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LETTER TO THE EDITOR

In Support of Research Into Rapid-Onset Gender Dysphoria

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As clinicians used to working in the field of child and adolescent gender identity development, dealing directly with the very significant distress caused by gender dysphoria, and considering deeply its multifactorial and heterogeneous etiology, we note the current debate arising from Littman's (2018) description of a phenomenon she described as Rapid-Onset Gender Dysphoria. Littman's paper on the subject was methodologically critiqued in this journal recently (Restar, 2019). While some of us have informally tended toward describing the phenomenon we witness as "adolescent-onset" gender dysphoria, that is, without any notable symptom history prior to or during the early stages of puberty (certainly nothing of clinical significance), Littman's description resonates with our clinical experiences from within the consulting room.

In our experience, it is commonplace for clinicians to engage in conversations regarding this phenomenon (Churcher Clarke & Spiliadis, 2019). Furthermore, from speaking with international colleagues, it seems to us that this phenomenon is also being observed in North America, Australia, and the rest of Europe. In addition, we are witnessing high levels of distress and comorbidity. Bechard, VanderLaan, Wood, Wasserman, and Zucker (2017) carried out a cohort study of referrals made for adolescents into a gender identity service which showed a high level of comorbid psychological difficulty as well as psychosocial vulnerability. They concluded that this supported a "proof of principle" for the importance of a comprehensive psychological assessment extending its reach beyond gender dysphoria. This is consistent with a previously published paper from Finland (Kaltiala-Heino, Sumia, Työläjärvi, & Lindberg, 2015) which identified the phenomenon of an over-representation of adolescent females with particularly complex needs presenting at gender clinics.

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While there is an ongoing debate about how many young people with gender dysphoria will go on to live their lives as trans-identified adults, what is certain is that it will not be all of them. Each existing and inclusive follow-up study has described a group who stop pursuing treatment (Turban & Keurroghlian, 2018), and this again echoes our clinical experiences.

Due to recent changes in patient demographics (Butler, de Graaf, Wren, & Carmichael, 2018), we cannot yet know how many of today's patients will desist or de-transition in the future. Existing literature on both young people and adults tells us that there are a number of possible outcomes. Of course, many young people with gender dysphoria will persist and thrive (Steensma, Biemond, De Boer, & Cohen-Kettenis, 2011). Others may persist and struggle (Dhejne, Öberg, Arver, & Landén, 2014). Some may no longer identify as transgender and find a way to adapt and thrive despite, or even perhaps because of, the process they have been through (Ashley, 2019), and some will likely move between these states (Steensma & Cohen-Kettenis, 2015). However, there is another group of people with gender dysphoria who desist or de-transition and who then express distress as a result of the path and/or treatments they have taken (Levine, 2018). We have to assume that today's young patients will go on to follow any or all of the pathways that their predecessors took. While we cannot know yet who will take which one, we do know that each young person is our patient. We have a duty of care to them all, whatever the outcome. That is why more research which may help clarify differing patient cohorts must be welcomed.

The burden of treatment for trans-identifying people is significant, whichever path they take. Any clinician working in the field of child and adolescent mental health struggles with the responsibility to provide ethical, meaningful, and effective care. When working with gender dysphoria, this already grave responsibility is heightened by the nature of the significant medical interventions that many young people seek. Unless we are free to discuss, explore, and research differential presentations of gender dysphoria, the range of interventions which might best serve each young person may not be available to them. We do not think that this is good enough for our patients. We are grateful to the academics and researchers involved in this much needed,

though difficult, conversation about how to continue to do our best for all of those who seek our help.

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