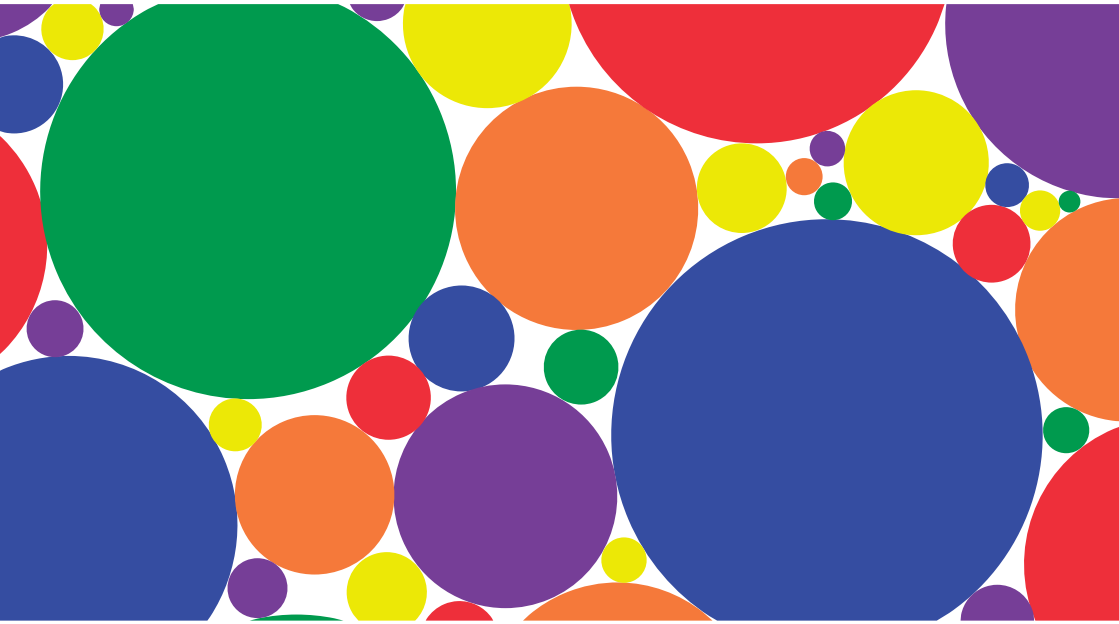
NHS

Medical care for gender variant children and young people: answering families' questions



Trans wellbeing and healthcare

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About this publication

This publication provides answers to the questions typically asked by parents of gender variant children and young people (up to the age of 17). It helps families to understand about gender variance and gives some suggestions about how to respond.

Parents, as well as other family members, are often deeply concerned if their children's behaviour is more like that of children of the opposite gender, or they show signs that they are not comfortable with their physical sex appearance.

The publication also gives contact details for the organisations that offer help and describes other sources of information that families should find useful.

This publication has been written in consultation with parents of gender variant children and young people, and is also based on the authors' work with this group.

In 2005, the Gender Identity Research and Education Society (GIRES), in collaboration with Mermaids, ran an international symposium for doctors from around the world who care for children and young people experiencing gender variance. GIRES and Mermaids remain in close contact with these professionals.

What is gender variance, and why does it happen?

Gender variance in children can show itself in the way they behave, in their dress or play, or in how they feel about themselves. Boys may say that they want to be girls, or that they actually are girls; and girls may wish to be, or believe themselves to be, boys. This is best understood as a natural, albeit unusual, variation in human development.

Typically, we are divided by our physical sex appearance into 'male' and 'female'. We tend to think that all human beings fall into two distinct categories: boys who become men, and girls who become women. Although we now live in a more equal society where boys and girls have many interests in common, we still expect that each group will dress somewhat differently and may often have rather different pastimes, perhaps play with different toys and have separate groups of friends.

Our reproductive organs and our brains have distinctly different male and female characteristics. The physical differences that can be seen at birth indicate the '*sex*' to which we are assigned, whereas '*gender identity*' describes the inner sense of knowing that we are boys/men or girls/women. '*Gender role*' describes how we behave in society.

In most cases, our *sex* appearance, *gender identity* and *gender role* are in agreement with each other. So, when the sex of a baby is seen at birth, it is assumed that the *gender identity* matches so that a male infant can be safely assigned as a boy, who will become a man, and a female infant can be assigned as a girl, who will become a woman.

However, a few individuals find that the way they look on the outside doesn't fit how they feel inside. The way they are expected to behave, and the *gender role* in which they are expected to live may be quite uncomfortable for them. This discomfort can be anything from slight

to severe. The persistent and profound experience of this discomfort in adults is sometimes described as '*gender dysphoria*' (dysphoria means unhappiness).

Severe gender variance is now understood to be biologically triggered, so that a baby may be born with a predisposition to experience this discomfort. Research studies indicate that small parts of the baby's brain progress along a different pathway from the sex of the rest of its body.

This predisposes the baby to a future mismatch between *gender identity* and *sex* appearance. When this mismatch becomes apparent it is regarded as gender variance.

My young son tells me that he wants to be a girl. Is that unusual?

It is unusual, but not rare.

In a survey of mothers in the Netherlands, 10 per cent reported that their children (aged up to 12 years old) had said, at least occasionally, that they wanted to be a member of the opposite gender. Other

studies confirm this. Gender variance may be exhibited by children as young as two years old; for example:

From the age of 2, Dennis Atkins (not real name) began to show a strong preference for toys and books designed for girls. When he started school, he liked it but gravitated towards the girls for making friends. He told a couple of the girls who were closest to him that he wanted to be a girl, which they found odd and they called him names.

My young son dresses in his sister's clothes. Is he likely to be transsexual?

It is one possible outcome, but there are other outcomes that are more likely.

It seems that *very few* young children who appear to be confused about their gender actually transition to live full time in the opposite gender role; in other words, as adults, they do not become transsexual people. So, some children, particularly when very young, may just like the look and feel of the clothes of the opposite gender, and this may mean nothing at all. Many eventually become gay or lesbian. In some, the gender variant behaviour or feeling disappears altogether.

In those who continue to experience gender variance, responses will be very varied because each person is unique, and will react differently to social circumstances. So, gender variance may be expressed in a wide variety of ways in both children and adults. A few will alleviate their discomfort by dressing in the clothes of the opposite gender occasionally, or even on a regular, but not continuous basis (crossdressing). The general term, which embraces all the varieties of unusual gender expression, is transgenderism. Many young people

who fall under this umbrella term prefer to be called trans boys (born with female genitalia, but identifying as boys) or trans girls (born with male genitalia, but identifying as girls).

Those young people who experience very severe discomfort may insist on changing their *gender role* on a permanent basis and may also seek medical treatment, at the beginning of puberty, to begin to align their *sex* appearance with their *gender identity* (see treatment on page 16). In these cases, the most likely outcome is that the condition will persist into adulthood so they will become transsexual adults.

So, whereas younger children may have outcomes that do not necessarily include becoming transsexual as an adult, those who continue to have strong cross-gender feelings at puberty almost invariably do become transsexual adults.

Because life can be very difficult for those who transition, some repress their need to do so for many years but find, later in life, that their gender discomfort is so great that they finally have to change their gender role and possibly have medical treatment.

Outcomes are, therefore, very varied and hard to quantify. The total number of adults in the UK who have sought medical help for severe gender discomfort is probably about 10,000, around half of whom have undergone full transition including surgery. So, transsexualism is very rare in the UK, which has a population of 60 million. Those who regard themselves as part of the much broader transgender spectrum of people are more numerous.

What is the difference between being transsexual and being gay or lesbian?

People often confuse the issues of sexual orientation and gender identity.

Sexual orientation is about being sexually attracted to men, or women, or both (bisexual) or, very occasionally, neither (asexual). As explained above, gender identity is the inner sense of knowing that we are boys/men or girls/women. So – sexual orientation is about whom you fancy, and gender identity is about who you are.

A transsexual person who has transitioned from living as a man to living as a woman (a trans woman) may be attracted to women and self-identify as lesbian, or attracted to men and self-identify as straight. Conversely, a person who has transitioned from living as a woman to living as a man (a trans man) may be attracted to men and self-identify as gay, or attracted to women and self-identify as straight. In *young* children it is sometimes difficult to tell the difference between those who will grow up to be gay, lesbian or bisexual, and those who will be transsexual, as their behaviours may be similar.

Transsexual people are not always sure until after they have transitioned permanently and had treatment, whether they will identify as straight, gay, bisexual or asexual.

What feelings do young people usually have about their gender variance?

In the Department of Health booklet *A guide for young trans people in the UK* (listed in Appendix 2) one of the team who produced it describes vividly the experience of gender variance, using such words as "alienation", "conflicts" and "discomfort".

As the booklet says, "There is no easy way to tell someone you're trans".

All the time that children try to deal with their gender discomfort by themselves, they feel loneliness, shame and even that they are freaks. As stated in the book *True Selves: Understanding Transsexualism* (listed in Appendix 2), "So much of their energy is focused on their gender confusion that their performance at school is often significantly affected".

Looking back on their childhoods, adult trans people may describe themselves as tainted by "patterns of worthlessness and shame... and a chronic need to apologize for oneself".[1]

At puberty, the stress may intensify as the body begins to develop in a way that the young person may find increasingly disgusting.

The following extracts from a letter written by Melissa Page (not real name) illustrate the stress experienced by young people who have to undergo full pubertal development in what is, for them, the wrong body:

1 Schaeffer, L and Wheeler, C (2004). Guilt in cross-gender identity conditions: Presentation and treatment. *Journal of Gay and Lesbian Psychotherapy*. 8(1/2) 117–127.

"The last two and a half years have been horrendous for me, with my body becoming so disgustingly adult male that I cannot bear it. Living in a male body hurts beyond belief. I sometimes feel as if I will go crazy with the sadness and desperateness of it. My body will never, ever be as I would like it to be and now, unfortunately, it is really a case of damage limitation. All I want is to be able to get on with my life as a female; at the moment, I am living in a limbo land – I have a female name and I dress in female clothes, but I have facial and body hair, which makes me feel horrible, I am the wrong shape for the clothes that I wear and I have genitalia which are completely alien and upsetting and which protrude through my clothes."

How do most parents feel about their child possibly being a transsexual person?

The reactions of parents differ widely, but most will feel very uncomfortable when their children exhibit marked gender variant behaviour, so if this is how you feel, you are not alone. Even those who are generally tolerant about most aspects of their children's behaviour may feel puzzled, anxious and embarrassed. If you are a parent in this position, you may also be fearful about the way your child may be treated by other children, especially at school. You will want to protect your child but you may not know how to achieve that.

Some children are able to hide their gender variant feelings for many years so, when they do reveal them, perhaps inadvertently, their parents are unprepared and shocked.

"I found my 11-year-old son in our bedroom one day. He had taken a skirt and shoes from my wardrobe, and was wearing them. At first I just

laughed and told him to take them off and put them back. A few weeks later, I found him again, doing the same thing. The first time, I assumed it was a 'one-off'. This time I thought, 'We've got a real problem here'. I just walked straight out of the room and left him to it. I felt physically sick. I didn't feel able to talk about it to him, or to anyone."

When they first perceive their children's gender variance, some parents may try to ignore it. Others may respond angrily and try to force a return to behaviour that they find acceptable. However, forcing the child to hide its feelings will not make them go away. If you are feeling guilty because you think that you have somehow caused this to happen, again, you are not alone. Many parents experience these doubts and concerns. However, it is important to understand that this is not the case. Gender identity is just naturally variable. It is nobody's fault. Nobody is to blame.

Even if you accept your child's gender variance you may still have a sense of bereavement and grief: "I have lost my daughter"; "I will never be a grandmother".

It is natural for parents to be worried, upset and even scared at the prospect of a child eventually transitioning permanently to live in the other gender role. However, you may find it comforting to know that the earlier these difficulties are addressed, the more comfortable and happy your child may be as an adult.

You may find it helpful to share your concerns with others in a similar situation, for instance by joining a support group such as Mermaids. A list of information sources is contained in Appendix 2.

At what stage should I be concerned about my child's gender variance?

You should try to be relaxed about cross-gender behaviour in your child, even if you do feel concerned. It is important that children do not feel judged or rejected because of who they are. Sometimes, in the case of a child who wishes to cross-dress, you may feel it is appropriate to negotiate some boundaries to this, by explaining to your child that although this isn't a secret, it is private and should be done at home, but perhaps not at school as other people may not understand. However, it is important not to make the child feel that this is something shameful.

Usually, transsexual adults describe feelings of gender discomfort that date back to their early childhood. Often these feelings are suffered in secrecy and shame, so if your child has confided in you, you should feel privileged that he or she has felt able to do so. You should rise to the occasion by being as accepting as possible, and reassure the child that you love him or her, no matter what.

Puberty may cause such intense anxiety in some young trans people that they are extremely vulnerable to depression and even suicidal feelings. Many trans adults say that they regret that they were not given medical care at this time.

During puberty, those who identify as boys, despite their female bodies, find periods and breast development intensely and even unbearably painful and disgusting. They sometimes become frustrated by their small stature compared with most other boys. As you can see from Melissa's letter above, those who identify as girls, in rapidly changing male bodies, are equally distressed as their voices deepen, as they grow facial hair and prominent Adam's apples, as they experience erections

and as they become taller than most other women. For transsexual adolescents, the physical changes they experience during puberty are difficult or impossible to reverse, and any reversal requires painful and costly surgical procedures. The irreversible effects cause life-long disadvantage because they often make it difficult, or even impossible, to 'pass', that is, to look and sound completely like a person of the opposite sex. This means that they may be 'read' on the street and consequently may suffer prejudice, harassment, humiliation and even violence.

So, if your son or daughter continues to exhibit gender variance as puberty approaches, you should begin to think very carefully about the best way to help your child and also how to cope with your own feelings, as well as those of other family members.

Can doctors reverse gender variance with medication?

No, there is no evidence that giving testosterone to masculinise a boy who feels like a girl, or oestrogen to feminise a girl who feels like a boy makes any difference to their gender identity. Gender identity appears to be indelible from before birth and, as far as anyone knows, there is no medication or other treatment that can make a young person or an adult develop a particular gender identity. In fact, the consequences of giving hormones to *emphasise* the sex characteristics of the body would risk making it even more at odds with the gender identity. This would increase the young person's stress.

Using other medication to alleviate the young person's stress may also be unhelpful unless, at the same time, the gender variance is also properly recognised and treated. If it is, the stress-relieving medication may no longer be needed.

Do many parents seek medical help for their gender variant children?

It seems that most parents with gender variant children do not seek specialist help.

We know that about 800 *adults* per annum are referred to the ten NHS gender identity clinics throughout the UK, and although most say they experienced the discomfort as far back as they could remember, only about 50 *children* per annum are referred to the one specialised medical centre in the UK, the Gender Identity Development Unit (GIDU) at the Tavistock and Portman NHS Foundation Trust, in London. Contact details for the GIDU are contained in Appendix 1.

There are several possible reasons for parents not seeking specialist help:

- Some parents will not regard gender variance as a problem, and therefore will not need help.
- In many cases, the family may be unaware of their child's gender variance. For gender variant children and young people, expressing their feelings within their families may seem impossible. What they see is a family, and the world beyond it, neatly divided into two gender expressions: boys and girls, in strict agreement with genital appearance and with no apparent tolerance for any variation from that 'norm'. They may fear that they will be rejected if they disclose their gender feelings.

- Some children may not even be able to find the words to express their feelings; they may simply know that they are 'different' and feel that they do not fit in. Some gender variant children have been known to say, in early childhood, that they feel like 'freaks', but they were unable to explain why.
- It is important for children that they 'fit in' with their peer group. They may be afraid of being bullied if they reveal their gender confusion. Boys who behave in feminine ways may be labelled sissies. Girls showing tomboy traits may experience more tolerance but not complete acceptance. Gender variant children have good reason to fear bullying if they reveal how they are feeling. According to a survey conducted among 872 transgender people in 2006, more than half of them had experienced bullying at school.[2] In a majority of these cases, the bullying included physical abuse and even unwanted sexual behaviour. About a quarter of the transgender people who participated in the survey reported having been bullied by their teachers. Both the young people mentioned earlier experienced bullying at school.

  When Denise (who had transitioned from living as Dennis) attended school, an older boy shouted out insults and then tried to pull her skirt down.

  Another, older, child, Melissa, who attended a different school and had also transitioned, experienced other pupils shouting out things like "Girl with a cock", "There's the he/she/it'', "Tranny boy", and other names.

2 Whittle S, Turner L, Al-Alami M (2007) *Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination*

http://archive.cabinetoffice.gov.uk/equalitiesreview/upload/assets/www.theequalitiesreview. org.uk/transgender.pdf

- It may not seem worthwhile to children and adolescents to reveal their gender feelings to anyone because they think nothing could be done anyway. They may be aware from sources such as the internet or from our publication *A guide for young trans people in the UK* that they will need to "look further than the UK for medical intervention". Although this intervention is available in 11 leading treatment centres overseas (see Appendix 1), it is likely to be out of reach for most young people in the UK.
- Some parents who do learn about their child's gender variance may try to ignore it or deny the way their child is feeling and hope that they grow out of it. Some may try to persuade their child that the feelings are wrong or not acceptable. Families may try to cope by rewarding typical gender behaviour, and punishing cross-gender behaviour.

What medical help is available for gender variant children?

Treatment for children and young people is provided in three sequential phases:

1 – Careful initial psychological observation, assessment and support

This includes work with the family and the school to ensure that a supportive environment is provided for children exhibiting cross-gender behaviour or dress.

2 – Suspension of puberty

As puberty approaches, the leading clinics will make a careful assessment of which children are almost certain to develop as

transsexual adults and which are unlikely to do so. No physical test is available for detecting and measuring gender variance that may develop into adult dysphoria and transsexualism. Hence, clinicians must rely on the young person's own account of his or her feelings, or information from the parents about the way the child talks and behaves and on psychological tests. However, the young person's response to the physical changes experienced in early puberty is a significant indicator of how likely it is that profound gender variance will persist. If it seems almost certain that the condition will persist, further physical changes (masculinisation or feminisation) may be suspended by means of medication which blocks the surge of sex hormones that occurs at puberty.

This medication (hormone blockers) relieves the young person's acute stress because it puts the physical changes of puberty on hold, giving the young person more time in which to make decisions about whether to live as a man or as a woman in the future. It is important to intervene early enough to suspend the physical changes because once they have occurred, they are difficult or even impossible to reverse. For young people who are first seen by the clinician at a later stage of puberty, the screening process would be just as thorough, but would be done as quickly as possible so that hormone blocking medication can be given to prevent further distressing physical development.

This treatment is monitored and controlled to ensure that potential complications do not arise, such as inadequate bone development, or unequal rate of growth between the trunk and the legs. Overall height is also carefully monitored. Additional medication may be offered to stimulate further growth in those intending to transition

from living as a girl to living as a man, so that their final height conforms as nearly as possible to the normal range for adult men.

In all cases, the young person must be able to give properly informed consent to this intervention. This means that they must understand the implications of treatment, the risks and benefits, and the consequences of not having treatment (Fraser (otherwise Gillick) competence, see Appendix 3).

Parents (or others with parental responsibility, Appendix 3) also need to give consent and be supportive as this is crucial to successful outcomes (see Parental Responsibility, Appendix 3). In cases of trans girls (with male gonads and genitalia), it should be made clear that suspension of pubertal development:

- limits the amount of tissue available for the later creation of a vagina and, consequently, surgical procedures may be required that would not otherwise be necessary; and
- may prevent the collection of semen for storage should fertility be desired later on.

In all cases, reassurance can be given that, if the young person's intention were to change during this phase, the medication would be stopped. This would allow the previous pubertal development to restart and normal fertility to be achieved, without harm to the young person.

3 – Changing the gender role and hormonal medication

Living full time in the gender role that accords with the gender identity is sometimes called the real life experience (RLE).

There is no general rule about the right time to start living in the opposite gender role. Young people may be advised to consider delaying the public expression of their gender identity because it is difficult to undo the effects of revealing this in social situations, especially school. As described above, it may make the young person the target of bullying. However, children such as Dennis (whose experience is outlined on page 15) feel such an intense need to express their true identities that they have to reveal them. If that is the case, very careful preparatory work needs to be done with all the people with whom the young person will be in regular contact: teaching staff, pupils and, sometimes, parents of other school pupils. Also, of course, other members of the wider family will need to know, and, perhaps, neighbours and friends.

Once the young person has made a firm decision to remain permanently in the new gender role, cross-sex hormonal medication may be offered. This is administered in a gradually increasing dosage that is ultimately adequate to masculinise or feminise the body. However, it is not usually offered before age 16. Some young people delay the start of changing the gender role until hormone medication is prescribed. In those transitioning from living as a boy to living as a girl, the feminising hormones have the added benefit of restricting overall height so that it conforms as nearly as possible to the typical range for adult females.

Some of the physical changes induced by cross-sex hormone medication are difficult or even impossible to reverse. Masculinising hormones (testosterone) lower the pitch of the voice and stimulate the growth of facial and body hair. Feminising hormones (oestrogen) cause the development of breasts. Consequently, the decision to commence this medication is more critical than the previous decision

to commence hormone blocking medication. Another factor to consider carefully is the effect on fertility. However, for several years following the commencement of cross-sex hormone medication, if it is stopped, normal levels of fertility can be achieved in both trans boys and trans girls.

Administration of cross-sex hormones to young people is also subject to their properly informed consent. In addition, clinicians seek the consent of the parents or guardians. As with the hormone blocking medication, it is usually felt that it is unrealistic to expect young people to be able to lead a successful life without family support. However, in law, 16 year olds are regarded as competent to make their own decisions (see Appendix 3). In all cases, continued counselling and advice should be offered to the young people, to the parents or guardians and to the schools.

In what ways does treatment in the UK differ from that in other countries?

There are different medical opinions about the timing of blocking medication for young people. There are, as yet, no very long term studies of the different approaches to treatment, although data are now being collected, particularly in the Netherlands. There, the treatment as outlined above (providing hormone blockers to suspend puberty before physical changes become marked) has been followed, according to strict protocols, for several years. So far, none of the young people treated there has subsequently expressed regret or reverted to the previous gender role. In March 2014, the GIDU adopted the approach recommended by the Endocrine Society. Young people experiencing profound and persistent gender dysphoria are offered suspension of puberty at an early stage of physical development (Tanner stage 2 in natal girls and Tanner stage 3 in natal boys).

The GIDU does not provide cross-sex hormones to those aged under 16. The dose is then lower than in the Dutch clinic. The GIDU continues to treat young people until their 19th birthday, and later if their transfer to an adult service is delayed.

Young people are eligible for treatment in the adult NHS clinics (once they are 17 years old) or by private practitioners (from 16 years old). Further information is available in the Department of Health publication *A guide to hormone therapy for trans people*.

What aspects of the care provided by the GIDU do families find most helpful?

Contact with the GIDU would be made via the family's GP and then the local child and adolescent mental health service (CAMHS). Typically the local CAMHS will have no experience of treating gender dysphoria and will wish to pass responsibility for any such cases to the specialists in the GIDU. Although relatively few families are referred to the GIDU, those that are do appreciate the education that it provides about gender variance in young children, as well as its talking therapies and counselling. For some young people, this also provides an opportunity to explore their gender feelings. In addition, the GIDU deals with other agencies, such as social services, GPs, schools, etc. One mother says that, in the case of her daughter, who was assigned as a boy at birth, "Jennifer (not real name) would not have been able to stay in school to do her GCSEs if two of the clinicians at the GIDU had not come to two meetings held at the school – our family GP also attended and I do feel that this also helped him to learn about trans issues, and he did provide extremely good care for her."

Is it possible to obtain treatment for my child in any of the overseas centres?

Appendix 1 contains a list of the overseas centres. The highly experienced Dutch clinicians are not permitted to treat young people from the UK. Similar restrictions also apply in Belgium and Germany. Currently, British families who wish their adolescent children to be psychologically assessed and, when appropriate, offered early suspension of puberty seek medical help in the USA. Clearly, that is an expensive option. Moreover, the families still need to arrange psychological support, administration of hormone blocking medication and medical tests in the UK. Nonetheless, some families are able to find enough money to cover the cost. They feel it worthwhile to alleviate the immediate suffering of their children and to minimise their future difficulties as trans adults.

At what stage would a young transsexual person be considered for surgery?

Surgery alters the body to conform as nearly as possible to the gender identity. Clinicians are, rightly, very cautious about offering surgery. Many of the procedures that most transsexual people typically undergo, such as removal of the testes or ovaries, are impossible to reverse. Currently, these procedures would also irreversibly rule out fertility, although advances in medical technology may, in the long term, enable the conception of genetically related children.

Those who have received hormone blocking medication during puberty will need fewer corrective interventions than they would otherwise have required. For instance, those transitioning from female to male would not require chest reconstruction and those transitioning from male to female would not require removal of facial hair.

Surgery is never contemplated for any young person while attending the GIDU. That possibility is only considered within an adult service and is, therefore, never undertaken before the age of 18. Indeed, it is extremely unusual for anyone aged under 18 to be offered surgery anywhere in the world.

What should I do if my gender variant child is being bullied at school?

Your child is entitled to protection. Under the School Standards and Framework Act 1998, children and young people are protected by the statutory duty on head teachers to prevent and tackle all forms of bullying. Schools must have anti-bullying policies and procedures in place. This legislation does not specifically refer to transphobic bullying. However, the government department that is responsible for schools is not prepared to tolerate the bullying of a child or young person for any reason. In some cases, the police may become involved. Each police force should have an officer whose duty it is to look after the needs of transgender people. You may find it helpful to contact the officer responsible for diversity at the headquarters of your local police force, who may put you in touch with the officer who acts as a liaison with transgender people in your community.

The Anti-Bullying Alliance may be able to offer helpful advice. Its list of regional co-ordinators may be found at:

www.anti-bullyingalliance.org.uk/Page.asp?originx_8898hb_4390198278453u82f_20068301547k

Other useful websites are www.bullyonline.org/ and www.bullying.co.uk/

If the school feels that it needs help, it might wish to contact the AntiBullying Alliance and also the Gendered Intelligence organisation, which specialises in training for professionals who work with young people: www.genderedintelligence.co.uk

Conclusion

Gender variance in young children is not rare, although it may not necessarily become adult transsexualism. Usually it requires no medical intervention until the approach of puberty. In cases where the child has an earlier and irrepressible need to change the gender role, on an intermittent or permanent basis, you and other family members may find it helpful to talk to others who have had this experience. You may contact Mermaids, the specialist support group. If the gender variance persists and you decide to seek medical help, you are likely to be referred to the GIDU, which provides psychological support but does not offer any medication until full puberty has been completed. If you wish to consider earlier medication you would need to approach one of the American treatment centres, but the cost for many would be daunting.

Where can I obtain more information?

See Appendices 1 and 2 which contain details of treatment centres and lists of recommended further reading and useful websites.

Appendix 1: Treatment centres

British specialist treatment centre

Gender Identity Development Unit at the Tavistock and Portman NHS Foundation Trust:

www.tavi-port.org/patient/tavistock-clinic/patient-services-anddepartments/gids.html?no_cache=1&sword_list%5B%5D=identity

Overseas treatment centres that offer early suspension of puberty to adolescents experiencing profound and persistent gender dysphoria

VU University Medical Centre, Amsterdam, The Netherlands

Ghent University, Belgium

Frankfurt University Hospital and Endokrinologikum Centre in Hamburg, Germany

Children's Hospital, Boston, Massachusetts, USA

Columbia University College of Physicians and Surgeons, New York, USA

Penn State College of Medicine, Hershey, Pennsylvania, USA

University of Texas Medical Branch, Galveston, Texas, USA

Washington University, St. Louis, Missouri, USA

Children's Hospital and Research Center, Oakland, California, USA

Child and Adolescent Gender Identity Clinic, Toronto, Canada

Royal Children's Hospital, Parkville, Victoria, Australia

Appendix 2: Further reading

Professor Peggy Cohen-Kettenis and Professor Friedemann Pfäfflin: *Transgenderism and Intersexuality in Childhood and Adolescence*, Sage Publications 2003, ISBN 0-7619-1711-X; book that can be ordered from booksellers and via the internet.

Mildred L Brown and Chloe Ann Rounsley: *True Selves: Understanding Transsexualism – For Families, Friends, Coworkers, and Helping Professionals*, Jossey Bass 1996, ISBN 0-7879-6702-5; book that can be ordered from booksellers via the internet.

Annelou de Vries, Henriette Delemarre-Van de Waal, Peggy CohenKettenis: *Caring for Transgender Adolescents in BC: Suggested Guidelines – Clinical Management of Gender Dysphoria in Adolescents*; Transcend Transgender Support and Education Society and Vancouver Coastal Health's Transgender Health Program; January 2006; article available online at: www.vch.ca/transhealth/resources/library/tcpdocs/guidelinesadolescent.pdf

Henriette Delemarre-Van de Waal and Peggy Cohen-Kettenis: Clinical management of gender identity disorder in adolescents: A protocol on psychological and paediatric endocrinology aspects, *European Journal of Endocrinology*, 2006; article available online at: www.eje-online.org/cgi/content/full/155/suppl_1/S131

Department of Health: *A guide for young trans people in the UK*; booklet available online at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074258

Department of Health: *A guide to hormone therapy for trans people*; booklet available online at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074258

Appendix 3: Fraser (Gillick) competence

It is usual for children and young people under the age of 16 to have the consent of an adult having Parental Responsibility (PR) for them, for every stage of treatment.

However, in some cases, the consent of any adult(s) having Parental Responsibility is not necessary, if the young person under 16 is deemed, by the doctor, to be 'Fraser' (or 'Gillick') competent.

Competence means that the young person must:

- understand the issues, and…
- retain the information long enough to…
  - consider the information appropriately, and…
  - make a decision based on the information received.

After the sixteenth birthday, a young person is automatically deemed to be competent (Family Law Reform Act 1969, section 8).

'Fraser' or 'Gillick' refers to a court case, *Gillick v West Norfolk and Wisbech Area Health Authority (1985)*, in which it was stated that, in order for those under the age of 16 to be regarded as competent, the young person must have, "not merely an ability to understand the nature of the proposed treatment, but a full understanding and appreciation of the consequences of both the treatment in terms of intended and possible side-effects and, equally important, the

anticipated consequences of failure to treat" (Re R, Lord Donaldson). This might apply where the child and the parent (or other person having Parental Responsibility) are not in agreement regarding treatment.

For further information see:
www.patient.co.uk/showdoc/40002288/

Parental Responsibility

A person with Parental Responsibility will include: the natural mother, automatically; the natural father, if married to the mother at the time of the child's birth or having subsequently married her, or having a section 4(1a) Order or 4(1b) Agreement (Children Act (CA) 1989); anyone with a Residence Order (s8 and s12, CA 89) or a Care Order (s31, s33(3) CA 89); anyone with a Special Guardianship Order (s14A, CA 89), or an Adoption Order; a Placement Order (local authority only, s22 Adoption and Children Act 2002).

In respect of children born before 1 December 2003, a natural father may now obtain PR by being entered on the relevant child's birth certificate at a later date, with the agreement of the mother.

In relation to births registered from 1 December 2003, a natural father who is not married to the mother of the child, but whose name was entered on the relevant child's birth certificate, will automatically have PR.

Step parents may acquire PR under s4A (CA 89). An Adoption Order will nullify any pre-existing PR rights.

Websites

Mermaids: Support and information for children and teenagers who are trying to cope with gender identity issues and for their families and carers:
www.mermaids.freeuk.com/

Gender Identity Research and Education Society (GIRES): Provides information and education based on research into atypical gender identity development, which includes 'Endocrine Treatment for Adolescents': www.gires.org.uk/

The Anti-Bullying Alliance: The Alliance brings together 65 organisations into one network with the aim of reducing bullying and creating safer environments in which young people can live, grow, play and learn. Its list of regional co-ordinators may be found at:
www.anti-bullyingalliance.org.uk/Page.asp?originx_8898hb_4390198278453u82f_20068301547k

Bullying Online: Offers information and advice to parents, children and schools: www.bullying.co.uk/

School Bully Online: Provides advice for children, parents and teachers:
www.bullyonline.org/schoolbully/index.htm

Gendered Intelligence: This organisation specialises in training for professionals who work with young people:
www.genderedintelligence.co.uk

Department of Health: For additional publications on transgender issues, please visit our website at: www.dh.gov.uk/sogi

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