preceding quotes demonstrate how delicate it can be for the participants to relate to puberty suppression in their therapeutic work. Puberty suppression can on the one hand be a facilitative intervention that creates space for reflection and hence encourages explorative work. On the other hand, it can prove the wrong message about how clients and families should manage gender dysphoria, and hence impede the facilitative work aimed to tolerate distress and explore new ways of living. The participants experience that if clients once have started on puberty suppression, it can be difficult to be open for other opportunities than gender binary solutions and further physical treatment, because it requires a lot of investment.

As described earlier, some clients and families expect the professional mental health workers to be transphobic and withholding of physical treatment. According to the participants, this can represent a further challenge to how they relate to puberty suppression, because some clients and families might experience them as withholding if they encourage exploration before they support puberty suppression. In order to handle this positioning, D tries to aware why clients and families might be vulnerable to experience them as hostile.

**Participant D**

You can understand why, because of course there is a history of professional people being (mhm) very judgmental. And unwilling to... take seriously what people feel (...) if you are very anxious or depressed... you are... alarmed by that, you worry about that, because it actually it might be the other way around (...) they are using their gender dysphoria as a... way of making sense... that is like oh, I would never say that (...) because that's what they think psychologists think... that's what they hear, and that, they really hate that.

According to D, gender variant people have earlier been treated with reparative therapy, and clinicians have thought that gender dysphoria is pathological. According to the participants, many gender variant youth do still experience that they are not respected by others and that their subjectivities are not affirmed. D tries to confirm the clients' experiences and be open for puberty suppression, and not explain gender dysphoria as the result of something else.

**Participant D**

I think different ways of thinking about it, one is that... to be honest... and this is not something that I ever thought... would work... but actually it sometimes does, that you can

actually use the offer of treatment as leverage, so actually some young people really do stop cutting their arms, if they think that they won't get treatment.

According to D, puberty suppression can sometimes be used as a facilitative intervention in order to motivate clients to engage with the psychological work. This is in line with how the participants attempt to go along with the clients and their families initially and facilitate space for reflection, before they intervene with explorative strategies at later stages of the treatment.

The participants have to balance between facilitative strategies, aimed to affirm the clients' experiences in a non-judgemental way and foster recognition, and explorative strategies, aimed to challenge and encourage negotiation. Puberty suppression is central to both strategies, because offering physical treatment can be an intervention to facilitate reflection, and hence exploration. Still, puberty suppression can also be an intervention that impedes exploration. The balance between facilitation and exploration may reflect the dilemmatic nature of the different needs that the participants experience that clients have, as described in the previous section. On the one hand, clients should be affirmed and their unique gender expression should be validated. Yet, clients should on the other hand be encouraged to explore different ways of doing gender.

### 3.3 Outcome

In this section I will focus on two processes that, according to the participants, emerged as important outcomes to aim for in order to improve the clients' ability to manage gender dysphoria and thrive well, and to enable clients to make decisions regarding puberty suppression. Firstly, the participants aim to help clients integrate thoughts and feelings and improve their psychological insight. Secondly, they aim to help clients negotiate actively with social discourses around gender, in order to explore more authentic ways of relating to others and expressing themselves. There is problematic to distinguish between integration and negotiation, because they are contingent and emerged as processes that the participants pay parallel attention to throughout the therapeutic work.

Many clients undergo physical treatment aimed to change the body and the gender expression. However, the participants were concerned that some clients are still going to be misgendered sometimes or experience that they do not look like a proper man or woman.

#### **Participant C**

Like I said before, sometimes I worry if they... if they present as too certain (yeah). Because there is conflict and there is going to be conflict and... that even physical interventions, they will masculinize or feminize the body... it will never be... the same as if someone...

genetically born I don't know, male or female. And at some point they will I guess get in touch with that.

In C's view, not all clients will pass as the gender they identify with, for example if others use the wrong pronoun. In addition to the physical treatment, clients should therefore explore how they handle that other people misgender them and how they negotiate gender and claim their right to identities, by relating actively to social discourses around gender.

**Participant D**

(...) start if say okay "suppose everybody read you as that, what's good about that? What are they gonna.. are they gonna approach you? Are they gonna want different things of you? (...) What are you expecting from that? (mhm). What's gonna be better about that?"

Here, D attempts to help clients to explore alternative ways of relating to others. The negotiation that D aims for can be seen as a manoeuvre to help clients become less dependent on what other people think about them, and to rely more on themselves. The importance of obtaining a position where one can negotiate with social discourses is also important in order to enable clients to engage in peer relations and intimate relationships, and meet developmental challenges. The ability to negotiate is related to the deconstructive work, and aims to encourage more autonomy in the way clients and their families relate to social discourses. D aims to help clients and their families to understand how social discourses around gender influence on their identity and the way they subscribe meaning to experiences, in order to encourage them to engage more actively.

Clients and their families need to have insight into their thoughts, feelings and motivations, in order to negotiate more actively the co-creation of meaning with others and relate to social discourses that influence how they experience themselves. Participants were concerned that some clients invest prematurely and passively in an identity as the other gender, at the expense of exploration of more authentic thoughts and feelings. In line with this, they emphasized how important it is that clients are able to tolerate negative emotions and additional problem, in order to explore other solutions, in addition to puberty suppression. An important part of the integrative work is therefore to help clients to explore how their inner feelings and thoughts are related to social discourses. According to D, clients depend on social contexts and discourses to make sense of their own thoughts and feelings regarding body and gender.

**Participant D**

(...) broaden the set of ideas they are bringing to bear on (mhm), what is, what they are feeling (mhm). The possibilities, ehm... emotionally in terms of the whole range of emotions they feel, to situate it in terms of... the relationships they have (mhm), family and... other young people. And to situate in a... social and political context as well (mhm). You know

of... what it means to be... in this... (mhm) world at this time, feeling a bad about your body you know and what that could tell us about (mhm) ehm, how you can accept your body more.

D talks about clients, for example girls that are male assigned at birth, who have internalized strict gender norms regarding what constitutes female bodies that they will never be able to fulfil, despite of puberty suppression and other physical treatments. In D's view, there is therefore important to explore how their normative views on gender can be oppressive, and help the clients to take into account that thoughts and feelings about oneself and one's body need to be integrated and seen in relation to social discourses.

**Participant D**

(...) it sounds like a cliché, but some people really do say it, you know, it's not a transition in the body, the main thing has to happen in your mind too. You have to be a male (mhm), or a female... in your mind, and the body just... comes up behind. And I don't think I have got there yet (mhm). When I first met you I hadn't got to that.

D emphasizes how reductionist it can be to abate the treatment of gender variant youth to a question about puberty suppression only, because it does not take into account that thoughts and feelings about oneself and one's body need to be integrated and seen in relation to other people and social contexts. In D's view, there is therefore important for women that are assigned male at birth to explore how they may have internalized oppressive gender norms, and find new ways of being a woman that do not solely rely on physical treatment. The same applies to men assigned female at birth. This may involve changing their body, but its also requires integration of thoughts and feelings in relation to their own body and discourses.

**Participant C**

(...) it's getting in touch with feelings and getting getting in touch with, I don't want to say a reality, because that's always challenged (yeah) but, ehm, lived experience maybe, of... doing gender in your preferred way (yeah). I think that's we would encourage experimentation.

C aims to help clients integrate their inner thoughts and feelings with lived experiences, in order to negotiate with social contexts in an honest way. This demonstrates how negotiation is related to integration. Development of an identity that is flexible and dynamic requires both an ability to negotiate with social discourses and to integrate this with thoughts and feelings.

The facilitative and explorative therapeutic strategies are responses to the participants' concern that many clients and their families have bought binary gender identities and an understanding of being born in the wrong body, at the expense of negotiation of identity with discourses. According to the participants, gender identity is the result of a complex relation between active negotiation with discourses and an appreciation of how social context influence on the individual's thoughts and feelings. The clients are neither passive victims of discourses, nor completely independent of social realities.

## 4 Discussion

The results I have presented indicate that the participants have a non-judgemental, non-binary and discursive approach to their work. They experience the therapeutic work as a balance between two strategies: first, the facilitative interventions aimed foster support and acceptance within the clients' family and local community in order to affirm the clients' felt gender identity, and, second, the deconstruction and exploration of different ways of relating to discourses and managing distress. Gender variant youth may be extra prone to experience that other do not respect their subjectivity, because of lack of appreciation of their gender identification in heteronormative discourses. These results can be seen as lying parallel with Wren's clinical experiences (2014) that many gender variant youth are in need for a binary and stereotypical gender identity. Paradoxically, explorative strategies that are aimed at deconstructing oppressive discourses can be experienced by some clients as a further lack of affirmation of their gender identity and a violation of their right to define themselves according to own subjectivity. A clinical question that arises from the results is therefore how clinical psychologists can grant gender variant youth with a subjectivity and meet their needs for affirmation, while at the same time challenge their thoughts, feelings and experiences of themselves, in order to enhance their capability to make informed decisions regarding puberty suppression and manage distress in relation to gender variance.

The facilitative work aims to foster acceptance and empathy and an understanding of gender variance as healthy. The participants' starting point is that gender variance is not pathological per se. On the contrary, there is the pressure to conform that creates distress. This is supported by empirical studies on the psychosocial consequences of breaking gender norms (Egan & Perry, 2001; Yunger, Carver, & Perry, 2004). As a consequence, the participants put a lot of effort in fostering acceptance of gender variance. These therapeutic strategies can be seen as lying parallel with the parental work that Ehrensaft (2012) and Hill and Menvielle (2010) emphasize. The results from the present study indicate that gender variant youth are in distinct need of recognition of their experienced gender identity, and not the one they were ascribed at birth. The expectations they bring are often centred around physical treatment, and participants do therefore consider puberty suppression as a facilitative strategy. In this respect, the facilitative work also have links to Lemma (2012), and her suggestion that therapy should be aimed at mirroring the distress resulting from the misgendering that many clients have experienced.

The explorative and deconstructive strategies are in line with poststructural and queer theory, in the sense that they aim to challenge dominant discourses that marginalize gender variant people. According to the participants, many clients have internalized strict norms regarding how bodies should look like, in order to qualify as either male or female. This can represent a challenge for the clients in the future, because the physical treatment is not necessarily able to alter all aspects of their body as much as is needed, in order to be accepted as male or female according to heteronormative values. The therapy is therefore directed towards deconstruction of social discourses and exploration of how clients negotiate nonconforming gender identity within social contexts. These strategies can be seen as an attempt to practice queer bioethics and resistance, because they refuse categories that usually organize genders and promote uncertainty and fluidity (Roen, 2016). The participants' concerns regarding physical treatment reflect Roen's assertion that medical interventions are in risk of treating gender variant bodies as separate objects that need to be fixed in place according to normative expectations. In addition to deconstruction of social discourse, the explorative work is also aimed to focus on different ways of relating to the experienced mismatch between what their body looks like and how the clients want it to be, instead of exclusively fixing bodies. Perhaps this reflects Saketopoulou (2014) and her concern that an exclusive focus on physical treatment as a way of mirroring gender variant clients' hatred towards their own body, could happen at the expense of mentalization of it and embodiment. Both Roen (2016) and Saketopoulou (2014) emphasize the concept of embodiment, defined as the striving of becoming someone and the understanding of the body as integrated with the self and not as an external object.

There are tensions between two facets: the facilitative strategies aimed to foster recognition and mirror how clients experience themselves, and the explorative strategies aimed to challenge marginalizing discourses that clients and families draw on. According to the participants, many clients draw on the discourse of being born in the wrong body. This can illustrate the dilemmatic nature between facilitation and exploration. This discourse of being born in the wrong body is a dominant cultural narrative, built on heteronormative assumptions about gender as determined by the body's sex. On an individual level, this narrative can in the first instance serve as a way of subscribing meaning to experiences of being atypical. However, the participants were concerned that an internalization of this discourse can be oppressive in the long term. Clients are ultimately going to live with the body they were born with, and this discourse could reproduce the assumption that gender variant people's bodies are wrong. The participants experience sometimes that if they affirm

the need for bodily changes, for example by opening up for puberty suppression, they give the wrong message about how to handle distress and what the solutions for the future are. A balance between exploration and facilitation is therefore required. Butler's theory on performativity and discourse can shed light on this dilemma (1990). The participants were concerned that they are in danger of reproducing discourses around gender as both something innate and unchangeable as well as the client's body as an object that requires medical intervention such as puberty suppression. Perhaps the participants' concern reflects Butler's assertion that the belief in a subjectivity prior to discourses makes people prone to believe that the way they regard gender is innate and unchangeable rather than discursively produced. However, Butler emphasizes that an understanding of gender as discursively produced does not mean that gender does not exist. On the contrary, discourses are constitutive of people's subjectivity and their lived experiences. Perhaps the therapeutic balance between facilitation aimed to affirm how clients identify and exploration aimed to enable negotiation with discourses in this respect reflect Butler's account of performativity.

The facilitative strategies are nuanced and include more than mere affirmation of how clients feel. The participants try to enable families to tolerate gender related distress, instead of intervening immediately with puberty suppression, in order to appreciate uncertainty and explore various outcomes. These strategies represent a practical intervention aimed to tolerate the dilemma that Butler describes between being constituted by and dependent on discourse at the same time as one is able to change it and negotiate. Clients are not mere victims of discourse, they are also able to negotiate with it. If the participants open up for puberty suppression, this can be a way of confirming how clients experience themselves, and thus reduce some of the distress and enable space for reflection. Still, it can also reinforce the expectations some clients have that the treatment is going to be medical, at the expense of the psychotherapeutic work. In this respect, the facilitative strategies reflect the call for queer ethics and an openness for fluidity on the behalf of the clients' development.

Fausto-Sterling's (2012) research on gender identity emphasizes the development of gender from presymbolic embodiment of gendered experiences to internalized representations of gender in continuous negotiation with social discourses. According to this perspective, gender identity is deeply embodied feelings that need to be validated by others. However, these experiences of gender are developing continuously in relation to social discourses. This understanding can shed some light on the experiences that the participants have regarding the need to both validate the clients' gender identity and subjectivities and challenge the discourses they draw on. Maybe the clients' therapeutic balance between

facilitative and explorative strategies in some way reflects Fausto-Sterling's conceptualization of gender identity as both deeply embodied and open for negotiation. In relation to this, Saketopoulou (2014) is concerned that an exclusive focus on physical treatment and recognition of the clients' experienced gender is not enough, because many gender variant youth have embodied heteronormative assumptions of what constitutes male and female bodies that influence on their negative relationship towards their own body. According to Saketopoulou, an increased ability to live comfortable with their own body will help clients to negotiate social discourses in a more flexible way. According to this perspective, maybe the facilitative strategies reflect an attempt to validate feelings and experiences that are presymbolic embodied, in order to enable exploration of different ways of doing gender in negotiation with others. Related to this therapeutic balance, the psychodynamic theorist Jessica Benjamin (2004) has suggested to go beyond the competition of realities between therapist and client and search for a mutual co-construction of meaning, as a therapeutic mean to overcome violation of subjectivities.

Psychodynamic models of personality and psychotherapy can shed some light on the therapeutic balance between facilitation and exploration, because they open up for an understanding of human subjectivity as constituted by unconscious forces, contradictions and costs. According to the participants, many clients have bought rigidly into heteronormative and constraining discourses, for example being born in the wrong body, and struggle to see the fluidity and ambiguity when it comes to gender. In line with Layton's (2004) perspective, one might hypothesize that the rigidity and lack of interest in exploration of gender that the participants experience among some gender variant youth, can result from experiences of being sanctioned or not accepted as gender-nonconforming in their relational history. The desire to behave nonconforming and related feelings have therefore been split off from the conscious psychic structure, as a defence against loss of love or approval. This results in an incapacity to see gender fluidity, tolerate uncertainty, and a need for affirmation.

Di Ceglie (2009b) focuses on the ability to symbolize unconscious identifications and motivations regarding gender when working with gender variant youth, in order to enable clients to make decisions regarding puberty suppression. An example from his clinical work is a seven year old client ascribed male at birth, but identifying partly as female (Di Ceglie, 2009a) After exploring gender identity for some time, it became clear that his grandmother, to whom he was deeply attached, had died few years earlier. This had been traumatic, and after using some time exploring the memories he had about her, the female identification gradually disappeared. Di Ceglie hypothesizes that the identification as female was an

unconscious identification with the grandmother, because he had not been able to mourn the traumatic loss of his grandmother. After being able to symbolize the loss, the female identification disappeared gradually. This serves as an example of how unconscious factors in some cases can contribute the clients' needs, and how an exploration of the gender identity development can be beneficial. Participants warned against attempts to explain why clients have become gender variant, and a risk with Di Ceglie's explanation is that it can aggravate the clients' deeply experienced identification and subjectivity. Di Ceglie emphasizes that a prerequisite for such an exploration is an unconditional acceptance and affirmation of the clients' experienced gender identity initially. His focus is on how clients can be able to make informed decisions by having more insight into their motives and identifications. Although none of the participants identified themselves with psychoanalysis, there are some similarities between the combination of facilitation and exploration as important therapeutic strategies, that the participants in the present study described, and the psychodynamic approaches to gender variant youth that Di Ceglie represents. Perhaps the explorative work described in the present study in some cases serve as an exploration of unconscious motives. Furthermore, one might hypothesize that the conceptualization of unconscious identification and the costs and contradictions involved in internalization of gender norms, represented by Layton, can shed light on why the participants focus on affirmation of gender identity initially, followed by careful exploration and deconstruction of discourses clients draw on, in order to create meaning on an individual level. Maybe the facilitative and explorative strategies are aimed to foster psychological insight and autonomy, in order to be able to question internalized one has internalized.

The results from the present study indicate that the work with gender variant youth can be dilemmatic and full of tensions and uncertainty. In this way, the results question the success stories that are reported from the Dutch and Canadian models, because they suggest that the processes behind decisions regarding puberty suppression are less either/or than the model of desisters and persisters give an impression of. The results indicate that following the pathway with puberty suppression can sometimes be in danger of foreclosing the exploration of alternative ways of relating to gender identity and managing distress, when working with some gender variant youth. Furthermore, early transition and unconditional support of puberty suppression can overlook other psychological needs that should be met. In line with the call for queer bioethics, the results indicate that the unconditional support of physical treatment and the gender binary norms that the GID diagnosis and the Dutch and Canadian models rely on are in danger of reproducing heteronormativity, by constraining the clients'

possibilities to express themselves outside of the binary norms. In this way, it indicates that clients who are uncertain and open for exploration regarding gender identity and expression should be regarded as healthy rather than pathological. The experiences by the participants in the present study also challenge the concept of GID, and call for a more flexible diagnosis that opens up for uncertainty, without relying on binary and stereotypical gender norms. On the other hand, participants usually offer puberty suppression to clients, even though they are concerned that it can contribute to foreclosure and a lack of exploration. In this way, they do not differ from the Dutch and Canadian models, that support physical treatment in order to change the body more in accordance to how clients want to express themselves. However, there may be differences in how they approach clients and the processes they are aiming for. While the Dutch and Canadian, according to the academic papers that are published, focus on investigating factors that can predict the outcome, participants in the present study focus more on negotiation with social contexts, questioning of heteronormative assumptions and an encouragement of change that is more based on the premises of the clients. Or it may be that the Dutch and Canadian clinicians have written less about processes. Their approach to clients may be more nuanced than the academic papers they have published indicate.

The present study can be seen as an exploration of the queer bioethical call for contextualized approaches and focus on uncertainty and openness in terms of different outcomes (Roen, 2016). The Dutch and the Canadian models have been criticized for the appreciation of certainty and the apparent lack of awareness of culture and gender norms. Academics have called for therapeutic approaches that attempt to combine an open attitude towards puberty suppression with an appreciation of uncertainty and a multiplicity of outcomes (Moller et al., 2009; Roen, 2011, 2016). The present study indicates that therapeutic processes that include a queer bioethical awareness are facing dilemmas when relating to puberty suppression, because in practice it can be difficult to offer clients puberty suppression, while at the same time not encourage foreclosure of exploration. In this respect, the results can provide insight into how some clinical psychologists attempt to be open for a variety of outcomes work with gender variant youth. The results also suggest that important outcomes are not primarily what gender identity the clients end up with, but rather their abilities to negotiate with social contexts and integrate discourses in autonomous ways.

As already mentioned, a limitation with the present study is that the focus of attention has been on clients that in different ways present with additional problems, for example by having non-supportive families or severe psychopathology. Thus, one should be careful with generalizing to clients who present with a different clinical picture. A general challenge with

psychotherapy research that use clinicians as informants is that research has shown that clients can be more reliable sources to therapeutic processes, and that therapists' descriptions do not necessarily mirror what is happening (Bohart & Greaves Wade, 2013). On the other hand, the goal with the present study has not necessarily been to get a detailed account of what is happening, but more an impression of what therapeutic processes clinicians aim for.

The present study has only included five participants, so it would be interesting to explore how other clinical psychologists relate to puberty suppression. It would also be interesting to interview clients or their families about the same processes, in order to explore their experiences, in contrast to the perspective of the clinician. Considering the results in the present study, indicating that many clients feel pressured to conform to heteronorms, and that exploration of alternative ways of managing gender variance than puberty suppression can be experienced as hostile, it would be interesting to get the clients' perspectives. Given the focus on discourse and the contextualization of clients, it would also be interesting to do research on clients' families, and how they frame gender variance. In addition, there is a lack of knowledge on what prospective narratives clients who are undergoing physical treatment and puberty suppression draw on, in order to gain insight into the expectations they have and how they can be supported better. Related to this, it would be interesting to meet clients who have undergone treatment, and ask them in retrospect how they experienced the processes. There is also a lack of research on cisgender identity as well. Knowledge about cisgender identity development would provide insight for clinical work with gender variant youth.

What are the take-home messages for clinicians working in the field from the present study? First and foremost, the results indicate that gender variant youth should be met with unconditional acceptance and appreciation of how difficult it is to question gender identity, being on the margins of discourse and live with uncertainty. These strategies should gradually be accompanied with careful exploration of relational history and deconstruction of assumptions that can be oppressive. Clinical psychologists should also have an awareness of queer theory and how heteronormative assumptions are permeating our culture, including the therapeutic setting. Important therapeutic goals are therefore to foster subjectivities that are able to question norms and hence contribute to queer resistance, together with attendance towards the embodiment of youth in development. The dilemmatic nature of the therapeutic work should also be appreciated, and the ability of the clinical psychologist to contain the distress and the uncertainty that clients and their families are facing, and at the same time explore a variety of solutions to how they can handle this, including puberty suppression, and different ways of expressing gender.

## 5 Conclusion

According to Butler's theory of gender as performative, humans can not express themselves when it comes to gender without relying on existing discourses to create meaning. Still, the same subjects that perform gender in accordance with the heteronorms are failing all the time. Every new performative act rests on already established forms of expression, but humans are intentional, and hence able to do it in new ways. The theory is supported by research on gender identity development. Fausto-Sterling (2012) shows that gendered thoughts and feelings develop in a continuous interaction with social contexts. They are therefore difficult to break, but not impossible. According to Hammack (2008), the personal narratives of our identity is dependent on master narratives in the culture, but at the same time require personal adaptation. Perhaps in this space between determinism and voluntarism, culture and individual, lies the therapeutic balance described in the present study. This includes the opportunities to explore new ways of understanding oneself in relation to others, while at the same time being able to negotiate and appreciate oneself as socially constituted.

The present study suggests that through a combination of facilitative and explorative therapeutic strategies, clients themselves can get into a position where they can explore different outcomes, instead of a search for predictors that guide the process. This is achieved by appreciating uncertainty and non-binary expressions instead of excluding it. In this way, the clients can become more active agents in negotiation with social discourses. In this respect, the results suggest an alternative to the Dutch and Canadian models that focus on external factors that can predict binary outcomes, instead of deploying processes that aim to grant gender variant youth with subjectivities that are able to question oppressive heteronorms. The results also indicate that uncertainty regarding gender identity is not pathological per se, and that non-binary gender variance can be healthy outcomes. In addition, the results focus on a group of gender variant youth that have not been granted much attention in the research, namely those who do not benefit from a quick transition into the other gender, have additional problems or present as non-binary or uncertain. The participants balance between exploration of new ways of performing gender and striving for autonomy on the one hand, and facilitative interventions aimed to foster acceptance for non-gender conformity and an enhanced ability to tolerate distress on the other hand. This represents one clinical strategy to help gender variant youth make decisions regarding puberty suppression.

## 6 References

- Bazeley, P. (2013). *Qualitative Data Analysis. Practical Strategies*. London: SAGE Publications.
- Benjamin, J. (1988). *The Bonds of Love*. New York: Pantheon Books.
- Benjamin, J. (2004). Beyond doer and done to: an intersubjective view of thirdness *The Psychoanalytic Quarterly*, *LXXIII*(1), 5-46. doi:10.1002/j.2167-4086.2004.tb00151.x
- Bohart, A. C., & Greaves Wade, A. (2013). The Client in Psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (6 ed., pp. 219-257). New Jersey: John Wiley & Sons.
- Boye, K. (2005). *Karin Boye. Complete Poems* (D. McDuff, Trans.). London: Bloodaxe Books.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. doi:10.1191/1478088706qp063oa
- Butler, J. (1990). *Gender Trouble*. New York: Routledge.
- Byne, W., Bradley, S. J., Coleman, E., Eyler, A. E., Green, R., Menvielle, E. J., . . . Tompkins, D. A. (2012). Report of the American Psychiatric Association Task force on treatment of gender identity disorder. *Archives of Sexual Behavior*, *41*(4), 759-796. doi:10.1007/s10508-012-9975-x
- Chodorow, N. (1978). *The Reproduction of Mothering. Psychoanalysis and the Sociology of Gender*. California: University of California Press.
- de Vries, A. L., & Cohen-Kettenis, P. T. (2012). Clinical management of gender dysphoria in children and adolescents: the Dutch approach. *Journal of Homosexuality*, *59*(3), 301-320. doi:10.1080/00918369.2012.653300
- Di Ceglie, D. (2009a). Between Scylla and Charybdis: Exploring Atypical Gender Identity Development in Children and Adolescents. In G. Ambrosio (Ed.), *Transvestism, Transsexualism in the Psychoanalytic Dimension*. London: Karnac Books.
- Di Ceglie, D. (2009b). Engaging young people with atypical gender identity development in therapeutic work: a developmental approach. *Journal of Child Psychotherapy*, *35*(1), 3-12. doi:10.1080/00754170902764868
- Drescher, J., & Byne, W. (2012). Introduction to the special issue on "The treatment of gender dysphoric/gender variant children and adolescents". *Journal of Homosexuality*, *59*(3), 295-300. doi:10.1080/00918369.2012.653299

- Drescher, J., & Pula, J. (2014). Ethical issues raised by the treatment of gender-variant prepubescent children. *Hastings Center Report*, 44 Suppl 4, 17-22.  
doi:10.1002/hast.365
- DSM-V. (2014). *Diagnostic and statistical manual of mental disorders* (5 ed.). Washington DC American Psychiatric Association.
- DSM-IV. (1994). *Diagnostic and statistical manual of mental disorders* (4 ed.). Washington DC: American Psychiatric Association
- Egan, S. K., & Perry, D. G. (2001). Gender identity: a multidimensional analysis with implications for psychosocial adjustment. *Developmental Psychology*, 37(4), 451-463.
- Ehrensaft, D. (2009). One pill makes you boy, one pill makes you girl. *International Journal of Applied Psychoanalytic Studies*, 6(1), 12-24. doi:10.1002/aps.185
- Ehrensaft, D. (2012). From gender identity disorder to gender identity creativity: true gender self child therapy. *Journal of Homosexuality*, 59(3), 337-356.  
doi:10.1080/00918369.2012.653303
- Fausto-Sterling, A. (2012). The dynamic development of gender variability. *Journal of Homosexuality*, 59(3), 398-421. doi:10.1080/00918369.2012.653310
- Giddens, A. (1996). *In Defence of Sociology. Essays, Interpretations and Rejoinders*. Cambridge: Polity Press.
- Gullestad, S. E., & Killingmo, B. (2013). *Underteksten. Psykoanalytisk terapi praksis*. (2 ed.). Oslo: Universitetsforlaget.
- Hammack, P. L. (2008). Narrative and the cultural psychology of identity. *Personality and Social Psychology Review*, 12(3), 222-247. doi:10.1177/1088868308316892
- Hembree, W. C., Cohen-Kettenis, P., Waal, H. A. D.-v. d., Gooren, L. J., Walter J. Meyer, I., Spack, N. P., . . . Montori, V. M. (2009). Endocrine treatment of transsexual persons: an endocrine society clinical practice guideline. *The Journal of Clinical Endocrinology & Metabolism*, 94(9), 3132-3154. doi:doi:10.1210/jc.2009-0345
- Hill, D. B., Menvielle, E., Sica, K. M., & Johnson, A. (2010). An affirmative intervention for families with gender variant children: parental ratings of child mental health and gender. *Journal of Sex & Marital Therapy*, 36(1), 6-23.  
doi:10.1080/00926230903375560
- Ibsen, H. (1905). *Peer Gynt. A Dramatic Poem* (W. C. Archer, Trans.). London: Walter Scott.
- ICD-10. (1993). *The ICD-10 Classification of Mental and Behavioural Disorders*. Geneva: World Health Organization.

- Käll, L. F. (2015). A path between voluntarism and determinism: tracing elements of phenomenology in Judith Butler's account of performativity. *Lambda Nordica*, 20(2-3), 23-48.
- Kaltiala-Heino, R., Sumia, M., Työlajärvi, M., & Lindberg, N. (2015). Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development. *Child and Adolescent Psychiatry and Mental Health*, 9. doi:10.1186/s13034-015-0042-y
- Kvale, S., & Brinkmann, S. (2009). *Interviews. Learning the Craft of Qualitative Research Interviewing* (2 ed.). London: SAGE Publications.
- Layton, L. (2004). *Who's that girl? Who's that boy? Clinical Practice Meets Postmodern Gender Theory* New York: Routledge
- Lemma, A. (2012). Research off the couch: re-visiting the transsexual conundrum. *Psychoanalytic Psychotherapy*, 26(4), 263-281. doi:10.1080/02668734.2012.732104
- Lev, A. I. (2006). Disordering gender identity. *Journal of Psychology & Human Sexuality*, 17(3-4), 35-69. doi:10.1300/J056v17n03\_03
- McLeod, J. (2013). Qualitative Research. Methods and Contributions. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (6 ed., pp. 49-84). New Jersey: John Wiley & Sons.
- Menvielle, E. (2012). A comprehensive program for children with gender variant behaviors and gender identity disorders. *Journal of Homosexuality*, 59(3), 357-368. doi:10.1080/00918369.2012.653305
- Moller, B., Schreier, H., Li, A., & Romer, G. (2009). Gender identity disorder in children and adolescents. *Current Problems in Pediatric and Adolescent Health Care*, 39(5), 117-143. doi:10.1016/j.cppeds.2009.02.001
- Paap, M. C., Kreukels, B. P., Cohen-Kettenis, P. T., Richter-Appelt, H., de Cuypere, G., & Haraldsen, I. R. (2011). Assessing the utility of diagnostic criteria: a multisite study on gender identity disorder. *Journal of Sexual Medicine*, 8(1), 180-190. doi:10.1111/j.1743-6109.2010.02066.x
- Roen, K. (2011). The discursive and clinical production of trans youth: gender variant youth who seek puberty suppression. *Psychology & Sexuality*, 2(1), 58-68. doi:10.1080/19419899.2011.536316
- Roen, K. (2016). The body as a site of gender-related distress: ethical considerations for gender variant youth in clinical settings. *Journal of Homosexuality*, 63(3), 306-322. doi:10.1080/00918369.2016.1124688

- Saketopoulou, A. (2014). Mourning the body as bedrock: developmental considerations in treating transsexual patients analytically. *Journal of the American Psychoanalytic Association*, 62(5), 773-806. doi:10.1177/0003065114553102
- Smith, Y. L., Van Goozen, S. H., Kuiper, A. J., & Cohen-Kettenis, P. T. (2005). Sex reassignment: outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychological Medicine*, 35(1), 89-99. doi:10.1017/S0033291704002776.
- Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. *Clinical Child Psychology & Psychiatry*, 16(4), 499-516. doi:10.1177/1359104510378303
- Steensma, T. D., McGuire, J. K., Kreukels, B. P., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 52(6), 582-590. doi:10.1016/j.jaac.2013.03.016
- Watts, S. (2014). User skills for qualitative analysis: perspective, interpretation and the delivery of impact. *Qualitative Research in Psychology*, 11(1), 1-14. doi:10.1080/14780887.2013.776156
- Willig, C. (2008). *Introducing Qualitative Research in Psychology* (2 ed.). New York: Open University Press.
- Wren, B. (2000). Early physical intervention for young people with atypical gender identity development. *Clinical Child Psychology and Psychiatry*, 5(2), 220-231. doi:10.1177/1359104500005002007
- Wren, B. (2014). Thinking postmodern and practising in the enlightenment: managing uncertainty in the treatment of children and adolescents. *Feminism & Psychology*. doi:10.1177/0959353514526223
- Youdell, D. (2006). *Impossible Bodies, Impossible Selves: Exclusions and Student Subjectivities*. Netherlands: Springer.
- Yunger, J. L., Carver, P. R., & Perry, D. G. (2004). Does gender identity influence children's psychological well-being? *Developmental Psychology*, 40(4), 572-582. doi:10.1037/0012-1649.40.4.572
- Zucker, K. J. (2008). Children with gender identity disorder: is there a best practice? *Neuropsychiatrie de l'Enfance et de l'Adolescence*, 56(6), 358-364. doi:<http://dx.doi.org/10.1016/j.neurenf.2008.06.003>

Zucker, K. J., Bradley, S. J., & Sanikhani, M. (1997). Sex differences in referral rates of children with gender identity disorder: some hypotheses. *Journal of Abnormal Child Psychology*, 25(3), 217-227.

# 7 Appendices

## 7.1 Appendix 1: NSD Approval

**Norsk samfunnsvitenskapelig datatjeneste AS**  
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

**NSD**

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Vår dato: 23.06.2015      Vår ref: 43609 / 3 / MSI      Deres dato:      Deres ref:

**TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER**

Vi viser til melding om behandling av personopplysninger, mottatt 30.05.2015. Meldingen gjelder prosjektet:

43609      *Hvordan jobber en psykoterapeutisk med ungdommer med kjønnsidentitetstematikk i forbindelse med pubertetsutsettende behandling?*

Behandlingsansvarlig      *Universitetet i Oslo, ved institusjonens øverste leder*  
Daglig ansvarlig      *Katrina Roen*  
Student      *Reidar Schei Jessen*

Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger er meldepliktig i henhold til personopplysningsloven § 31. Behandlingen tilfredsstiller kravene i personopplysningsloven.

Personvernombudets vurdering forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, <http://www.nsd.uib.no/personvern/meldeplikt/skjema.html>. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://pvo.nsd.no/prosjekt>.

Personvernombudet vil ved prosjektets avslutning, 01.01.2016, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Katrine Utaaker Segadal

Marte Byrkjeland

*Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.*

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## 7.2 Appendix 2: Inquiry to participate in research project

### Inquiry to participate in research project

” How do clinical psychologists work therapeutically with gender variant youth during puberty suppression and waiting to develop gender identity? ”

#### **Background**

There has been increased attention toward transgender health and treatment of gender identity disorder among youth the last 30 years (hereby I will refer to gender identity disorder and transgender youth as gender variant youth). Most countries in the western world have established special clinics, which focus on development of treatment programs. The common approach on gender variant youth is to start puberty suppression through hormone blocking in order to save some time before making a decision regarding gender identity. As a result of the medical focus on puberty suppression within the programs, the psychological work is not very well evaluated. There is a lack of information about the developmental consequences of breaking gender norms and awaiting a decision regarding ones own gender identity during the puberty suppression

The research question is therefore to explore the psychotherapeutic work with gender variant youth during puberty suppression and the psychological consequences of potential marginalization. There is also a focus on how the clinicians facilitate a negotiation between societal expectations and the young persons wishes.

As a participant you are going to be interviewed for about 1 hour about your reflections on your clinical work with gender variant youth. You will have the chance to review the data and keep in touch with the interviewer and the supervisor.

There is not going to be focused on information about your patients, but on your work and your clinical rationale.

#### **What happens with the information about you?**

All the information will be treated confidential. Only student and supervisor will have access to the anonymous transcribed data, while the records will be deleted after transcription.

The participants will not be recognised in the publication.

The project will be terminated approximately June 2016. The anonymous transcribed data will be stored at the Institute of Psychology.

#### **Participation is voluntary**

It is voluntary to participate, and it is possible to regret without giving any reason. If you regret, the information you have given will be anonymous.

If you want to participate, please contact clinical psychology student **Reidar Schei Jessen**, on reidar.jessen@gmail.com . Supervisor is professor Katrina Roen, katrina.roen@psykologi.uio.no. Roen is also responsible for the study.

The project is reported to Norwegian Social Science Data Services.

## **Consent of participation**

I have received information about the project, and I am willing to participate.

-----  
(Signed by the participant, date)

## 7.3 Appendix 3: Semi-structured interview guide

### Semi-structured interview guide

July 2015

Initial information to the participant:

- My goal is to explore how you work with gender variant youth, with special emphasis on some themes. But what is most interesting for me is to get a picture of how you work with the clients that are referred to you.
- I am not here to evaluate
- I encourage you to focus on complexity rather than simplicity.
- What are your expectations and thoughts regarding the conversation?
- The data will be treated anonymous, and will only be circulating between me and my supervisor.

Topics to be addressed:

1. What are your main clinical psychological rationales or therapeutic schools in your work as a clinical psychologist working with young people and gender issues?
  - What psychological approaches do you find particularly useful for working with young people seeking or undergoing puberty suppression?
2. How do you handle the patient's gender ambivalence within the psychotherapeutic work?
  - What do you find challenging, and what do you find interesting, in this area of psychotherapeutic work?
3. What are your reflections on gender and gender development, based on your experience of working with young people who question their gender identity?
  - How do you think insights from this area of psychological work could inform the way gender development is understood more broadly?
4. How would you describe clients' expectations of puberty suppression?
  - How would you describe your role in relation to clients' expectations of puberty suppression?