

Australian children and adolescents with gender dysphoria: Clinical presentations and challenges experienced by a multidisciplinary team and gender service

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Abstract

This prospective study examines the clinical characteristics of children ($n = 79$; 8.42–15.92 years old; 33 biological males and 46 biological females) presenting to a newly established, multidisciplinary Gender Service in New South Wales, Australia, and the challenges faced by the clinicians providing clinical services to these patients and their families. The clinical characteristics of the children were comparable to those described by other paediatric clinics providing gender services: a slight preponderance of biological females to males (1.4: 1); high levels of distress (including dysphoria about gender), suicidal ideation (41.8%), self-harm (16.3%), and suicide attempts (10.1%); and high rates of comorbid mental health disorders: anxiety (63.3%), depression (62.0%), behavioural disorders (35.4%), and autism (13.9%). The developmental stories told by the children and their families highlighted high rates of adverse childhood experiences, with family conflict (65.8%), parental mental illness (63.3%), loss of important figures via separation (59.5%), and bullying (54.4%) being most common. A history of maltreatment was also common (39.2%). Key challenges faced by the clinicians included the following: the effects of increasingly dominant, polarized discourses on daily clinical practice; issues pertaining to patient and clinician safety (including pressures to abandon the holistic [biopsychosocial] model); the difficulties of untangling gender dysphoria from comorbid factors such as anxiety, depression, and sexual abuse; and the factual uncertainties present in the currently available literature on longitudinal outcomes. Our results suggest the need to bring into play a biopsychosocial, trauma-informed model of mental health care for children presenting with gender dysphoria. Ongoing therapeutic work needs to address unresolved trauma and loss, the maintenance of subjective well-being, and the development of the self.

Keywords

gender dysphoria, gender identity, gender diversity, transgender, adverse childhood experiences, family narratives, systems theory, holistic (biopsychosocial) practice, children and adolescents

I. Introduction

Over the last decade, across Europe and the United States, the rates of children (including adolescents) presenting with psychological distress have continued to increase (Twenge et al., 2019; World Health Organization, 2019). The reasons for this increase are the subject of current research and broader social debate. As part of this global trend, the incidence of children presenting with distress pertaining to sex assigned at birth—termed *gender dysphoria* (American Psychiatric Association, 2013)—has also been reported to be increasing (Zucker, 2019). The current study examines the clinical characteristics of children presenting to a newly established, multidisciplinary Gender Service at a tertiary care hospital in New South Wales, Australia, and the challenges faced by the clinicians providing clinical services to these patients and their families.

Our gender clinic was established in December 2013 in the wake of increased referrals to our hospital Endocrinology Department for children experiencing gender dysphoria. Along with their distressed families, these children (sometimes with court orders in hand) came to Endocrinology typically seeking treatment with puberty-suppressing medications.

In establishing a clinical service, we consulted published guidelines and data from other services. At the time, the two available sets of guidelines were roughly equivalent (Hembree et al., 2009; World Professional Association for Transgender Health, 2011). The guidelines suggested a model of treatment that involved the following: (1) provision of

information, psychological support, and parental or family counseling in younger children; (2) puberty suppression with gonadotropin-releasing hormone (GnRH) agonists in children for whom the gender dysphoria persisted and who were distressed by the development of secondary sex characteristics with the onset of puberty; (3) *medical* gender-affirming treatment (with cross-sex hormones) for children 16 years and over; and (4) a subsequent option for *surgical* gender-affirming treatment. Despite the existence of guidelines, the evidence base for all aspects of treatment was and remains sparse.

Many clinics and researchers had observed that a significant proportion of youth with gender dysphoria presented with psychological or psychosocial vulnerability factors and psychological comorbidities (Di Ceglie et al., 2002). More recently, the Australian Trans Pathways study (2020) in youth (14–25 years) has likewise reported high levels of distress, expressed in high rates of self-harm (79.7%), suicidal thoughts (82.4%), and attempted suicide (48.1%), and in substantial psychological comorbidities (depression [74.6%], anxiety [72.2%], post traumatic stress disorder [25.1%], personality disorders [20.1%], and psychosis [16.2%]) (Strauss et al., 2020). In parallel, Warrior et al. (2020) found elevated rates of autism diagnosis or traits related to autism in transgender adults and gender-diverse individuals. Studies also reported that youth with gender dysphoria experienced high levels of social and relational problems—difficulties with parent/carers, relationship difficulties with peers, and bullying/harassment/victimization (De Vries et al., 2016; Di Ceglie et al., 2002)—and that those with supportive families and supportive peer relationships had better psychosocial outcomes (Simons et al., 2013).

In addition, we—the clinicians working in the Gender Service—became aware of a broad array of sociopolitical discourses, perspectives, beliefs, points of view, stories, and counter-stories (Delgado, 1989; Scher and Kozłowska, 2018) that affected our work and challenged us in a variety of ways. In particular, two dominant discourses came into play in our interactions with patients and families, support groups, and other medical professionals, both within and outside our hospital network, and in the context of public discourse and controversy.

One point of view—under the rubric of the *gender affirmative model* (Hidalgo et al., 2013; Keo-Meier and Ehrensaft, 2018)—supported the acceptance and affirmation of the child’s felt sense of gender. It also suggested that “decision-making should be driven by the child or adolescent whenever possible” (p133) (Telfer et al., 2018).¹ Children, families, self-help groups, and clinicians adhering to this point of view support social and medical interventions that—if the child so desired—correct the identity/body mismatch. Social interventions include a transition in which the child, family, and school use the child’s preferred name and encourage the child to dress in whatever way supports the child’s subjective experience of gender. Medical interventions equate with those in published guidelines (see above). And, though the gender affirmative model explicitly acknowledged that “gender identity and expression [should be] enabled to unfold over time, as a child matures, acknowledging and allowing for fluidity and change” (Hidalgo et al., 2013: 287–288), the available options under this model were strongly influenced and progressively constrained by the imminent approach of puberty.

Another point of view—antithetical to that described above—came to be presented by older patients who regretted their treatment under the gender affirmative model (BBC, 2019; BBC News 2020; Bell, 2020a; D’Angelo, 2017; 2020b) and by clinicians who were

concerned about the medicalization of gender questioning or distress, the irreversible nature of some gender-affirming interventions, and the lack of a solid evidence base (D'Angelo, 2020a; Entwistle, 2019). This perspective emphasized that children's conceptions of themselves are still developing through the teenage years and that they can be harmed when clinicians unquestioningly accept the individual child's assertion of gender identity or when clinicians fail to challenge the child's beliefs pertaining to that identity or fail to understand the developmental trajectory that had brought the child to what is often a place of distress and suffering. It highlighted that gender dysphoria and the child's suffering did not arise *de novo* but needs to be understood and contextualized in relation to the child and family story. As noted by one patient speaking from this perspective, individuals with gender dysphoria "need . . . access to psychological support from impartial practitioners who do not subscribe to gender identity ideology and are able to help people explore their thoughts and feelings about their sex, sexuality and the underlying causes of their gender dysphoria" (Personal Communication, Keira Bell, September 2020).

In the above context of diverse sociopolitical discourses, the clinicians in our Gender Service tried to provide children presenting with gender dysphoria—and their families—a comprehensive biopsychosocial assessment that endeavored to explore and understand each individual child's story, along with that of the family, in an effort to identify and address the broad range of factors that were contributing to the child's distress and loss of well-being. The assessment was run in a stepwise manner. Clinicians from adolescent medicine provided referral triage, a baseline biopsychosocial assessment, a medical assessment (including puberty staging), and medical information and education to the child and family. Clinicians from Psychological Medicine conducted a comprehensive individual and family assessment, put together the child's developmental story (the context in which the issues, dysphoria, and distress have arisen), and documented (or not) the diagnosis of gender dysphoria and mental health comorbidities. The Psychological Medicine team also provided the child and family with an individualized mental health treatment plan. Clinicians from Endocrinology, who saw a subset of children, again provided advice about the broad range of options and pathways, and in some cases they oversaw the initiation of puberty blockers. Because of the imminent approach of puberty, puberty blockers—because they are reversible—afforded the child and family time for additional reflection. The team hoped that against the background of such explorations, the child and family would be in a better position to consider, reflectively and with full awareness of the consequences, the decisions that they would make—and the pathway that they would eventually choose—to respond to the child's gender dysphoria. Children and families who decided to engage in ongoing psychotherapy and family work—which was recommended for the majority of children and families—were encouraged to identify appropriate local resources, most likely in cooperation with their primary care providers. Older children and families who wanted to pursue cross-sex hormones were transitioned to adolescent/adult services as they neared the age of 16.

In the current study, we report the clinical characteristics of the children presenting for assessment of gender dysphoria to our Gender Service. We also report on the manner in which a broad array of sociopolitical discourses, perspectives, beliefs, points of view, stories, and counter-stories played themselves out in the assessment and treatment processes—between the child, family, and multidisciplinary team, within the

multidisciplinary team itself, and in the broader hospital network (overseeing two paediatric hospitals).

2. Method

The Gender Service is a multidisciplinary service located in a tertiary care children's hospital in New South Wales. From December 2013 to November 2018—a 5-year period—children and their families presenting to the service were given the opportunity to participate in a research project documenting clinical presentations, clinical pathways, and outcomes.

Measures included the following: age-of-onset of the child's dysphoria; the child's distress pertaining to gender; social connectedness with peers; family clinical functioning (including the family's response to the child's gender dysphoria); adverse childhood experiences (ACEs) reported as part of the developmental story; and the Global Assessment of Functioning (GAF), where patients with physical or psychological impairment fall into the lower brackets (score <81) (see Kozłowska et al., 2021, for more detail regarding measures). The *Diagnostic and Statistical Manual of Mental Disorders* (DSM)–5 was used to document clinical diagnoses (including gender dysphoria) (American Psychiatric Association, 2013).

Prior to the clinical assessment, children and families filled out two self-report questionnaires: the Depression, Anxiety, and Stress Scales (DASS) (Lovibond and Lovibond, 2004; Patrick et al., 2010) and the SCORE family assessment questionnaire (SCORE-15) (Carr and Stratton, 2017; Fay et al., 2013).

Qualitative assessments of key themes were undertaken. The child and family's expectations from the clinic—what they wanted from the Gender Clinic on presentation—were documented. In addition, the main challenges faced by the clinicians in the multidisciplinary team—as discussed in monthly multidisciplinary meetings and documented through notes taken by team members—were brought together and synthesized into key themes (Braun and Clarke, 2006).

The study was approved by the Hospital Ethics Committee. Participants and their legal guardians provided written informed consent in accordance with national health and medical research council guidelines.

3. Data analysis

Descriptive statistics were used to assess the clinical characteristics and comorbidities for key variables of interest. T-tests and chi-square tests were used for comparative analyses between groups for continuous and categorical variables, respectively. Qualitative data were analyzed thematically.

For further between-group analyses, the age-of-onset variable—four categories—was transformed into a binary variable: early developmental pathway (toddlerhood) vs. school-age developmental pathway (primary school, as puberty approaches, and post-pubertal). Likewise, the gender distress variable—four categories—was transformed into a binary variable: low distress (no distress and some distress) vs. high distress (very distressed and extreme distress). Only one child had reported no distress.

For the analyses, all scores on the DASS-21 were multiplied by 2 to calculate subscores and total scores for children, mothers, and fathers (Lovibond and Lovibond, 2004). For a normative reference point, DASS values from a group of healthy controls ($n = 155$) were provided (Hilton et al., in preparation).

Information from family narratives—as it emerged through family assessment interviews—was transformed into continuous or categorical variables (where appropriate) or otherwise subjected to thematic analysis, to bring out the texture of the child and family's lived experience (Braun and Clarke, 2006).

Information regarding the challenges for us, as clinicians, in the first 5 years of the Gender Service was also subjected to thematic analysis (Braun and Clarke, 2006; Dallos and Vetere, 2005).

4. Results

4.1. Demographic characteristics of the children and their families

The final sample comprised 79 children aged 8.42–15.92 years (mean = 12.84; SD = 1.90; median = 13.33) presenting with feelings of dysphoria pertaining to the gender that had been assigned to them at birth (see Figure 1 and Table 1). Thirty-three (41.8%) children were biological males, and 46 (58.2%) were biological females (confirmed on chromosomal testing). The children and their families came from all parts of the state of New South Wales—the Sydney metropolis area ($n = 48$; 60.8%), other small cities (Newcastle and Wollongong) ($n = 13$; 16.5%), and country regions ($n = 18$; 22.8%). They were predominantly from a Caucasian-European background (see Table 1). Just over a third lived in a nuclear family with both biological parents: the remainder lived in a range of family constellations (see Table 1).

4.2. Family expectations from the gender clinic

The majority of children ($n = 61$; 77.2%) said that they were attending the clinic because they were seeking a referral to Endocrinology for medical intervention—most commonly, the prescription of puberty-blocking medications. The majority of parents had the same goal(s) as their children ($n = 56$; 70.9%), but more parents ($n = 70$; 88.6%) than children ($n = 33$; 41.8%) were interested in a more holistic approach that included psychological support and intervention for the child and family. The second most common expectation was the provision of a formal diagnosis of gender dysphoria (52; 65.8% of children [and families]).

In nine cases (11.4%), the children or attending parent reported that the child's other parent was—or would be if they were aware—strongly opposed to the idea of gender dysphoria, the child attending the Gender Clinic, and any interventions that affirmed the child's subjective experience of gender. In these nine cases, the attending family intimated that the other parent's opposition could potentially be enacted as violence toward the child or in the form of legal action pertaining to the child's treatment.

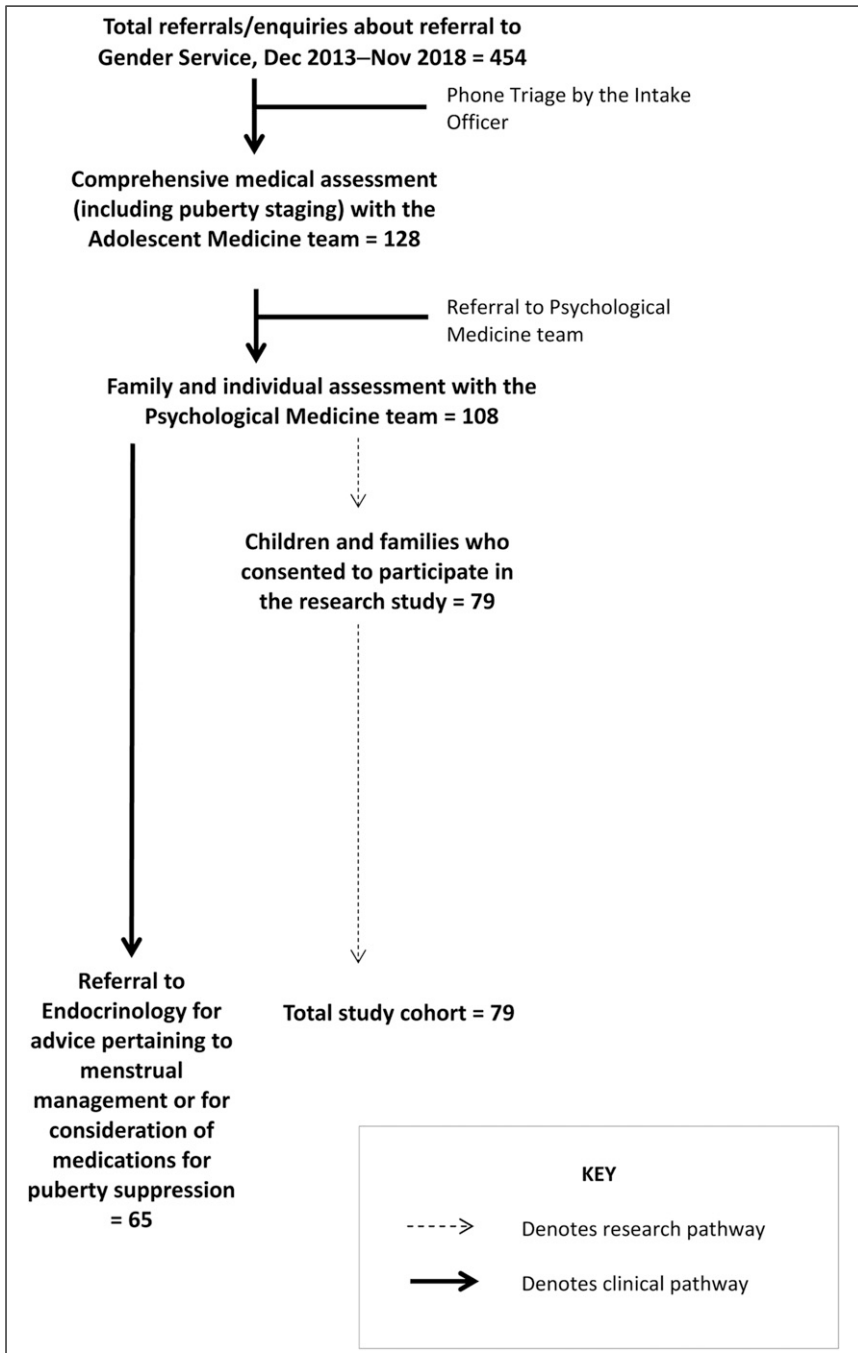


Figure 1. Referral and assessment pathway in the Gender Service.

Table 1. Demographic characteristics of the children and their families.

Demographic characteristic	Participant no. (<i>n</i> = 79)	Percentage
Biological sex		
Male (XY)	33	41.8
Female (XX)	46	58.2
Race		
European Caucasian	68	86.1
Aboriginal	4	5.1
Asian	2	2.5
Eastern	1	1.3
Maori	1	1.3
South American	1	1.3
Mixed (European + other)	2	2.5
Family constellation		
Bio mother and bio father	30	38.0
Bio mother (re-partnered)	14	17.7
Bio father (re-partnered)	10	12.7
Bio mother alone	21	26.6
Bio father alone	1	1.3
Foster care	3	3.8
Family socioeconomic status		
Professional	27	34.2
White collar	23	29.1
Blue collar	22	27.9
Unemployed	7	8.9

4.3. Clinical characteristics of the children

Forty-one (51.9%) children had reported experiencing dysphoria about gender from toddlerhood or preschool age; 22 (27.8%) from the early primary school years; 12 (15.2%) as puberty approached or was in process in late primary school or early high school years; and 4 (5.1%) when they were postpubertal. Statements of disclosure, for example, “Is it true they can do an operation to make me a girl?” (age 5) or “I want to be a boy” (age 13)—most commonly to the child’s mother (*n* = 43 [54.4%]) or both parents (*n* = 9 [11.4%])—were reported at 2.5–14.8 years (mean = 10.5; median = 12.00) (see Table 2). The role of the internet in the child’s inner story and disclosure process varied. While the majority of children reported that the internet/documentary films had not played a role in their growing awareness of gender dysphoria (45/79; 57.0%), a subset (28/79; 35.4%) reported that seeing information on the internet or via a documentary had contributed to their feeling, “This is me” (see Table 2). The remainder (6; 7.6%) reported using the internet to gain more information—often together with a parent—after they had disclosed their feelings of dysphoria.

Levels of distress pertaining to puberty commencement and secondary sex characteristics were high (see Table 2). Prepubertal children expressed their distress in

Table 2. Clinical characteristics of children presenting for assessment of gender dysphoria.

Clinical characteristic	Participant no. (<i>n</i> = 79)	Percentage
Gender identity at presentation		
Male to female	26	32.9
Female to male	42	53.2
Neutral	1	1.3
Gender fluid	3	3.8
Confused	7	8.9
Time of onset of gender dysphoria		
Toddlerhood	41	51.9
School-age (5–10 years)	22	27.8
Prepubertal (as puberty approaches)	12	15.2
Postpubertal	4	5.1
Age of first disclosure		
Preschool years (2.5–5 years)	13	16.5
School-age years (7–12.5 years)	30	38.0
Adolescent years (13–14.8 years)	28	35.4
No verbal disclosure	8	10.1
Whom the child disclosed to		
Mother	43	54.4
Father	3	3.8
Both parents	9	11.4
Friend (face to face)	7	8.9
Therapist	5	6.3
Online (to friends or class)	4	5.1
No verbal disclosure	8	10.1
Role of the internet/film		
No role	45	57.0
Found gender dysphoria online or via film documentary “this is me” pre-disclosure	28	35.4
Used the internet to get more information—often with a parent—after disclosure	6	7.6
Puberty stage on presentation		
Tanner stage 1 (prepubertal)	18	22.8
Tanner stage 2 (pubertal)	23	29.1
Tanner stage 3 (pubertal)	11	13.9
Tanner stage 4 (pubertal)	14	17.7
Tanner stage 5 (postpubertal)	13	16.5
Child gender distress		
No distress	1	1.3
Some distress	21	26.9
Very distressed	35	44.3
Extreme distress	22	27.8

(continued)

Table 2. (continued)

Clinical characteristic	Participant no. (n = 79)	Percentage
GD diagnosis at assessment		
No GD diagnosis given at assessment	4	5.1
DSM-5 GD	61	77.2
DSM other specified GD (insufficient information)	10	12.7
DSM unspecified GD (clear reason why GD criteria were not met)	4	5.1
Comorbid mental health conditions and symptoms		
No comorbid mental health condition/symptoms	9	11.4
Anxiety	50	63.3
Depression	49	62.0
History of self-harm	39	49.4
Suicidal ideation (past or current)	33	41.8
Any behavioural disorder (includes ADHD)	28	35.4
Behavioural (other than ADHD)	18	22.8
ADHD	13	16.5
Current self-harm	13	16.3
Autism (diagnosis by paediatrician or formal testing)	11	13.9
Learning difficulty	11	13.9
Suicide attempt	8	10.1
Eating disorder	2	2.5
Psychosis	1	1.3
Intelligence quotient (per formal testing or estimated from school report)		
Superior (≥ 120)	14	17.7
Average (80–119)	57	72.2
Borderline (70–79)	7	8.9
Delayed (>70)	1	1.3

GD: gender dysphoria; DSM: Diagnostic and Statistical Manual of Mental Disorder; ADHD: Attention Deficit Hyperactivity Disorder.

statements such as “I don’t want to have my puberty,” “I didn’t want any of it [puberty] to happen,” or “Boys don’t have boobies.” Some children’s statements were tinged with more extreme expressions of distress: “I felt broken [when puberty commenced]”; “I don’t care if there are side effects or risk of death . . . I’ve wanted to be a girl my whole life.” A minority expressed fear of future regret or uncertainty regarding medical intervention: “I am worried I will make a mistake and not be able to change it”; “I don’t want to go against Mother Nature to change my body.” The pattern of the gender dysphoria (male-to-female, female-to-male, gender neutral, gender fluid, and confused), pubertal staging at presentation, and percentage of children meeting criteria for a gender dysphoria diagnosis (DSM-5) are reported in [Table 2](#).

Comorbid mental health diagnoses and other indicators of psychological distress were common (70/79; 88.6%) (see [Table 2](#)). Functioning on the GAF was impaired (range, 25–95; mean = 54.68; median = 55): 4/79 (5.1%) fell into the two upper brackets (≥ 81) denoting healthy function.

4.4. Comparisons between toddlerhood onset and later-onset gender dysphoria

There were no differences between children with later onset of gender dysphoria (38/79; 48.1%) and those with an early onset in toddlerhood and the preschool years (41/79; 51.9%) with regard to DSM-5 diagnoses, ACEs, child total DASS score, family functioning (clinician rated), and SCORE-15 total score (child rated). The differences pertaining to history of self-harm ($\chi^2 = 3.64$; $p = 0.056$) and suicidal ideation ($\chi^2 = 3.55$; $p = 0.060$) were trend level only and raised the possibility that children with a later onset of gender dysphoria might be more likely to have a history of self-harm or to experience suicidal ideation.

4.5. Comparisons between children with high and low gender distress

Children with high levels of gender distress (57/79; 72.2%) were more likely to have a diagnosis of depression ($\chi^2 = 11.81$; $p < 0.001$) and a history of self-harm ($\chi^2 = 11.86$; $p < 0.001$), and to have experienced suicidal ideation ($\chi^2 = 6.98$; $p = 0.008$), than those with lower gender distress (22/79; 27.8%). There were no differences between groups with regard to DSM-5 diagnoses, ACEs, child total DASS scores, family functioning (clinician rated), and SCORE-15 total scores (child rated).

4.6. ACEs and family functioning

The majority of families (77/79; 97.5%) reported one or more ACEs (0–13; mean = 5.0; median = 4) during the family assessment interview. The most common ACEs pertained to relational stressors, including family conflict, loss by separation (e.g., from a parent or grandparent), bullying, maternal mental illness, and paternal mental illness (see [Table 3](#)). In almost two-fifths of families (31/79, 39.2%), the ACEs included one or more maltreatment events—emotional abuse, physical abuse, sexual abuse, or exposure to domestic violence (1–5 maltreatment events; mean = 2.1; median = 2). Child protection services had been involved with approximately half of these families reporting some type of maltreatment event (14/31; 45.2%)—that is, in almost a fifth (14/78; 17.9%) of the sample as a whole. Not surprisingly, clinicians rated almost three-quarters of the families (58/79; 73.4%) as presenting in a state of stress due to family conflict or perturbations to family function in the context of other ACEs (see [Table 3](#)).

Families were challenged by the children's experience of gender dysphoria. Just under half the children (36/79; 45.6%) described their families as supportive. In these families, everyone with whom the child was close knew about the child's dysphoria, and the child felt supported by the family as a whole. In the other families (43/79; 54.4%), one or more family members—including siblings, grandparents, or extended family—were rejecting/ambivalent or had not been told about the child's dysphoria in order to

Table 3. Family functioning, ACEs, and peer relationships as reported by the child and family during the clinical interview process.

Characteristic of interest	Participant no. (n = 79)	Percentage
Family functioning (clinician rated based on information from the clinical interview)		
Harmonious	21	26.6
Some conflict	27	34.2
High conflict	22	27.8
Other major stress	9	11.4
ACEs		
No adverse childhood experiences reported	2	2.5
Family conflict	52	65.8
Loss by separation	47	59.5
Bullying	43	54.4
Maternal mental health	39	49.4
Paternal mental health	30	38.0
Financial stress	21	26.6
Domestic violence	18	22.8
Frequent moves of house	17	21.5
Maternal physical health issue	15	19.0
Loss death	15	19.0
Sexual abuse	15	19.0
Physical abuse	12	15.2
Emotional abuse	11	13.9
Neglect	9	11.4
Custody issues	8	10.1
Out-of-home placement (foster care)/change of placements (whom the child lived with)	8	10.1
Illness (the child's own physical health)	8	10.1
Paternal physical health issue	7	8.9
Migration	3	3.8
Peer relationships		
More than one close friend	50	63.3
One close friend	5	6.3
No close peer relationship ever	16	20.3
No close peer relationship now, but has in past	5	6.3
Negative peer relationship	3	3.8

ACE: adverse childhood experience.

avoid conflict or rejection. Overall, one-quarter of children (21/79; 26.6%) had a parent who, because of personal or religious beliefs, was struggling to accept the child's gender dysphoria (for patterns of parental response, see [Table 4](#)). Four children (5.1%) had experienced threats of violence from a family member in regard to their gender identity.

4.7. Peer relationships

Despite the high rate of reported bullying (43/79; 54.4%), at the time of assessment, 50 children (63.3%) had more than one close friend, and 5 (6.3%) had one close friend (see Table 3).

Table 4. Parent responses to the child's gender dysphoria (reported at the family assessment interview).

Parent response	Mothers (including foster mothers) (<i>n</i> = 79)	Fathers (<i>n</i> = 79)
Accepting	66 (83.5%)	41 (51.8%)
Rejecting	3 (3.8%)	5 (6.3%)
Ambivalent	7 (8.9%)	14 (17.7%)
No information	—	18 (22.8%)
Others	3 (3.8%) ^a	1 (1.3%) ^b

^aOne mother was deceased; one was absent from the child's life due to past abuse and neglect; and one was erroneously perceived as unsupportive by the child due to the child's psychosis.

^bOne father was erroneously perceived as unsupportive by the child due to the child's psychosis.

Table 5. DASS scores for children with gender dysphoria, their mothers and fathers, and healthy cis-controls

	Depression subscale	Anxiety subscale	Stress subscale	Total DASS score ^a
	Range	Range	Range	Range
	Mean	Mean	Mean	Mean
	Clinical cutoff range ^a	Clinical cutoff range	Clinical cutoff range	Clinical cutoff range
Child healthy cis-controls (<i>n</i> = 155)	0–24 12.9 10/155 (6.5%)	0–24 2.77 19/155 (12.3%)	0–14 5.68 13/155 (8.4%)	0–72 11.26
Child DASS (<i>n</i> = 54)	0–42 20.26 41/54 (75.9%)	0–40 18.15 46/54 (85.2%)	0–42 21.72 44/54 (81.5%)	2–112 56.79
Mother DASS (<i>n</i> = 40) ^b	0–40 10.29 21/48 (43.81%)	0–30 6.7 17/48 (35.4%)	0–34 15.33 26/48 (54.6%)	0–86 32.33
Father DASS (<i>n</i> = 25) ^b	0–24 6.24 7/25 (28.0%)	0–14 3.04 3/25 (12.0%)	0–24 9.68 4/25 (16.0%)	0–52 18.96

DASS: Depression, Anxiety, and Stress Scale.

^aAdult clinical cutoffs are as follows: Depression subscale (≥ 10); Anxiety subscale (≥ 8); and Stress subscale (≥ 15).

^bIn children, the total DASS score is a validated measure of perceived distress (Patrick et al., 2010).

4.8. Self-report about depression, anxiety, and stress on the DASS

Data were missing on the DASS for 25/79 (31.6%) children, 39/79 (49.4%) mothers, and 12/37 (32.4%) fathers. Only 37 fathers had attended the family assessment.

DASS scores confirmed the high levels of depression, anxiety, and stress felt by the children and their mothers (see Table 5). Children presenting with gender dysphoria had significantly higher ($t[61.79] = 11.946$; $p < 0.001$) total DASS scores (range, 2–112 [mean = 56.79]) than 155 (age, 8.33–15.97 years; mean = 12.9) healthy cis-controls (range, 0–73 [mean = 11.26]). The two groups were comparable on age ($t[207] = 0.237$; $p = 0.813$) and biological sex ($\chi^2 = 0.09$; $p = 0.760$).

4.9. Self-report about family function on the SCORE-15

Data were missing on the SCORE-15 for 20/79 (25.3%) children, 14/79 (17.7%) mothers, and 47/79 (59.5%) fathers.

Self-report data about family function were discrepant with the narratives of the presenting children and their families during the family assessment interview. On self-report, only a small number of children, mothers, and fathers identified family adjustment and family function in the clinically severe range (see Figure 2 and Table 5).

5. Key challenges facing the multidisciplinary team

The key themes relating to the clinical challenges confronted by the Gender Service clinicians from 2013 onward—a regular subject of discussion in multidisciplinary meetings—are reported below.

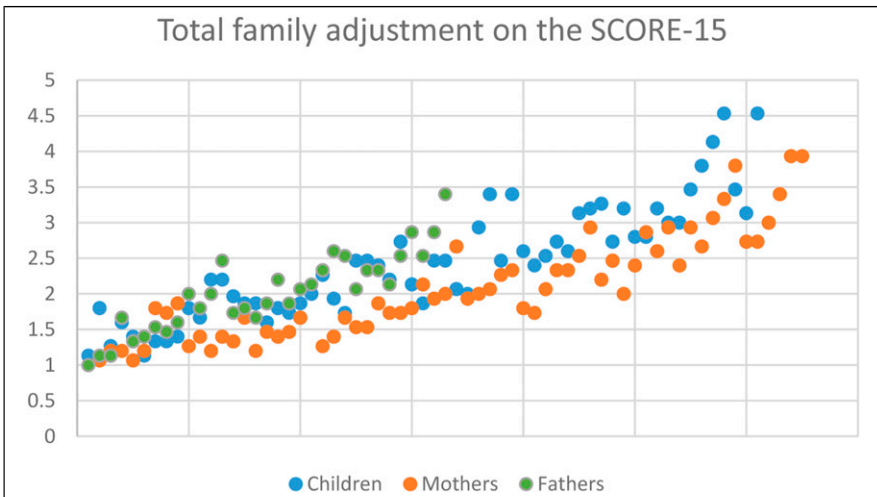


Figure 2. SCORE-15. Scatter plot of overall family functioning for children, mothers, and fathers. The overall score represents an average of the 15 five-point Likert scale items. Low scores of 1 or 2 on that scale indicate few family adjustment problems, and high scores of 4 or 5 indicate clinically significant problems.

5.1. Enactment of sociopolitical discourses in the health system

The first theme was the enactment—within the health system on multiple system levels—of different sociopolitical discourses. On the team level, while all clinicians were affirming of the children as individual persons who were experiencing substantial distress, some clinicians were more sympathetic to the gender affirmative model, whereas others tried to maintain a more neutral position of holding in mind the potential diversity of patients' needs and the associated paths into the future. On the hospital network level—with two paediatric hospitals within the network—the clinicians in one hospital consistently strived to provide effective clinical services, whereas clinicians at the other hospital declined to see the patients at all, citing lack of resources/funding, philosophical and ethical issues, and lack of an evidence base. And on the health ministry level, yet to be announced are guidelines, a service plan, and designated funding for gender dysphoric patients. On the broader societal level, the news media regularly published emotionally charged, one-sided stories that polarized public discussions concerning children with gender dysphoria (Australia Associated Press, 2018; Knox, 2019; Our Duty, 2020).

5.2. Conflation of gender affirmation and medical intervention

The second theme concerned the way in which the gender affirmative model—the dominant sociopolitical discourse—shaped the expectations of the children (and families) presenting to the service (see Section 4.2). It appeared to us that a large subgroup of children equated *affirmation* with *medical intervention* and appeared to believe that their distress would be completely alleviated if they pursued the pathway of medical treatment. Very often, we the clinicians felt that our efforts to work from a biopsychosocial perspective, along with our therapeutic efforts to discuss different aspects of the medical situation, fell on deaf ears. Lost were our efforts to highlight the many different pathways in which gender variation could be expressed, to explain potential adverse effects of medical treatment, to explore issues pertaining to future fertility and child rearing, and to highlight the importance of ongoing psychotherapy. With regard to the last item, we had a strong commitment to exploring issues of self and to helping the children both to understand the context in which their own distress (and potential mental health comorbidities) had arisen and to reflect, more generally, on their concerns, expectations, and future prospects. This same overall dynamic also put many parents—who were trying to support their children in a more holistic way but who were aware of potential long-term harms—in a difficult and untenable situation. The drivers of this dynamic appeared to include not simply the gender affirmative model itself but information from peers, previously encountered health workers, and the internet; many children arrived at the clinic with strongly entrenched beliefs and with no interest in further exploring their medical, psychological, social, or familial situation. It also became apparent to us that many children did not have the cognitive, psychological, or emotional capacity to understand the decisions they were making (see also Section 7).

5.3. Patient safety

The third theme that emerged was that of long-term patient safety. A number of factors contributed to this particular challenge. First, the voices of various older patients who perceived themselves as being harmed by the treatments that they had sought and received under the gender affirmative model began to be heard in conferences and news reports (BBC, 2019; Bell, 2020b; D'Angelo, 2020b); these narratives highlighted that children, families, and clinicians had no reliable way of ascertaining whether a child's decision to engage in irreversible medical interventions for gender dysphoria would prove to be "right" or "wrong" in the long term for that particular individual. Second, the evidence base for using puberty blockers and cross-sex hormones—and for their potential long-term side effects—continued to be sparse and contradictory (Bränström and Pachankis, 2020a, 2020b; De Vries et al., 2011, 2014). Third, it became apparent to us that children in early and mid-adolescence found it difficult to consider issues concerning parenthood and fertility, along with the impact of medical interventions on their future capacity to bear children, because the issues were not yet pertinent to them at their present developmental stage.

Patient safety in the short term was also of concern, especially in relation to the following: the children's high rates of suicidal ideation and reported maltreatment (see Table 2), including a potential for violence from a parent because of the child's gender dysphoria or because the child was seeking treatment for gender dysphoria; the mental health's system reluctance to provide services to the children; the children and families' reluctance to engage with the mental health system; and the potential additional stresses on the child and family system that can arise when parents disagree about the correct treatment pathway—which can also potentially give rise to future, deeply divisive legal actions (Whitbourn, 2020).

5.4. Clinical challenges

The fourth set of themes related to clinical challenges that we encountered in our daily clinical work and that we discussed on many occasions in our multidisciplinary meetings.

5.4.1. At the threshold: clinical engagement. Despite the clinicians' perspective that families presenting to the Gender Service were typically in substantial distress and struggled in many domains of family function—as evidenced by their stories of conflict, relationship breakdown, parental mental illness, and maltreatment (see Table 3)—the families themselves did not perceive themselves in this way (see Figure 2 and Table 6). The families did not seem to understand the possible connections between the family story—sometimes across generations—and the child's clinical presentation with distress, anxiety, depression, and gender dysphoria. Not surprisingly, families tended to medicalize the child's distress, attributing it solely to gender dysphoria as an isolated phenomenon, with the consequence that the family identified the medical pathway as providing the only potential way forward. The motivation to engage in individual or family work to explore the broad range of difficulties and psychological, family, or loss/trauma issues contributing to the clinical picture was generally low.

Table 6. SCORE-15: clinical cutoffs on family strengths, difficulties, communication, and adjustment.

	Family strengths score	Family difficulties score	Family communication score	Total family adjustment score
	Range	Range	Range	Range
	Mean	Mean	Mean	Mean
	Clinical cutoff ^a (percentage of sample above clinical cutoff)	Clinical cutoff (percentage of sample above clinical cutoff)	Clinical cutoff (percentage of sample above clinical cutoff)	Clinical cutoff (percentage of sample above clinical cutoff)
Child	1.00–4.80	1.00–5.00	1.00–4.40	1.13–4.53
SCORE-15 (<i>n</i> = 59)	2.38 4.91 (0.00%)	2.44 4.25 (6.78%)	2.42 4.55 (0.00%)	2.41 4.29 (3.39%)
Mother	1.00–4.20	1.00–4.40	1.00–4.40	1.00–3.93
SCORE-15 (<i>n</i> = 65)	1.96 2.89 (9.23%)	2.12 3.17 (16.92%)	2.05 3.40 (3.08%)	2.07 2.92 (15.38%)
Father	1.00–3.20	1.00–3.80	1.00–2.80	1.00–2.87
SCORE-15 (<i>n</i> = 32)	1.98 2.89 (9.38%)	1.95 3.17 (6.25%)	2.07 3.40 (0.00%)	1.91 2.92 (0.00%)

^aClinical cutoffs— ≥ 90 th percentile—are drawn from normative data for parents and high school teenagers (Fay et al., 2013, #7578).

5.4.2. The complex relationship between gender dysphoria and sexual abuse. One of the first clinical challenges that emerged via a number of cases was the complex relationship between gender dysphoria and sexual abuse. The two amalgam cases outlined below highlight the core questions that we asked ourselves: were the children's negative feelings toward their bodies related to gender dysphoria or were they a manifestation of past trauma in the context of past sexual abuse? And how were these factors to be disentangled?

Avery was an adolescent male (XY chromosomes) in the early stages of puberty who experienced substantial feelings of disgust and distress when looking at, touching, or washing the genitals. Avery was clear that he did not want to mature into a man, but he was not clear about his subjective sense of gender. Avery had been sexually abused as a young prepubertal boy, and the abuse had involved inappropriate touching of the genitals.

Jordan was an adolescent female (XX chromosomes) who identified as a boy. Jordan was adamant that he wanted male sex hormones and to surgically remove his breasts. Jordan was not interested in lower surgery. Jordan had experienced puberty early, and as a school-aged child, Jordan had been sexually abused by a neighbor over a long period of time. The touching of Jordan's breasts had been a key element of the abuse.

5.4.3. The complex relationship between gender dysphoria and depression. The clinical presentations of numerous patients flagged that the causal relationship between depression and gender dysphoria was potentially complicated.

Brooklyn suffered from bouts of depression. When Brooklyn was depressed, Brooklyn experienced severe gender dysphoria—which included unrelenting intrusive thoughts at night—and wanting to be of the opposite sex. When Brooklyn was euthymic, the gender dysphoria dissipated, and Brooklyn experienced their gender as being the same as the gender that they had been assigned at birth.

Learning from these clinical cases, we prioritized the need to identify and treat depression in children presenting with gender dysphoria. We emphasized to children and families that attending to the treatment of comorbid depression—and other mental health disorders—would improve the child’s well-being and facilitate the decision-making process.

What these cases of depression—represented by our amalgam vignette—made clear to us is that the individual’s experience may change across time and that longitudinal outcome research—which includes, but is not limited to, the complex role of depression and its potential impact on feelings of gender dysphoria—is much needed.

5.4.4. The complex relationship between gender dysphoria and autism. We experienced there to be a complex interplay between the presence of autistic traits, gender dysphoria, and the associated difficulties that emerge for parents and clinicians. In paediatric clinical practice, children with autistic traits frequently display repetitive behaviours and restricted interests, and the children perseverate on objects, topics, or themes—which can change over time. In this context, we found that a key concern for many parents (and clinicians) is whether the child’s gender dysphoria will be stable over time or whether with time, the child’s intense focus on, and experience of, gender dysphoria will shift to something else. In parallel, parents (and clinicians) find themselves in a state of anxiety not knowing whether the child is so focused on gender dysphoria that the child is unable to attend to and process the wide-ranging information and difficult issues that need to be considered. In such situations—where the child with autistic traits does not engage in conversations exploring the numerous options, potential side effects, fertility issues, and such matters—how is capacity for assent (in children, <16years) and consent (in adolescents, ≥16 years) to be ascertained? Here we note again that though gender identity and expression should, in the abstract, be allowed to unfold over time, the time available for this unfolding is often short because of the imminent approach of puberty.

5.4.5. Gender dysphoria and psychosis. The literature on psychosis and gender dysphoria is sparse. Though uncommon, nothing precludes patients with psychosis from becoming gender dysphoric. We have also clinically encountered a number of cases, however, in which the gender dysphoria emerges not along the dimension of gender/sexuality but as an expression or product of the psychosis itself—as illustrated by the following amalgam case.

Ezra had been diagnosed with autism as a toddler. Ezra's milestones had been delayed. As a preschooler Ezra was fascinated by ceiling fans, dripping water, and opening and closing doors, and was uninterested in conventional toys. At school, Ezra had ongoing difficulty making friends. Eventually, Ezra learnt to engage in boy-type games with the boys and girl-type games with the girls. But Ezra never felt close to any of the boys or girls. By the end of primary school, Ezra felt distressed about not fitting in but did not talk to anyone about it. In early high school Ezra watched a documentary about gender dysphoria and identified strongly with the idea of not belonging in one's own body. Ezra tried out the opposite gender role but did not feel comfortable with that either. At assessment Ezra was very distressed, said they did not feel comfortable with the human body, and said that the species they came from did not belong on earth with humans.

5.4.6. Gender dysphoria and the agendas of parents. Although the majority of children with gender dysphoria present with the support (at least to some degree) of one or both parents, the situation is not always that straightforward. Disagreement between the parents is common, and in such cases, the dissenting parent (usually the father) may even assert that the gender issue and treatment request were being driven by the other parent (usually the mother). A further potential complication is that the child can be triangulated into marital conflict between the parents, acted out via the issue of gender dysphoria. Understanding such cases within family systems and child protection frameworks, and possibly even calling in protection services, may sometimes be necessary. In yet another scenario, it becomes clear that whatever particular problems or conflicts the child may be experiencing, the motivation for engaging with the Gender Service and seeking medical intervention comes from the parent(s), not the child. In such cases, the multidisciplinary team needs to ensure that the child's voice is heard and heard clearly.

5.5. Research challenges

The fifth challenge pertained to the issue of research. In this context, we had set up research as part of the clinic's routine activity, enabling us to contribute to the evidence base regarding children who present with gender dysphoria. In the process of writing up data from our clinic, we became aware that the process of knowledge development—ours and that of other researchers—was at risk of being thwarted by ideology (Singal, 2020). In 2019, in response to this issue, the Society for Evidence-Based Gender Medicine was founded “to promote safe, compassionate, ethical and evidence-informed healthcare for children, adolescents, and young adults with gender dysphoria” (Society for Evidence-Based Gender, 2020) (<https://www.segm.org>).

5.6. Clinician safety

The sixth issue that emerged was clinician safety.

5.6.1. The experience of the endocrinology (medical) members of the multidisciplinary team. Despite the existence of published guidelines (see Section 1) and the understanding that the effects of puberty-suppressing medication—the GnRH agonists—

were temporary and reversible, no data were (or are) available on whether delaying the exposure of the brain to a sex steroid affects psychosexual, cognitive, emotional, or other neuropsychological maturation. Moreover, GnRH agonists for puberty suppression were neither governmentally approved nor publicly reimbursed; their use and paid supply within the Gender Service was therefore “off-label” and outside of an established legal or government-endorsed medical framework. These factors undermined clinicians’ felt sense of safety.

Unlike puberty-suppressing medications, many of the effects of cross-sex hormones are long-term and not reversible. In 2017—the fourth year of the study—a change in Australian laws allowed prescription of cross-sex hormones to children ≥ 16 years who were assessed by clinicians to be competent to provide informed consent—or if not deemed competent, to have the parent or legal guardian provide informed consent (Telfer et al., 2018). Under this new law, responsibility for the decision to prescribe cross-sex hormones was put onto the clinician rather than, as before, onto the court. With the change in law, some families began to put increased pressure on clinicians from our Gender Service (and clinicians in New South Wales, more generally) to provide cross-sex hormones before the children turned 16 and sometimes as young as 12 (data from our clinic). Clinicians found themselves needing to rebuff demands from some families for cross-sex hormone treatment before the age of 16 years.

The issue of consent—for puberty blockers, cross-sex hormones, and the medical treatment pathway more broadly—has recently been brought up by detransitioner Keira Bell in the court system in the United Kingdom (Bowcott, 2020).

5.6.2. The experience of the psychological medicine members of the multidisciplinary team. In the wake of the above-described change in Australian law, some families presented to the clinic with the expectation that a child nearing the age of 16 could attend the Gender Service, see the mental health team for a one-off consultation, collect a diagnosis of gender dysphoria, and move to another service to obtain Stage 2 treatment (cross-sex hormones), with no engagement in a therapeutic process. From the clinician perspective, we recognized the emergence of this “conveyor belt,” or “tick the box,” mentality—the medical model for treating gender dysphoria stripped bare of holistic (biopsychosocial) care—as being driven by the misguided belief that affirmation of gender dysphoria equates to a medical intervention pathway. Enacted in this way, we felt that this particular sociopolitical discourse put significant pressure on us as clinicians within the Gender Service to abandon ethical, reflective practice in mental health. As is highlighted by the material in Text Box 1—excerpts from two letters by UK clinicians—our experience of these pressures is not unique. Importantly, the clinicians’ concerns mirror research findings pertaining to high rates of loss and trauma (Giovanardi et al., 2018; Kozłowska et al., 2021) and of social disadvantage (Sandfort, 2020) in individuals with gender dysphoria.

Text Box 1. Psychosocial concerns of clinicians: Two letters from the United Kingdom.

The following is an excerpt from a 2019 letter that Kirsty Entwistle, a clinical psychologist who previously worked at the Gender Identity Development Service (GIDS) in Leeds, wrote to Polly Carmichael, Director of the GIDS at the Tavistock Clinic.

There are children who have had very traumatic early experiences and early losses who are being put on the medical pathway without having explored or addressed their early adverse experiences. At GIDS no one directly tells you that you're not allowed to suggest that perhaps these early experiences might be connected to a child's wish to transition but if you make the mistake of suggesting this in a team meeting you run the risk of being called transphobic.

...

I also felt that [we were seeing] an overrepresentation of the young people who were living in poverty. I had a young person whose family were living within such extreme financial constraints that he considered it a treat to buy a can of pop. I also had another young person who was living in a very complex and unstable arrangement who arrived to sessions in a poor state of hygiene and said that there wasn't money for hygiene products. How is it ethical to undertake a gender identity assessment with the view to a medical pathway when there are children and young people do not have their most basic needs met? (Entwistle, July 19 2019)

The following is an excerpt from a 2019 resignation letter that Catherine Williamson sent to the Senior Operational Manager covering Sheffield GIDS, Sheffield Health and Social Care, NHS Foundation Trust.

Over the last eighteen months, I have repeatedly discussed my clinical concerns about the inadequacy of the assessment pathways at the clinic. I have also regularly highlighted the increasing vulnerability and complexity of people referred to the clinic. That is, that although a minority of people have gender identity concerns, for a majority, medical transition is the solution to difficulties separate from gender. This is supported by audits I have undertaken. These patients may meet the diagnostic criteria for gender dysphoria and transsexualism, but their primary difficulties are not about gender. These include autism, past trauma, significant childhood and adolescent bullying, personality disorder, mental illness, body dysmorphia and eating disorders. The clinic is wedded to a medically-focused pathway which does not adequately explore this context. The service fails to fully consider the psychological and social factors which might influence a person's decision to transition. Wider political pressures and the demands of a lengthy waiting list have led to a focus on streamlining the service which has eclipsed clinical robustness. Similar concerns have been raised by clinicians working in gender services in other NHS Trusts.

6. Study limitations

This study has a number of limitations, including the cross-sectional nature of the study, relatively small sample size, probable underreporting of autism—the diagnosis was reported only if it had been formally made by a paediatrician or by clinicians from a specialist autism service—and relatively low number of postpubertal children and children with late-onset gender dysphoria (because our hospital takes referrals only up to 16 years of age). Future research will need to examine whether children with late-onset gender dysphoria are continuous with those who present at earlier ages or whether they reflect a different clinical group. Future studies will also need to ascertain whether the challenges that we have described while providing clinical services to children with gender dysphoria and their families are reflective of other clinicians and other gender clinics around the world.

7. Discussion and conclusion

The current prospective study examined the clinical characteristics of children (including adolescents) presenting to a newly established, multidisciplinary Gender Service in New South Wales, Australia, along with the challenges that clinicians faced in providing clinical services to these patients and their families. We found that the clinical characteristics of the children presenting to our service were comparable to those described by other paediatric clinics: a slight preponderance of biological females to males and high levels of distress and comorbid mental health disorders. While previous studies of children have highlighted high rates of abuse, bullying, discrimination, victimization, and family rejection or lack of family support in a general way—often under an umbrella heading of “abuse and victimization experiences” (p326) (Chew et al., 2020)—the results from our study, including the developmental stories told by the children and their families, highlight that many of these experiences have occurred within the family setting itself. That is, our results highlight that many of the ACEs reported by the children and families—family conflict, bullying, parental mental illness, financial stress, maltreatment, and a breakdown of the family system—occur within the family system itself and that the ACEs reflect a long-standing history of relational stress and a chronic disruption of what are normally comfortable and nurturing attachments.

Our findings indicate that engagement with families, a trauma-informed model of mental health care, and ongoing discourse pertaining to the effects of unresolved trauma and loss need to be part of all gender dysphoria clinics and the services with which they collaborate. Because of their impact on subjective well-being and the development of the self, specific loss and trauma events present crucial opportunities for both long-term psychotherapy and more immediate, targeted treatments. The move to a more comprehensive, holistic model of care—one that takes into account the individual’s developmental history and the experiences that make up that history—has also been echoed in the work of other clinician-researchers (D’Angelo, 2020a; Entwistle, 2019; Giovanardi et al., 2018; Kozłowska et al., 2021; Williamson, 2019).

Our study found that the children and families who came to the clinic had clear, preformed expectations: most often, children and families wanted a diagnosis of gender

dysphoria to be provided or confirmed, together with referral to endocrinology services to pursue medical treatment of gender dysphoria. Parents (vs. children) also largely came with the same expectations, though they were more likely to be interested in incorporating holistic (biopsychosocial) elements, including treatment of mental health comorbidities, family support/therapy, and long-term psychotherapy for the child. It was our impression that these expectations had been shaped by the dominant sociopolitical discourse—the gender affirmative model. It will be interesting to track the expectations of children and families in the years to come as sociopolitical discourses become more varied and diverse and as the voices are heard of both those who have done well and those who not done well via the medical pathway.

Our study also found that despite the high rates of family conflict, relationship breakdowns, parental mental illness, and maltreatment (see [Table 3](#))—and our own clinical perspective that both individual and family work were indicated for the majority of families—few families rated themselves as being in a clinically severe range on self-report (SCORE-15). Coupled with the dominant sociopolitical discourse—the gender affirmative model that prioritizes the medical treatment pathway—it is not surprising that the large majority of children and families were not motivated to engage in or to remain engaged in ongoing therapy. These data bring three important phenomena into focus. First, when children and families were given the space and structure to tell the child’s developmental story—nested in the story of the family—they were able to identify and provide a detailed narrative of the key issues that had contributed to the child’s presentation and distress. Without this space and structure, the issues remain undeclared and unaddressed. Second, some families—but also some clinicians—function within a non-holistic (non-biopsychosocial) framework where the child’s developmental experiences are disconnected from their clinical presentation. This non-holistic framework is likely to promote a healthcare delivery model that dehumanizes the child (by not examining the child’s and family’s lived experience) and that promotes medical solutions (correcting the identity/body mismatch) for a problem that is much more complex. Third, as noted earlier, our experience suggests that, insofar as the gender affirmative model is taken as equivalent to medical intervention, clinicians (including ourselves) who work in gender services are coming under increasing pressure to put aside their own holistic (biopsychosocial) model of care, and to compromise their own ethical standards, by engaging in a tick-the-box treatment process. Such an approach does not adequately address a broad range of psychological, family, and social issues and puts patients at risk of adverse future outcomes and clinicians at risk of future legal action.

We conclude our discussion with a brief note about the issue of polarization. One of the biggest challenges for clinicians working with children who present for assessment of gender dysphoria is the effect of polarized sociopolitical discourses on their daily clinical practice. Polarization happens when people become divided—in this case with reference to their views about gender dysphoria in children—into sharply opposing groups. Complex phenomena are then often simplified along a single dimension that disregards other dimensions, that dismisses the lived experience of others, and that closes off questioning, hypothesizing, and consideration of, and engagement with, opposing viewpoints. We have seen these processes at work throughout our clinical practice, as described in the present article. Polarized views are unhelpful to clinicians who are at the

front line trying to provide holistic clinical care to a distressed group of children and such views are just as unhelpful to the children and families themselves. To provide adequate care, clinicians need to understand and confront the complexity of the clinical presentations. They need, in particular, to use a broad, holistic, systemic (i.e., biopsychosocial) framework that takes into account the full range of interacting factors—social, economic, relational, family, psychological, and biological—that have defined the life circumstances of the child and the family seeking care for gender dysphoria.

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Note

1. In Australian law, decision-making pertaining to puberty suppression and cross-sex hormones that is driven by the child or adolescent is sanctioned if the child or adolescent is Gillick competent and if both of the child's parents and clinicians are in agreement.

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