GENDER DYSPHORIA AND DISADVANTAGE

November 2025




CSJ The Centre for Social Justice

Contents

Foreword

In January this year we launched a paper called *Change the Prescription* – it dealt with rising mental health problems in young people. Among other things, it looked at how the welfare system operates, the medical context, the online world, and the impact of family life.

One thing that came up repeatedly in the research but did not feature in that report was the issue of gender dysphoria. We took the decision, given the sensitivity of the subject matter, and the uncertainty of the evidence, that we needed to tackle it separately. This paper is our attempt to do that.

This is new territory for the CSJ and it is unlikely to form the basis of long-term campaigning, but what came through in our initial research and now more strongly in this considered paper, is the strong link between disadvantage and gender dysphoria.

The links with neurodiversity are becoming increasingly well established in the research literature and this paper further strengthens that link. But we also look at children in the care system, those experiencing family dysfunction, adverse childhood experiences, disability, and more besides. It finds that many young people presenting at gender clinics are grappling with a range of other problems in their day-to-day lives.

It warns that without acknowledging the truly complex profiles of young people with gender dysphoria, vulnerable children and young people could find themselves medicalised for a condition that is often a response to, or manifestation of, other stressors.

It paints a picture of a cohort of young people who are often not just struggling with their sex, but with fundamental questions of identity – who am I? Where do I belong?

The purpose of this report is not to fuel what is often a high volume and emotive public discourse, but to better inform the decision making of those at the sharp end: the physicians, policy makers and politicians charged with the care of these often deeply unhappy young people.

As such, there are few recommendations in this report but at the heart of those we have is the principle for physicians and policy makers to better understand the lives of the young people they are seeing and so to ensure that their response as individuals (and by proxy the response of wider society) remains proportionate and evidence based.

Edward Davies
Director of Research, Centre for Social Justice

Executive Summary

Is gender dysphoria a condition that could affect anyone, or are some young people more likely to experience this sometimes distressing condition more than others? In recent years there has been an explosion in the number of young people being referred for gender dysphoria, with the increase in cases amongst teenage girls being particularly stark.

As the Cass Review recommends, the dynamic between gender dysphoria and other complexities needs further research, and this report goes some way to filling that gap. Through qualitative interviews with transgender adults, interviews with charities who support young people who happen to be experiencing gender dysphoria, and interviews with sector experts, this report draws from frontline voices to illustrate some of the material deprivations and social disadvantages that correlate with young people experiencing gender dysphoria.

From these interviews, further bolstered by academic research and Freedom of Information requests (FOIs), we have found several factors that indicate a young person is more likely to experience gender dysphoria. Among others, children with autism, Adverse Childhood Experiences (ACEs), separated parents, mental ill-health, living in care, or having a sexual offender as a parent are all more likely than their peers to experience gender dysphoria.

The CSJ understands the following areas to be overrepresented among young people with gender dysphoria:

1. **Neurodiversity**

   Autism is hugely overrepresented among young people with gender dysphoria, and this overrepresentation is becoming more pronounced. 32.4 per cent of young people referred to the NHS Children and Young People's Gender Service (North West) from Gender Identity Development Service (GIDS) had an autism diagnosis and 11.7 per cent had an ADHD diagnosis – far higher than the estimated 2 per cent and 5 per cent national population averages for autism and ADHD.[1] These numbers also mark an increase compared with referred patients in 2012.[2] As one charity told the CSJ, "Particularly at referral stage, when there is gender dysphoria, there's normally a strong link between neurodivergence and the young people who are exploring their identity or lived gender."

2. **Adverse Childhood Experiences (ACEs)**

   ACEs are overrepresented among young people with gender dysphoria. The CSJ heard from one trans-identifying adult who had 10 half siblings on her father's side and whose father had been in prison, but described her childhood as "normal". The CSJ also heard from charities that stressed the unusual and concerning circumstances in the young people's lives they work with who present with gender dysphoria. Among other ACEs, young people with gender dysphoria are much more likely to have a registered sex offender as a parent, and more likely than the national average to have been a Looked After Child (LAC). As one charity CEO told the CSJ: "Gender dysphoria is rising. Is it a new response to trauma in children and young people, rather than an actual rise in prevalence?"

1 FOI Request submitted by CSJ

2 Holt, V., et. al., *Young people with features of gender dysphoria: Demographics and associated difficulties*, 2016.

3. Challenging Family Relationships

As one GP told the CSJ, "there is nearly always something difficult that's gone on in the family when someone comes to me with gender dysphoria." These complexities can span from living with separated parents to having a parent with drug or alcohol addictions. In 2012, the most recent year for which the data is available, only a third of patients referred to GIDS were living with both parents – half the rate of the national population in the same year. With the complexity of cases increasing in the last decade, there is no indication that this is any less representative today.

4. Negative Attitudes Towards Sexual Orientation

Family and self-perceptions of sexual orientation are thought to contribute to some people experiencing gender dysphoria. Some studies have found high rates of non-heterosexual orientation among detransitioners, with some detransitioners stating "internalised homophobia" as a factor that led to their gender dysphoria. Charities and transgender adults spoke to the CSJ about gender non-conforming behaviour and how that can also shape a person's experience of gender identity.

5. Mental Ill-Health

The report found high instances of mental ill-health among those with gender dysphoria, including depression, anxiety, and multiple-personality disorder. In Finland, over 75 per cent of the "referred adolescent population needed specialist child and adolescent psychiatric support due to problems other than gender dysphoria, many of which were severe, predated and were not considered to be secondary to the gender dysphoria."[3] Baroness Cass told the CSJ that "You should not be making decisions about gender, about possible medications, when you're not in a stable mental state. For somebody who's seriously depressed or suicidal or hyper anxious, then you do need to address that in order for them to be in the sort of state where they can make those decisions."

6. Eating Disorders

A correlation exists between young people experiencing both eating disorders and gender dysphoria, with this being particularly pronounced for girls. Autism is also more pronounced among girls with anorexia, similar to its overrepresentation amongst girls with gender dysphoria. A GP told the CSJ that "there tends to be a crossover between eating disorders and the autistic spectrum. But there is a move away from eating disorders and towards transitioning, with transitioning being promoted as the 'beautiful solution'."

7. Socioeconomic Deprivation

Although the most recent academic review of the links between area level deprivation and gender dysphoria found no correlation, the deprivations and disadvantages associated with the above factors are largely understood and known. Mental ill-health, ACEs, and family breakdown all operate along a socioeconomic gradient, and high referral rates for gender dysphoria in deprived areas such as Blackpool raise further concerns. Journalist Helen Joyce told the CSJ that "In Blackpool there's a shocking number of looked after girls who are identifying as trans, and that's the same place that has the highest rate of child sexual exploitation. These girls are looking for every and any way they can to express their misery. And gender dysphoria is one way."

3 Cass, H., *The Cass Review*, 2024, p91.

If young people who have experienced trauma, struggled socially due to anxiety or autism, or endured the care system are more likely than their peers to develop gender dysphoria, this has implications for a gender-affirming model of treatment, and should shape our understanding of gender dysphoria more broadly.

This report lays out that it is some of Britain's most vulnerable people who are navigating the bumpy road of gender dysphoria, and so it is imperative that their social, medical and emotional needs are met in the best possible way.

Social Contagion

The CSJ also heard, in connection with the above, concerns about the extent to which gender dysphoria is a "social contagion". People with gender dysphoria spend more time online than their peers, and CSJ polling found that 63 per cent of adults think children and young people questioning their gender are overly influenced by social media and 50 per cent think they are overly influenced by their peers.[4] Even among 18 to 24 year olds, 51 per cent agree (vs 24 per cent disagree) that young people are more likely to have gender dysphoria if their friends also have gender dysphoria.

As the Cass Review summarises, gender dysphoria is not purely biological but is also shaped by psychological and social factors. The overrepresentation of disadvantage and deprivation among those with gender dysphoria should sound the alarm for treating gender dysphoria in isolation from other areas of concern. If the root causes of distress in a person's life can be addressed, perhaps fewer young people will experience the concerning condition of gender dysphoria.

In light of the above, it is vital that:

- Full histories of patients are taken at time of referral
- Underlying mental health conditions are treated prior to gender-related care
- A gender-affirming model of care is met with healthy scepticism.

Those who have had adverse childhood experiences, experienced childhood trauma, suffered the loss of a parent, endured mental health conditions, or navigated the world with autism, are all more likely than their peers to experience gender dysphoria. It is our country's deprived and disadvantaged young people who must navigate this often distressing condition.

Our policymakers and leaders must not be blind to the complex profiles of these young people. Without acknowledging the truly complex profiles of young people with gender dysphoria, vulnerable children and young people could find themselves medicalised for a condition that is really a response to, or manifestation of, other stressors.

4 Nagata, J. M., et. al., *Screen use in transgender and gender-questioning adolescents: Findings from the Adolescent Brain Cognitive Development (ABCD) Study*, 2024.

Introduction

The Cass Review highlighted the growing number of clinicians who "feel that we are medicalising children and young people whose multiple other difficulties are manifesting through gender confusion and gender-related distress."[5] This paper serves to examine those other difficulties young people with gender dysphoria often face, teasing out the links between areas of disadvantage in a young person's life and the presentation of gender-related distress.

The focus of this report is to identify characteristics and demographics that indicate a person is more likely to experience gender dysphoria. The areas of disadvantage and deprivation this report examines are overrepresented among young people with gender dysphoria. While the CSJ does not claim these characteristics or experiences necessarily *cause* gender dysphoria, we maintain that understanding this *correlation* deserves more attention and research before life-altering courses of treatment are offered to such vulnerable people.

This report explores sensitive and controversial topics, and efforts have been made to report findings as respectfully as possible. No offence or harm is intended by this report or words used. Transgender adults who spoke to the CSJ are all referred to by their preferred pronouns in the report, when pronouns are used. "Gender dysphoria" is used most in this report as it is the more commonly used term in research publications and clinical settings, and is recognised widely by the general public.[6] The CSJ heard transgender adults use this term happily to describe their experience and yet several of the charities the CSJ spoke with expressed reluctance to use it due to a perceived negative framing. No offence is intended by the use of this phrase.

This report will cover sensitive information about suicide and other challenging topics. If you or someone you know may be affected by this content, Samaritans are there for you. You can call them for free on 116 123, email them at jo@samaritans.org, or visit samaritans.org to find your nearest branch.

5 Cass, H., *The Cass Review*, 2024, p13.

6 Cass, H., *The Cass Review*, 2024, p18.

Methodology

This report is drawn from interviews with transgender adults, teachers, and charities who support young people. With the exception of one charity the CSJ spoke to, the charities did not specialise in working with transgender people or people experiencing gender dysphoria, but had direct experience of their service users presenting with gender dysphoria, and in many cases had noticed an increase in cases in recent years. Interviews with healthcare professionals and medical journalists further helped inform this report. Alongside these interviews and focus groups, a literature review, FOIs, and opinion polling have aided the writing of this report.

We are grateful to the charities that spoke with us, in addition to the experts who shared their insight, and especially the focus group participants who had direct experience of living with gender dysphoria.

Original nationally representative polling conducted by Whitestone for The Centre for Social Justice of 2,065 adults in Great Britain, between 18th and 20th July 2025.

Please note that the views, findings and recommendations presented in this report are those of the CSJ alone and not necessarily those of any organisation or individual who has fed into or enabled our research.

Glossary

Gender Dysphoria: A marked incongruence between one's experienced/expressed gender and assigned gender

Gender Non-Conforming: When a person's behaviour does not align with traditional expectations about what is appropriate to their gender

Gender Variance: An umbrella term that denotes variability between an individual's sex and gender identity

Neurodiversity and Gender Dysphoria

Overview

There is a growing body of research that suggests a heightened co-occurrence between autism spectrum disorders (ASD) and gender dysphoria, with an increasing number of studies showing an overrepresentation of ASD among those who have gender dysphoria, and vice versa.[7] ASD is defined as a "neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave",[8] with environmental and genetic factors which affect the development of the brain both playing a part.[9]

Although autism is not in and of itself a disadvantage – and many people on the autism spectrum choose to describe it as an *advantage* – autism is a disability under UK law. Moreover, autistic young people are more likely to experience lost learning in school and suffer poor mental health.[10] They are also more likely to be unemployed compared with other disabled people and non-disabled people (7 in 10 autistic adults are out of work, compared with 5 in 10 of all disabled people and 2 in 10 for non-disabled people).[11] Therefore, young people with ASD who experience gender distress may already be facing several other challenges.

This overrepresentation of ASD among young people with gender dysphoria is highlighted by a response the CSJ received to an FOI request, which revealed that 32.4 per cent of young people referred to the NHS Children and Young People's Gender Service (North West) from GIDS had an autism diagnosis[12] – more than 16 times higher than the 1-2 per cent of the national population that is estimated to have autism.[13]

The exact overrepresentation of young people with ASD also presenting with gender dysphoria is difficult to calculate; studies provide a range of answers. But two things seem to have consensus: those on the spectrum for autism disorders are overrepresented, and this overrepresentation is becoming more pronounced.[14]

7 Janssen, A., et. al., *Gender Variance Among Youth with Autism Spectrum Disorders: A Retrospective Chart Review,* 2016.
8 National Institute of Mental Health, *Autism Spectrum Disorder*, 2024.
9 Hodges, H., et. al., *Autism spectrum disorder: definition, epidemiology, causes, and clinical evaluation*, 2020.
10 Bloomer, A, *Parents of autistic children are being pushed into poverty, new survey finds,* 2025.
11 National Autistic Society, *The Buckland Review of Autism Employment is published*, 2024.
12 FOI Request submitted by CSJ.
13 National Autistic Society, What Is Autism, 2025.
14 Glidden, D., et al., *Gender Dysphoria and Autism Spectrum Disorder: A Systematic Review of the Literature*, 2016.

In the past ten years, the co-occurrence between gender dysphoria and autism has become more prevalent. The Cass Review's case study sample found that in 2015 6.8 per cent of young people with gender dysphoria also had a diagnosis of ASD, but this stood at 16.6 per cent in 2021.[15] Meanwhile audits of Ireland's National Gender Service (NGS) found only 3 per cent of service users had ASD in 2014, rising to 34 per cent in 2019, and an estimated 90 per cent in 2022.[16] Although academic studies that examine the trend in co-occurrence over time are limited, a review of the 143 studies on the topic published prior to April 2022 found only one study that had recorded this data.[17] This study found a moderate increase in the co-occurrence between 2012 and 2015.[18]

Chart 1: Studies showing increasing co-occurrence between ASD and gender dysphoria

A: Cass Review

Source: Cass, H., The Cass Review, 2024, p6.

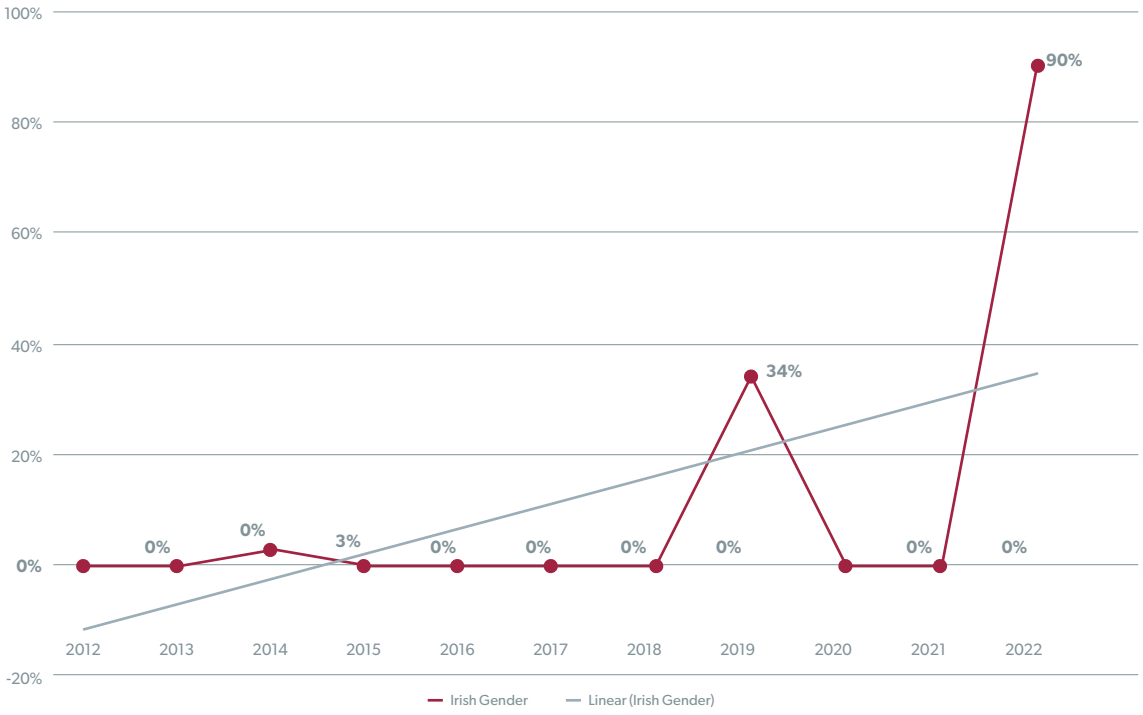
15 Cass, H., *The Cass Review*, 2024, p6.

16 Iona Institute, *Up to 90pc of people using Irish gender service may be autistic, audit finds*, 2022.

17 Taylor, J,. et. al., *Characteristics of children and adolescents referred to specialist gender services: a systematic review,* 2024.

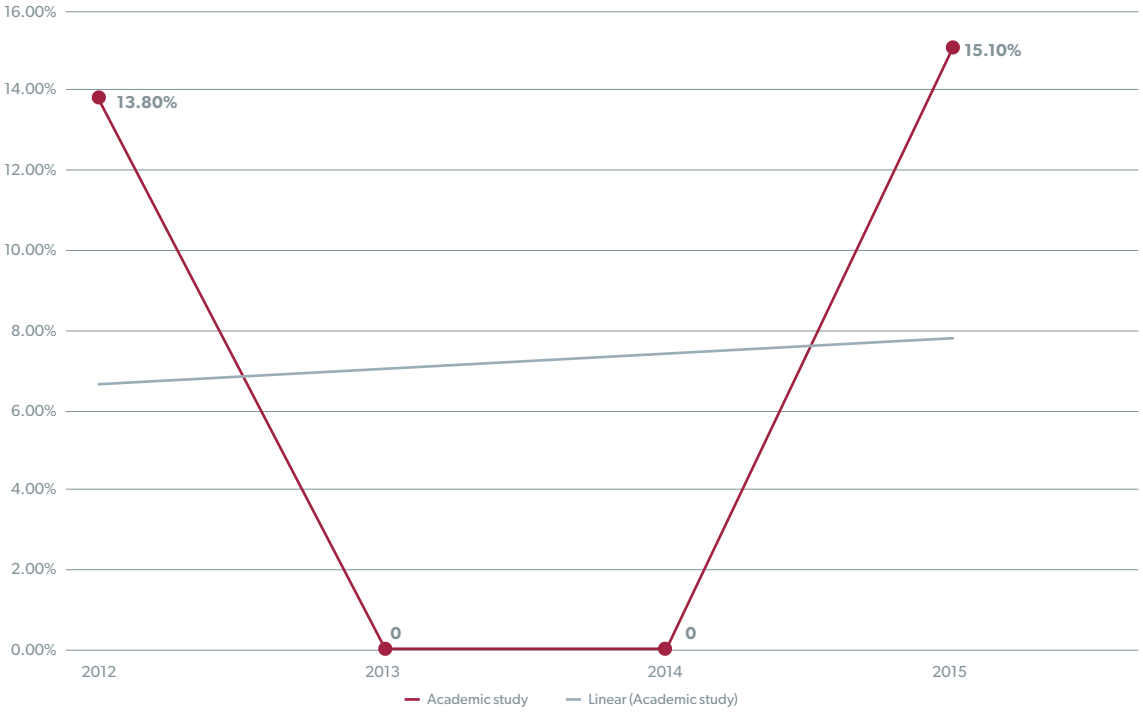
18 Morandini, J, S,. et. al., *Shifts in demographics and mental health Co-morbidities among gender Dysphoric youth referred to a specialist gender Dysphoria service*, 2022.

B: Ireland's National Gender Service



Source: Iona Institute, Up to 90pc of people using Irish gender service may be autistic, audit finds, 2022.

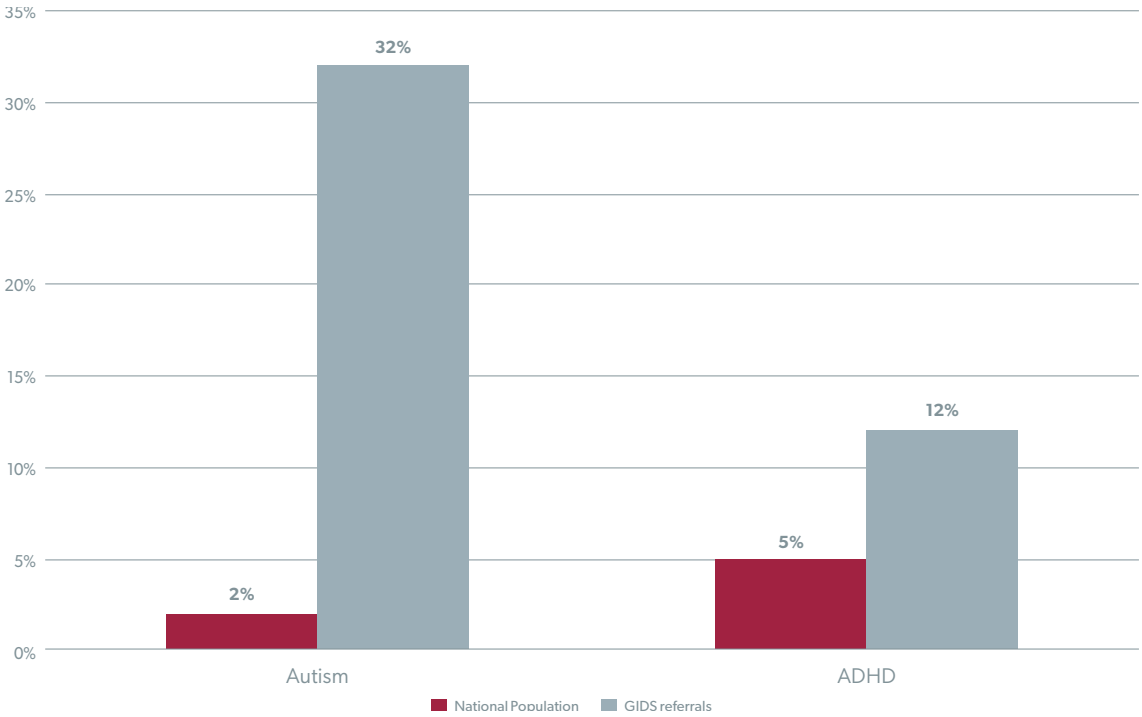
C: Academic Study



Source: Morandini, J, S,. et. al., Shifts in demographics and mental health Co-morbidities among gender Dysphoric youth referred to a specialist gender Dysphoria service, 2022.

An FOI request submitted to Alder Hey Children's NHS Foundation Trust revealed that 32.4 per cent of young people referred to the NHS Children and Young People's Gender Service (North West) from GIDS had an autism diagnosis and 11.7 per cent had an ADHD diagnosis – far higher than the (estimated) 2 per cent and 5 per cent national population averages for autism and ADHD.[19]

Chart 2: Prevalence of Autism and ADHD within GIDS referrals to the North West Gender Service compared with average population



Source: FOI Request submitted by CSJ.

As the above graphs show, estimates for the exact co-occurrence between gender dysphoria and ASD vary. It is likely, however, that studies underestimate the co-occurrence between ASD and gender dysphoria given that not all those on the spectrum for autism will have received a diagnosis. A study from 2015 of 166 young people from GIDS found that 54.2 per cent of young people scored in the autistic range when they took the Social Responsiveness Scale (SRS), a measure used for screening for an Autism Spectrum Disorder (ASD) condition.[20] However, not all of these young people had been previously diagnosed with ASD.[21]

International studies confirm an above population average for co-occurrence between autism and gender dysphoria. In 2011, Amsterdam was reporting that up to 10 per cent of the young people referred for gender dysphoria were also presenting with ASD,[22] and a Finnish study from 2015 found that 26 per cent of applicants to one gender dysphoria clinic were on the spectrum for autistic disorders.[23] At the largest gender clinic in Australia, 45 per cent of gender dysphoria patients have autism – far higher than the three per cent of the general Australian population diagnosed with autism.[24]

19 FOI Request submitted by CSJ

20 Policy Exchange, *Asleep At The Wheel*, 2023, p34.

21 Policy Exchange, *Asleep At The Wheel*, 2023, p34.

22 Cass, H., *The Cass Review Interim Report*, p30.

23 Department of Children, Disability and Equality, *LGBTI+ Youth in Ireland and Across Europe:A two-phased landscape and research gap analysis*, 2021, p113.

24 Rouse, A., *'Changing genders is no fix for autism': Almost Half of kids at Australia's biggest gender clinic have autism but expert warns sex swap isn't the answer for some*, 2020.

The prevalence of autism among patients with gender dysphoria is heightened among female patients. In the Australian clinic mentioned above, 45 per cent of 383 patients had "mild to severe" autism, with 72 per cent of those being born female.[25] Academic studies confirm that there are more cases of autism among female patients with gender dysphoria than in male patients, at least for the adult population.[26]

There are also higher than average levels of gender dysphoria within the autistic population, with this being particularly pronounced among females.[27] Academic studies have found that gender variance is present in between 5.4 per cent to 7.2 per cent of autistic youths, and 11.3 per cent of adults, compared with a range of 0.7 per cent to 5 per cent in non-autistic populations.[28]

With a co-occurrence between gender dysphoria and autism being so firmly established, gender referrals should not be blind to the neurodivergent needs of patients. The remainder of this chapter examines further why autistic young people presenting with gender dysphoria need particular care, and evaluates the merits of a gender-affirming response.

Why might autism and gender dysphoria be linked?

Although the increased awareness and diagnosis of autism in the last decade goes some way to explain this increase in presentation of ASD with gender dysphoria, it is not a sufficient explanation on its own. Given that around 1.1 per cent of the UK population is estimated to be on the autistic spectrum, and 32 per cent of young people referred from GIDS to the new North West gender clinic have an autism diagnosis, increased awareness of autism does not explain this significant overrepresentation.

There are several theories as to the overrepresentation of autism among those with gender dysphoria, with one explanation being the tendency of people with autism to have a "one track mind" and the ability to develop a deep level of knowledge in a particular area and become overly determined on a particular end result.[29] Another is the view that autistic people struggle to make social connections with their own sex, and therefore are more likely to consider themselves as a different gender. The third theory is that autistic people are less bound by social conformity, and so are more likely to express themselves in different ways. Understandably, all three of these attempts to explain the overrepresentation of autism among people with gender dysphoria can interlink, with neither explanation implying gender-affirming care is necessarily the best approach.

All of the charities and experts the CSJ spoke with raised the overlap between young people presenting with gender dysphoria and the prevalence of autism or neurodivergence, whether formally diagnosed or suspected. Most expressed concern at the potential vulnerability of these young people owing to their neurodivergence, particularly when it came to navigating information and accessing the help they need.

25 Rouse, A., *'Changing genders is no fix for autism': Almost Half of kids at Australia's biggest gender clinic have autism but expert warns sex swap isn't the answer for some*, 2020.

26 Pecora, L. A., et. al., *Gender identity, sexual orientation and adverse sexual experiences in autistic females*, 2020.

27 Pecora, L. A., et. al., *Gender identity, sexual orientation and adverse sexual experiences in autistic females*, 2020.

28 Pecora, L. A., et. al., *Gender identity, sexual orientation and adverse sexual experiences in autistic females*, 2020.

29 Rouse, A., *'Changing genders is no fix for autism': Almost Half of kids at Australia's biggest gender clinic have autism but expert warns sex swap isn't the answer for some*, 2020.

The Chief Executive of a charity working with young people in the North East focused on building young people's well-being and self confidence, shared that "I've worked a lot with autistic kids, on the severe end of the spectrum. To me, it's almost like they're looking at the criteria to be a girl, and go, 'Oh, I'm not that. So I must be a boy.' They're not. You see what I mean? It's not nuanced at all. It's very much black and white, because that is literally how they think. They then become the other sex, and then like, 'Well, I'm not this either.' And then they're a bit lost." The Chief Executive added that although she was aware she was making a generalisation, she still felt that, with children with autism, it was wrong to immediately "accept the trans element" of someone's identity because it would "very much reinforce the idea" rather than helping an autistic child think through what they are feeling objectively.

Relatedly, Dr Katharine Townsend, a GP based in Cambridge, told the CSJ that "People on the autistic spectrum find it difficult to fit in and connect with their peers. When you feel uncomfortable with your own peer group, your own sex, if you might be someone who prefers cooking to sport or more gentle aesthetics, then you start in your autistic brain to think 'I am behaving like a girl, therefore perhaps I am a girl.'"

A similar view was expressed by a mother with an autistic child, who works at a charity in Leicestershire that supports girls struggling at school. She told the CSJ:

> *"My daughter's got autism and gets called a boy quite a lot. [...] And she does wear boys clothes. You will not catch her in girls clothes, even down to the underwear. She wears boxer shorts. That is a sensory thing for her, though. [...] I was a tomboy when I was younger – she is very much, that's it. It is very much a sensory thing. And when she was younger, I think six, seven, she was just like, "oh, one of the teachers counted the girls on the table and the boys on the table, and they got it wrong." And I said, "Why?" "Because she counted me on the girls table." [I told her] "you are a girl sweetheart." [...] She didn't understand that because she was wearing the boys clothes. You know, a lot of people at school were saying she was a boy. I mean, now she laughs it off, [...] she can get called a boy by people. Sometimes for people who have got autism, if they're being told that a lot, they are then thinking that that's who they are. You know, we've had those conversations. She's now 12 years old. I am very aware, and I know that she definitely is a girl who wants to be a girl, wants to identify as a girl. She just feels so comfortable in boys clothes because it's the sensory side."*

As a counter to this, one person the CSJ spoke to who had both gender dysphoria and autism confirmed that there was "definitely an overlap" between gender dysphoria and neurodivergence but attributed this in part to the idea that "a lot of trans people can be misdiagnosed [as neurodivergent] because a lot of trans people at a young age can act differently to other people of their age and gender because it's not how they identify." Although the CSJ's review of the literature available concerning the diagnosis of autism could not confirm this, it does confirm overlapping traits between autism and gender dysphoria, including sensory issues and barriers to social participation.[30]

30 Cooper, K., et. al., *The lived experience of gender dysphoria in autistic adults: An interpretative phenomenological analysis*, 2021.

Several charities spoke of the social acceptance that came for autistic young people once they announced to their peers that they had gender dysphoria. The convener of a mental health support group in Leicestershire observed that a lot of the young girls she knew that identified as non-binary would also have neurodiverse traits. She said

> *"It's like a kind of a club. It's like that there is a group of them [sic], so that becomes something of a safety thing, because they feel accepted by people that are different, and difference is a thing that brings them together, whatever that difference may be, and that becomes a social connection and a support in that way."*

She added that in her social circle of mums of teenagers, she had realised that this "social connection and support" can occasionally backfire. She shared that in a couple of cases "I've seen people that have transitioned, who've then [...] gone back the other way, and said [...] actually, this wasn't me, and they recognised that they were mixed up, and they were struggling at the time to do with where they fitted in. So that was what felt like a community that was right for them [but only for a time]".

It should also be noted as an area of concern that children diagnosed with a neurodevelopmental disorder are three to six times more likely to have a mental disorder than their peer group.[31] As the mental health chapter examines in greater depth, questioning gender identity can, in some cases, exacerbate mental ill-health, compounding existing struggles in young people's lives.

An Oxfordshire-based charity that supports young people with complex needs told the CSJ that challenges faced by neurodivergent people can compound mental ill-health, with lots of other factors interacting altogether:

> *"Particularly at referral stage, when there is gender dysphoria, there's normally a strong link between neurodivergence and the young people who are exploring their identity or lived gender. [...] Obviously relatable and understandable is poor mental health, so social interaction is really difficult and isolation, therefore access to education is also difficult. It's hard to necessarily pinpoint, I think, what the cause of it is, but it is all like a bit of soup. [...] There's lots that is obviously going on." The charity added that for neurodivergent people, "it is known that mental health is probably going to be a lot more challenged, and their anxiety is going to be a lot more challenged, and their anxiety is going to be higher because their brains are taking on a lot more."*

All of these insights raise concern at the immediate acceptance of a new gender identity for an autistic young person. Given the extra support autistic people may need when processing information, this same support should be shown if they present with gender dysphoria. The social acceptance and the easier stereotypical box ticking of male or female behaviour might be welcome changes for an autistic person announcing they are trans, but this immediate comfort can mask the deeper challenges of relating to one's peers as one's authentic neurodiverse self.

31 King's College London, *Mental Health Problems in Neurodevelopmental Disorders*, 2016.

Responding to gender dysphoria in autistic young people

There was a general sense that autistic young people were more likely to question the world around them and their place in connection with it, and questioning their gender was a fairly standard part of that process. An autistic trans person told the CSJ that if "you have autism, your position in society is a lot different to a neurotypical person, so you're forced to question stuff about yourself, which allows you to do a lot of introspection. And eventually, if you are transgender, [you] will eventually question your gender identity."

Charities held differing views, however, on how best to respond to a neurodivergent young person who presents with gender dysphoria. On the one hand, some charities believed a gender-affirming response enabled young people to safely explore their identity, regardless of neurodiverse traits. While others stressed the need for ensuring autistic people process the information they receive critically.

As already established above, the susceptibility of autistic people to question their gender identity make gender-affirmative responses fraught with potential harms. As the Cass Review made clear, psychosocially challenging problems must always be addressed in the treatment of a young person with gender dysphoria.[32] For autistic young people, these challenges may well be more numerous than in a neurotypical person, not least in terms of barriers to full participation in school life and social activities.[33]

Dr Katharine Townsend told the CSJ that the best way to treat an autistic person presenting with gender dysphoria is to "build a relationship" with the patient first so as to understand them better. Unfortunately, however, too often in her experience such patients become "angry" when not referred to a gender clinic, having already determined for themselves the course of treatment they need.

Related to Townsend's advice, several charities (including those that explicitly said they affirmed a person's identity immediately) noted that autistic people may take longer than neurotypical peers to process questions about identity. They also noted the particular influence social media can hold for autistic people, with some charities being concerned at the echo-chambers autistic people can be dragged into. Indeed, academic studies have found that while internet use among individuals with autism may not be higher than the population average, people with autism are more prone to compulsive internet use than their peers.[34]

One medical professional told the CSJ that autistic people "spend a lot of time on the computer, on the internet and sites like Tumblr and Reddit. Eventually they'll come across a site that encourages them to pursue questioning along that line and they find themselves among a like minded group of young people. They find themselves in something of an echo chamber and tend to find that the narrative of transitioning is the "golden egg" that solves the problems [of] disconnect with peers, or mental health, or even disconnect with their own selves."

32 Cass, H., *The Cass Review*, 2024, p30.

33 Cass, H., *The Cass Review*, 2024, p30.

34 Finkenauer, C., et. al., *Brief Report: Examining the Link Between Autistic Traits and Compulsive Internet Use in a Non-Clinical Sample*, 2012.

More research into the drivers of the co-occurrence between autism and gender dysphoria will only better serve autistic individuals experiencing gender distress. Unfortunately, research into this co-occurrence is often discouraged for fear of implying a causation rather than a correlation.[35] The Chief Executive of an LGBT sexual health charity in Leicestershire told the CSJ that he was "really cautious about any way of framing [the relationship between autism and gender dysphoria] that sets up a causal relationship. But I think that there are things that constellate." Several other charities the CSJ spoke with expressed similar reluctance to imply a causation, while not denying a strong correlation, for fear of invalidating their young people's experience or coming across as "anti-trans". Without more research into the links between ASD and gender dysphoria, raising concerns for autistic young people experiencing gender distress will continue to be a taboo topic, for fear of causing offence.

RECOMMENDATIONS

- NHS England should require all young people referred to an NHS gender service to be screened for Autism Spectrum Disorders and other neurodevelopmental conditions, with a separate care pathway followed if a condition is diagnosed.
- The Department for Health and Social Care should work with NHS England to mandate the release of data pertaining to gender dysphoria and Autism Spectrum Disorders so that more research into the links between these conditions can be carried out.
- The Department for Health and Social Care should prioritise research into the links between gender dysphoria and Autism Spectrum Disorders when it comes to apportioning National Institute for Health and Care Research funding.

35 Autism Research Institute, *Gender Discomfort and Autism*, 2023.

Adverse Childhood Experiences

CSJ research, alongside existing research, has found an overrepresentation of Adverse Childhood Experiences (ACEs) in people with gender dysphoria.

ACEs are known to have a wide range of negative consequences on a person, including a heightened likelihood of ill mental and physical health, difficulty in making meaningful relationships later in life, heightened susceptibility to risky behaviours such as drug or alcohol misuse, and educational attainment challenges, too.[36] ACEs are also known to correlate strongly with economic deprivation, with growing up in a low-income household increasing the likelihood of ACEs.[37]

Children with a history of ACEs are also more likely than their peers to experience gender dysphoria. Research shows that young people with gender dysphoria are more likely to have a parent as a registered sex offender, have suffered a form of sexual abuse, or have experience of being a Looked After Child (LAC). They are also more likely to have experienced the death of a parent or endured family mental health problems, as well as have experience of other challenging family relationships. This report will examine the links between family makeup and breakdown and gender dysphoria in a separate chapter and look at other ACEs in this chapter.

One high profile whistleblower raising concerns about GIDS, Dr Kirsty Entwhistle, a former clinical psychologist employed by GIDS, had a caseload at GIDS that "included children with parents who'd been long-term psychiatric patients, families where the mother had accused the father of rape, a number of children who had only 'minimal verbal communication skills', and 'many' who had witnessed domestic violence."[38] The overrepresentation of such horrendous childhood experiences should raise serious concerns. The likelihood of childhood trauma resulting from such a background is high, and possible trauma and associated mental health complications make for complex and vulnerable young people.

Of course, one cannot say definitively whether a complicated childhood makes a person more likely to have gender dysphoria, and the research in this area, like many other areas of gender dysphoria, is limited. But the limited research that does exist makes clear that those with gender dysphoria are more likely to have already experienced challenging life circumstances. An academic review of 143 studies from 131 published articles on gender dysphoria found a higher presence of ACEs among those with gender dysphoria than seen in the general population of children and adolescents.[39]

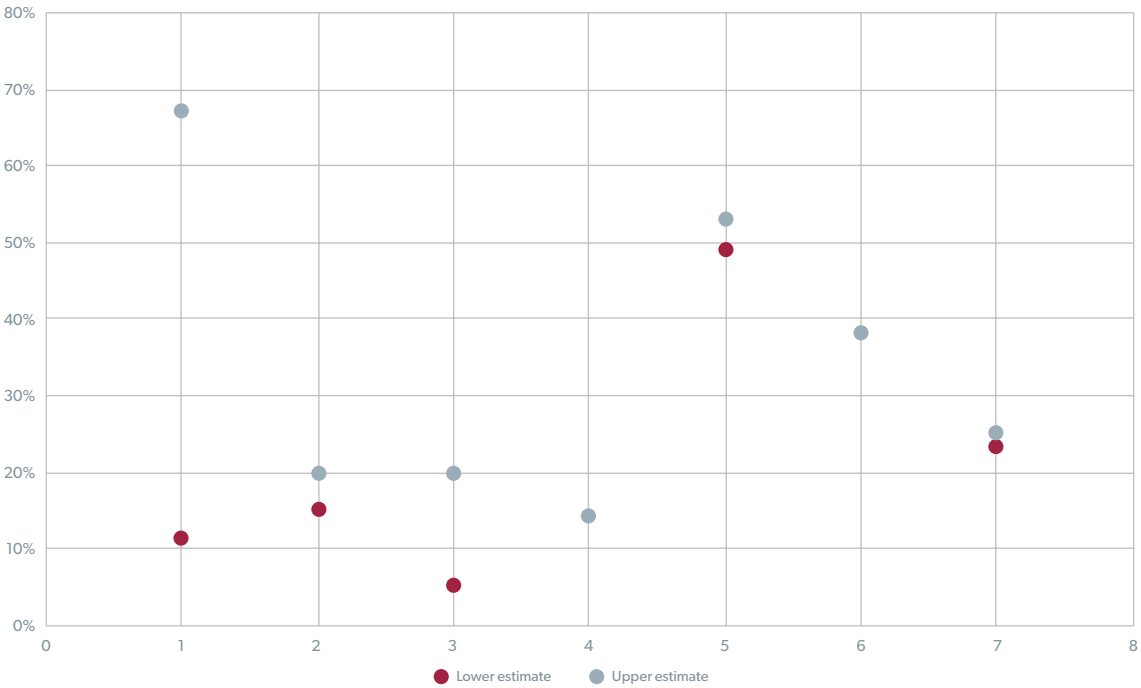
36 Liverpool CAMHS, *What are Adverse Childhood Experiences ACEs?*, 2025.

37 Lewer, D., et. al., *The ACE Index: mapping childhood adversity in England*, 2020.

38 Barnes, H., *Time to Think: The Inside Story of the Collapse of the Tavistock's Gender Service for Children*, 2023, pp226-227.

39 Taylor, J,. et. al., *Characteristics of children and adolescents referred to specialist gender services: a systematic review,* 2024.

Chart 3: Proportion of people referred to a clinic for gender dysphoria that have adverse childhood experiences



Source: Taylor, J,. et. al., Characteristics of children and adolescents referred to specialist gender services: a systematic review, 2024.

The CSJ's interviews with experts, charities and adults with gender dysphoria confirmed that traumatic or challenging backgrounds were not outliers among young people with gender dysphoria. A CEO of a charity working to help the mental wellbeing of young people shared with the CSJ that in her experience, "100 per cent if you look at the kids who are trans and you understand their backgrounds, there [are] always other things going on there." She stressed that such children had experienced "the worst case scenario" of an upbringing, detailing examples such as being taken "cruising for women" with a parent, or a child's grandparents being in court for abusing the child's parents.

It is worth noting that when the CSJ spoke to adults with gender dysphoria, many did not disclose key details about their childhood even if asked, and those answers that were given did not always reveal the full picture. One focus group participant, for instance, shared with the CSJ during an informal conversation after the conclusion of the focus group that she had 10 half-siblings on her father's side and one half-sibling on her mother's side and that her father had been in prison for a period of time and then "fell off the radar." Earlier in the day, this same person had said she had quite a normal childhood. Such a case highlights the difficulty in ascertaining the full history of a person presenting with gender dysphoria, particularly when no relationship exists between the young person in question and the health provider or assessor. Setting a minimum length of time that a clinician must spend with a patient before concluding a comprehensive assessment would help mitigate against this challenge. Comprehensive personal and family histories of young people presenting with gender dysphoria must be adopted so that this area can be further studied and the appropriate support provided. As the Cass Review noted, ACEs and broader adversity within the family setting are important factors to be aware of when assessing a patient's needs.[40]

40 Cass, H., *The Cass Review*, 2024, p94.

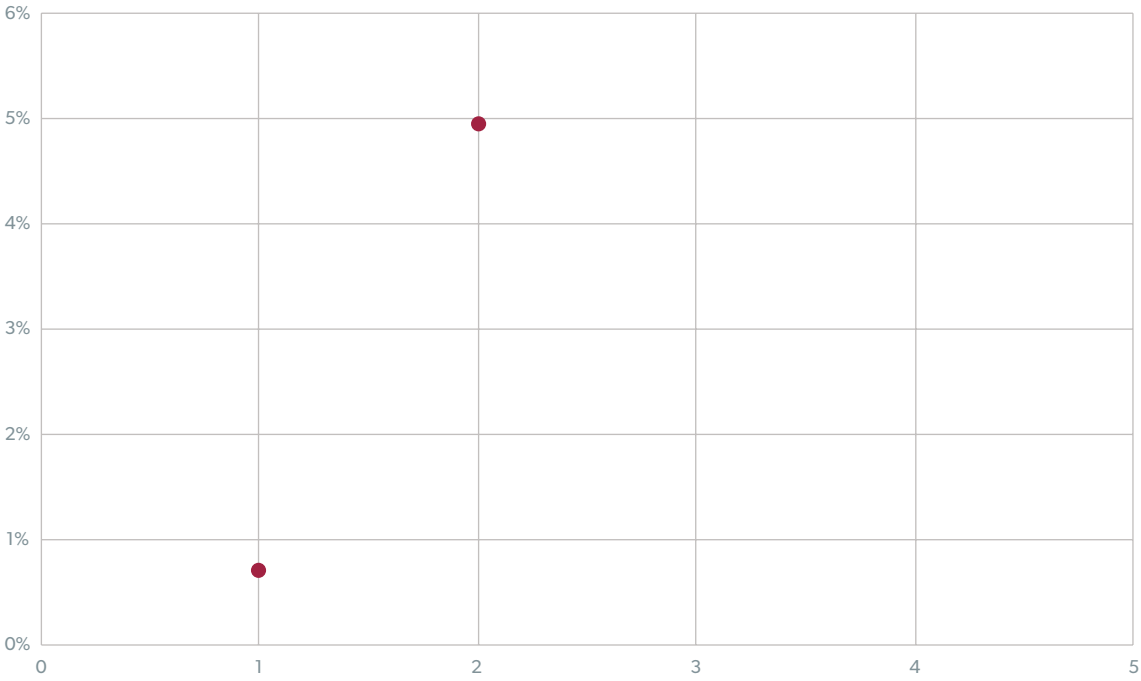
Looked After Children

Since GIDS opened in 1989, Looked After Children have been overrepresented amongst its patients. A clinical audit conducted in 2002 of the first 124 cases seen by GIDS since it opened found that 27 per cent had some experience of being in care.[41] This is massively higher than the national average of young people with experience of being a Looked After Child, which is 0.58 per cent.[42]

Other studies confirm an overrepresentation of looked-after young people among those with gender dysphoria. In an academic study that reviewed the files of 185 young people referred to GIDS between 2009 and 2011, looked-after young people represented 4.9 per cent of the cohort, and adopted people represented 3.8 per cent of referrals.[43] Although this is a long way off the 27 per cent of the first cases seen by GIDS, it is still significantly higher than what would be proportionate.

Such an overrepresentation of looked-after young people among those with gender dysphoria is still found in referrals today. According to a response to a Freedom of Information request, those referred to the NHS Children and Young People's Gender Service (London) from GIDS were more likely to have experience of being in care than the national average. Although the FOI response could not disclose the exact number, it did inform that between 1 and 5 of those young people referred had been looked after. This gives a range of between 0.78 per cent and 3.89 per cent of the referred population having experience of being looked after — with even the lowest figure in the range exceeding the national average of 0.58 per cent. Likewise, between 1 and 5 of the 111 patients referred to the North West gender clinic had experience of being looked after – somewhere between 0.90 per cent and 4.50 per cent of cases.

Chart 4: Number of young people referred to gender clinics with experience of being looked after compared with national average



Sources: Ceglie, D. D., et. al., Children and Adolescents Referred to a Specialist Gender Identity Development Service: Clinical Features and Demographic Characteristics, 2002. Gov UK, Children looked after in England including adoptions, 2024. FOI Request submitted by CSJ.

41 Ceglie, D. D., et. al., *Children and Adolescents Referred to a Specialist Gender Identity Development Service: Clinical Features and Demographic Characteristics*, 2002.

42 Gov UK, *Children looked after in England including adoptions*, 2024.

43 Matthews, T., et. al., *Gender Dysphoria in looked-after and adopted young people in a gender identity development service*, 2019.

As the Policy Exchange report *In Absentia Parentis* details, Looked After Children are particularly vulnerable, with many having experienced "severe trauma, abuse, and neglect before entering care"[44] and are "significantly more likely to have experienced abuse or neglect, and to struggle with their mental health or to be neurodivergent" compared with peers.[45]

Sexual Abuse

People who have experienced sexual abuse are more likely to experience gender dysphoria than the general population.[46] A history of sexual abuse is particularly overrepresented among girls presenting with gender dysphoria.[47]

Once again, the data in this area is somewhat limited but several studies show a heightened experience of sexual abuse among patients with gender dysphoria. A Canadian study from 2018 that examined the prevalence of "psychosocial and psychological vulnerabilities" in 50 child and teen cases of gender dysphoria found that 10 per cent had a history of sexual abuse[48] – higher than the 7.8 per cent of Canadians who experience sexual abuse before the age of 15.[49] Other studies find the rate of sexual abuse among those with gender dysphoria to be closer to 20 per cent.[50]

The American College of Paediatricians states that it is "possible that some individuals develop [gender dysphoria] and later claim a transgender identity as a result of childhood maltreatment and/or sexual abuse. This is an area in need of research."[51]

When the CSJ spoke to a charity that supports people who have experienced sexual abuse, the therapy coordinator shared that in her experience most clients express questions about gender identity after, not before, experiencing sexual trauma. She added that "we find that a lot…" When asked about the role sexual trauma plays in shaping gender identity, she said that "it's almost like a sense of taking back control." She said it was unclear whether the root cause of gender dysphoria in some cases could be the sexual trauma experienced, but noted that "there have been times when I've been concerned" at the presentation of gender dysphoria post-sexual trauma. She noted that in these cases the mental health of clients was particularly complex.

Sexual abuse is known to impact on a person's mental health and wellbeing, including anxiety, depression, eating disorders, sleep disruption and insomnia, dissociation, PTSD and personality disorders.[52] As this report outlines, gender dysphoria also has high rates of co-occurrence with anxiety, depression, eating disorders, and personality disorders. Such a correlation should raise concerns.

44 Policy Exchange, *In Absentia Parentis: How the care system has become captured by Gender Ideology*, 2025, p7.

45 Policy Exchange, *In Absentia Parentis: How the care system has become captured by Gender Ideology*, 2025, p13.

46 Thoma, B., et. al., *Disparities in Childhood Abuse Between Transgender and Cisgender Adolescents*, 2021, and Barnes, H., *Time to Think: The Inside Story of the Collapse of the Tavistock's Gender Service for Children*, 2023.

47 Nadrowski, K., *A New Flight from Womanhood? The Importance of Working Through Experiences Related to Exposure to Pornographic Content in Girls Affected by Gender Dysphoria*, 2023, p3.

48 The British Psychological Society, *Many children and teens with gender dysphoria also experience mental health issues*, 2018.

49 Statistics Canada, *Profile of Canadians who experienced victimization during childhood, 2018*, 2022.

50 Taylor, J,. et. al., *Characteristics of children and adolescents referred to specialist gender services: a systematic review,* 2024.

51 American College of Pediatricians, *Gender Dysphoria in Children*, 2018.

52 Centre of Expertise On Child Sexual Abuse, *Key messages from research on the impacts of child sexual abuse*, 2023.

Exposure to Pornography

Pornography came up on several occasions as a factor that could increase the likelihood of experiencing gender dysphoria. Given the young age at which children first watch pornography (the average age for first watching pornography is 13 but 27 per cent have watched it by age 11), exposure to pornography might not be considered an adverse childhood experience based on how widespread its consumption is, but the explicit content of the material consumed at such a young age makes a strong case for including it in this chapter.[53]

Dr Katharine Townsend, a Cambridge-based GP, explained how early exposure to pornography means that young people tend to watch more extreme forms of pornography at a younger age, in many cases leaving people "reviled" by what they see and concluding that they have gender dysphoria when their own sexual desires don't match the pornographic behaviour of those they have watched online.

Relatedly, the CSJ has previously found that young boys ranked "body image" as the biggest effect of pornography on young men today.[54] Although there is little research into the effect of pornography on gender dysphoria, it is perhaps unsurprising that if pornography affects body image, one's concept of one's own gender identity could also be affected by it.

A 2024 academic study further corroborated this theory, particularly for women and girls, whose exposure to pornography may increase the shame and fear of becoming a woman.[55] This study also found that autistic girls might struggle more to process the pornographic content they watch and have increased difficulty separating the tropes they see online from reality.[56] Given the sometimes degrading content found in pornography, girls can grow up associating being a woman with acts they instinctively feel repulsed by, concluding that they might not be a woman if what they see depicted is not what they want from sexual experiences.

Writing in *Good Girls: A Story and Study of Anorexia*, Hadley Freeman references the views of former GIDS clinicians Dr Anna Hutchinson and Dr Melissa Midgen, who cite external factors for contributing to the rise in females in particular experiencing gender dysphoria. Freeman writes:

> *"They cite, as external factors, the internet, in particular Instagram and online pornography, both of which, in their own ways, make some girls feel that they just don't fit in as females."*[57]

Likewise, the Cass Review found that "Young people who are already feeling 'different' may have that sense exacerbated if they do not fit in with the demonstrations of masculinity and femininity they are exposed to socially and/or online."[58] Undoubtedly, pornography can feed into these demonstrations of gender.

When asked about the impact of pornography on identity, a charity that supports victims of sexual abuse told the CSJ that due to the oversexualisation of some groups, particularly those belonging to the LGBTQ+ community, they "don't […] doubt that [pornography] has had an impact" on gender dysphoria and identity.

53 Cass, H., *The Cass Review*, 2024, p110.

54 Centre for Social Justice, *Lost Boys: State of the Nation*, 2025, p53.

55 Nadrowski, K., *A New Flight from Womanhood? The Importance of Working Through Experiences Related to Exposure to Pornographic Content in Girls Affected by Gender Dysphoria*, 2023.

56 Nadrowski, K., *A New Flight from Womanhood? The Importance of Working Through Experiences Related to Exposure to Pornographic Content in Girls Affected by Gender Dysphoria*, 2023.

57 Freeman, H., *Good Girls: A story and study of anorexia*, 2023, p122.

58 Cass, H., *The Cass Review*, 2024, p122.

Exposure to pornography has been shown to correlate with increased probability of being a victim of sexual abuse, and, as detailed in this chapter, a history of sexual abuse is overrepresented among girls presenting with gender dysphoria.[59]

Undeniably, the increase in young people affected by gender dysphoria coincides with widespread access to the internet and social media, often through personal devices, which makes the consumption of pornographic content ever more accessible. Although it is impossible to conclude that exposure to pornography leads to gender dysphoria, the impact of pornography on gender identity is largely unknown and under researched. Care should be taken, therefore, to record a patient's experience with pornography as part of a patient's history taking when referred to a gender dysphoria service, and expert help provided to autistic patients who may have a harder time processing the material they have consumed. This will help future study of the possible links between pornography and gender dysphoria and the possibility of traumatic exposure.

Sex Offending

In the book *Time to Think: The Inside Story of the Collapse of the Tavistock's Gender Service for Children*, investigative journalist Hannah Barnes records that former clinical psychologist, Dr Kirsty Entwhitsle, had a caseload at GIDS where three per cent were families where a parent was a registered sex offender.[60] Working from the basis that most sex offenders are male, Barnes calculates the presence of sex offenders amongst Entwistle's caseload of families to be ten times higher than the population average.[61]

Although it seems that this overrepresentation has not been replicated in any other studies, this dramatic finding highlights the adverse experiences of young people presenting with gender dysphoria. Harrowing statistics like this echo the insight of the aforementioned charity CEO – the young people they work with who have gender dysphoria have often experienced "the worst case scenario" in life.

Responding to Trauma

Trauma is known to manifest itself in myriad ways, many being of harm to the trauma-affected person. Trauma can lead to alcohol and substance misuse, self-harm, suicidal thoughts and other physical and mental health problems.[62] Trauma can arise from any Adverse Childhood Experience.

Trauma is also thought to sometimes cause body dysmorphia.[63] The link between trauma and body dysmorphia is better researched than the link between trauma and gender dysphoria, although many would deem there to be a significant overlap. Some clinicians and academics hold the view that gender dysphoria can be onset as a response to trauma-related dissociation and detachment from the body.[64, 65] The chapters on mental health and eating disorders explore this link further, including the co-occurrence between body dysmorphia, eating disorders, and gender dysphoria.

Several charities the CSJ spoke to shared the view that young people might question their gender identity post-trauma, believing that this allowed a young person to reclaim an element of control over their lives.

59 Nadrowski, K., *A New Flight from Womanhood? The Importance of Working Through Experiences Related to Exposure to Pornographic Content in Girls Affected by Gender Dysphoria*, 2023, p3.

60 Barnes, H., *Time to Think: The Inside Story of the Collapse of the Tavistock's Gender Service for Children*, 2023, pp226-227.

61 Barnes, H., *Time to Think: The Inside Story of the Collapse of the Tavistock's Gender Service for Children*, 2023, p227.

62 Mind, *Trauma: How could trauma effect me?*, 2023.

63 Malcolm, A., et. al., *Childhood maltreatment and trauma is common and severe in body dysmorphic disorder*, 2021.

64 Colizzi, M., et. al., *Dissociative symptoms in individuals with gender dysphoria: is the elevated prevalence real?*, 2015.

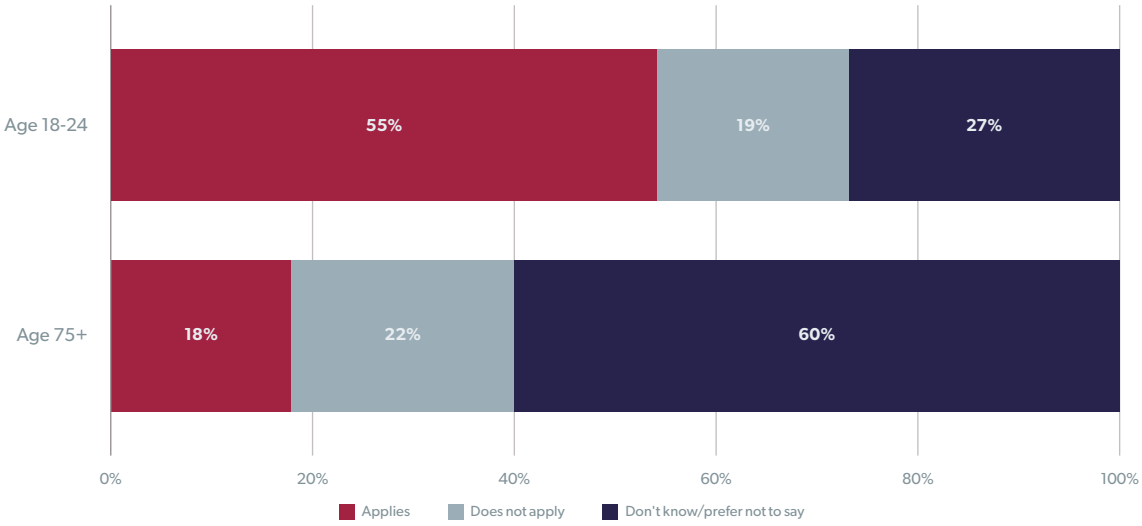
65 Kersting, A., et. al., *Dissociative disorders and traumatic childhood experiences in transsexuals*, 2003.

One charity CEO bluntly framed it: "You can see why these kids don't want the identity they've got." She later said: "I think part of it is they think it's this kind of magic solution, and then the real underlying issues aren't really dealt with, and they just carry them through."

Another CEO of a small mental health charity: "Gender dysphoria is rising. Is it a new response to trauma in children and young people, rather than an actual rise in prevalence?"

CSJ polling found that younger respondents were much more likely to recognise a person questioning their gender as someone responding to trauma. 55 per cent of 18-24 year olds said that a young person questioning their gender could be responding to trauma, compared with only 18 per cent of over 75s, with both age groups similarly likely to think such a person is not responding to trauma (18 per cent and 19 per cent, respectively).[66]

Chart 5: Response to the question: In your experience, would you say that the following descriptions tend to apply to children and young people who say they are questioning their gender, or not? Responding to trauma



Source: CSJ polling.

RECOMMENDATIONS

1. NHS England should mandate comprehensive personal and family histories of young people presenting with gender dysphoria.
2. NHS England should establish a minimum length of time that a clinician must spend with a patient before concluding a comprehensive assessment.
3. NHS England should include experience with pornography as part of a patient's history taking when assessed by a clinic for gender dysphoria.

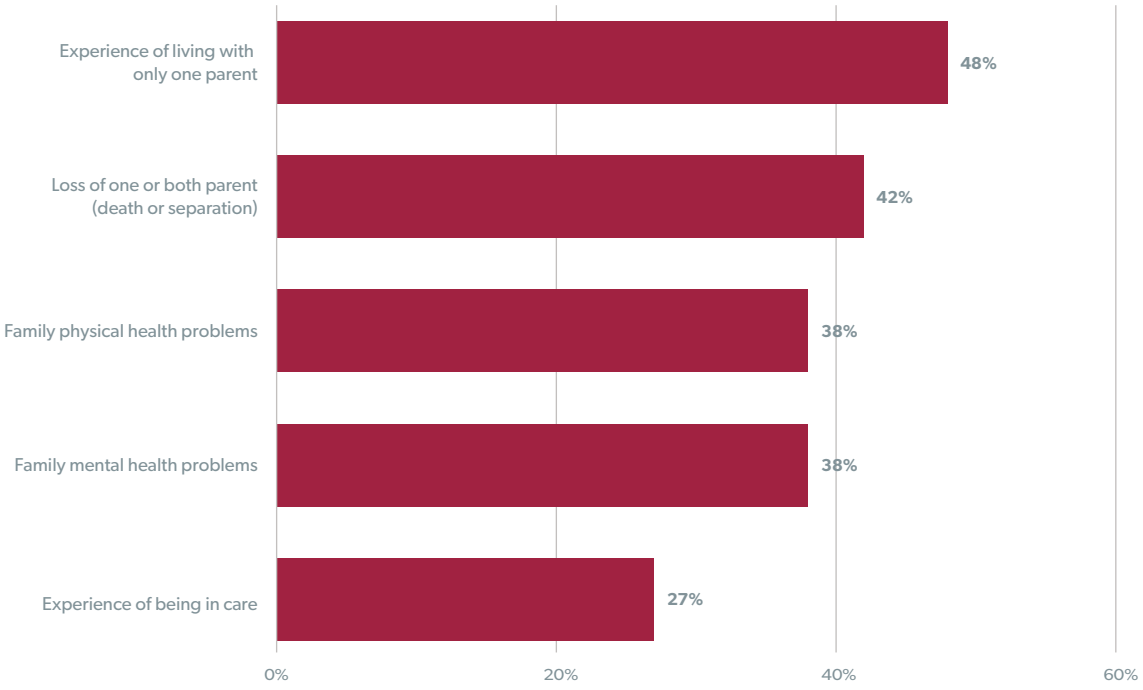
66 CSJ polling.

Challenging Family Relationships

Speaking to both young people with gender dysphoria and charity leaders working with affected young people revealed a pattern of family difficulties existing before the onset of gender dysphoria.

The following chart shows the prevalence of difficult family circumstances among the first 124 cases seen by GIDS.[67]

Chart 6: The prevalence of challenging family circumstances among the first 124 cases seen by GIDS



Source: Ceglie, D. D., et. al., Children and Adolescents Referred to a Specialist Gender Identity Development Service: Clinical Features and Demographic Characteristics, 2002.

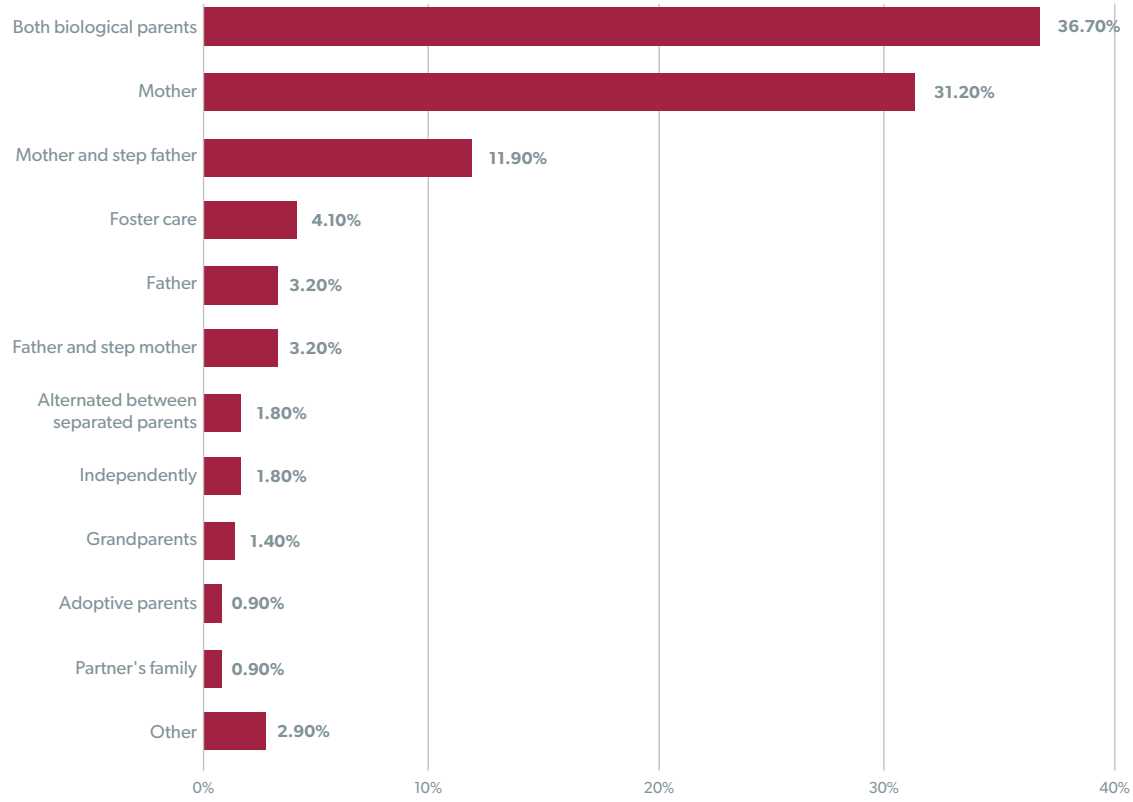
As the Cass Review noted, and as the above chart makes clear, adversity within the family setting is an important factor to be aware of when assessing a patient's needs.[68] Similar to ACEs more broadly, one cannot say definitively whether a complicated childhood makes a person more likely to have gender dysphoria, and the research in this area, like many other areas of gender dysphoria, is lacking. Once again, the need for comprehensive family histories of young people presenting with gender dysphoria must be adopted so that this area can be further studied and patterns identified.

67 Ceglie, D. D., et. al., *Children and Adolescents Referred to a Specialist Gender Identity Development Service: Clinical Features and Demographic Characteristics*, 2002.
68 Cass, H., *The Cass Review*, 2024, p94.

The CSJ is keenly aware of the importance of strong families in creating resilient and well-adapted children. Divorce is known to have consequences on young people: a child aged between 7 and 14 when their parents divorce is 16 per cent more likely to suffer from behavioural problems than their peers.[69] Children living in one-parent, blended, or step-families are about twice as likely to suffer from mental disorders, or to need psychological support, compared with children living with both biological parents.[70] Among the myriad other challenges family breakdown presents in a child's life, it seems a heightened susceptibility to gender dysphoria is another such case.

The chart below shows the different living arrangements at the time of referral experienced by GIDS patients in 2012.[71] Just over a third of patients were living with both biological parents, which is much lower than the 2010-2011 national average of two-thirds of children who lived with both biological parents.[72]

Chart 7: The living arrangements at time of referral for GIDS patients in 2012



Source: Holt, V., et. al., Young people with features of gender dysphoria: Demographics and associated difficulties, 2016.

69 Goughs Solicitors, *Divorce and the impact on a child's mental health*, 2023.

70 Goughs Solicitors, *Divorce and the impact on a child's mental health*, 2023.

71 Holt, V., et. al., *Young people with features of gender dysphoria: Demographics and associated difficulties*, 2016.

72 Department for Work and Pensions, *Percentage of children living with both birth parents, by age of child and household income; and estimated happiness of parental relationships*, 2013, p5.

Dr Katharine Townsend observed that in her professional experience as a GP "there is nearly always something difficult that's gone on in the family when someone comes to me with gender dysphoria." She explained that it "could be divorce of parents or as simple as having moved town at a vulnerable age or having a sick sibling."

Such a trend was corroborated by a focus group held in Buxton with people with gender dysphoria. When asked about their family background, there were cases of divorce, having a twin, or being raised by a father rather than mother or both parents. While cases like having a twin do not make for a challenging childhood, it bolsters the view that the family dynamics are somewhat unusual in the backgrounds of young people with gender dysphoria.

Relatedly, one charity CEO lamented the absence of positive family role models in the lives of young people presenting with gender dysphoria, particularly when it came to mothers. She told the CSJ: "The kids that I know who've transitioned, the common denominator is their mothers are […] unstable, the mental instability of their mothers. And again, it's a massive generalisation, but that's the common denominator for us, where the mothers aren't a good role model, or are quite weak." Of course, this does not mean that maternal challenges cause gender dysphoria, but it does highlight the challenging familial relationships some young people with gender dysphoria experience. The charity CEO added that in many cases the mother of the child with gender dysphoria would have a preexisting dependency on drugs, smoking, or alcohol.

Preserving Family Relationships

Dr Katharine Townsend reflected on family dynamics when a child presents with gender dysphoria: "these teenagers say their parents are rejecting them but actually they are the ones rejecting their parents. The parents are heartbroken and want a relationship with their child, but are being denied it." She added that the practice of schools affirming a student with gender dysphoria before informing the parents served to exacerbate this tension and rightly was discouraged following the Cass Review. Schools must not stand at odds with Government guidance concerning gender identity and preferred pronouns.

Draft Government *Guidance for Schools and Colleges: Gender questioning children*, was published in 2023, with recommendations for schools fully outlined.[73] Schools, however, are not legally obliged to follow it as the guidance is non-statutory. This means that although schools are advised to seek parental input before aiding the social transition of a pupil through acceptance of preferred pronouns, parents may not actually be informed or consulted.[74]

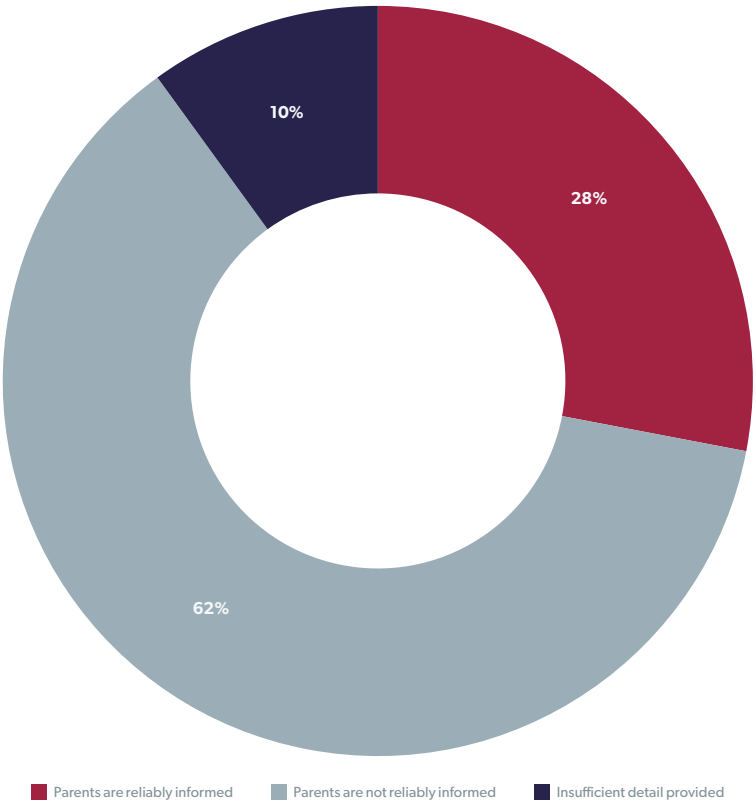
A survey conducted of over 150 schools for a Policy Exchange report found that, overwhelmingly, schools were not informing parents when a child expressed feelings of gender distress while at school.[75]

73 Department for Education, *Gender Questioning Children: Non-statutory guidance for schools and colleges in England, Draft for consultation*, 2023.

74 Department for Education, *Gender Questioning Children: Non-statutory guidance for schools and colleges in England, Draft for consultation*, 2023, p13.

75 Policy Exchange, *Asleep At The Wheel*, 2023, p38.

Chart 8: The number of schools that inform parents of a child expressing gender-distress at school



Source: Policy Exchange, Asleep At The Wheel, 2023, p39.

Indeed, the practice on the ground stands at odds with the recommendations provided by the guidance. A CSJ focus group with school teachers found that:

> *"The reality, from my experience [and] from the experience of many parents, is that most schools do not follow any guidance or any policy whatsoever. […] In my case, the school is blatantly saying "we will not be following that." And what are you following? "We don't have a policy. We are just doing things on a case-by-case basis." What is a case-by-case basis? No one knows. So, there is a horrendous lack of clarity of what the schools are doing. There are definitely frequent cases where schools are social[ly] transitioning children behind parents' backs, and parents only find out about it by chance. So, parents are excluded from the situation that is developing and can become very serious."*

Another CSJ focus group heard that:

> *"One of the issues that we found is, even if you have a universal policy across the school, that it's rarely applied the same within the school [...] we did a big piece of research around LGBT about three years ago, and one of the things that came out was that, for some staff, even though technically, the rules were that to change a name on a register, you needed parental consent and you need to go through the system, some staff were willing to just, you know, just cross the name off and write the new name on."*

The CSJ also found that some charities would accept social transition by using preferred names and pronouns with a child, but not always reveal that to parents. One charity worker who works with a charity that helps girls who are struggling said:

> *"I had a young person who wants to be a boy, and then I think the referral came through with the female name, but I'd had information from school of like, what he wanted to be called, so I just went in straight away and said, 'I'll go with whatever you want.'*
>
> *And he was like, [...] 'I don't mind.'*
>
> *And I was like, 'It's whatever you want?'*
>
> *And he was like, 'Okay, can you call me like this name and use these pronouns?'*
>
> *And so we always did, but he was like, 'Just if you ever have to call home, [...] please don't say you know this name.'*
>
> *And I was like, 'Yeah, that's fine.'*
>
> *And then I think school had spoken to me, and they were like, 'Well, we've been told to call them this.'*
>
> *I was like, 'Okay, well, I'm not school. I'm [a charity], so in this half an hour, I'll call you what you want.'*
>
> *And then, yeah, they had ADHD and autism."*

A balance needs to be struck between ensuring clients of charities feel supported and comfortable enough to benefit from the help being offered, and safeguarding concerns that arise from accepting the social transition of a minor. Given that using preferred pronouns is not a neutral act, and its impact on mental health and future gender identity is hotly contested, it should not be assumed a *de facto* positive for charities to affirm a new gender identity through their work. At the same time, provided charities are not interacting with that young person on a daily basis, the comparative impact of using preferred pronouns in that setting compared with a school setting is much smaller.

RECOMMENDATIONS

- The Department for Education should make schools guidance on gender questioning children statutory, noting the safeguarding need of informing a parent of a child's wish to go by different preferred pronouns.

Negative Attitudes Towards Sexual Orientation

Related to the preceding chapter on challenging family relationships, academic literature and the CSJ's qualitative interviews indicate that opposition towards certain sexual orientations – either expressed by family, peers or personal discomfort – as well as family members discouraging gender non-conforming behaviour – correlate with later presentations of gender dysphoria. While the CSJ does not intend to present sexual orientations as a disadvantage, there are links between opposition to sexual orientation or traditionally non-conforming behaviour and gender dysphoria that are worthy of elucidation, and opposition to sexual orientations or behaviour can, understandably, create challenges for a young person.

Opposition to LGB Identity

Several sources point to family opposition to sexual orientation, or difficulty accepting oneself as lesbian, gay, or bisexual, featuring among those with gender dysphoria. Several clinicians from GIDS have confirmed that although rare for parents to prefer a trans child to a lesbian, gay, or bisexual child, such instances did occur during their time for various cultural and religious reasons.[76]

David Bell, a former consultant psychiatrist at the Adult Department at the Tavistock and Portman NHS Foundation Trust, has previously argued that "Some children who show characteristics of being gay/lesbian find that this is not tolerated by the family (often very overtly, but equally often in a more subtle even unconscious way); the children internalise this intolerance of their sexual orientation, which becomes manifest as hatred of their own sexual bodies."[77] He also notes that "It is not uncommon for a lesbian girl, for example, to think that because she is attracted to the same sex that she must 'really' be a boy."[78]

The Cass Review reported similar findings, including views on sexual orientation amongst a child's peer group influencing perceptions of identity. It found that:

- "Clinicians and parents reported that gay students are still being stigmatised and bullied in school and there is sometimes a perception that there is less validation for them than for trans pupils."
- "In some strictly religious cultures, being transgender is seen as preferable to being same-sex attracted as it is then perceived as a physical rather than a psychological issue."[79]

76 Barnes, H., *Time to Think: The Inside Story of the Collapse of the Tavistock's Gender Service for Children*, 2023, p165.
77 Bell, D., *First do no harm*, 2020, p2.
78 Bell, D., *First do no harm*, 2020, p2.
79 Cass, H., *The Cass Review*, 2024, p119.

Practices in Iran, where transgenderism is more accepted than LGB identities, give further credence to opposition to certain sexual orientations leading to a presentation of gender dysphoria. Iran's legalisation of sex reassignment surgery, which exists alongside laws that can punish homosexuality with capital punishment, can lead to some people feeling "pushed into having gender reassignment surgery", either by the culture at large or from direct family threats.[80] The view that a person could be trapped in the wrong body is deemed more socially and morally palatable than same-sex attraction.

Of course, the UK is largely accepting of different sexual orientations and far less hostile than countries like Iran, but the role views on sexuality can play in shaping perceptions around gender should not be dismissed. The demographics of detransitioners further bolster concerns around views on sexuality leading to gender dysphoria. Although detransition is another area of gender dysphoria that is understudied, a study of 100 detransitioners found that 23 per cent cited homophobia or difficulty accepting themselves as lesbian, gay, or bisexual as a reason for initial transition.[81] Among the female respondents, only 8.7 per cent considered themselves heterosexual prior to transition, with the others identifying as homosexual, pansexual, bisexual or with multiple sexual orientations.[82] Another study of detransitioners found that 52 per cent expressed a psychological need for learning to cope with internalised homophobia.[83]

Gender Non-Conforming Behaviour

Another trend we noticed from the focus group participants was parents who discouraged gender non-conforming behaviour in their children. One participant said she got told off for "playing with dolls", while another said "my mum used to try and push feminine things on me, and I just didn't want it […], you know, that's not me."

There was a sense that this stifling of expression was a point of hurt or difficulty in the child's relationship with their parents at the time, but there was no indication that it led to a lasting tension. Indeed, for the most part, the focus group participants who had gender dysphoria said their parents were welcoming of their gender identity or at least had not cut off contact even if they suspected they weren't fully supportive. This corroborates what Dr Katharine Townsend told the CSJ, which was that parents "desperately want a relationship" with a child experiencing gender dysphoria, despite many patients saying their parents "want nothing to do with them."

A charity worker who supports young girls from challenging backgrounds told the CSJ of a family with a son that wanted to try dance and was supported by his parents in that decision, but she warned of parents that don't support children engaging in activities deemed too feminine or masculine. She said:

80 BBC, *The gay people pushed to change their gender*, 2014.

81 Littman, L., *Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners*, 2021.

82 Littman, L., *Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners*, 2021.

83 Vandenbussche, E., *Detransition-Related Needs and Support: A Cross-Sectional Online Survey*, 2021.

> *"I think when you haven't got that [support] and you can't do that, you will have young people that say, 'Well, I'll go the full [transgender] way, because mum or dad won't talk to me if I'm just exploring the options, so I'm just going to go all in and go that way. And then sometimes that can be where they have to row back, because it's not them. They just haven't been given the space, the environment, or the support to explore. Or it can go the other way, where they just repress everything, and then you end up with a lot of mental health problems, a lot of damaging behaviour, because they are just repressing so much of themselves because they don't feel safe to explore those opportunities and explore their own authentic personality."*

On the wider point of gender non-conforming behaviour, however, several charities spoke of the role of schools in navigating gender dysphoria in young people. The main criticism voiced was that school uniforms can be restrictive and both limit individual expression and force an appearance that makes young people uncomfortable.

A former teacher turned charity CEO told the CSJ that "Some of the uniforms these kids are made to wear are horrible." She said that "Now schools are so rigid about the uniform. So, if you're a girl and you want to be a bit of a tomboy, you have to go around wearing a kilt […] and the blouses are fitted for girls […] you don't want to wear all this […] and there's no kind of flexibility whatsoever." She added that in one school she works in with young people there was resentment among the girls towards someone with gender dysphoria. She explained: "Their resentment of them was that they said 'We're only allowed to wear stud earrings, but they're allowed to change gender.' You see what I mean? It builds resentment. They didn't really care about the trans element to it, not bothered at all. It was more that all of these allowances are made for this one kid and they're not given an inch and they're not allowed any of the individuality."

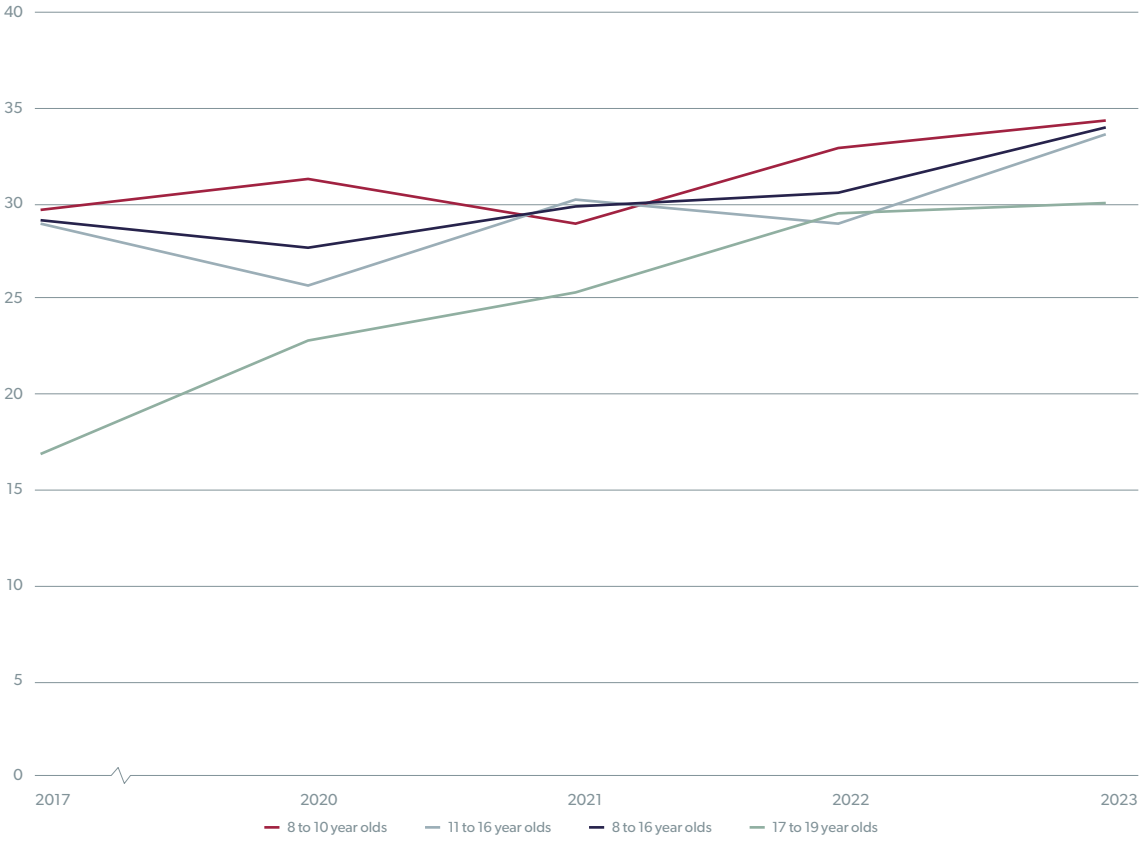
Another charity worker told the CSJ that uniforms can give some students ultimatums – either be uncomfortable as a girl having to wear skirts, or identify as non-binary so as to wear trousers. They observed that "I think schools have become so rigid over the last 15 years in attitude and behaviour. You know, you have to wear the right uniform; you can't have makeup on; you can't wear nail varnish; you cannot have your hair this colour, it has to be a natural hair colour; you cannot have your piercings on show."

Reflecting on these dynamics, Baroness Cass told the CSJ "It's helpful in any setting where you can take the problem out. So if girls and boys can wear unisex uniforms, it's one less problem […] The more you're not having to make committed decisions early on, the better. I'm not saying that all schools have to have unisex uniforms; it just can be helpful."

Mental Ill-Health

The mental health of young people today is notoriously poor, with increasing concerns at an international level about the mental health of Generation Z.[84] The mental health of young people has been worsening in recent years, with a particular increase in the number of teenage girls presenting with a mental health condition. In 2023, almost half (47.6 per cent) of 17 to 19 year old females in England had a possible or probable mental health disorder.[85]

Chart 9: Percentage of boys that have a possible or probable mental health condition

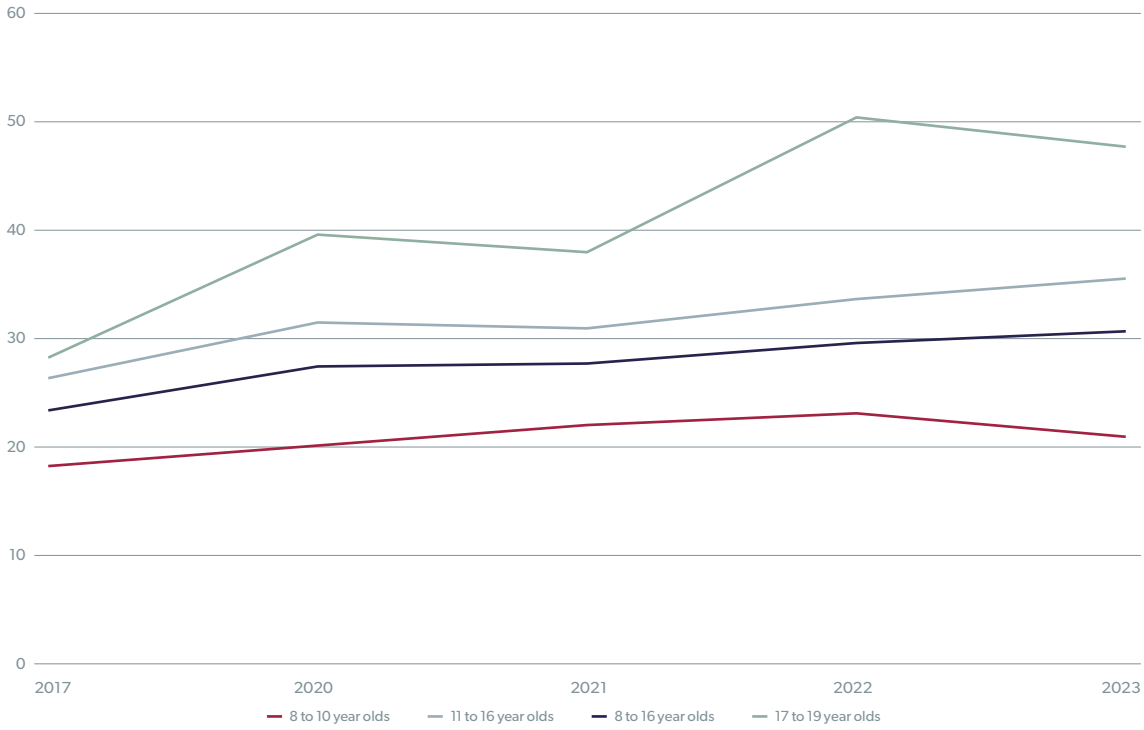


Source: NHS England, Mental Health of Children and Young People in England 2023 - wave 4 follow up to the 2017 survey: Data tables, 2023.

84 Cass, H., *The Cass Review*, 2024, p10.

85 NHS England, *Mental Health of Children and Young People in England 2023 - wave 4 follow up to the 2017 survey: Data tables*, 2023.

Chart 10: Percentage of girls that have a possible or probable mental health condition



Source: NHS England, Mental Health of Children and Young People in England 2023 - wave 4 follow up to the 2017 survey: Data tables, 2023.

If the mental health outlook is poor across the youngest generations as a whole, the picture amongst those with gender dysphoria is much worse, with mental health disorders often pre-existing the onset of gender dysphoria. The Cass review spoke to clinicians working in child and adolescent mental health and paediatric services and heard an increase in the number of young people presenting with issues around gender identity alongside mental health difficulties.[86] It also found that "clinicians working in the NHS have seen increased rates of some more specialist mental health conditions such as functional tic-like behaviours, BDD [body dysmorphic disorder] and functional neurological conditions. These changes have been observed internationally, and preceded Covid-19, although some got worse during the pandemic."[87]

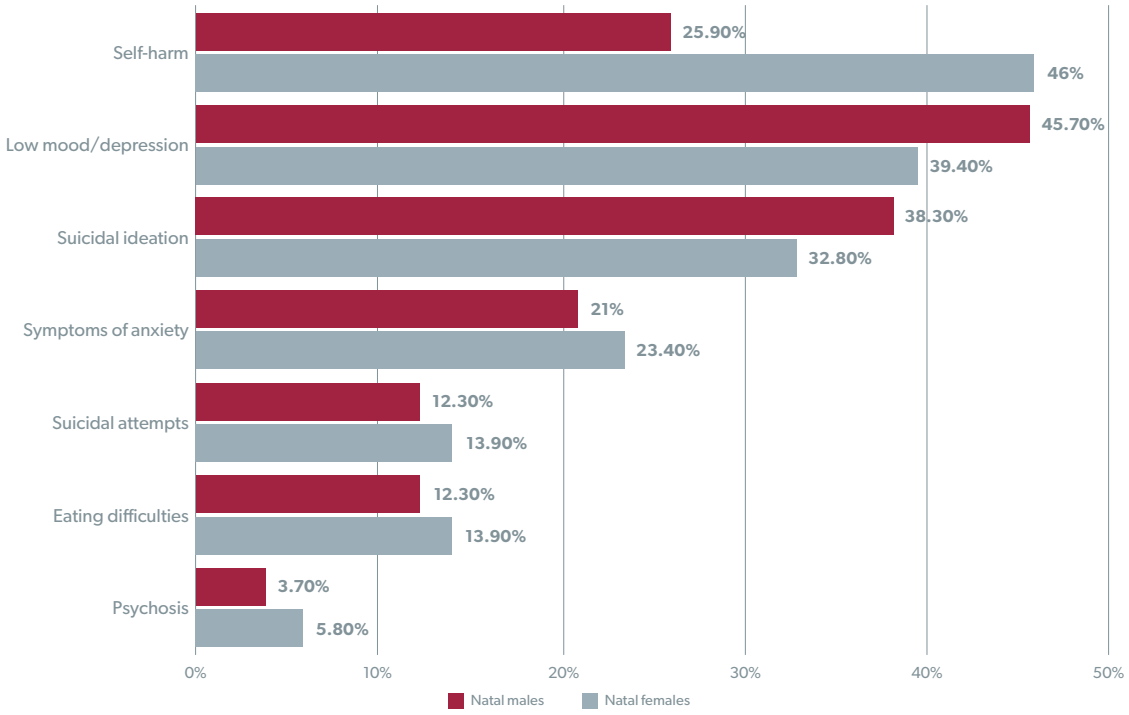
A recent Finnish paper found that those with gender dysphoria had much more complex mental health needs than their age matched peers, with mental health needs being greater in recent cohorts than in earlier ones.[88]

Among those with gender dysphoria, instances of self harm and suicide are much higher than among age matched peers. A study of a large US data set found that people aged between 6 and 21 years old with gender dysphoria were three to five times more likely to have experienced suicidality or self-harm compared with those without gender dysphoria.[89]

86 Cass, H., *The Cass Review*, 2024, p90.
87 Cass, H., *The Cass Review*, 2024, p112.
88 Cass, H., *The Cass Review*, 2024, p91.
89 Mitchell, H. K., et. al., *Prevalence of gender dysphoria and suicidality and self-harm in a national pediatric database*, 2022.

A study from GIDS published in 2016, looking at the referred patient cohort from 2012, found high numbers of associated mental health difficulties among those patients with gender dysphoria, with a third of natal females having either low mood or depression, self-harm, or suicidal ideation, and a quarter of natal males having experienced the same.[90]

Chart 11: Associated mental health difficulties among GIDS patients referred in 2012



Source: Holt, V., et. al., Young people with features of gender dysphoria: Demographics and associated difficulties, 2016.

Mental Health Pre-Onset of Gender Dysphoria

Understandably, there is a chicken-or-the-egg dynamic to conversations around mental health and gender dysphoria. Mental health disorders and poor mental health are known to both pre-exist the onset of gender dysphoria as well as follow the onset. But across the existing research on mental health and gender dysphoria, there is a clear pattern: if a person has poor mental health, they are more likely to experience gender dysphoria. Given that the population with gender dysphoria has more cases of poor mental health than the population average, not all mental health challenges can be considered secondary to issues around gender.

Indeed, in Finland over three quarters of the "referred adolescent population needed specialist child and adolescent psychiatric support due to problems other than gender dysphoria, many of which were severe, predated and were not considered to be secondary to the gender dysphoria."[91]

Likewise, a recent study of over 1,000 parental reports of children with gender dysphoria found that 57 per cent of cases had a prior history of mental health issues, and that mental health problems preceded the onset of gender dysphoria by an average of 3.8 years.[92]

90 Holt, V., et. al., *Young people with features of gender dysphoria: Demographics and associated difficulties*, 2016.

91 Cass, H., *The Cass Review*, 2024, p91.

92 Diaz, S. et. al., *Rapid-Onset Gender Dysphoria: Parent Reports on 1,655 Possible Cases*, 2023.

Focus Group Insight

The focus group participants with gender dysphoria typified this profile. There were participants who had had depression, anxiety, multiple personality disorder, and several who had multiple of these, often with diagnoses of autism or ADHD too.

In many cases, what the participants shared about their mental health was quite separate from their gender dysphoria, making a point that the gender dysphoria was not the cause of other mental health matters.

One participant shared that:

> *"For me, aside from the whole trans thing, my life has been this massive uphill fight for a score of mental health issues. So I always had difficulties in school because when it came to mixing with other children I didn't act like all the other kids, and that's what led to me getting my autism diagnosis in 2014. And then on top of that, I've been seeing doctors about depression and anxiety since 2019. But even then, there were symptoms that my autism diagnosis and depression and anxiety didn't explain that I was having to deal with. And when I was in sixth form, I actually got kicked out because my mental health symptoms were so overwhelming that it impacted my ability to study. [...] So I spoke to my doctor [and a private clinic] and they said I have dissociation and trauma and this is what they're positive I have [...] They are getting me on trauma stabilization, one on one courses, and then the hope from there is that they'll refer me to a psychiatrist who will actually diagnose me of a condition that I'm pretty positive I have at this point. So when I was told 'you probably have this condition', I went and I researched it, and I learned everything I possibly could about it. I got scholarly articles, I got papers written by psychiatrists, all sorts. And it really does feel like that answer to all the problems I've had in my life. So I've had this massive uphill battle, excluding all the trans issues, about my mental health, and it's still not anywhere near over, because I have to fight to get diagnosed [with this other condition] and then I have to fight to get treatment after I'm diagnosed, and it's a lot."*

Another shared that: "Through my teenage years, I went into a really depressive state. I won't go into too much detail, but over the course of my teenage years, I had a total of four attempts on my life."

Another participant, who had multiple personality disorder, said "I've been with psychiatrists and in and out of hospitals since 1984." She said:

> *"I was born having panic attacks and anxiety from word go, and I didn't know about it, and it controlled all the gender stuff. [...] [After the gender reassignment operation, I spoke to] the psychiatrist in charge of the gender stuff and I said, 'I've just come out of one room and into another room, and I'm totally different. I feel totally different.' He said, 'It's just a mood change.' But in actual fact, I have multiple personalities. It goes through multiple extreme male, extreme female and no middle ground. This is not bipolar. It's just extreme male, extreme female. Because when a male, I got into karate. I was female – I was absolutely beautiful, right? See? And there was no in between, and I've been trying to get used to that in me for 40 years. I've been getting treatment for psychiatry. I've ended up with six personalities now. And I know these six personalities, but the one that really stands out is [...] I revert back into a child, a young girl."*

Some participants, however, did say their poor mental health was linked to their gender dysphoria, particularly as concerns depression brought on by considering all that was involved with the process of transition. A couple of participants noted that they were "so depressed" or "immediately went into a depression" after seeing what was involved with transition and how out of reach it seemed. One person explained: "I thought, Christ, all this I've got to do, and I couldn't handle it, and there was nobody to talk to in those days. You know, it was just not done." But, in most cases, the poor mental health of focus group participants was, at least according to the participants, separate from matters arising from their gender identity.

Charity and Expert Insight

The overlapping diagnoses of gender dysphoria, poor mental health, and other conditions such as autism was mentioned by several of the experts and charity workers the CSJ spoke with during the project. Overall, there was a sense that poor mental health can precede the onset of gender dysphoria and not always be linked.

A General Practitioner who wished to remain anonymous told the CSJ:

> *"transgender [...] is a mental health condition and it shouldn't be treated with cross hormones and puberty blockers [...] If you get the diagnosis [of gender dysphoria], and they want the drugs, particularly if you're a boy, particularly adolescent boys, or young students, they want the drugs before they transition. The drugs are a very big component. Most of them are on the autistic spectrum, if not all. If we were to deal with that properly or, certainly in the boys, the autism spectrum. In the girls, severe anxiety or body dysmorphia. If we dealt with that, or the depression or the loneliness or the anxiety then all these other things would slide away gradually over time."*

Another GP, Dr Katharine Townsend, told the CSJ that in her experience, the "vast majority of girls [who present with gender dysphoria] are on antidepressants and see transitioning as the way to sort it out."

A charity that supports women and girls who have experienced sexual abuse told the CSJ that among their service users who question their gender, a lot "present with different mental health diagnoses" and there "tends to be a lot of personality disorders as well." They added "In particular with clients that are identifying as non binary [...] there tends to be a lot of personality disorders, and it's not always been diagnosed properly. [...] I would say that that's probably one of the most common [mental conditions that presents in our clients with gender dysphoria]."

The distinction between gender dysphoria and wider mental health challenges highlights the importance of treating the two matters separately, and ensuring a mental health assessment is conducted for those referred to gender services. As Barnes documents in her book *Time To Think,* recent practice at GIDS was to fast-track medical intervention at the expense of more time consuming psychological exploration, and to sideline co-existing complexities such as depression or anxiety once gender dysphoria was raised.[93]

Baroness Cass succinctly told the CSJ that, when both gender dysphoria and mental health concerns are present, underlying mental health conditions should be treated as a priority. She explained:

> *"You should not be making decisions about gender, about possible medications, when you're not in a stable mental state. For somebody who's seriously depressed or suicidal or hyper anxious, then you do need to address that in order for them to be in the sort of state where they can make those decisions. Some people would worry that the depression is secondary to the fact that they're not getting the treatment that they want. I think clinicians would have to make a judgment about that. But I think people do have to be in a good enough state of mental health to make a complex decision."*

Indeed, many people do worry that poor mental health in people with gender dysphoria arises from the delay in gender-affirming care. While there are inevitably cases where ongoing distress will arise from delays in gender-affirming care, the principle of not making life-altering decisions while in a depressive or anxious state should be upheld, particularly when it concerns minors.

93 Barnes, H., *Time to Think: The Inside Story of the Collapse of the Tavistock's Gender Service for Children*, 2023.

Mental Health Post-Onset of Gender Dysphoria

Although this report's focus is primarily concerned with the material, social, and psychological conditions pre-onset of gender dysphoria, the intertwined relationship between gender dysphoria and mental health meant that our research uncovered insights about the mental health of people with gender dysphoria post-diagnosis or post-transition, too.

Focus group participants who had gender dysphoria all noted that their mental health had been poor prior to transition, but there were mixed responses as to their mental health post-transition.

One participant said that it had been a bit mixed, with other people's attitudes to their transition being the cause of poor mental health:

> *"I've gotten so much more confident now. I can be myself and be who I am, and I feel like in that aspect I'm definitely much better off knowing that I'm trans and able to be openly trans. The downside to that is a lot of people in my age group are either teenagers or have just stopped being teenagers, and teenagers are cruel, so in social situations I do get put down a lot, and I get treated badly by the people who are the same age as me, which is why I tend to make friends with people older than me because I don't need the childish behaviour anymore. So there's an upside and a downside. I'd say, overall, I'm better off, though."*

Others weren't quite so positive. One person said that since transition their mental health had been quite mixed:

> *"Overall, I'm not, like, stuck in my head. I, in a way, feel joy a lot more. It's not just one emotion, which is apathy or lack of emotion. But because of that, any issues, like what's going on [in the world], it does affect me a lot more. I can't just switch my brain off anymore. Mental health wise, it's gone down when it's in the sort of bad area. But I want to take that because I actually feel alive, rather than just a robot."*

Another participant said their mental health had been impacted by aspects of transition, in particular access to egg freezing:

> *"I think my mental health went bad when I was fighting for my egg freezing because I want biological children. And before I came out, before I went through my medical transition, I came to this conclusion that I'd never have biological children. But because I'm born in a female body, I can conceive and carry a child myself – but that's not me. So for me to have biological children, I need to freeze my eggs and go through that. I had to fight for funding, and I was originally told I wasn't allowed. So I went, I applied for funding for egg freezing, because it's thousands of pounds, and I was refused it, and that was where my mental health went down, because I kind of was like, I'm never gonna have biological children… and I ended up in the mental health unit. And then when I came out of the mental health unit, I thought, I'm gonna fight it. And I did afford it, and I managed to get funding for it, so I froze my eggs. But that was the period that my mental health dropped. When I was told, basically, you're not allowed children, you know."*

The oldest focus group participant, who had undergone gender-reassignment surgery in the 1980s, said that her mental health took a dive post transition and she returned to the psychiatric ward.

Although making claims as to the implications of different treatments on the mental health of people with gender dysphoria is beyond the scope of this report, the above insights seemed worthy of inclusion so as to show the varied mental health of patients *after* the onset of gender dysphoria. The CSJ did not hear of such varied mental health presentations *pre*-onset.

Gender Dysphoria as a Mental Health Condition

Research for this report also raised the question of whether gender dysphoria itself should be designated as a mental health condition. Several of the experts the CSJ spoke with stressed that gender dysphoria itself is, despite its reclassification in the UK in 2018, a mental health condition rather than a sexual health condition. Indeed, the DSM-5-TR (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision) published by the American Psychiatric Association, lists gender dysphoria as a mental, not sexual, health diagnosis.[94]

Dr Katharine Townsend told the CSJ "Doctors are treating it medically whereas it should be treated as a psychological problem, not a medical problem." She added "The irony is treatment of a so-called sexual health condition with puberty blockers and cross-sex hormones trashes your sexual health."

Dr Helen Joyce, journalist and author of *Trans: Gender Identity and the New Battle for Women's Rights*, argued that "If somebody is so dissociated from their own body that they think there's something wrong about the fact that they're male or female, then that a priori is something very bad with them." Joyce also questioned the merits of always seeking a diagnosis.

94 American Psychiatric Association, *What is Gender Dysphoria?*, 2025.

The CSJ's report *Change the Prescription* further elaborated on the harms of overdiagnosis in mental health more broadly, noting that aggregate levels of diagnoses do not always present a fair picture of the health of a society, nor do they indicate the best course of treatment.[95] When applied to gender dysphoria, such a line of argument would suggest that simply diagnosing a person with gender dysphoria does not, in and of itself, prescribe a course of treatment, or alleviate the condition.

Relatedly, Suzanne O'Sullivan's book *The Age of Diagnosis: Sickness, health and why medicine has gone too far* stresses the harms of overdiagnosis, many of which can be applied to gender dysphoria. She writes about how "diagnostic creep" can draw more people from the fringes into a category of an illness, and how a diagnosis for a mild presentation of an illness can often cause more harm than good.[96] In the example of gender dysphoria, a simple 'wait and see' how a person's trajectory unfolds can offer a better approach than quick labelling and diagnosis of a condition, particularly when treatment waiting lists are lengthy and often feel out of reach.

Such a view was echoed by Dr Katharine Townsend. She felt that we are "diagnosing depression all too quickly," and that being "unhappy is seen as a problem that should be treated rather than a part of normal life." She said "Doctors are too ready to make a diagnosis of a mental health condition rather than expecting children to find life bumpy. They are too ready to go down the therapy route." Being a Cambridge-based GP, she observed that "30 years ago the stress of Cambridge [University] would trigger mental health whereas now people are coming to Cambridge already on antidepressants and with mental health problems. […] The anti-depressants aren't working and a transition is seen as the next fix."

When asked about the implications of redesignating gender dysphoria as a mental or sexual health matter, Baroness Cass told the CSJ: "I think clearly it matters from the point of view of some trans people, but I think from the point of view of children's health care, the important thing is that you take account of the fact that there can be significant mental health issues in this population, and you make sure that you address them."

RECOMMENDATIONS

- NHS England should align clinical practice with the DSM-5-TR definitions by recognising gender dysphoria as a mental health diagnosis.
- NHS England should ensure that young people referred to a gender service undergo a mental health assessment.

95 Centre for Social Justice, *Change the Prescription: A new approach to mental health*, 2025.

96 O'Sullivan, S., *The Age of Diagnosis: Sickness, health and why medicine has gone too far*, 2025.

Eating Disorders

There is a strong co-occurrence between gender dysphoria and eating disorders, despite the complex interplay between eating disorders and gender dysphoria not being well understood.[97] As with the other disadvantages and deprivations detailed in this report, disordered eating is another one that has links with lower socio-economic groups, despite the cliché that anorexia is a rich white-girl phenomenon.[98] A study of teenage girls found that disordered eating was more common among those of lower, not higher, socio-economic groups, meaning that once again it is the most vulnerable who are suffering.[99]

It is known that many young people with gender dysphoria present with an eating disorder. Sometimes the eating disorder pre-dates the gender dysphoria and sometimes it follows it.[100]

In 2016, GIDS published a study looking at other difficulties experienced by young people with gender dysphoria. It found that 13.9 per cent of girls and 12.3 per cent of boys with gender dysphoria had experienced eating difficulties[101] – almost 25 times higher than the population average of 0.5 per cent of 11-16 year olds who had an eating disorder in 2017.[102]

A Canadian study from 2017 asked 923 transgender people aged between 14-25 about their gender identity, eating behaviors, stigma they experience, and protective factors in their lives. Participants were asked if, over the last 12 months, they had experienced any episodes of binge eating, or had tried to lose weight by fasting, using pills, taking laxatives, or vomiting. Of those surveyed, 75 per cent reported at least one of these behaviours. Among the 14-18 year olds, 42 per cent reported binge eating, 48 per cent reported fasting, 7 per cent used pills, 5 per cent took laxatives, and 18 per cent reported vomiting – higher than the rates for the 19-25 age group.[103]

97 Cass, H., *The Cass Review*, 2024, p112.

98 Freeman, H., *Good Girls: A story and study of anorexia*, 2023, p37.

99 Gibbons, P., *The Relationship Between Eating Disorders and Socioeconomic Status: It's Not What You Think*, 2001, as cited in Freeman, H., *Good Girls: A story and study of anorexia*, 2023, p37.

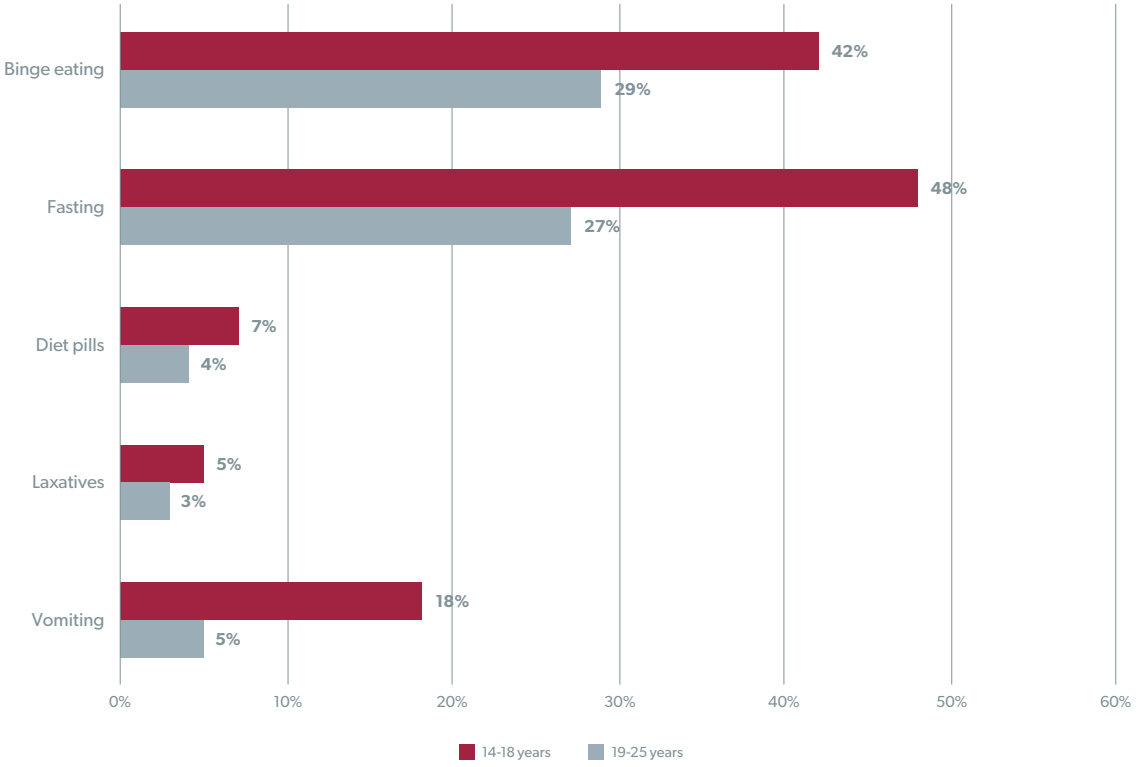
100 Cass, H., *The Cass Review*, 2024, p112.

101 Holt, V., et. al., *Young people with features of gender dysphoria: Demographics and associated difficulties*, 2016.

102 House of Commons Library, *Eating Disorders Awareness Week 2024, Debate Pack*, 2024, p3.

103 Duke Psychiatry and Behavioural Sciences, *Gender Dysphoria and Eating Disorders*, 2023.

Chart 12: per cent of transgender people aged 14-25 who have experienced disordered eating in the past year



Source: Duke Psychiatry and Behavioural Sciences, Gender Dysphoria and Eating Disorders, 2023.

Such disordered eating among young people with gender dysphoria has been found by other studies, too. A US study from 2015 found that transgender college students were four times more likely than female students to have an eating disorder.[104] And a US study from 2013 found high school students with gender dysphoria were three times more likely to restrict their eating than students without gender dysphoria.[105]

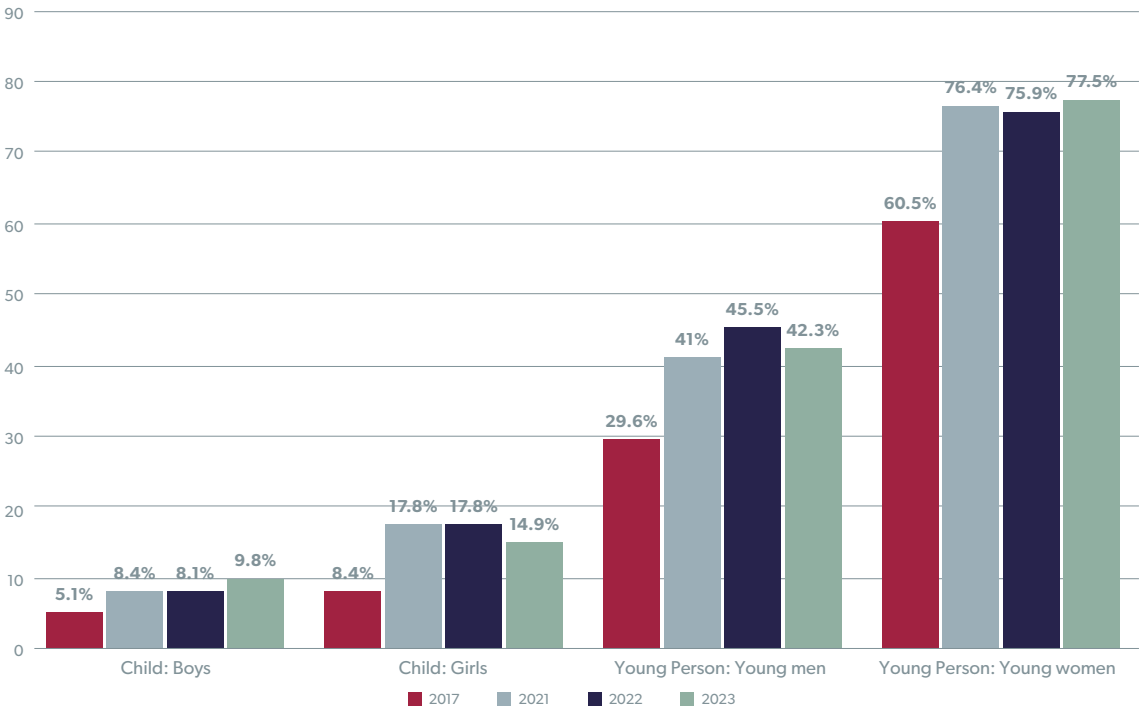
More broadly, there has been an increase in the number of cases of eating disorders in young people over recent years – similar to, but less pronounced than, the increase in cases of gender dysphoria in young people.

The charts below show the increase since 2017 among boys and girls who are screening positive for possible eating problems, as well as the increase in the number of children and young people with a diagnosed eating disorder. As with gender dysphoria, females are more likely to be affected than males.

104 Diemer, E., et. al., *Gender Identity, Sexual Orientation and Eating-Related Pathology in a National Sample of College Students*, 2015.

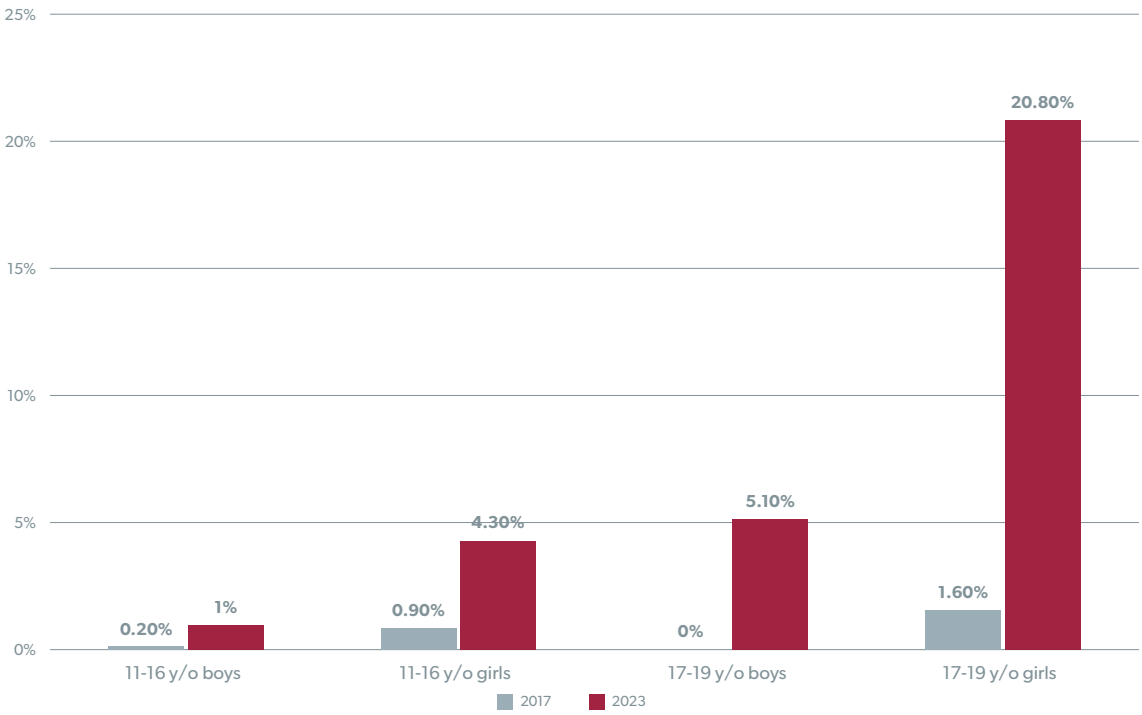
105 Guss, C. E., et. al., *Disorder Weight Management Behaviours, Nonprescription Steroid Use, and Weight Perception in Transgender Youth*, 2017.

Chart 13: the per cent of children and young people (17 to 19 years old) who screened positive for possible eating problems



Source: NHS England, Mental Health of Children and Young People in England, 2023 - wave 4 follow up to the 2017 survey, 2023.

Chart 14: Percentage of children and young people with an eating disorder



Source: NHS England, Mental Health of Children and Young People in England, 2023 - wave 4 follow up to the 2017 survey, 2023, as cited in Cass, H., The Cass Review, 2024, p111.

A good amount of academic literature offers hypotheses for the prevalence of co-occurrence between eating disorders and gender dysphoria. Both disorders are, in many cases, thought to be linked to a dissatisfaction with one's body image and a strong desire to change it. Some people with gender dysphoria might restrict calories in order to delay puberty, or males with gender dysphoria might engage in disordered eating behaviour in order to appear more feminine.[106]

There is also a growing body of research that compares gender dysphoria and eating disorders as two different ways of reacting to stress. Much has been written about the increasing levels of stress children and young people feel today, and the mental health chapter touches on this more. But it is perhaps unsurprising that eating disorders are correlated with social media use in young people – as are cases of gender dysphoria.[107]

Hadley Freeman, author of *Good Girls, A story and study of Anorexia*, insists there is a link between anorexia and gender dysphoria. She observes that at the age of puberty, more girls than boys are referred for gender dysphoria and notes that "Puberty is also when anorexia generally takes root, as it is when girls are especially susceptible to mental health problems."[108] She writes that:

> *"In the winter of 2021 I spoke to Anastassis Spiliadis, a psychotherapist who has worked in GIDS and eating disorder clinics, and he told me: 'We are heading to a similar sex ratio in GIDS as in eating disorder clinics, which are 90-95% female in the adolescent cohort. That makes me think about female adolescence, and how that can be traumatic for some girls, and whether we are doing a good enough job to support young people and to help them connect with their bodies in a healthy way'."*[109]

Freeman believes that "Eating disorders and gender dysphoria are disorders of the body: body obsession, body hatred, body alienation. They are both rooted in the belief that if you change your body you will no longer hate yourself."[110]

Dr Melissa Midgen, a child and adolescent psychotherapist who worked for several years at GIDS and now works with people with eating disorders, is quoted in Freeman's book as saying:

> *"Girls and women have always found ways to show their distress through their body, and have used their bodies to restrict womanhood, whether that means sex or the demands of adulthood. Anorexia is very much about that, and gender dysphoria is an extension and elaboration of that, with the added bonus that you can totally reinvent yourself and be part of a tribe."*[111]

This is not to say that all cases of gender dysphoria in girls can be explained away by disordered eating or reacting to modern stereotypes of women's bodies, but it does offer insight into the complex psychology that can be a root cause of gender dysphoria, and the immense vulnerability of such young women.

106 Within Health, *Anorexia in the transgender community*, 2023.
107 Cass, H., *The Cass Review*, 2024, p110.
108 Freeman, H., *Good Girls: A story and study of anorexia*, 2023, p110.
109 Freeman, H., *Good Girls: A story and study of anorexia*, 2023, p111.
110 Freeman, H., *Good Girls: A story and study of anorexia*, 2023, p112.
111 Freeman, H., *Good Girls: A story and study of anorexia*, 2023, p117.

Eating Disorders, Gender Dysphoria, and Autism

There is an association between eating disorders and autism, despite the nature and cause of this association being poorly understood.[112] Some theories hypothesise that autistic people might develop a keen interest in repetitive behaviours like calorie counting that can develop into anorexia, or restrict calorie intake in order to appear thinner in the hope of greater social acceptance.[113]

It is understood that females are particularly likely to have a dual diagnosis. A 2020 study found that 20-35 per cent of women with anorexia met the criteria for an autism diagnosis.[114] Another study found that although only 10 per cent of patients with an eating disorder had a diagnosis of autism when commencing treatment, an additional 17.5 per cent received a diagnosis for autism during treatment.[115]

The treatment for eating disorders in autistic people tends to be less successful than in the rest of the population.[116] But there is reason to suggest that a diagnosis of autism can make treatment and recovery of an eating disorder more effective.[117]

In *Good Girls, A story and study of Anorexia*, author Hadley Freeman writes:

> *"As far back as the 1980s there was a theory that anorexia might be a female twist on autism. 'Initially there was a lot of scepticism around this but recent studies are showing that among patients who have chronic anorexia, who don't respond to treatment, as many as 30-35% have, not full-blown autism, but autism spectrum disorder,' says Dr Agnes Ayton, chair of the Faculty of Eating Disorders at the Royal College of Psychiatrists. It's easy to see a connection between autism and anorexia: the rigidity, the obsessiveness, the lack of realistic self-perspective, the retreat from the world. 'It's mainly males who are diagnosed with autism and it's mainly females who are diagnosed with eating disorders. But females are very good at masking their autistic symptoms. They mimic, they repeat social rules, they can hide autistic features behind a façade. But then adolescence comes along and this can get trickier as social interactions become more complicated, which may then lead to anorexia,' says Professor Kate Tchanturia, Professor of Psychology in Eating Disorders at King's College London and author of Supporting Autistic People with Eating Disorders."*[118]

Indeed, Dr Katharine Townsend remarked that "there tends to be a crossover between eating disorders and the autistic spectrum. But there is a move away from eating disorders and towards transitioning, with transitioning being promoted as the 'beautiful solution'." She added that this was particularly pronounced for women.

112 Adams, K. L., et. al., *Potential mechanisms underlying the association between feeding and eating disorders and autism*, 2024.
113 Eating Disorders Victoria, *Eating disorders and autism*, 2025.
114 Eating Disorders Victoria, *Eating disorders and autism*, 2025.
115 Parsons, M. A., *Autism diagnosis in females by eating disorder professionals*, 2023.
116 Adams, K. L., et. al., *Potential mechanisms underlying the association between feeding and eating disorders and autism*, 2024.
117 Eating Disorders Victoria, *Eating disorders and autism*, 2025.
118 Freeman, H., *Good Girls: A story and study of anorexia*, 2023, pp38-39.

Freeman writes in *Good Girls* that "Anorexia, gender dysphoria and autism are, potentially, a three-ringed Venn diagram, with adolescent girls in the middle, sometimes dealing with one of these issues, sometimes more."[119]

More research should be carried out into the relationship between autism, eating disorders, and gender dysphoria. Just as the presence of autism can make the treatment of eating disorders more challenging, so too could it impact the successful treatment of gender dysphoria.

RECOMMENDATIONS

- NHS England should standardise the recording of eating disorders in history taking of people presenting with gender dysphoria.
- The Department for Health and Social Care should work with NHS England to mandate the release of data pertaining to gender dysphoria and Eating Disorders so that more research into the links between these conditions can be carried out.
- The Department for Health and Social Care should prioritise research into the links between gender dysphoria and Eating Disorders when it comes to apportioning National Institute for Health and Care Research funding.

119 Freeman, H., *Good Girls: A story and study of anorexia*, 2023, p111.

Socioeconomic Deprivation

The majority of the areas of disadvantage identified in this report have clear socioeconomic parallels, with people from a lower socioeconomic class more likely to experience such challenges.

The socioeconomic dimension of mental health cannot be ignored. As the CSJ has highlighted in previous reports, it is the UK's most disadvantaged who suffer more when it comes to mental health.[120]

NHS data shows children aged 8 to 16 years with a probable mental disorder are more than twice as likely to live in a household that has fallen behind with rent, bills or mortgage (18.7 per cent) than those unlikely to have a mental disorder (6.8 per cent).[121] They are also more than twice as likely to not be able to afford to keep the home warm enough (19.9 per cent compared with 7.6 per cent).[122] The mental health crisis among children and adolescents has an undeniable socio-economic component.

Similarly, children from poorer backgrounds are more likely to have an Adverse Childhood Experience (ACE). Children growing up in poverty are three times more likely to experience an ACE, with deprivation increasing the risks of ACEs.[123] Children in poverty are also much more likely to experience childhood trauma, with children whose parents report poverty during pregnancy nine times more likely than their wealthier peers to face additional traumatic experiences.[124]

Family breakdown also features along a socioeconomic gradient, with parental separation known to have a negative impact on the financial security of a family, as well as parental separation being more pronounced in poorer households.[125] Almost 20 per cent of children fall into relative poverty after the separation of their parents, with those living with their mothers most affected.[126] And parental separation is more likely to affect couples with lower educational attainment, and financial stress often exacerbating marital difficulties.[127]

Given the overrepresentation of mental ill-health, ACEs and family breakdown among those experiencing gender dysphoria, the correlation of the above factors with socioeconomic profile should raise concerns when it comes to young people presenting with gender dysphoria.

Unfortunately, there is limited research available on socioeconomic profile and how it pertains to gender dysphoria. And, perhaps surprisingly, the most recent paper examining this link found no correlation between area level deprivation and presentation of gender dysphoria in young people.[128]

120 Centre for Social Justice, *Change the Prescription: A new approach to mental health*, 2025.

121 NHS England, *Mental Health of Children and Young People in England, 2023 - wave 4 follow up to the 2017 survey,Part 4: Social and economic context*, 2023.

122 NHS England, *Mental Health of Children and Young People in England, 2023 - wave 4 follow up to the 2017 survey,Part 4: Social and economic context*, 2023.

123 Farooq, B., et. al., *The association between poverty and longitudinal patterns of adverse childhood experiences across childhood and adolescence: Findings from a prospective population-based cohort study in the UK*, 2024.

124 UCL News, *Children in poverty at greater risk of childhood traumas*, 2020.

125 Centre for Social Justice, *Family Structure Still Matters*, 2020.

126 UK Date Service, *How does a couple's separation affect income, employment and well-being?*, 2015.

127 The Divorce Surgery, *Divorce Statistics and Trends in the UK (Updated Nov 2023)*, 2023.

128 Jarvis, S. W., et. al., *Epidemiology of gender dysphoria and gender incongruence in children and young people attending primary care practices in England: retrospective cohort study*, 2025.

Reflecting on this recent paper, Baroness Cass told the CSJ:

> *"You could argue that maybe two things are balancing out: that people from higher socioeconomic class are more likely to seek help, and maybe people from lower socioeconomic class, or people who are more disadvantaged in other ways, are more likely to have gender dysphoria. Maybe those two are cancelling each other out. I don't know. I think the researchers were surprised because for most conditions they do see a gradient, and so they were moderately surprised that they didn't."*

A paper examining a large Finnish data set, however, did find a positive correlation between adolescent transgender identity and mother's low education, accumulating family life events, lack of family cohesion and perceived lack of family economic resources, despite the researcher's initial hypothesis.[129]

The relationship between deprivation and gender dysphoria needs further study, particularly given the undeniable correlation of other factors with gender dysphoria which do operate along a socioeconomic gradient.

The particular case of high referral rates from Blackpool also raises questions about the role deprivation plays in making a person susceptible to gender dysphoria. In Blackpool, referrals for gender dysphoria are more than three times higher than the national average.[130]

Helen Joyce remarked to the CSJ that the high incidence of gender dysphoria in Blackpool suggests that, although gender dysphoria can be an elite issue, it also affects those that "nobody cares about". She commented that "In Blackpool there's a shocking number of looked after girls who are identifying as trans, and that's the same place that has the highest rate of child sexual exploitation. These girls are looking for every and any way they can to express their misery. And gender dysphoria is one way."

129 Kaltiala, R., et. al., *Family Characteristics, Transgender Identity and Emotional Symptoms in Adolescence: A Population Survey Study*, 2023.

130 The Times, *Gender referrals for children three times higher in Blackpool*, 2022.

Social Contagion

Although it is sometimes thought controversial to attribute an increase in gender dysphoria to peer influence, with the term "social contagion" known to be of particular distress to some people, the CSJ heard from several charities and experts who raised the question of to what extent gender dysphoria could be described as a "social contagion".[131] Might it follow that those who are excessively online, or overly influenced by peers rather than parents, are more likely to experience gender dysphoria?

As the Cass Review notes, "Peer influence during this stage of life is very powerful. As well as the influence of social media, the Review has heard accounts of female students forming intense friendships with other gender-questioning or transgender students at school, and then identifying as trans themselves."[132]

Similar concerns were expressed by several charity workers who noted the intense relationships formed by some people after questioning their gender. A mental health charity based in the Midlands told the CSJ that they ran a mental health support café but "had issues with a particular group that came." Within the group, several were:

> *"[questioning their] gender identity and a number of them would be non-binary, who had issues with their mental health, but found this was a place of safety for them to socialize. And it became, it actually became disruptive. The actual person who runs it is actually transgender, and so they were obviously being quite accepting of them, but even they could see that it was causing issues because it became such a close knit group, and then their behaviour, together with the neurodiversity, became disruptive. So it's hard, it is hard, and I don't know where I'm going with that, really, but it was a group that became a problem because that group then became so confident with themselves as that group, they didn't see the wider group of people coming in with need, and their need was different."*

The fact that a group of young people can become so tight knit may not be a cause for concern necessarily, but excessive peer-orientation isn't necessarily something to celebrate. The harms of peers supplanting parents as the key role models and authority figures in a child's life are well known, with anxiety, weakened emotional resilience, and higher levels of stress all more likely.[133] The detrimental influence friends can have on each other during their teenage years should not be underestimated.

131 Cass, H., *The Cass Review*, 2024, p117.

132 Cass, H., *The Cass Review*, 2024, p122.

133 Neufeld, G., *Hold Onto Your Kids: Why parents need to matter more than peers*, 2019.

CSJ polling found that adults largely agree (44 per cent net agree vs 22 per cent net disagree) that young people with gender dysphoria are more likely to have friends with gender dysphoria, and 50 per cent think young people with gender dysphoria are overly influenced by their peers (vs 17 per cent who think such a statement does not apply to young people with gender dysphoria). Such a view is maintained among 18-24 year olds, with 51 per cent of them agreeing (vs 24 per cent disagreeing) that young people with gender dysphoria are more likely to have friends with gender dysphoria.

Among the people the CSJ spoke with who had gender dysphoria, peer to peer transmission of information had clearly played a large role. One participant said "I learned about being trans when I was about 13 because I had a friend come out as trans, and I had never heard of it before, and she explained it to me. And at that time, I remember thinking, well, that's kind of how I feel." This person didn't "really consider the idea that my gender was the opposite side of the spectrum" until three years later.

The role of TV shows and YouTube channels were also attributed with progressing their gender dysphoria. One participant said about the show *There's Something About Miriam* (a 2004 reality TV show about male contestants who compete for Miriam's affection, only to be told at the end that Miriam is a male who has yet to undergo a medical transition), "that's what helped me transition."[134] Another participant said "I spent years watching videos on YouTube of people transitioning and being so depressed" as they were "envious of these people."

The concept of social contagions more broadly is explored by Suzanne O'Sullivan in *The Sleeping Beauties: And Other Stories of Mystery Illness.* While O'Sullivan does not draw parallels with gender dysphoria, the social contagions she details do raise questions about the role of culture in shaping an illness. Across history, there have been a plethora of examples of how certain illnesses can afflict certain cultures. O'Sullivan writes:

> *"Outbreaks of mass psychosomatic illness happen all over the world, multiple times per year, but they affect such unrelated communities that no one group gets the chance to learn from another."*[135]

One medical journalist who spoke to the CSJ, who wishes to remain anonymous, considered social contagion in the context of culture specific epidemics, and cited the example of the laughter epidemic in Tanganyika. An event from the 1960s, the Tanganyika laughing epidemic was an outbreak of mass hysteria affecting girls at a secondary school now located in Tanzania. 95 of the 159 pupils at that school experienced extended bouts of laughter, averaging seven days, which forced the school to temporarily close. Symptoms also included fainting, respiratory problems, and rashes. Soon after the initial outbreak, laughter outbreaks affected other schools, with the total outbreak lasting 18 months, closing 14 schools within a 100 mile radius, and affecting 1,000 pupils. The medical journalist drew parallels with gender dysphoria, noting that gender dysphoria can spread through schools and friendship groups, with similar cultures and girls most affected.

134 Hogan, M., *'She was tough, but it broke her': why There's Something About Miriam was reality TV's most shameful low*, 2024.
135 O'Sullivan, S., *The Sleeping Beauties: And Other Stories of Mystery Illness*, 2021, p11.

Social contagions are known to affect women more than men, with Helen Joyce drawing parallels between this and the rise in females being diagnosed with gender dysphoria in her book *Trans: Gender identity and the new battle for women's rights*. She writes:

> *"A new medical paradigm, therefore, may do something more profound than give doctors a new way to understand what they see: it can change what they see. Sometimes, a new condition is born – and sometimes it gains sudden popularity. The history of medicine is scattered with psychosomatic diseases that appeared, spread like wildfire and died away as medical thinking changed again. One sign a new condition may fall into this category is that it mainly affects teenage girls and young women."*[136]

Speaking to the CSJ, Joyce said emphatically that gender dysphoria is a social contagion. Joyce said that the social contagion is spread both from adults to young people through schools, as well as peer to peer. She elaborated that there is "horizontal transmission from child to child." Joyce remarked that "We've never tried leaving children to bring each other up without adults around to oversee them and give them structure" but "chat rooms, fanfiction websites, Reddit and in-game chats for computer games" mean that "we let children off into spaces, into a tunnel on their own, unsupervised by adults for very large periods of time." She observed that "new mental illnesses are being created by influencers on TikTok, and that's done by young people without adults at all. It's that unsupervised, horizontal spread of ideas, coupled with teachers spreading the idea to pupils, especially girls, that drives the social contagion."

Role of Social Media

The role social media plays in spreading ideas about gender dysphoria is significant. The American College of Paediatricians notes that there is an increasing trend among adolescents to self-diagnose as transgender after binges on social media sites such as Tumblr, Reddit, and YouTube.[137] This suggests that there is a social contagion element to some instances of gender dysphoria. Such a theory is compounded by the fact that in many schools and communities, there are entire peer groups "coming out" as trans at the same time.[138]

Young people with gender dysphoria are more likely to spend longer on social media and the internet than other young people. One study of almost 10,000 adolescents found that trans-identifying adolescents reported 4.51 more hours of total daily recreational screen time including more time on television/movies, video games, texting, social media, and the internet, and those who identified as gender questioning spent 3.41 more hours of daily screen time.[139] The screen use for trans-identifying and gender questioning adolescents was also associated with higher rates of problematic use than the population average.[140]

It is perhaps unsurprising, therefore, that CSJ polling found a concern for the influence of social media on young people. We found that 63 per cent of respondents think young people questioning their gender are overly influenced by social media (vs 13 per cent who disagree). And such a concern is also shared by members of the LGBT community, as illustrated below.

136 Joyce, H., *Trans: Gender identity and the new battle for women's rights*, 2021, p106.

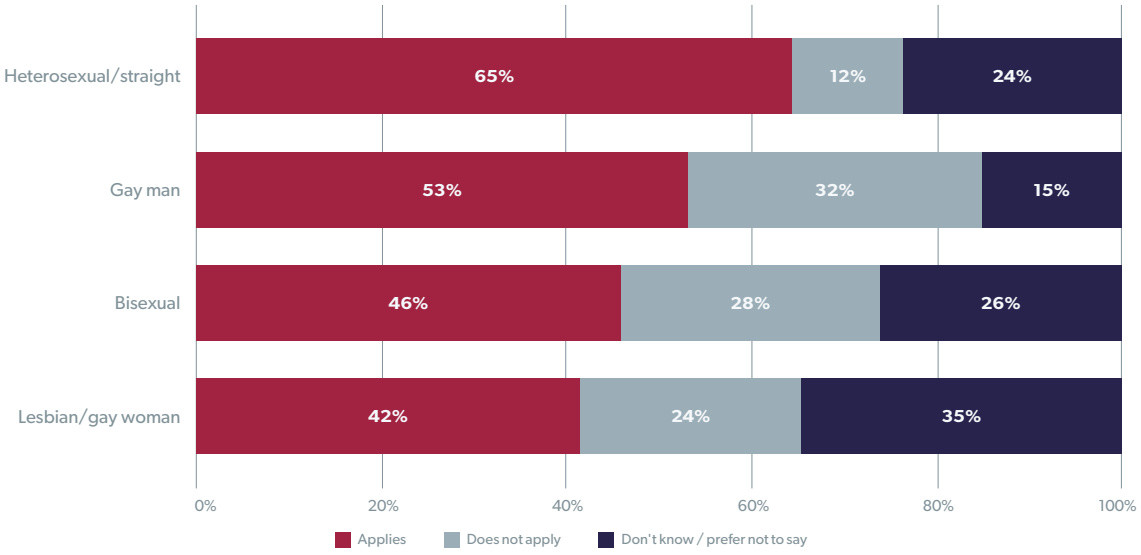
137 American College of Pediatricians, *Gender Dysphoria in Children*, 2018.

138 American College of Pediatricians, *Gender Dysphoria in Children*, 2018., and Littman, L., *Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports, 2018.*

139 Nagata, J. M., et. al., *Screen use in transgender and gender-questioning adolescents: Findings from the Adolescent Brain Cognitive Development (ABCD) Study*, 2024.

140 Nagata, J. M., et. al., *Screen use in transgender and gender-questioning adolescents: Findings from the Adolescent Brain Cognitive Development (ABCD) Study*, 2024.

Chart 15: Response to the question: In your experience, would you say that the following descriptions tend to apply to children and young people who say they are questioning their gender, or not? Overly influenced by social media



Source: CSJ Polling.

The role of social media in connection with social contagion theory was raised several times by charities the CSJ spoke with. Although many charities stressed the value social media brings in making access to information easier, others noted how it can lead down certain "rabbit holes".

A convener of a mental health support group in the Midlands told the CSJ that "[Social media is] filtering something in that maybe if it hadn't been there, would never have existed […] I do think there is something about what is coming from social media and the amount of harm we see from that, and things like self harm and things like that, and the pressures around suicide. There are groups forming who are telling people how to [commit suicide], and that worries me."

Likewise, a charity that works with young women who have experienced sexual abuse told the CSJ that "A lot of our young people like pages that sort of encourage self injury […] especially now with TikTok." They added that social media can be "safe spaces for some people, but then it can be quite dangerous because you're in subsets, like there's a right or wrong way to be trans or non-binary or a feminist and everything's questioned and constantly comparing ourselves to [others]."

Another charity that supports young people struggling with mental health overall had a positive view of social media as they thought it gave "more accessibility for questions to be asked" and although "there is the opportunity for harmful content, there is also the opportunity for connection, community and supportive content as well." They did express some concerns, however, for neurodivergent people accessing information via social media and going down rabbit holes. They explained: "You've got some people who will really struggle to look beyond something that's […] in front of them. So it's, you know, absorbed very literally. You'll have maybe other people who do not understand so many aspects of social dynamics in the world, but they go on deep dive searches. They come across things that are really harmful. But then with that, you'll also have those that do those searches too […] and require a lot of information and detail, which, again, then is hard to process and dynamically apply."

List of Recommendations

Referrals

- NHS England should mandate a consistent data collection and patient's history taking at the time of referral. This should include:
  - a mental health assessment;
  - screening for Autism Spectrum Disorders and other neurodevelopmental conditions, with a separate care pathway followed if a condition is diagnosed;
  - recording of eating disorders in history taking of people presenting with gender dysphoria;
  - recording of experience with pornography as part of a patient's history;
  - comprehensive personal and family histories of young people presenting with gender dysphoria;
  - a minimum length of time that a clinician must spend with a patient before concluding a comprehensive assessment.

Research

- The Department for Health and Social Care should work with NHS England to mandate the release of data pertaining to gender dysphoria and Autism Spectrum Disorders, as well as gender dysphoria and Eating disorders, so that more research into the links between these conditions can be carried out.
- The Department for Health and Social Care should prioritise research into the links between gender dysphoria and Autism Spectrum Disorders, as well as gender dysphoria and Eating Disorders, when it comes to apportioning National Institute for Health and Care Research funding.

Wider Policy

- The Department for Education should make schools guidance on gender questioning children statutory, noting the safeguarding need of informing a parent of a child's wish to go by different preferred pronouns.
- NHS England should align clinical practice with the DSM-5-TR definitions by recognising gender dysphoria as a mental health diagnosis.

Annex 1:
Polling Tables

Q1. To what extent do you agree or disagree with the following statements?

	It is concerning that young people with autism are more likely to experience gender dysphoria	It is concerning that young people who have been in care are more likely to experience gender dysphoria	Exploring your gender identity is a healthy part of growing up	It is concerning that young people who have anorexia are more likely to experience gender dysphoria	It is concerning that young people who have had adverse childhood experiences are more likely to experience gender dysphoria	Pupils should be able to wear both the "boys" and "girls" uniform at school, regardless of their sex
Unweighted base	2065	2065	2065	2065	2065	2065
Weighted base	2065	2065	2065	2065	2065	2065
NET: Agree	48%	51%	51%	50%	54%	38%
Strongly agree (4)	16%	17%	16%	16%	17%	14%
Agree (3)	32%	35%	36%	34%	38%	24%
Disagree (2)	12%	10%	17%	10%	9%	21%
Strongly disagree (1)	5%	5%	13%	4%	4%	26%
NET: Disagree	17%	16%	31%	14%	13%	48%
Don't know	35%	33%	18%	36%	32%	14%
Mean	2.91	2.94	2.66	2.95	2.99	2.31
Standard deviation Standard error	0.86	0.85	0.97	0.82	0.8	1.08
	0.02	**0.02**	**0.02**	**0.02**	**0.02**	**0.03**

Q2. To what extent do you agree or disagree with the following statements?

	If a young person says they have gender dysphoria, they should be affirmed in their new identity without question	If an autistic young person says they have gender dysphoria, they should be affirmed in their new identity without question	Charities working with young people should not have to inform a child's parents of a child's wish to use different preferred pronouns	Questioning your gender is an overall positive thing to do	Children and young people from middleclass families are more likely to identify as transgender or non-binary than children and young people from working class families	Children and young people from middleclass families are more likely to experience gender dysphoria than children and young people from working class families
Unweighted base	2065	2065	2065	2065	2065	2065
Weighted base	2065	2065	2065	2065	2065	2065
NET: Agree	21%	21%	28%	31%	25%	23%
Strongly agree (4)	5%	6%	10%	9%	8%	7%
Agree (3)	16%	15%	18%	23%	17%	17%
Disagree (2)	28%	27%	23%	23%	19%	20%
Strongly disagree (1)	28%	26%	25%	20%	11%	10%
NET: Disagree	56%	53%	48%	43%	30%	30%
Don't know	23%	26%	24%	26%	45%	47%
Mean	1.98	2.02	2.17	2.28	2.4	2.37
Standard deviation	0.92	0.93	1.02	0.98	0.96	0.93
Standard error	0.02	0.02	0.03	0.03	0.03	0.03

Q3. To what extent do you agree or disagree with the following statements?

	Gender dysphoria is a condition that could affect anyone	Transgender people are more likely to come from disadvantaged backgrounds	Young people are more likely to have gender dysphoria if their friends also have gender dysphoria	Transgender people are more likely to come from privileged backgrounds	Gender ideology has gone too far	Puberty blockers should be banned for under 18s	School age children and adolescents should be able to socially transition (e.g. go by different pronouns) at school without a teacher informing a parent first
Unweighted base	2065	2065	2065	2065	2065	2065	2065
Weighted base	2065	2065	2065	2065	2065	2065	2065
NET: Agree	47%	14%	44%	21%	72%	71%	20%
Strongly agree (4)	14%	5%	14%	7%	43%	46%	7%
Agree (3)	33%	9%	31%	15%	29%	25%	13%
Disagree (2)	14%	28%	15%	24%	9%	6%	26%
Strongly disagree (1)	11%	17%	7%	13%	5%	4%	34%
NET: Disagree	25%	44%	22%	37%	14%	10%	61%
Don't know	27%	42%	34%	42%	14%	19%	20%
Mean	2.69	2.04	2.76	2.25	3.29	3.39	1.91
Standard deviation	0.95	0.89	0.9	0.93	0.87	0.83	0.96
Standard error	0.02	0.03	0.02	0.03	0.02	0.02	0.02

Q4. In your experience, would you say that the following descriptions tend to apply to children and young people who say they are questioning their gender, or not?

	Seeking attention	Trying to be cool	Confused about who they are	Responding to trauma	Struggling with other challenges in life
Unweighted base	2065	2065	2065	2065	2065
Weighted base	2065	2065	2065	2065	2065
Applies	48%	42%	63%	37%	55%
Does not apply	21%	27%	13%	18%	13%
Don't know / prefer not to say	32%	32%	24%	45%	33%

	Rejecting gender stereotypes	Likely to change their mind later	Likely to make a full transition	More likely to be gay or bisexual than transsexual	From disadvantaged backgrounds
Unweighted base	2065	2065	2065	2065	2065
Weighted base	2065	2065	2065	2065	2065
Applies	45%	46%	19%	39%	14%
Does not apply	16%	14%	30%	16%	36%
Don't know / prefer not to say	40%	41%	51%	45%	49%

	From privileged backgrounds	Overly influenced by their peers	Overly influenced by social media	Trying to fit in socially	Happy	Depressed
Unweighted base	2065	2065	2065	2065	2065	2065
Weighted base	2065	2065	2065	2065	2065	2065
Applies	20%	50%	63%	45%	16%	45%
Does not apply	31%	17%	13%	22%	43%	17%
Don't know / prefer not to say	48%	33%	24%	33%	41%	38%

Annex 2:
FOIs

Freedom of Information Team
Great Ormond Street Hospital for Children NHS Foundation Trust
Great Ormond Street
London
WC1N 3JH
E: FOITeam@gosh.nhs.uk

9 April 2025

Dear Requestor,

Re: FOIRQ8886

Thank you for your request for information processed under the Freedom of Information Act 2000.

Your following request for information and Trust response in Bold:

Q.1. How many patients were transferred to the NHS Children and Young People's Gender Service (London) from GIDS?

129 patients were transferred to the NHS Children and Young People's Gender Service (London) from GIDS.

Q.2. Of those referred, how many were:
-presenting with an eating disorder?

Section 12(1) of the FOIA allows the Trust to refuse a request where the cost of compliance is estimated to exceed the appropriate limit. The appropriate limit for Section 12 purposes is defined by The Freedom of Information and Data Protection (Appropriate Limit and Fees) Regulation 2004 - SI 2004 No. 3244 ('Fees Regulation').

Under regulation 3 of the Fees Regulation the appropriate cost limit for the Trust is £450. The Fees Regulation also states that all authorities should calculate the time spent on the permitted activities at the flat rate of £25 per person, per hour. This means that the appropriate limit will be exceeded as it would require more than 18 hours work for the Trust to carry out the following activities to comply with the request:

- **determining whether the information is held**
- **locating the information, or a document containing it**
- **retrieving the information, or a document containing it and**
- **extracting the information from a document containing it**

We are unable to answer this question as this information is currently not being captured reliably on EPIC and is not held in an easily accessible format This will eventually be captured in the EPIC Research script that currently sits with EPR Build team, but it will take a few months to build, and another few months for research to backdate all data for the Tavistock cohort.

In order to provide this information, it would be necessary to manually examine 129 individual patient records. With our current cohort of 129 patients and estimating 10 minutes to review each of the patient's notes, this would exceed the statutory 18-hour cost limit by 3.5 hours (129 x 10 = 1290 mins (21.5 hours), therefore, the requested information is withheld from disclosure under the provisions of Section 12(1) – Cost Limit, of the FOIA.

-presenting with a mental health condition?

Section 12(1) of the FOIA allows the Trust to refuse a request where the cost of compliance is estimated to exceed the appropriate limit. The appropriate limit for Section 12 purposes is defined by The Freedom of Information and Data Protection (Appropriate Limit and Fees) Regulation 2004 - SI 2004 No. 3244 ('Fees Regulation').

Under regulation 3 of the Fees Regulation the appropriate cost limit for the Trust is £450. The Fees Regulation also states that all authorities should calculate the time spent on the permitted activities at the flat rate of £25 per person, per hour. This means that the appropriate limit will be exceeded as it would require more than 18 hours work for the Trust to carry out the following activities to comply with the request:

- **determining whether the information is held**
- **locating the information, or a document containing it**
- **retrieving the information, or a document containing it and**
- **extracting the information from a document containing it**

We are unable to answer this question as this information is currently not being captured reliably on EPIC and is not held in an easily accessible format This will eventually be captured in the EPIC Research script that currently sits with EPR Build team, but it will take a few months to build, and another few months for research to backdate all data for the Tavistock cohort.

In order to provide this information, it would be necessary to manually examine 129 individual patient records. With our current cohort of 129 patients and estimating 10 minutes to review each of the patient's notes, this would exceed the statutory 18-hour cost limit by 3.5 hours (129 x 10 = 1290 mins (21.5 hours), therefore, the requested information is withheld from disclosure under the provisions of Section 12(1) – Cost Limit, of the FOIA.

-diagnosed as autistic?

Section 12(1) of the FOIA allows the Trust to refuse a request where the cost of compliance is estimated to exceed the appropriate limit. The appropriate limit for Section 12 purposes is defined by The Freedom of Information and Data Protection (Appropriate Limit and Fees) Regulation 2004 - SI 2004 No. 3244 ('Fees Regulation').

Under regulation 3 of the Fees Regulation the appropriate cost limit for the Trust is £450. The Fees Regulation also states that all authorities should calculate the time spent on the permitted activities at the flat rate of £25 per person, per hour. This means that the appropriate limit will be exceeded as it would

require more than 18 hours work for the Trust to carry out the following activities to comply with the request:

- **determining whether the information is held**
- **locating the information, or a document containing it**
- **retrieving the information, or a document containing it and**
- **extracting the information from a document containing it**

We are unable to answer this question as this information is currently not being captured reliably on EPIC and is not held in an easily accessible format This will eventually be captured in the EPIC Research script that currently sits with EPR Build team, but it will take a few months to build, and another few months for research to backdate all data for the Tavistock cohort.

In order to provide this information, it would be necessary to manually examine 129 individual patient records. With our current cohort of 129 patients and estimating 10 minutes to review each of the patient's notes, this would exceed the statutory 18-hour cost limit by 3.5 hours (129 x 10 = 1290 mins (21.5 hours), therefore, the requested information is withheld from disclosure under the provisions of Section 12(1) – Cost Limit, of the FOIA.

-diagnosed with ADHD?

Section 12(1) of the FOIA allows the Trust to refuse a request where the cost of compliance is estimated to exceed the appropriate limit. The appropriate limit for Section 12 purposes is defined by The Freedom of Information and Data Protection (Appropriate Limit and Fees) Regulation 2004 - SI 2004 No. 3244 ('Fees Regulation').

Under regulation 3 of the Fees Regulation the appropriate cost limit for the Trust is £450. The Fees Regulation also states that all authorities should calculate the time spent on the permitted activities at the flat rate of £25 per person, per hour. This means that the appropriate limit will be exceeded as it would require more than 18 hours work for the Trust to carry out the following activities to comply with the request:

- **determining whether the information is held**
- **locating the information, or a document containing it**
- **retrieving the information, or a document containing it and**
- **extracting the information from a document containing it**

We are unable to answer this question as this information is currently not being captured reliably on EPIC and is not held in an easily accessible format This will eventually be captured in the EPIC Research script that currently sits with EPR Build team, but it will take a few months to build, and another few months for research to backdate all data for the Tavistock cohort.

In order to provide this information, it would be necessary to manually examine 129 individual patient records. With our current cohort of 129 patients and estimating 10 minutes to review each of the patient's notes, this would exceed the statutory 18-hour cost limit by 3.5 hours (129 x 10 = 1290 mins (21.5 hours), therefore, the requested information is withheld from disclosure under the provisions of Section 12(1) – Cost Limit, of the FOIA.

-had a history of suffering from physical or mental abuse?

The Trust has estimated that to collate the information requested would exceed the statutory 18-hour cost limit for processing your request for information under the provisions of Section 12 (Cost Limit) of the Freedom of Information Act (FOIA) 2000.

Section 12(1) of the FOIA allows the Trust to refuse a request where the cost of compliance is estimated to exceed the appropriate limit. The appropriate limit for Section 12 purposes is defined by The Freedom of Information and Data Protection (Appropriate Limit and Fees) Regulation 2004 - SI 2004 No. 3244 ('Fees Regulation').

Under regulation 3 of the Fees Regulation the appropriate cost limit for the Trust is £450. The Fees Regulation also states that all authorities should calculate the time spent on the permitted activities at the flat rate of £25 per person, per hour. This means that the appropriate limit will be exceeded as it would require more than 18 hours work for the Trust to carry out the following activities to comply with the request:

- **determining whether the information is held**
- **locating the information, or a document containing it**
- **retrieving the information, or a document containing it and**
- **extracting the information from a document containing it**

We are unable to answer this question as this information is currently not being captured reliably on EPIC and is not held in an easily accessible format This will eventually be captured in the EPIC Research script that currently sits with EPR Build team, but it will take a few months to build, and another few months for research to backdate all data for the Tavistock cohort.

In order to provide this information, it would be necessary to manually examine 129 individual patient records. With our current cohort of 129 patients and estimating 10 minutes to review each of the patient's notes, this would exceed the statutory 18-hour cost limit by 3.5 hours (129 x 10 = 1290 mins (21.5 hours), therefore, the requested information is withheld from disclosure under the provisions of Section 12(1) – Cost Limit, of the FOIA.

-had been 'looked after'?

The Trust is withholding this information under Section 40 of the Freedom of Information Act (FOIA) 2000, where a low number of patients of 5 or fewer but greater than 0(<5 but >0*) is linked to specific treatments. We are withholding this information as disclosure would significantly increase the risk of individuals being identified and could potentially be a breach of their rights under the Data Protection Act DPA) 2018.

The Trust holds the view that Section 41 (1) of the FOIA is also applicable as disclosure of this information would give rise to an actionable breach of confidence. Your request is therefore exempt under Section 40(2) and Section 41(1) of the FOIA.

Further Notes:

The response we have provided under the Freedom of Information Act 2000 is in line with the information held on the date your request was received by the Trust. Should you have any further queries, please do not hesitate to contact the FOI Team and quote the above reference number on any related correspondence.

The information provided is Trust copyright. You may re-use this Great Ormond Street Hospital for Children NHS Foundation Trust copyright information in accordance with the Open Government Licence:

http://www.nationalarchives.gov.uk/doc/open-government-licence/version/2/

N.B. Re-use of personal data is not allowed under this license. For information which is not Great Ormond Street Hospital for Children NHS Foundation Trust copyright, e.g., external websites, please contact the named party directly.

Yours sincerely

Freedom of Information Team

Great Ormond Street Hospital for Children NHS Foundation Trust

Enclosed: Your Rights

Your Rights

Should you have any questions relating to the response to your request for information, please do not hesitate to contact the FOI Team. Alternatively, you are entitled to make a request for an internal review within two months from the date of receiving the response to your original request. You can also write to Mr Nikki Fountain – Business Manager – Medical Director's Office at the following email address:

Nikki.Fountain@gosh.nhs.uk

If you remain dissatisfied with the outcome of the internal review, you have the right to appeal to the Information Commissioner as the final stage of the FOI process. You can contact the Information Commissioner's Office at icocasework@ico.org.uk.

Freedom of Information Team
Great Ormond Street Hospital for Children NHS Foundation Trust
Great Ormond Street
London
WC1N 3JH
E: FOITeam@gosh.nhs.uk

2 July 2025

Dear Requestor,

Re: FOIRQ9076

Thank you for your request for information processed under the Freedom of Information Act 2000.

Your following request for information and Trust response in bold:

How many patients were transferred to the NHS Children and Young People's Gender Service (London) from GIDS aged 13-18 inclusive?

88 patients aged 13-18 inclusive were transferred to the NHS Children and Young People's Gender Service (London) from GIDS.

Of those referred, how many were:

a) presenting with an eating disorder?

b) presenting with a mental health condition?

c)diagnosed as autistic?

d)diagnosed with ADHD?

Section 12(1) of the FOIA allows the Trust to refuse a request where the cost of compliance is estimated to exceed the appropriate limit. The appropriate limit for Section 12 purposes is defined by The Freedom of Information and Data Protection (Appropriate Limit and Fees) Regulation 2004 - SI 2004 No. 3244 ('Fees Regulation').

Under regulation 3 of the Fees Regulation the appropriate cost limit for the Trust is £450. The Fees Regulation also states that all authorities should calculate the time spent on the permitted activities at the flat rate of £25 per person, per hour. This means that the appropriate limit will be exceeded as it would require more than 18 hours work for the Trust to carry out the following activities to comply with the request:

- **determining whether the information is held**
- **locating the information, or a document containing it**
- **retrieving the information, or a document containing it and**
- **extracting the information from a document containing it**

We are unable to answer this question as this information is currently not being captured reliably on EPIC and is not held in an easily accessible format This will eventually be captured in the EPIC Research script that currently sits with EPR Build team, but it will take a few months to build, and another few months for research to backdate all data for the Tavistock cohort.

In order to provide this information, it would be necessary to manually examine 88 individual patient records. As per section 12 of the FOI Act, we do not need to respond to an FOI request where the estimated time to obtain the data exceeds the 18-hour time limit. With our current cohort of 88 patients and estimating 30 minutes to review each of the patient's notes, this will exceed the 18-hour time limit (88 x 30 = 2640 mins =44 hours). Therefore, the requested information is withheld from disclosure under the provisions of Section 12(1) – Cost Limit, of the FOIA.

e) had been 'looked after'?

<5 but >0*

*** The Trust is withholding this information under Section 40 of the Freedom of Information Act (FOIA) 2000, where a low number of patients of 5 or fewer but greater than 0(<5 but >0*) is linked to specific treatments. We are withholding this information as disclosure would significantly increase the risk of individuals being identified and could potentially be a breach of their rights under the Data Protection Act DPA) 2018.**

The Trust holds the view that Section 41 (1) of the FOIA is also applicable as disclosure of this information would give rise to an actionable breach of confidence. Your request is therefore exempt under Section 40(2) and Section 41(1) of the FOIA.

Further Notes:
The response we have provided under the Freedom of Information Act 2000 is in line with the information held on the date your request was received by the Trust. Should you have any further queries, please do not hesitate to contact the FOI Team and quote the above reference number on any related correspondence.

Yours sincerely

Freedom of Information Team

Great Ormond Street Hospital for Children NHS Foundation Trust

Enclosed: Your Rights

Your Rights

Should you have any questions relating to the response to your request for information, please do not hesitate to contact the FOI Team. Alternatively, you are entitled to make a request for an internal review

within two months from the date of receiving the response to your original request. You can also write to Mr Nikki Fountain – Business Manager – Medical Director's Office at the following email address:

Nikki.Fountain@gosh.nhs.uk

If you remain dissatisfied with the outcome of the internal review, you have the right to appeal to the Information Commissioner as the final stage of the FOI process. You can contact the Information Commissioner's Office at icocasework@ico.org.uk.

Alder Hey Children's NHS
NHS Foundation Trust

Eaton Road
Liverpool
L12 2AP

www.alderhey.nhs.uk

13th May 2025

Portia Berry-Kilby

portia.berry-kilby@centreforsocialjustice.org.uk

Dear Ms Berry-Kilby

Re: FOI request FOIAGEM2425/004

Further to your request under the Freedom of Information Act 2000, please find a response to your questions below.

How many patients were transferred to the NHS Children and Young People's Gender Service (North West) from GIDS?
Of those referred, how many were:

Q1 Presenting with an eating disorder?

A1 Information not held – the Trust does not routinely collate or hold this information centrally as part of its management or performance data. In order to ascertain the data the Trust would be required to access personal data of the individuals and as such the data is exempt under Section 40: Personal data.

Q2 Presenting with a mental health condition?

A2 Information not held – the Trust does not routinely collate or hold this information centrally as part of its management or performance data. In order to ascertain the data the Trust would be required to access personal data of the individuals and as such the data is exempt under Section 40: Personal data.

Q3 Diagnosed as autistic?

A3 Of the 111 transferred from the open caseload held by Tavistock and Portman NHS Trust to the Children and Young People's Gender Service (North West), there were 36 children and young people who had an autism diagnosis.

Q4 Diagnosed with ADHD?

A4 Of the 111 transferred from the open caseload held by Tavistock and Portman NHS Trust to the Children and Young People's Gender Service (North West), there were 13 children and young people who had an ADHD diagnosis.

Alder Hey Children's NHS
NHS Foundation Trust

Q5 Had a history of suffering from physical or mental abuse?

A5 The Trust is unable to respond to all or specific elements of your request where the response would indicate five or less individuals. The Trust is withholding this information under Section 40 (Personal Information) of the Freedom of Information Act (FOIA) 2000 to reduce the risk of any individuals being identified. The Trust is of the view that disclosure of such information would significantly increase the risk of individuals being identified and as such would constitute a breach of their personal data.

The Trust has applied exemption Section 40(2) of the FOIA and is therefore withholding the information as disclosure which may identify an individual would breach their rights under the Data Protection Act 2018. The grounds for application of this exemption include:
• Any data relating to patients or staff is third party data, furthermore health data is classified as sensitive personal data within the Data Protection Act 2018. As such, Section 40 (2) of the FOIA applies along with the Trusts duty of confidentiality. Therefore under s.2 (3) (f) (ii) of the FOIA, there is an absolute exemption from disclosure on the grounds that it would contravene the First Data Protection Principle.

• The Trust has a duty under the Data Protection Act 2018 and specifically the First Data Protection Principle to ensure personal data regarding staff and patients is processed fairly and lawfully. Disclosure of such data which may identify an individual, either through the data alone or other data in conjunction with that data which may identify an individual would therefore breach this principle.

• The Data Protection Act 2018 defines sensitive personal data to include data relating to the "physical or mental health or condition" of a person. Any such information about specific individuals falls within this category and disclosure of such data including statistical data, with any potential likelihood of identification would breach the Data Protection Act 2018.

Q6 Had been 'looked after'?

Q6 The Trust is unable to respond to all or specific elements of your request where the response would indicate five or less individuals. The Trust is withholding this information under Section 40 (Personal Information) of the Freedom of Information Act (FOIA) 2000 to reduce the risk of any individuals being identified. The Trust is of the view that disclosure of such information would significantly increase the risk of individuals being identified and as such would constitute a breach of their personal data.

The Trust has applied exemption Section 40(2) of the FOIA and is therefore withholding the information as disclosure which may identify an individual would breach their rights under the Data Protection Act 2018. The grounds for application of this exemption include:
• Any data relating to patients or staff is third party data, furthermore health data is

Alder Hey Children's NHS
NHS Foundation Trust

classified as sensitive personal data within the Data Protection Act 2018. As such, Section 40 (2) of the FOIA applies along with the Trusts duty of confidentiality. Therefore under s.2 (3) (f) (ii) of the FOIA, there is an absolute exemption from disclosure on the grounds that it would contravene the First Data Protection Principle.

• The Trust has a duty under the Data Protection Act 2018 and specifically the First Data Protection Principle to ensure personal data regarding staff and patients is processed fairly and lawfully. Disclosure of such data which may identify an individual, either through the data alone or other data in conjunction with that data which may identify an individual would therefore breach this principle.

• The Data Protection Act 2018 defines sensitive personal data to include data relating to the "physical or mental health or condition" of a person. Any such information about specific individuals falls within this category and disclosure of such data including statistical data, with any potential likelihood of identification would breach the Data Protection Act 2018.

Should you not be happy with the information provided you have a right to request a review of our response. In the first instance this should be addressed to:

Information Governance Manager
Eaton Road
Liverpool
L12 2AP

If you ask for a review and are dissatisfied with the outcome, under Section 50 of the Freedom of Information Act you then have a right of appeal to the Information Commissioner. The Information Commissioner's address is:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

Yours sincerely

Information Governance Team

Alder Hey Children's NHS Foundation Trust

Freedom of Information Team
Great Ormond Street Hospital for Children NHS Foundation Trust
Great Ormond Street
London
WC1N 3JH
E: FOITeam@gosh.nhs.uk

2 July 2025

Dear Requestor,

Re: FOIRQ9077

Thank you for your request for information processed under the Freedom of Information Act 2000.

Your following request for information and Trust response in bold:

How many patients were transferred to the NHS Children and Young People's Gender Service (London) from GIDS aged 12 and under?

41 patients aged 12 and under were transferred to the NHS Children and Young People's Gender Service (London) from GIDS.

Of those referred, how many were:
a) presenting with an eating disorder?
b) presenting with a mental health condition?
c) diagnosed as autistic?
d) diagnosed with ADHD?

Section 12(1) of the FOIA allows the Trust to refuse a request where the cost of compliance is estimated to exceed the appropriate limit. The appropriate limit for Section 12 purposes is defined by The Freedom of Information and Data Protection (Appropriate Limit and Fees) Regulation 2004 - SI 2004 No. 3244 ('Fees Regulation').

Under regulation 3 of the Fees Regulation the appropriate cost limit for the Trust is £450. The Fees Regulation also states that all authorities should calculate the time spent on the permitted activities at the flat rate of £25 per person, per hour. This means that the appropriate limit will be exceeded as it would require more than 18 hours work for the Trust to carry out the following activities to comply with the request:

- **determining whether the information is held**
- **locating the information, or a document containing it**
- **retrieving the information, or a document containing it and**
- **extracting the information from a document containing it**

We are unable to answer this question as this information is currently not being captured reliably on EPIC and is not held in an easily accessible format This will eventually be captured in the EPIC Research script that currently sits with EPR Build team, but it will take a few months to build, and another few months for research to backdate all data for the Tavistock cohort.

In order to provide this information, it would be necessary to manually examine 41 individual patient records. With the cohort of 41 and estimating 30 minutes to review each of the patients notes, this will exceed the 18-hour time limit (41 x 30 = 1230 mins =20.5 hours). Therefore, the requested information is withheld from disclosure under the provisions of Section 12(1) – Cost Limit, of the FOIA.

e) had been 'looked after'?
<5 but >0*

* **The Trust is withholding this information under Section 40 of the Freedom of Information Act (FOIA) 2000, where a low number of patients of 5 or fewer but greater than 0(<5 but >0*) is linked to specific treatments. We are withholding this information as disclosure would significantly increase the risk of individuals being identified and could potentially be a breach of their rights under the Data Protection Act DPA) 2018.**

The Trust holds the view that Section 41 (1) of the FOIA is also applicable as disclosure of this information would give rise to an actionable breach of confidence. Your request is therefore exempt under Section 40(2) and Section 41(1) of the FOIA.

Further Notes:
The response we have provided under the Freedom of Information Act 2000 is in line with the information held on the date your request was received by the Trust. Should you have any further queries, please do not hesitate to contact the FOI Team and quote the above reference number on any related correspondence.

Yours sincerely

Freedom of Information Team

Great Ormond Street Hospital for Children NHS Foundation Trust

Enclosed: Your Rights

Your Rights

Should you have any questions relating to the response to your request for information, please do not hesitate to contact the FOI Team. Alternatively, you are entitled to make a request for an internal review within two months from the date of receiving the response to your original request. You can also write to Mr Nikki Fountain – Business Manager – Medical Director's Office at the following email address:

Nikki.Fountain@gosh.nhs.uk

If you remain dissatisfied with the outcome of the internal review, you have the right to appeal to the Information Commissioner as the final stage of the FOI process. You can contact the Information Commissioner's Office at icocasework@ico.org.uk.

The Centre for Social Justice
Kings Buildings
16 Smith Square
Westminster, SW1P 3HQ

www.centreforsocialjustice.org.uk
@csjthinktank