Understanding the Decision Making Process of Beginning Hormone Therapy for Trans Individuals: a Grounded Theory Study

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January 2020

This thesis is submitted in partial fulfilment of the requirement for the Professional Doctorate in Counselling Psychology

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Abstract

Research indicates the trans population experiences significantly higher levels of mental health difficulties and suicidal ideation compared with the rest of the population. Existing literature relating specifically to psychological therapists is explored and four main gaps identified. These gaps surround lack of support for the trans community, long waiting times, the urgency of need often leading to self-prescription of hormones, and the compromising gate-keeping roles of professionals working with this population. Seven participants, who had all made the decision to take hormones, were interviewed. Semi-structured interviews addressed their help seeking behaviour and decision making process to take hormones, as well as their experiences of the system and the professionals in it. Fewer participants than desired were recruited, and the abbreviated version of grounded theory was therefore implemented. The decision-making behind that and its potential consequences are discussed. Using grounded theory, a stage model of the decision-making process to take hormones was drawn, and four categories and 14 subcategories identified. The categories were "identity frustration," "meeting the gate-kept world," "survival mechanisms," and "escalating identity crisis." In discussing these results, the main problems indicated by the results of these findings regarded the mismatch between the urgent need for treatment trans people have, systemic issues of long waiting times, and a general sense of a gap between trans people and the professionals working with them, enforcing gatekeeper roles and feelings of being misunderstood and unsupported. Implications for counselling psychology practice and suggestions for further research are discussed.

Acknowledgements

I would first like to thank the participants who took part in this study. I am honoured by the personal stories they shared with me, and grateful for their courage to open up about difficult and emotional experiences, and helping me to understand these.

I would also like to thank my supervisor Dr. Angela Ioanna Loulopoulou for her guidance and ongoing support throughout. I would also like to thank my second supervisor, Dr. Parveen (Perry) Bhatarah, as well as the rest of the staff on the doctorate at London Metropolitan University, who taught me much of what I know about both research and clinical practice. I have learned so much, and for that, I am eternally grateful. I would like to thank the funds Augustinus Fonden and Soransk Samfund for enabling me to carry out this project with their contributions. I hope you will consider it to be as worthwhile as I do.

A huge thank you to Kimberley and Vashti for all your support throughout this course, both academically and emotionally. You have been there from the beginning, and your support has, especially at the most difficult stages of this process, been vital in getting me through. Lastly, but most importantly, I would like to thank my father Jens, without whom none of this would have been possible.

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"You must always be yourself, no matter what the price. It is the highest form of morality."

– Candy Darling.

Key words

Cis/cis-gender: people whose gender identity aligns with their assigned sex at birth

FM: Female-to-Male trans person, commonly also shortened to FtM

GIC: Gender Identity Clinic

LGBT: Lesbian, Gay, Bisexual and Trans people (also referred to as LGBTQIA)

MF: Male-to-Female trans person, commonly also shortened to MtF

Mis-gendered/mis-gender: to be addressed/addressing a person with a pronoun different to the gender with which they identify.

TGNC: Trans and Gender Non-Conforming

Trans/transgender: people whose gender identity does not align with their assigned sex at birth

Chapter 1: Literature Review

1.1 Introduction

Mental health difficulties are common amongst the trans population (e.g. Budge, Adelson & Howard, 2013; Rotondi et al., 2013) and suicide rates are high (e.g. McNeil et al., 2012; Bailey, Ellis & McNeil, 2014). Arguably, this population is not yet well understood, and researchers today still wonder what causes trans identities to develop, how this group can be best supported, and the factors influencing a person's decision to medically transition (Yarhouse, 2015).

Because trans clients are referred to a mental health professional for assessment of their mental readiness to begin transitioning (e.g. Bouman & Arcelus, 2018), this issue may be of particular interest to mental health professions. Although there is a growing body of literature on the trans phenomenon, both with regards to diagnostic and phenomenological perspectives, research still indicates that, considering how much influence mental health professionals have, we do not know enough about these clients and the nature of their difficulties (e.g. Bailey et al., 2014).

Throughout this chapter, the reasons for choosing this research topic and my epistemological standpoint, as well as how I position myself in relation to it will be reflected on. The existing research regarding trans people and mental health will be explored, and research gaps and questions will be identified.

1.2 Reflexive Statement

When I first decided to research this topic, I was inspired by all the research suggesting how much scrutiny, stigma and mental health difficulties the trans population experiences. I wanted to seek out this misunderstood and unsupported population and come to understand and support them, and hopefully contribute to positive progress within the field. Being married to a woman, I felt I related to feelings of being labelled and having assumptions made about me. As such, I wanted to study this particular population because, whilst not being trans myself, I felt able to relate to being in a minority population. However, throughout my research I came to the difficult realisation that I can never truly understand what it is like to be trans because I am not trans. My drive then became a combination. I was driven by a sense of injustice for the trans population, and potentially also some guilt over not being trans and thereby trying to give voice to a lack of understanding and support that is not actually mine. Moreover, I felt guilty about being part of a profession which seems to lack this understanding and support. In light of this, I worried my lack of being part of it would hinder my ability to provide support for this population

It seems to me that society has a certain common understanding of what people are and what they are not. When this understanding is challenged, we become uncomfortable. When I initially approached this topic, I placed a lot of value on studies “proving” the existence and development of trans identities. Studies of brain scans and hormonal activity during pregnancy (e.g. Jing-Ning et al. 1995) gave me a sense of being able to show the reader that there really is no question about the existence of trans identities, and thus convince them of the need to provide better support for this population. Upon reflection, perhaps I too was uncomfortable with the idea of having my understanding of what it means to be trans challenged. When I first presented this study at a conference, I did so using a poster I had designed of a fully bearded man with heavily made up eyes. At the conference, I was made aware of how presumptuous this felt to the trans people who saw it, and it was at this point I realised just how little I understand what it is like to be trans. In this way, I made several assumptions in the beginning, which I later came to realise were problematic. However, the fact that this was, and still is, such a steep learning curve for me also highlighted the necessity of improving wider understanding of this population.

I have learned that context can really influence a person's moral standpoints. I imagine most people consider themselves open-minded and inclusive, but what this means to us can only really be known when we are put in a specific situation where a moral judgement has to be made. I considered myself open minded, but managed to offend people with my poster without even realising it. Upon reflection, I think I was so focused on producing a capturing poster, that I did not stop to consider what message I was sending, and whether that aligned with my aim and my own epistemological standpoints. I have always struggled with the idea that people have to be *one thing*, upon which society imposes standards and values, and we take it upon ourselves to decide what is accepted within these boundaries and what is not. I would never knowingly impose my understanding of somebody like that; I simply just did not realise that this was what I was doing with my poster. I feel this problem of accidentally stigmatising somebody due to ignorance is one very relevant to this study; through my literature review, I have found I am not the only clinician to do so.

Gender used to be - and to many still is - an easily defined study subject (Schulenberg, 2013). Arguably, we believe somebody is either a man or woman, just as people either have brown eyes or not. However, gender can also be understood as a social construct rather than a biological one. The understanding of gender can be constructed and deconstructed over and over, and the experiences one encounters throughout their lifetime can help shape this understanding (Wickramasinghe, 2010).

Throughout this work, I have come to think about the concept of gender in a much more abstract way than I ever did before. Being of a social constructivist epistemological positioning influences the way I study gender identity in that, as with most concepts studied from this positioning, I view gender as a socially constructed concept, which cannot be understood irrespective of time, place and cultural context (Willig, 2001). More unique to the study of gender identities is the question of how our society has constructed the concept of gender, and what this means for how we view it and work with it. Moreover, a social constructivist epistemology influences the way in which gender is studied in that it bases the value of research on whether it is valuable for the good of humankind (Blakemore, Berenbaum & Liben, 2009). In other words, one is encouraged to ask: does it help anyone? The theories presented in this chapter on how a trans identity develops are intentionally limited; I have not found them relevant to helping either the trans population or the clinicians working with them. Arguably, a focus on how an identity develops in this way keeps us in the rhetoric that the development of that identity may be avoided. In their guidebook for trans people and the professionals working with them, clinicians Bouman and Arcelus (2018) point out that researchers are not interested in why cis gender identities develop, and thus argue they similarly should not be interested in why trans identities develop.

It should be noted that referring to the trans population as objective definitions arguably indicates a positivistic epistemology which could be challenged. Terms and definitions within trans identities could also be considered social constructs. Due to recommendations outlined in the following section, the term *trans* will be used throughout this study for ease of reference. However, this is understood to be a flexible and socially constructed, rather than a fixed and objective definition. Therefore, other labels or terms are used, if these were used in the referenced study, as I do not wish to replace another researcher's construct of this concept with my own.

Following this work and my subsequent reflections, I no longer understand gender to be a binary concept. I have now realised, that aside from going against my own epistemological positioning, understanding gender in this way also goes against two important values of counselling psychology. First, I need to listen to the person's own identification and understanding of themselves. Secondly, as noted in the handbook of counselling psychology, it is important to never think one knows it all, and to always engage in continuous learning (Woolfe et al., 2013).

1.3 Terminology and grouping

Trans or *transgender* is often used as an umbrella term which covers all gender expressions differing from what was assigned at birth (Ehrbar, 2012; Bouman & Arcelus, 2018). In her notes on trans issues in therapy, gender therapist and social sciences researcher Zandvliet (2000) points out that there are many different groups and identities within gender identification as a field. In his collection of transsexual case studies, psychotherapist Ehrbar (2012) notes that some clients feel more comfortable identifying with one terminology over another and emphasises that this is paramount to what dictionary definition they technically belong to. The American Psychiatric Association recommends using the term *Transgender and Gender Nonconforming* (TGNC) people (APA, 2015). However, Bouman and Arcelus (2018) describe *trans* as the most inclusive of the umbrella terms describing people who are not cis. Moreover, *trans* was the expressed preference by most of the participants in this study, and as such, it was the chosen term to use. In light of this preference as well as the recommendations in the literature, this thesis will use the word *trans* to define all individuals who do not identify with their assigned sex at birth.

Most research on this group of sexual minorities is conducted on LGBT as a group, rather than on its separate components, despite the trans identity being a gender identity rather than a sexual orientation (Woolfe et al., 2013). According to the American Psychological Association, it is important that people in general - but especially clinicians - stop confusing trans issues with issues to do with sexual orientation and gender expression (APA, 2015). A possible reason for this grouping could be medical and psychological history; there are several examples of feminine gay men or masculine gay women who have present-day researchers questioning whether these people would in fact have transitioned, had it been possible in their time (Dworkin & Pope, 2012). Furthermore, as a transition takes place, an overlap between homosexuality and trans identity is often assumed. That is, if a person is born male and is attracted to males, prior to the transition this individual may be perceived as a homosexual man, even if the person really identifies as a heterosexual woman (Selvaggi & Giordano, 2014). It could also be argued that all LGBT people are facing similar challenges in terms of having society doubt the legitimacy of their identity and whether it was a choice (Merryfeather, 2011). However, it should be noted that several individual differences and ways of identifying are taken for granted when such conclusions are drawn. Gender identities and sexual orientations are often complex intrapsychic processes, which tend to be separate (Zandvliet, 2000). Researchers have also argued that grouping trans people as a sexual minority and trying to find common denominators for all of them is to disrespect the difference we are trying to accommodate for to begin with (Desmarias & Gray, 2014). As Lyons et al. (2015) argued in their investigation of trans people’s experiences of residential drug treatment settings, this grouped categorisation is slowing down the understanding of this population.

1.4 Trans people and today's society

The World Professional Association for Transgender Health (WPATH) is an international organisation offering information and guidelines for trans people and professionals working with them, based on research within the fields of medicine, sociology and psychology. The WPATH's Standards of Care are adopted by many countries, including the UK, to help inform the way this client group is cared for (Coleman et al., 2012; NHS, 2013).

According to the Gender Identity Research Society, it is estimated the trans population is around 1% of the overall UK population (Glen & Hurrell, 2012; Reed et al., 2009), although no exact number of trans individuals appears to exist. This may be due to lack of disclosure (Coleman et al., 2012). Moreover, as Bouman and Arcelus (2018) point out, it is hard to know who to include when trying to count trans people, because different cultures have different traditions for gender expressions. As such, prevalence numbers most commonly refer to the amount of people who seek treatment at a clinic.

What we do know is that there has been a steep increase in the amount of people who seek treatment in recent years (e.g. Bouman & Arcelus, 2018; Westcott, 2018). Suggested reasons for this include a reduction in stigma and an increase in knowledge across the general population about what being trans means and what treatment is available. According to clinical psychologist Yarhouse (2015), this may be because gender identity can exist along a continuum, and Bouman and Arcelus (2018) point out that the increased presence of trans people in the media may be encouraging more people to reflect over their own gender identities. In the American Psychological Association's latest guidelines for clinicians working with trans people, the first one is that one should understand that gender is non-binary concept, and to accept and validate all forms of gender expression (APA, 2015). The association defines non-binary individuals as those who do not identify with their assigned sex, but also not with a binary understanding of another gender (APA, 2015). Research from the USA suggests that feeling this way is actually very common amongst young people (Flores et al., 2016). It has been suggested that similar tendencies have been suggested to exist in the UK (Metastasio et al., 2018). According to these studies, gender non-binary or non-conforming individuals were found to also experience psychological distress and discomfort similar to those identifying as trans, and as such, it was argued that attending to and taking seriously these people's feelings is vital.

In some Native American cultures, many more than two different gender identities used to exist and gender was understood as something separate from biological sex (Blakemore, Berenbaum & Liben, 2009). According to some social constructivist theories, gender roles were created because they were helpful in the division of labour and knowing who was responsible for things like looking after children or going hunting (Blakemore et al., 2009). Considering psychodynamic theories, understanding one's biological sex and how it is different from one parent and similar to another, may help young children learn about their place in the family and society (Breen, 1993). However, for the reasons gender roles were helpful at one time, it is now argued that the presence of gender roles are decreasingly relevant in modern society (Blakemore et al., 2009). Consequently, some social constructivists understand gender to be something people *do* rather than *have* (Messner, 2000; Westbrook & Schilt, 2014).

It seems there are complicated factors to take into account when considering trans research. It has to be assumed all sectors involved have the trans individual's best interest at heart, though all trans people may not agree with this assumption. However, deciding exactly what is in their best interest is evidently not a simple task. Guidelines set out by the NHS and other bodies are in place because, as psychologist Yarhouse (2015) notes, it would be unethical to proceed with such invasive steps without feeling some degree of certainty that this is right for that person. Presumably, *some degree* is the operative term here though, because research shows that some people do change their minds (Dhejne, et al., 2014), and we may never be able to completely account for that.

Cass (1979) developed a model for the formation of homosexual identity consisting of six stages, beginning with *identity confusion* and *comparison* and ending with *identity acceptance, pride* and *synthesis*. Interestingly, it was found that in between these was *identity tolerance*, where one's homosexual identity is tolerated, but not yet accepted. Though, as pointed out earlier in this review, it may be helpful to draw a clear distinction between sexuality and gender identity, I did wonder whether a similar process takes place in the formation of a trans identity.

1.5 Some Clinical History

The first documented example of a person identifying with a binary expression of a gender differing from their biological sex assigned at birth was recorded to have occurred around 1829. Joseph Lobdell was born female, but lived all of his adult life as male, and even married a woman. He was, however, eventually arrested for his lifestyle (Milton, 2015). In 1949, a sexologist named Caudwell coined the term *transsexualism*, but he advocated it should be viewed it as mental disorder (Murjan &

Bouman, 2015). At first, individuals who felt this way were given conversion therapy, which aimed to reduce the desire to change gender (Lipsitz-Bem, 1994). However, it seems from the literature that people began medically transitioning even earlier, as the first recorded medical male-to-female (MF) transition was in 1930 (Meyerowitz, 1998), while the first medical female-to-male (FM) transition took place in 1945 (Kennedy, 2007).

In 1980, *transsexualism* was included in the Diagnostic and Statistical Manual of mental disorders (DSM) for the first time, in the manual's third edition (Milton, 2015). This definition was later changed to *gender identity disorder* in the DSM-IV (Lev, 2006), and according to the most recent version, the DSM-V, it is now called *gender dysphoria* (APA, 2013). *Gender identity disorder* and *gender dysphoria* both define the condition to be characterised by pronounced emotional difficulty regarding gender identity. As emphasised with the change to the word *dysphoria*, the name was altered to de-pathologise, and instead highlight the emotional distress, which accompanies these feelings (Yarhouse, 2015). Finally, unlike its predecessors, DSM-V no longer has gender dysphoria placed under Paraphilias and Sexual Dysfunctions, but instead under it's own separate section (Beek, Cohen-Kettenis & Kreukels, 2018).

As with its prevalence, no specific cause of the development of a trans identity is known (Glen & Hurell, 2012). Some feel identifying such causes would be helpful because if professionals understand the origins and aetiologies of a patient's gender identity, it enables them to develop more helpful relationships with those patients (Bouman & Arcelus, 2018). On a more practical level, knowledge about potential biological predispositions for gender identity can be helpful in identifying potential health risks also associated with such predispositions (O'Hanlan, Gordon, & Sullivan, 2018), and several theories do exist. In neurology, the brain structure of trans people has been found to be more similar to that of the gender they identify with, rather than their assigned gender (Garcia-Falguera & Swaab, 2008). Another prominent hypothesis is that the flow of specific sex hormones to the foetus during pregnancy can result in the genitalia developing in accordance with one sex, whilst the brain develops in accordance with another (Kreukels & Guillamon, 2016). Regarding psychosocial factors, it was not possible to locate any studies suggesting direct links, and Bouman and Arcelus (2018) note that evidence suggesting cultural and psychosocial factors have anything to do with being trans is limited, as is the importance of such evidence.

1.6 Trans People and Mental Health

1.6.1 An Overview of the Research so Far

The vast majority of the existing research on trans identities and mental health is concerned with quantitative evidence indicating the psychological difficulties faced by this community. In their qualitative study investigating depression and anxiety within the trans population, Budge et al. (2013) found that out of their 351 participants, almost 50% met the diagnostic criteria for clinical depression and about 45% for anxiety. Other researchers have found the estimated depression rate to be as high as 66.4% (Rotondi et al., 2013). Trans individuals have also been found to be more vulnerable to HIV transmission, as a result of needle use when injecting illegal hormones (Nolen-Hoeksema, 2011; Rotondi et al., 2013; Beckwith et al., 2018), as well as low self-esteem and substance abuse (Woolfe et al., 2013; Nuttbrock et al., 2014). Finally, Newfield et al. (2006) found self-reported quality of life to be lower amongst trans people compared with the rest of the population. However, it should be noted that this study only involved FtM trans individuals. More recently, Wolford-Clevenger et al. (2018) have noted that the trans population is still at high risk of suicide and that more research into this is needed.

Existing studies suggest that suicidal ideation appears to be common within the trans population. The Trans Mental Health Study of 2012 surveyed 889 participants in the UK and found that the rate of suicide ideation amongst trans people was as high as 84%, attempts was at 48%, and over half of these reported more than one attempt (McNeil et al., 2012). Elsewhere, among trans women with a history of sex work, Nemoto, Bödeker and Iwamato (2011) found that out of their 573 participants, nearly 75% reported suicidal ideation and 64% of these reported past attempts as well. Clements-Nolle, Marx and Katz (2006) found suicide attempts in trans people to be linked with sexual victimisation, gender-based discrimination, substance abuse and depression. Out of their 515 participants, 32% reported past suicide attempts. Based on these findings, it was concluded that there was an urgent need for suicide prevention interventions for this population. Yet, the American Foundation for Suicide Prevention investigated the rate of reported trans suicide attempts again in 2014, with a sample size of 6,456, and found that the number had gone up to 41% and that almost half of these were under the age of 24 (Haas, Rodgers & Herman, 2014).

In a qualitative study investigating suicide protective factors, 133 trans adults answered open-ended questions which were analysed using thematic analysis. Themes of social support and feeling comfortable in one's gender identity were identified as helpful regarding suicide prevention, and issues around lying to professionals about trans related health care and needing care in a more timely manner were noted to be compromising (Moody et al., 2015). While this study offers some insight into why suicide rates amongst this population are so high, qualitative research on the area is very limited, and as such, a deeper understanding of factors influencing suicidal ideation among this population might be gained from conducting more qualitative research. Wolford-Clevenger et al. (2018) did a peer review across 45 studies on trans mental health published between 1991 and 2017, and their findings similarly suggested that factors such as religion, race and amount of social contact significantly impact one's risk of suicide. Equally, findings by Horvath et al. (2014) also suggested culture to have a significant importance in this matter. Moreover, the researchers noted how difficult this topic is to study, since much is assumed and constructed as a premise for this kind of research. Nevertheless, the magnitude of these findings arguably identifies a significant need for improving the mental wellbeing of trans individuals.

A prominent theory as to why minority populations such as this one experience high rates of mental health difficulties and suicidal ideation is the minority stress model. Originally developed by Meyer (2003), this model proposes that members of minorities are more likely to experience psychological stress than the rest of the population. This is due to various factors, but mainly interpersonal stigma and discrimination. Such factors arguably cause a hostile and stressful environment for the member of a minority, which is likely to negatively affect both their physical and mental wellbeing. Relating to sexual and gender identity minorities, an added stressor has been found to be the initial denial and hiding (Testa et al., 2017). Regarding trans people specifically, Testa, et al. (2015) developed the Gender Minority Stress and Resilience (GMSR) model, based on Meyer's (2003) model, but specifically measuring minority stress associated with gender identity. Their measure was developed based on extensive literature reviews which were then tested on 844 trans participants, where it was found to be a good match (Testa et al. 2015). Using this measure, negative expectations of the helpfulness of the system and non-disclosure have been found to be strongly correlated with the levels of emotional distress experienced by this minority population (Testa et al., 2017). The GMSR model and the theory behind it also aligns with previous findings by Moody et al. (2015).

In summary, this area appears to have been widely researched. However, it seems the trans population still lacks support, and that improvement of the mental wellbeing of this population in general is needed.

1.6.2 Counselling Psychology and Trans Clients

According to Lemma (2012a), the experience of working with a trans client is a unique one, as the mismatch between the person the client feels they are and how they appear can be visually present, depending on where in the transitioning stage that client is. She moreover notes that this felt mismatch or gap can be very present in the therapeutic space, and that she felt a strong transference from the client in her case study, suggesting the importance of her experiencing this gap too (Lemma, 2012b).

Lyons et al. (2015) conducted a qualitative study investigating the experiences of 34 trans people within addiction treatment settings. Here, stigma was found to be a barrier to treatment-seeking and the researchers noted they were unable to locate any literature documenting positive experiences with mental health professionals amongst the trans population. In other research regarding the therapeutic setting, one topic commonly discussed was issues with transphobia amongst both therapists and clients (Snelgrove et al., 2007; Rachlin, Green & Lombardi, 2008).

Another topic of interest is the notion that 'normality' is desirable. That is, a tendency has been suggested in the literature by which concluding whether one is male or female, gay or straight is worked towards by both therapists and clients (Neal & Davies 2000; Desmarais & Gray 2014). This lack of creative validation may be an issue because trans clients may struggle with self-acceptance when they feel they are not 'real' men, women, or transsexuals (Rachlin et al., 2008). At the same time, it is arguably understandable that a client who expresses they 'never felt quite right' in their body would want to find some clarity, and that the therapist would want to encourage that (Woolfe et al., 2013).

Transitioning is seemingly more acceptable in society if you transition from one stereotype into another (Gamble 1997; Dworkin & Pope 2012; Hughto et al., 2005). Indeed, therapists have reported that experiencing confusion regarding whether to consider a client male or female has a stalling effect on therapy (Quinodoz, 2002). In his suggestions on how to work therapeutically with trans clients, Yarhouse (2015) suggested affirmative therapy. The aim of affirmative therapy is to empower the client, as it strives to find the balance between being able to own one's own experiences and identity, whilst also being comfortable sharing this with the world. According to Zandvliet (2000), people in general - but especially in Western cultures - do not have a tradition for valuing difference and are thus concerned with finding reasons, explanations, and new set groups for the different people to fit in. Therapeutically, an issue with this tendency is that trans clients may feel very concerned with figuring out why they are this way before they can accept it, and affirmative therapy aims to help the client let go of this concern (Yarhouse, 2015). Awaiting individuals' own construct and understanding of themselves before trying to impose one seems a good fit with the social constructivist epistemology. However, it should be noted that it was not possible to locate any studies indicating the effectiveness of this approach.

In their study on trans people who receive hormone therapy, Hembree, Cohen-Kettenis & Gooren (2018) suggest that it is time for professionals to stop putting trans people in a box. In their experience, trans people find it to be out-dated. They further note that this tendency is particularly problematic because as it is now, it is difficult to access gender-affirming treatment if you do not identify with a binary gender.

Overall, the research indicates that the trans population on average experiences more mental health difficulties than the cis population (e.g. Rotondi et al., 2013; Nuttbrock et al., 2014; Moody et al., 2015). Yet, clinicians note that when meeting a trans client, it should not be assumed that their difficulties revolve around that, or that they are even related to their trans identity (Lemma, 2012b; Arcelus & De Cuypere, 2018).

1.7 Issues and Gaps Identified

In light of the existing research, various issues and gaps within the research have been identified. Throughout this section, the main gaps identified will be discussed. Overall, two main issues seem to exist. The first one is that the trans population needs more support, and secondly, that professionals are trying, but somewhat failing to support this population as well as we potentially could be.

According to National Geographic editor in chief Susan Goldberg (2017), a gender revolution is currently taking place in which we as researchers and as professionals are beginning to actually seek input from the trans people themselves. Up until now, we have just made assumptions about them and researched the population based on those assumptions. Whilst bearing in mind that, inevitably, assumptions were also made in order to carry out this research, four main gaps were identified. The main gaps regarded *lack of support for the trans community*, *waiting times and NHS guidelines*, *hormone use*, and *the gatekeeper function*.

1.7.1 Lack of Support for the Trans Community

Zandvliet (2000) argues that while medical interventions play a substantial role in many people’s transition, the process is, above all, an emotional and a cognitive one. She also argues that the course of this personal transformation is hugely influenced by factors such as fear, shame and guilt. Other researchers argue that sociocultural factors and personal support networks in turn influence the two latter factors (Palmer, 2002; Moody et al., 2015).

According to family therapist and professor Shirley Emerson (1996), families of trans individuals have been found to experience difficulty adapting to the change that transitioning entails and have even reported a sense of loss when their child transitions. Naturally, after a perceived loss, a grieving process follows and researcher Norwood (2012) suggests it may therefore be difficult for a family to provide the necessary support for the trans individual. Factor and Rothblum (2007) asked 295 transgender adults and their siblings about their childhood, and found that the transgender participants felt significantly less supported by their parents compared with their cisgender siblings. Flentje, Heck and Sorensen (2014) investigated characteristics of trans persons who sought treatment for substance abuse and found that the trans persons of their study on average experienced more family conflict and mental health difficulties compared with cis persons. It should be noted that these findings were based on people who sought treatment on their own account, and consequently did not account for substance misusing people who did not seek treatment.

One major barrier between medical and mental health professionals and their trans clients appears to be stigma. A qualitative study investigating the experiences of trans students in college found that perceived levels of interpersonal support and peer acceptance influenced how motivated they felt regarding their studies and their perceived ability to do well (Goodrich, 2012). Similarly, and perhaps not surprisingly, Sanchez, Sanchez and Danoff (2009) discovered that increased access to health care providers and greater financial means was associated with risk-reducing behaviours. This finding was supported by Lyons et al. (2015), who found stigmatisation to be a significant barrier, as their participants reported being reluctant to seek help because they felt uncomfortable or unwelcome in many group help settings due to their trans identity.

Poteat, German and Kerrigan (2013) studied the impact of perceived stigma on 55 trans medical patients, using grounded theory. The findings of this study indicated that although power hierarchies are already in place between medical doctors and their patients, such hierarchies are experienced to a greater extent with trans patients due to stigma. While this study shines an interesting light on an otherwise under-researched issue, it should be noted that the participant number of this was 55. This is an unusually large number for a qualitative study, and one might wonder whether some data richness was lost as a consequence (Fassinger, 2005). More recently, research in Italy has suggested the stigma and prejudice of society negatively impacts the mental wellbeing of trans individuals and moreover leads to internalised stigma for them (Scandurra et al., 2018).

Also using grounded theory, Snelgrove et al. (2012) conducted a study on the perceived barriers by 13 physicians to providing adequate healthcare to trans patients. The most central theme indicated uncertainty regarding how best to provide this care.

Perceived reasons for this were lack of knowledge and training on the matter. There appeared to be a general sense of worry amongst these professionals of not knowing enough about transgenderism to be able to provide sufficient care. Indeed, it is arguably problematic that there are no clear training pathways for professionals wanting to specialise in working with trans people (Murjan & T'Sjoen, 2018).

Research focusing on the patient side of this issue indicates that they have a similar perception of this problem (Corliss et al., 2007; Rachlin, Green & Lombardi, 2008). Whilst it should be noted these studies were conducted in the United States and Canada and are thus based on their respective health care systems, literature from the UK addressing this issue indicates similar tendencies (Neal & Davies, 2000; UK Trans Info, 2016).

Counselling psychologist Richards et al (2015) point out that supporting trans individuals is a difficult field because it is not an illness to be trans, but it does improve one's wellbeing to receive appropriate treatment for it. Arguably, this touches on an interesting dilemma specific to counselling psychologists, as the value of moving away from the medical model and not distinguishing between the ill and the well (Woolfe et al., 2013) could be seen as conflicting with the need of a diagnosis in order to receive support. Discussing the future of homosexuality and transgenderism in the DSM and International Statistical Classification of Diseases and Related Health Problems (ICD), Drescher (2015) noted that changes and developments are in the pipeline for both the DSM and the ICD to try to resolve the conflict between recognising that this population needs support and treatment, but without the stigma.

Overall, it appears there is much empirical evidence for the notion that this community needs further support. Yet, the more recent studies produce no more positive outcomes than their predecessors and it could thus be argued that this need still exists.

1.7.2 Waiting times and NHS guidelines

The NHS criteria for starting hormone therapy are as follows: 1) documentation for gender dysphoria diagnosis, 2) capacity to make fully informed decisions regarding treatments, 3) to be over 17 years of age and 4) if there are any significant mental health or medical concerns, these must be well controlled (NHS, 2013; Action for Trans Health, 2014). It was not possible to locate any more recent guidelines and these still appear to be the ones referred to in current research (e.g. Metastasio et al., 2018), and it is thus assumed the criteria have not changed since 2014.

As well as legal name and sex change on identity documents and medically necessary treatments, one of the components of the transitioning process is what is often referred to as the *real life experience*. The real life experience requires the individual to live as the desired gender for a time before any medical treatment can commence (Coleman et al., 2012).

According to a report by UK Trans Info (2016), releasing numbers gathered between August and October 2015, the average waiting time before first appointment with a gender identity clinic (GIC) after referral was 47 weeks for England, 31 for the UK overall, with one GIC reporting an average wait of four years. Moreover, 15% of the overall UK trans population reported having to wait over 52 weeks for their first appointment after referral. Whilst it was not possible to retrieve any newer statistics from this source, a study this year by LGBT support organisation Stonewall asked 871 trans and non-binary people across England, Wales and Scotland about their experiences. They found that 62% feel the wait for medical treatment is too long, with many participants expressing a fear of not being able to make it through the excessive waiting times (Backmann & Gooch, 2018). Additionally, in an article by BBC News earlier this year, it was reported that despite an NHS pledge in 2016 to bring waiting times for gender-affirming treatment down, these are on the rise. This was deemed due to an inability to keep up with the rise in demand for such treatment. It was also stated that the average waiting time for a gender clinic appointment following a GP referral is now 18 months, with the shortest waiting times having risen to 51 weeks on average, and the longest up to two and a half years (Westcott, 2018). Metastasio et al. (2018) conducted a series of case studies involving seven TGNC people referred to a general psychiatric setting who were self-prescribing hormones prior to being prescribed them by the GIC. Based on this study, the researchers recognised the increasing problem of long waiting times and note that more people are starting to self-prescribe hormones because of it. The researchers further suggest clinicians prepare themselves to help and guide people who self-prescribe, as the presence of this phenomenon can no longer be avoided.

In summary, it appears from the research that despite attempts to bring waiting times down, the continuous increase in referrals makes it difficult for the GICs to do so. It furthermore seems a shift is happening in research focus on to managing the consequences of the long waiting times as well.

1.7.3 Hormone use

According to Haas et al. (2011), depressive symptoms and suicide rates have been found to decrease after cross-sex hormone therapy begins. Gorin-Lazard et al.

(2012), who studied the relationship between cross-sex hormone therapy and quality of life in France and found that these two factors were significantly positively correlated, also reported to find this tendency. This was found by measuring self-reported quality of life in trans individuals having undergone hormone treatment, those who had not, and members of the cis population. It should be noted however, that the sample size of this study was 61, and only 17 individuals represented the proportion who had not undergone hormone therapy. This number is relatively low compared with other quantitative studies cited in this review, yet this study still shines an important light on the area of trans health. It indicates hormone treatment to be a crucial part of the process, the significance of which is potentially at times overlooked compared with surgical treatment. More recently, research has found psychological distress to decrease after hormone treatment had started for their participants (e.g. Heylens et al., 2014; Tucker et al., 2018). Similar findings were reported by Fisher et al. (2014), who studied the effects of hormone treatment on individuals with gender dysphoria, argued this improvement likely had to do with individuals beginning to feel more at ease with their physical appearance. These indicators of how much hormonal treatment can lessen psychological distress for trans individuals constitutes an important point in the rationale for the current study.

In Canada, a study examining 433 trans persons found 26.8% reported they had at some point used non-prescribed hormones (Rotondi et al., 2013). A study in the USA found that 30.3% of their participants reported engaging in non-prescribed hormone use (Benotsch et al., 2013). Moreover, Rotondi et al. (2013) also found that a few of their participants even reported having performed surgical procedures on themselves. Here in the UK, 23% of people referred to a gender identity clinic were found to already be self-prescribing hormones (Mooney et al., 2017).

Suggested reasons for illegal hormone use included long waiting lists, desires to speed up the transition process, and factors disqualifying individuals for hormone treatment, such as other medical conditions and, in some countries, lack of health insurance (Benotsch et al., 2013; Rotondi et al., 2013). In Australia, researchers discovered that difficulty accessing hormones contributes significantly to mental distress for trans individuals (Riggs, Ansara & Treharne, 2015) and in Thailand, it was deemed less likely for hormone use to be legally prescribed than for it not to be (Gooren et al., 2014).

When a patient obtains hormones via a health care professional, they are screened for medical contraindications to ensure the risk level is minimum (Reback & Fletcher, 2014; Bouman & Arcelus, 2018). If medical risk is detected, this will be attended to before the hormone therapy can commence. Thus, illegal hormone use puts the individual at risk of medical side effects such as HIV (Rotondi et al., 2013), liver failure and even death (Garofalo et al., 2006). According to researchers Mepham et al. (2014), people who self-prescribe hormones are often not aware of the monitoring and preparations necessary to ensure it is done safely, as well as the risks involved. People may self-prescribe hormone dosages much higher than they should be taking, leading to risks to their health and undesired changes to appearance. Finally, because hormone dosages are based on blood test results, it is arguably not possible to safely self-prescribe (Bouman & Arcelus, 2018).

These findings on illegal hormone use indicate a sense of urgency and that not meeting trans needs for treatment carries consequences not only for their mental wellbeing, but also for physical health.

1.7.4 Gatekeeping

As previously stated, the UK guidelines for beginning hormone therapy require that any significant mental health concerns must be *well controlled* (Action for Trans Health, 2014). Several reasons have been suggested for this guideline, but most prominent is the fact that changes to the body occur when one takes hormones, some of which are irreversible. One of these irreversible consequences can be impairment to reproductive functioning, especially when people decide to transition at a young age (Chen & Simons, 2018). Significantly, Chen et al. (2017) have found that when trans youths are offered fertility preservation prior to beginning hormone therapy, many are uninterested, partly because it will delay their transition.

This notion of ensuring mental health difficulties are well controlled is of interest to mental health professionals. As the hormone treatment will not commence until this is resolved, mental health professionals are arguably given a *gatekeeper function*, as at that time they are in effect standing between the individual and their transition (Lev, 2006; Yarhouse, 2015). Some clinicians try to offer a combination of emotional support and assessment for treatment suitability (May, 2002). However, as Zandvliet (2000) noted, needing the therapist's permission to transition is a major issue as the very idea of this is incompatible with a non-judgmental relationship in which the client can disclose anything, which, as noted in the counselling psychology handbook, arguably is the core of therapy (Woolfe et al., 2013). Whilst it should be noted that such permission is ordinarily given by a psychiatrist rather than a counselling psychologist (Bouman & Arcelus, 2018), the potential impact on how mental health professionals overall are viewed should be considered.

Transitioning may be seen as a process of migration in that there is much adjustment and even loss associated with it, not just for the family but also for the individuals themselves (Zandvliet 2000). The author further argues that many are not adequately prepared for this, and that this can often cause distress. Psychotherapist Ehrbar (2012) supports this notion and adds that there is a tendency among trans clients to say what they believe the therapist wants to hear, rather than engage in an open exploration of their feelings, out of fear that the therapist will slow down the transitioning process if struggles are disclosed.

Bearing in mind the difficulties trans individuals are likely to encounter during the transitioning process purely due to the nature of it (e.g. Ehrbar, 2012), combined with the waiting times (Action for Trans Health, 2016), and inadequate support (e.g. Snelgrove et al., 2012), it would arguably be unreasonable to expect little or no emotional distress. In fact, in order to meet the criteria for a gender dysphoria diagnosis, a person needs to be experiencing a great deal of emotional distress (APA, 2013) and according to Lemma (2013), when trans individuals pursue a medical transition, it is because they want it to relieve the painful incongruence they experience. As such, one has to be emotionally distressed, yet not *too* emotionally distressed. So how distressed is *too* distressed?

According to Bradford et al. (2013), it is common for trans people to have felt uncomfortable when interacting with health professionals, and to feel they have had to educate them. Moreover, research has found that is commonly their experience that the fact that they are trans has negatively affected the treatment they receive (Whittle, Turner & Al-Alami, 2007). Indeed, trans people are also scrutinised more than any other group when seeking trans related healthcare, especially considering they are otherwise well

(Murjan & T'Sjoen, 2018). In order to access surgery now, trans people need the approval of two mental health professionals, which some argue is unnecessary (Bouman et al., 2014), and potentially feeds a further division between trans people and the professionals working with them.

In their study about trans individual who self-prescribed hormones, Metastasio et al. (2018) conclusively stressed the importance of clinicians understanding the severity of the psychological distress a TGNC person goes through whilst waiting, and the lengths they will go to in order to speed the process up. It was also emphasised that having a good relationship with patients is vital, in order to increase the likelihood that they will share with you if they are self-prescribing hormones and to be able to best support these people. In line with this, other clinicians have suggested that upon assessment, NHS clinicians ask patients about self-prescribed hormones, what they are taking, and where they got it from (Bouman & Arcelus, 2018). As with many of the clinical guidelines, it seems this is in place to improve health care for this population; however, one could also wonder whether this line of questioning might make them feel interrogated and further fuel this gate-keeping perception. In conclusion, it seems there are problems within the current system, causing people to not want to work with it.

1.8 Benefits of Further Research to Counselling Psychology

1.8.1 Potential Contributions

When the American Foundation for Suicide Prevention reported that 41% of their transgender participants had attempted suicide, it was pointed out that higher numbers were found amongst those who said they would like transition-related health care services, but had not had any. This was concluded to indicate that unmet needs of such services exacerbated suicide risk (Haas et al., 2014). This finding was supported by Newfield et al. (2006), who asked 446 FM transgender participants about their quality of life, which was assessed with a questionnaire addressing factors such as social and physical functioning, work and health. The researchers found that their overall rates were significantly lower than for the cisgender population. The researchers also found that the 67% of participants who were receiving hormone treatment rated their quality of life significantly higher than those who were not in treatment. Meeting requests for hormonal care was thus concluded to be associated with improved quality of life.

As clinician Yarhouse (2015) points out, many different factors influence the way in which a person transitions. More specifically, he explains that different steps carry different considerations. He notes that there are *reversible* steps like changing one's hair-style and clothing, *partially reversible* steps such as hormone therapy and then the *irreversible* surgical steps. The author further notes that little is known about these considerations and that more research needs to be done on the topic. Furthermore, researchers note that coping strategies likely change throughout the transitioning process (Budge et al., 2013), which arguably indicates that further understanding is needed into what goes on for these clients at each stage of the process.

With regards to counselling psychology specifically, Zandvliet (2000) reports that trans clients, while receiving a therapeutic service they are paying for, sometimes feel they have to educate their therapists on transgenderism. More recently, Poteat et al. (2013), who reported similar findings in their research, further added that possible reasons for this were lack of training and interpersonal stigma among professionals. The authors concluded that these factors in turn strengthen the power gaps between them and their patients. In the American Psychological Association's latest guidelines for clinicians working with trans people, it is stated that psychologists should have awareness of how their knowledge and attitudes towards trans people can affect the care they provide for these people (APA, 2015). As such, a consensus appears that improvements in our understanding of this population are needed.

1.8.2 Conclusion and Research Questions

Throughout this review, it has become apparent that the trans population is one which could be both better researched and better understood. I believe that the issue of the gatekeeper function, in combination with the reported issues around waiting times, hormone use and its common self-prescription opens up a gap in the research, which is of specific interest to counselling psychology. As such, I propose to investigate the following research questions:

How do trans individuals decide to begin hormone therapy?

What factors influence the decision of *when* to seek hormone therapy?

To what extent is ‘waiting time’ a distressing part of the transitioning process?

How are mental health professionals viewed by trans people?

Chapter 2: Methodology

2.1 Research Design: Setting the Methodological Context

This chapter will explain and justify the chosen methodology for this study. The first part of the chapter will outline the considerations involved in the process of choosing the methodology. It will explain what led to the choice of the abbreviated version of the constructivist grounded theory approach and how I as the researcher position myself in relation to this approach.

2.1.1 Reflexive Statement

Throughout this work, I have come to think that it is impossible to be completely objective. Both in terms of how I understood and analysed the data, but also in terms of things I used to think were somewhat objective, such as the questionnaire. When discussing the researcher's influence on the outcome via the questionnaires, Willig (2001) gives the example of asking someone how they felt during a medical procedure, invoking a theme of "emotion," and then even if the respondent disagrees with its importance, he or she still positions himself or herself in relation to that theme. In this way, I believe all my previously established assumptions about the trans population as misunderstood, the waiting times as an issue, and mental health professionals as relevant to the process, have influenced the way I have carried out this research. This is reflected in my interview schedules (appendix E, G and H), where questions address waiting times specifically. Like Willig (2001), I *make* waiting times an important factor because I ask participants to position themselves in relation to it. However, I found that throughout the interviews, participants would name the issue of long waiting times before I even got to this question. I attempted to stay aware of my own influence nonetheless, and the structure of the questionnaire, among many other things, was continuously reflected upon through memo writing (appendix I).

As constructivist grounded theory does not assume there is an objective truth to discover, this approach allows for the researcher's own biases to be taken into account (Charmaz, 2011). Indeed, I found the recruitment process increased my awareness of my own role in all of this, from the way I phrased my recruitment ads, to the research questions I asked. My early memos witness a confusion between ethical constraints and a personal desire to hear out everyone who came forward. Throughout the interviews, I found I was frequently asked by participants about my personal motivation for the project and specifically about whether I was a member of the LGBT population myself. This led to a lot of reflections and re-evaluation of my decision not to disclose that information. I did at times feel this portrayed me as closed off to the participants, and perhaps that it led to the assumption that I am not a member of the LGBT population, or at least that I am not trans. In the interviews, I think this influenced the way I interacted with the participants. That is, with hindsight, I think I was trying to over-compensate and be very open, in an attempt to disprove potential impressions that I was closed off. This was likely also due to me feeling eager to show that I could be empathic and conduct this study without necessarily being trans myself. Upon reflection, I believe this eagerness was also due to my own insecurities and the earlier identified conflict of wanting to help, but fearing I might not be able to, because I will never truly know what their struggle is like.

This was the stage of the research process where I really became aware of what assumptions and preconceptions I brought to the work. According to Charmaz (2014), the danger of this is when we are unaware of it. As noted in chapter one, I presented a poster of my research at a conference before the participant recruitment had begun and I was surprised to learn this had offended some people. I believe this is an example of the exact danger Charmaz (2014) is referring to. Although this is arguably problematic in itself, the danger to the research was not necessarily that my poster was offensive, rather, it was the fact that I was unaware of this. I used to consider myself very open-minded and inclusive, and therefore assumed *I* would know how not to offend. From a research point of view, I am somewhat grateful that I brought an offensive poster to a conference back then because, as Charmaz (2014) points out, it is often only when our taken-for-granted standpoints are challenged that we even become aware of their existence.

2.1.2 Overview: Qualitative Research Methodologies

Qualitative research aims to gain an in-depth understanding of the complexities of human experiences. It aims to make sense of the meaning individuals bring to a research phenomenon. According to Patton (1990), the qualitative approach is in contrast to the quantitative approach because of their different ways of testing hypothesis. That is, he argues that the quantitative method of hypothesis testing creates an artificial research context, which is removed from social reality. In contrast, the qualitative approach seeks to understand research phenomena as they naturally occur. That is, qualitative research seeks to understand and make sense of how people manage certain situations (Willig, 2001). In this study, these are situations such as waiting, dealing with GPs and GICs, and managing the potential consequences and all one’s fears. As such, a qualitative approach was deemed most suitable for this study.

The qualitative approach investigates the *why* and *how* of human behaviour and decision making, and not the *when* and *where*. Qualitative research explores the totality of a situation, which is why the sample sizes are significantly smaller than in quantitative studies (Sandelowski, 1995). Qualitative methods are iterative, as the researcher goes back to the material repeatedly in order to better their understanding of the data. This provides the researcher with some flexibility, as it allows for the data to change and evolve. This flexibility permits a deeper understanding of a particular phenomenon (Whittemore, Chase & Mandle, 2001).

2.1.3 The Selected Methodology: Constructivist Grounded Theory

As this research is looking for an explanation of how the decision of beginning hormone therapy is made, and for patterns in the decision-making processes between the different participants, grounded theory (Thornberg, 2011) was the methodology of choice for this study.

The grounded theory approach was originally proposed by Glasser and Strauss (1967), but the two came to disagree on the exact nature of the approach (Charmaz, 2014). In short, the traditional approach to grounded theory proposed that the researcher was discovering the participants' reality and that the theories emerging from the data were separate from the researcher (Glaser & Strauss, 1967). However, Strauss and Corbin (1994) felt there was no pre-existing reality to discover, but rather, that we are co-creators of this reality. The constructivist approach to grounded theory developed around the same time as the concept of constructivism became more prominent. This approach placed even more emphasis on the aspect of constructivism than Straussian grounded theory, claiming the researcher is an active re-constructor of the participants' meaning-making (Charmaz, 2014). As such, the adapted approach to grounded theory in this instance was more Straussian and constructivist, rather than the classic approach proposed by Glasser and Strauss (1967). Arguably, constructivist grounded theory encourages an empathic understanding of the participants' thoughts and actions. It also feels open and reflexive, whilst still being somewhat firm in nature as the traditional approach to grounded theory.

The philosophy of the constructivist epistemology retains that scientific knowledge is constructed by the scientific community and that the models this approach aims to construct are with regards to events of the natural world (Ponterotto, 2005). This fits well with my own epistemological positioning, as I believe gender is a social construct and I am aware of how this might influence the data that emerges between the participants and myself (Thornberg, 2011).

2.1.4 Epistemological Positioning

According to Charmaz (2014), the constructivists approach to the grounded theory method combines pragmatism and relativism. Pragmatism assumes theories and beliefs should be understood in terms of their practical application, and how successful that is (Bryant & Charmaz, 2007). As noted earlier in this chapter by Blakemore et al. (2009), concepts are understood based on their helpfulness to humankind. In relation to this work, such positioning is relevant because I feel that it bridges the gap between research and clinical practice within counselling psychology, because the pragmatic aspect arguably ensures clinical application of the findings is held in mind. Relativism assumes all knowledge is relative to factors such as time, history, culture, and place (Lonka & Lindblom-Ylänne, 1996). Theories are constructed and come about as a result of interactions between participants, the researcher, and the field (Charmaz, 2011). As such, it is assumed that multiple realities exist, as do multiple perspectives of these multiple realities. In the current study, the way society views gender and subsequently treat trans people was deemed hugely important for understanding the factors involved in people's decision to seek out hormone therapy, as was participants view of society or 'the system' they were going to enter once this decision was made.

Realist ontology is also present here because I believe the processes I am investigating take place regardless of whether I study them or not (Willig, 2008). That is, I think trans people decide to seek out hormone treatment regardless. They have done so since before I began studying the topic, and I believe they will continue to do so after I am done. However, processes are not static, so it would not be possible for me to completely capture this decision making process. Rather, I contribute to the construction of my understanding of it. As such, symbolic interactionism also has its place within this work, which helps foster reflexivity in the way constructivist grounded theory aspires towards (Charmaz, 2014).

Oliver (2011) notes that the acknowledgement of some overall, though socially constructed reality, which is experienced subjectively, is critical realist way of thinking. She adds that it is not possible to step out of one's own viewpoints, and that there consequently will always be a gap between reality and our understanding of that reality. This also aligns with my understanding of what I am investigating for this study. That is, I am researching the transitioning process, and believe that the existence of this process is accepted by my participants and the reader. At the same time, as noted in my reflections, I accept that within that, individual understandings and experiences also exists, which will likely differ from mine. According to Kempster and Parry (2014), this is a common viewpoint of a critical realist researcher using the grounded theory approach. My subscription to the fact that individual experiences of socially constructed phenomena can vary greatly thus nuances my positioning, in that it is not just social constructivist, but has elements of critical realism within it as well.

2.1.5 Abbreviated Version

When the abbreviated version of grounded theory is implemented, the methods of grounded theory analysis are used, but processes and their consequences in the wider sense are not clarified, and one risks the analysis becoming too descriptive (Willig, 2001). In the abbreviated version, theoretical saturation is not reached, as this version works only with the data, and the researcher cannot leave the dataset to go out and find more data and refine the analytic outcome (Willig, 2008). As such, Willig (2008) notes that the abbreviated version should never be the first choice, but can be a necessary way of conducting a grounded theory study where quality or amount of data may compromise the quality of a full version study.

When I set out to conduct this research, I suspected I might not conduct the amount of interviews appropriate for application of the full version of grounded theory for three reasons. Firstly, it was because the trans population is a minority. Secondly, it was because, as noted in chapter one, I suspected members of this minority population might be reluctant to talk to a mental health professional, depending on their views of such. Finally, I had set myself strict ethical guidelines regarding participant recruitment in that I would not approach any potential participants directly. Rather, I wanted to advertise the study, and wait for potential participants to approach me to minimise the risk that anyone would feel pressured to partake. I felt interviewing trans people themselves, who voluntarily came forward was important, and as such, I was prepared to conduct an abbreviated version of grounded theory to preserve those values. Subsequently, when recruitment came to a natural end after the seventh interview, I decided the abbreviated version would be most suitable.

According to Bryant and Charmaz (2007), the amount of data required for a good grounded theory analysis depends on the quality of the data and the questionnaires. They further note that providing the analysis enables the researcher to answer their research questions, the abbreviated version can be implemented.

2.1.6 Alternative Research Approaches and Discrepancies within the Current One

The main debate within grounded theory methodology is about induction versus deduction and about whether categories and theories are discovered or constructed. When grounded theory was originally developed, the idea was that induction would ensure influence by the researcher was minimal (Glasser & Strauss, 1976), however this assumption quickly became debatable. The nature of the coding process alone was arguably deductive in nature, as the researcher looks for specific tendencies and elects which are important (Strauss & Corbin, 1994), prompting the question of whether a researcher can ever really be completely objective, especially within qualitative work. In its original form, grounded theory aspired to *discover* knowledge within the data (Glasser & Strauss, 1976), suggesting this knowledge was already there. Willig (2008) explained this by comparing the role of the researcher to that of a midwife, delivering an already formed baby, and notes how problematically positivistic this is for a qualitative research approach. Dey (1999) points out that one only really discovers because they are looking for something, and notes that Columbus would not have discovered America, had he not set out to find the Indies to begin with. Similarly, Silverman (1993) states that without a pre-existing theory, nothing can be researched, because if we have pages and pages of transcript, we need to know what we understand this data to represent before we can analyse. The assumption of pre-existing knowledge to discover also conflicts with my own epistemological positioning, as I believe myself and my participants to be co-creators of meaning, and I feel my decisions, from what questions I asked to what I took the responses to mean, have heavily influenced the outcome of this study.

Ultimately, as the research topic and questions of interest were narrowed down, it came down to choosing between interpretive phenomenological analysis (IPA) and grounded theory. IPA was considered because it would offer a detailed understanding of the emotional experience of deciding to seek out hormones and of all the obstacles encountered whilst doing so. Indeed, within psychological research, grounded theory has been criticised for being too preoccupied with uncovering social processes, at the expense of psychological and phenomenological experiences (Willig, 2008), and it should be noted that Glasser and Strauss (1967) themselves were sociologists, rather than psychologists. However, once the research questions were finalised, these were predominantly concerned with gaining an understanding of the processes involved in this decision-making, as well as its sociocultural context, and as such, grounded theory was deemed most appropriate.

2.2 Procedure

Throughout this section, participant recruitment and selection are explained, and the ethical considerations associated with these decisions discussed. It is also explained how the data was collected, managed, and analysed.

2.2.1 Participants

The group of participants consisted of individuals who identify with a trans identity, which for the purpose of this study was defined as those who 'identify with a gender different from their assigned sex at birth.' Conflicts exist within the literature regarding the specific definitions (e.g. Desmarias & Gray, 2014; Lyons et al, 2015), and this study did not wish to accidentally exclude participants who could add richness to the data.

Furthermore, an additional inclusion criterion was that the participants had made the decision to begin hormone therapy. This criterion was selected due to the focus on how this decision is made, whether participants felt supported through it and possible struggles experienced. As such, it was assumed that these considerations would be best portrayed by those who have made the decision to undergo hormone therapy.

The number of participants recruited for this study was seven. I recruited participants by approaching LGBT organisations, charities and societies around the UK. The charities approached were MindOut, Pink Therapy, the Clare Project, FTM London, Depend, Trans London, Beaumont Society, and university LGBT societies. Upon approaching these organisations, ads containing information about the study were given to administrators of the organisations (appendix A) for them to pass on to possible participants, who then contacted me if they were interested. As discussed earlier in this chapter, a reason for this approach was for the potential participants not to feel pressured into participating. Another reason was to give the organisations a chance to ask clarifying questions prior to introducing the study to their members or clients, which was deemed important because of the emotional and personal nature of the subject matter. Participants were given a £10 Amazon voucher in exchange for their participation, which I paid for myself. This fairly low value was set in the hope that money would not be the main motivation for participating, whilst I still wanted to give something as a token of appreciation for their time and for sharing their experiences with me.

As noted earlier, I had hoped to recruit more than seven participants, but had not expected this would be possible, partly because being openly trans is fairly rare (Glen & Hurrell, 2012; Reed et al., 2009). Moreover, people may feel reluctant to disclose their personal material due to the emotional difficulties it may bring up for them, or due to worries of disclosing criminal activity related to illegal hormone use. Please see an elaboration of these ethical considerations in later in this chapter, and appendix B for a distress protocol.

The participants consisted of three FM and three MF trans people, and one de-transitioned female, although they did not all identify as such. Preferred terms identified with included trans man, man, trans woman, woman, and non-binary. The GICs in which they sought treatment varied and included places in London, Sheffield, Liverpool, Leicester and Brighton. The average age of participants was 46 years old, with the eldest participant aged 75, and the youngest 21. The participants were all from the UK and all met the inclusion criterion of having made the decision to take hormones. Moreover, although this was not a criterion for participation, all the participants in this study had also begun taking the hormones.

2.2.2 Data Collection

Upon the first meeting between the participants and myself, they were given an information sheet (appendix C) and a consent form (appendix D) to read through and sign before their participation could commence.

In this study, the data was collected with the use of semi-structured interviews. The interview schedule (appendix E) and questions were based on interest and information gained through the literature review and the reason for the individual interviews was to gain an in-depth understanding of the process by which trans individuals decide to begin hormone therapy, the factors that influence the process, as well as their understanding or experiences of mental health professionals. It was the aim that using semi-structured interviews would allow for both my own agenda and for the participants to have the opportunity to explore the aspects of their account they themselves deemed to be important (Barriball & While, 1994). With the use of prompt questions, I would lead the participants towards the material of interest, yet the participants maintained the freedom to choose what specific material they wished to explore.

The semi-structured interviews were conducted on a one-to-one basis in a space that was professional and confidential, such as private rooms in the university or in external, hired library offices, local to the participants. The interviews were expected to take an hour on average, so a maximum of two hours was set aside for each to allow time for consent and other forms to be completed and to explain the structure of the interview, the interview itself, and debriefing. The average interview time was 56.3 minutes, with the shortest interview length being 49.2 minutes, and the longest 68.8 minutes. The interview schedule was brought along to each interview, which were audio recorded and transcribed. Each question in the interview schedule had probes and prompts to supplement them (Barriball & White, 1994) aiming to direct the conversation towards material which would answer the research questions.

Upon completion of the interviews, participants were given a debrief sheet (appendix F), ensuring the participants that the data would be anonymised, stored safely and securely, and disposed of once the analysis was complete. Providing participants with such forms is in accordance with the BPS’s code of human research ethics (BPS, 2010). They were also given the opportunity to ask any questions they might have, or add any comments or information they would like to.

2.2.3 Data Management

The recorded interviews were stored securely on an encrypted USB, as in accordance with the BPS’s code of human research ethics (BPS, 2010). Anonymity was ensured by changing the participants’ names and leaving out other identifiable information. As noted earlier, participants were informed of their right to withdraw their participation up until four weeks after their interview had taken place; no participants elected to do so.

2.2.4 Data Analysis

Once the first three interviews were completed and transcribed, these were coded and initial drafts of categories began to form. Initial coding was done in a line-by-line manner and constituted the first, subtle bridge between the raw data and the initial stage of analysis (Charmaz, 2014). Once the initial coding of an interview was complete, the focused coding began. Here, the process focused in on what was considered the most relevant or useful initial codes as a way of sifting through the data. According to Charmaz (2014), focused coding accelerated the analytic process, without losing the detail captured during initial coding. Rather, it is a way of sharpening or condensing what is being found. Charmaz (2014) also notes that it is often during the focused coding that when a researcher is made aware of the preconceptions held and how these may not match with what emerges in the data, and she emphasises the importance of staying mindful of this.

After the first three interviews, initial subcategories and categories were generated based on the coding and a theory was generated of how the decision to take hormones is made. This theory thus became a working model of the process this study aimed to capture. This stage was also an opportunity to discover whether my sampling techniques were effective and whether I needed to make any changes to them before recruiting further participants. Based on the initial draft of categories and model, it was decided that no changes needed to be made to the recruitment process; however, a change was made to the interview schedule, as I decided to remove the question addressing the definition of a counselling psychologist (appendix G). My initial intention in asking this question was to address the participants' existing knowledge about mental health professionals and understanding of their role in this process to gain understanding of whether these were understood more as a source of emotional support or as gatekeepers. However, in the interviews it felt like I was coming across as trying to test the participants and I did not find those conversations added richness to the data, and as such, I removed the question. Following the fifth interview, the material was then re-analysed in the same way, and further, minor changes were made to the questionnaire (appendix H).

The aim of analysing the data in this way is to capture how the social problem of beginning hormone therapy is perceived and tackled by the participants; their difficulties relating to it and how they work with these.

2.2.5 Memos

Memos are observations, questions and thoughts, which are captured throughout the research, but especially during the analysis process (Bryant & Charmaz, 2007). The goal with memo writing is to catch such thoughts and observations in order to capture considerations and questions to pursue (Charmaz, 2014). According to Pidgeon and Henwood (1997), documenting the research process in this way works to demonstrate a clear path is demonstrated between the raw data and the understanding the researcher comes to have of it, as well as increasing reflexivity. The hope is that memo writing would ensure this by active engagement with both the data and with critical reflections throughout, and minimise the risk that meaning and connections within the data are lost (Charmaz, 2014). Memo writing began shortly after ethics approval was gained in early 2017, and continued until the final stages of analysis. Appendix I shows an excerpt from the memos recorded throughout this study.

According to Willig (2001), memos can vary in length and from, and can be both abstract and concrete, and according to Charmaz (2014), there are many ways of writing memos but as long as the aforementioned goals of memo keeping are reached, the method is somewhat unimportant. Throughout this study, memos were written on post-it notes and note pads, some of the memos related to specific excerpts of the data, and others were just thoughts, observations, or conflicts I was experiencing.

2.3 Ethical considerations

Ethical approval from the ethics board was received on February 23rd 2017 (appendix K) and ethical considerations were given to the participants' rights. For this study, it was considered that participants might become distressed throughout the interviews, due to information derived from the literature and the fact that the questions were addressing potential emotional struggles during a time that was suspected to have been difficult for the participants. Therefore, it was vital to ensure that the participants knew their participation was voluntary and that they could withdraw at any time, up until four weeks after their interview (appendix C). Participants were also sent PHQ-9 and GAD-7 questionnaires (appendix J) immediately after expressing their interest in taking part in the study, prior to meeting with me. These questionnaires assessed levels of experienced symptoms of depression and anxiety. The aim with them was to ensure participants were fit to take part and to minimise the risk that they would feel distressed by the personal material which might come up during the interviews, as suggested by the BPS guidelines (BPS, 2010). If participants expressed levels above *moderate* (indicated by a score above 10) in either questionnaire, I deemed it unethical to include these individuals in the study, and as such, they were not interviewed. This happened in one instance, where I chose to write the participant a lengthy email thanking them for their interest, explaining the reason for excluding them and suggesting different mental health sources and support organisations for them to pursue if interested. I then reflected on the feelings I experienced with having to exclude this person in my memos.

A distress protocol was also put in place (appendix B). I considered the criteria for implementing this protocol throughout each of the interviews. A few of the participants became tearful during their interviews, at which points I would ask them if they were OK, suggest they take a moment, and make sure they felt OK to continue before doing so. No further need to implement the distress protocol took place, and none of the participants expressed interest in support from any of the organisations listed on the debrief sheet (appendix B), but they were all given the sheet to take away nonetheless.

Although I chose to define this participant group as trans, I appreciate many different definitions and identities exist within the trans community as an umbrella term (Ehrbar, 2012) and the participants themselves did sometimes identify as otherwise; it was therefore important to be mindful of not offending them. This notion is particularly important with this group of participants, as it has been found that language, and specific word use is important when working with individuals whose gender identities differ from the cis female or male "norm" (Bernal & Coolhart, 2012). My way of managing this issue was to begin each interview by asking the participant how they identified and what their preferred pronouns were.

2.3.1 Additional Reflexive Statement

Throughout the interviews, a mismatch between the material the participants and myself wanted to discuss sometimes appeared. I believe this mismatch appeared because, as I had hoped, participants seemed to go into the interview at times with just as much of an agenda as myself. That is, I had set up the recruiting process, as discussed earlier, in a way that aimed to recruit only people who really wanted to take part. In the interviews, some participants had written things down they wanted me to know, and most of the time this was relevant for my research questions, though not all of the time. Aiming to establish a balance, I tried to manage this by allowing some exploration of seemingly irrelevant material, but with the use of prompts tried to steer the conversation back to relevant material. However, it should be noted this was not a prominent issue, and that some of this seemingly irrelevant material actually turned out to add richness to the data, especially regarding the theme of *survival mechanisms,* which will be discussed in chapter three.

Following the interviews, I felt so honoured that the participants were choosing to share their sensitive, emotional stories with me, that in analysing the material, I wanted to quote everything they had said. I wanted to honour them by doing something good and useful with it. To an extent, these worries diminished during the analysis process, because I felt the model and the categories were forming and thus that the work was achieving what I had set out for it to do. As such, I stayed aware of this desire to do the data justice as a motivational factor rather than a fear.

Chapter 3: Analysis

3.1 Reflexive Statement

Throughout the interviews, several participants mentioned that more trans people are needed in trans care roles, as cis clinicians cannot truly understand them. This was perhaps not surprising given the negative experiences with health care professionals they told me of, as well as my own view of this population as a misunderstood one. Yet, as I am not trans, and I do not believe the participants thought I was, I wondered whether the participants were telling me that *I* cannot truly understand them, and that did surprise me. Upon reflection, I think the main reason for my surprise was my own, old preconception of myself as somebody who did understand, dating back from before the conference poster. However, I could not help but find this to be symptomatic of themes and categories discussed in this chapter surrounding the gatekeeper factor, and wondered if both parties are widening the gap between this population and the professionals working with it. Bluntly put, it seemed we as professionals have not given trans people a reason to think we understand and are able to support them, so now they enter meetings and relations with us assuming we will not. So what steps can we take to close this gap? I suppose this analysis, in which trans people themselves were asked, is my humble attempt at just that.

3.2 The Model

As the categories and subcategories all represent stages of the decision making process to take hormones, a model of this process was drawn. The model aims to capture the help-seeking behaviour that motivated the participants to make this decision. The categories are listed in chronological order, with the category at the top being the first stage and the category at the bottom being the final stage that was determined to take place in this decision making process.

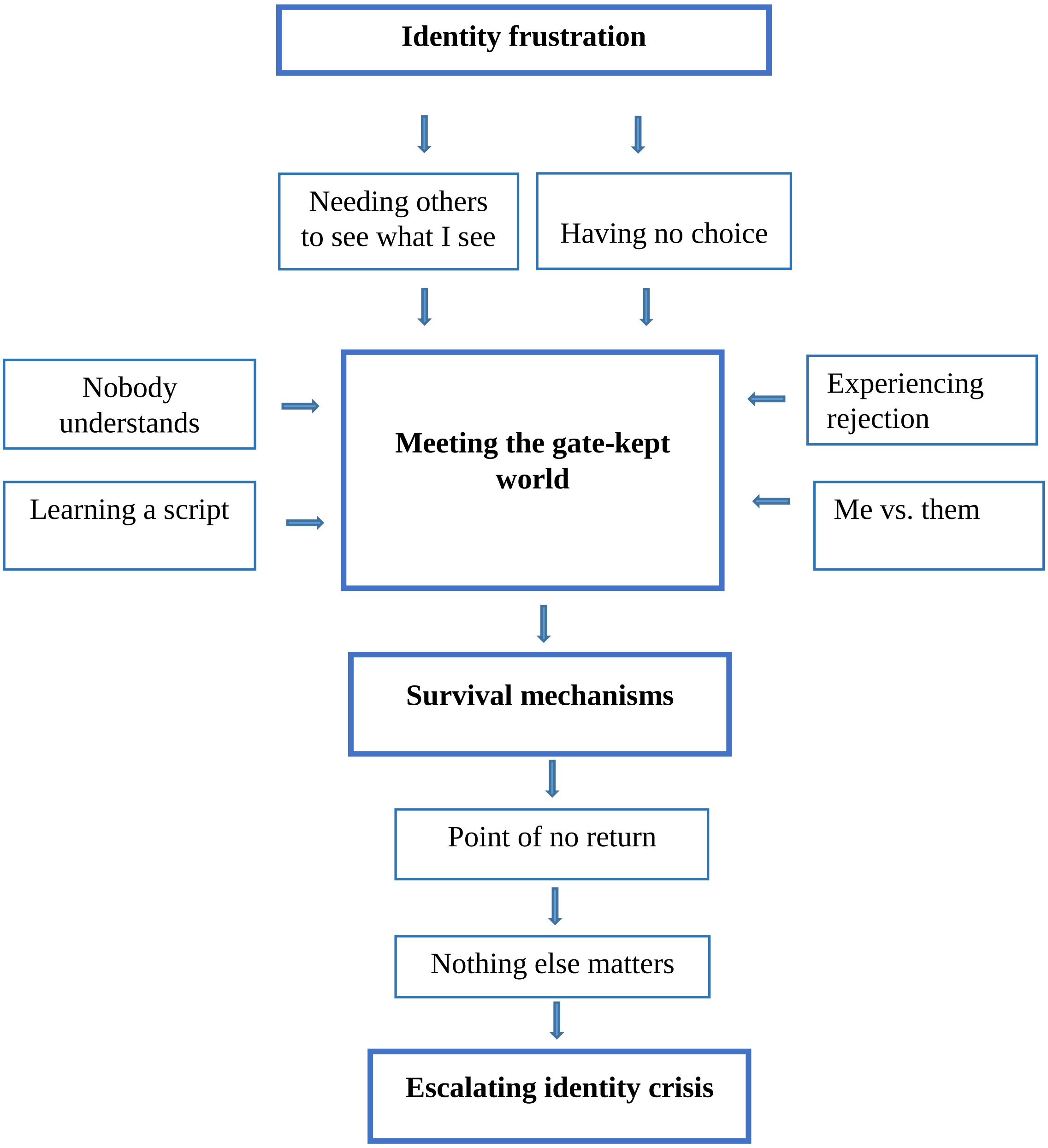

Figure 1: A model of the help-seeking decision making process to take hormones

Four categories and 14 subcategories were identified. Each category represents a stage of the process of a trans person deciding to take hormones. The model in figure 1 above was constructed to show the decision making process to take hormones, stage by stage. Table 1 below shows a summary of all the categories and subcategories constructed in this study. Examples and explanations are provided of each subcategory throughout the chapter, and a full list of categories and subcategories, and how these developed can be found in appendix L. Participants are referred to either by their synonym or by the first letter of their synonym throughout the chapter.

Category	Subcategory	Participants
Identity frustration	Knowing from an early age	ABDEFG
	Needing others to see what I see	BCDEFG
	Having no choice	ABEFG
Meeting the gate-kept world	Nobody understands	ABCDEG
	Me vs. them	ACDFG
	Experiencing rejection	ABCDEG
	Waiting	ABCDFG
	Learning a script	ABCDEG
Survival mechanisms	Activism	AEFG
	I guess it could have been worse	ABCDEFG
	Building up to a contest	ABCEFG
Escalating identity crisis	Point of no return	ACDEFG
	Nothing else matters	ABDEFG
	Fearing death	ACEFG

Table 1: Table of categories and subcategories

3.3 Categories and Subcategories

3.3.1 Category 1: Identity frustration

The first stage of the decision making process to seek hormone therapy initially centres around the realisation that one is different from their peers. For most participants, this also involved an early awareness of being trans. A tendency of passing early judgement became apparent. One participant noted:

> "(…) *having spent all my life trying to bury it and to pretend it didn't exist. You know, thinking that freaks and perverts and funny people do that, and I'm definitely not one of those.*" (Danielle, 514-517).

As suggested in this quote where Danielle is talking about first thinking she might be trans, early feelings of hatred and despair towards self appeared, and she seemed to decide against being trans, before even having fully realised that she was. This feels important to later frustrating feelings about their own trans identity, as well as the strategies participants employed to deal with it. Moreover, this category touches on realising and accepting the inevitability of one's identity, seeking external validation, and beginning to reflect over the transitioning process, its potential risks and consequences, and the system.

3.3.1.1 Subcategory: Knowing from an Early Age

Category	**Subcategory**	**Focused code**	**Initial code**	**Core text**	**Partici-pants**
Identity frustration	Knowing from an early age	Taking pride in the ability to supress trans identity, due to the pain it was expected to cause.	Finding she has been trans for as long as she can remember. Supposing she managed to supress her trans identity very well.	"I've been trans for as long as I can remember, but I wasn't actively so. I've managed to supress it very well until about 20 years ago I suppose." (D, 4-6)	ABDEFG

Table 2: Category 1, subcategory: Knowing from an early age

When asked about their decision to begin hormone therapy, many participants began talking about what their childhood was like, or rather, what they were like as children. It felt almost as if they were saying that their living in the sex they were assigned at birth would have never worked, and that this was clear from the beginning.

As indicated in the example in table 2 above, it was often made clear that an early awareness of being trans did not mean coming out early or seeking treatment early. In fact, a sense of pride and achievement seemed to be attached to childhood memories of supressing, hiding or even denying trans identity. This felt controversial, as it was often accompanied by intense frustration and emotional agony at the same time. One participant painted a vivid picture of this agony:

> "*Yeah, it was… err, I wanted to rip off the outside. I had this feeling that… there was so much inside that I couldn't get rid of. I remember just throwing myself into a ball, trying to rip my boy's parts off, just to get to what the real me was.*" (Fran, 61-65)

It appeared that both the desire to supress and hide trans identity, and the desire to do the opposite, were rooted in a need for emotional self-protection. As such, it appeared participants were experiencing a conflict, in that they wanted and needed desperately to transition to eliminate the pain they were feeling for good, but equally needed to look after their fragile selves in the here-and-now, and avoid the perceived pain and struggle that would come with seeking treatment.

The apparent result of this conflict came across as an emphasis on reasons why things could not have gone down differently, or why one could not have eliminated the emotional agony any sooner. It was as if, in the interviews, they were reassuring themselves of this, and explaining to themselves why supressing their identity initially was for the best. As will be explored later, I wonder whether this might have been yet another way of protecting themselves, because recognising that some of this pain could have been avoided in itself was too painful.

3.3.1.2 Subcategory: Needing Others to See What I See

Category	Subcategory	Focused code	Initial code	Core text	Partici-pants
Identity frustration	Needing others to see what I see	Seeking confirmation of own gender identity.	Thinking she had to know if the psychiatrist felt her conclusion that she was trans was appropriate.	"My first thought was that I would go and see X (*psychiatrist*) (…) to see whether he felt the conclusions I was reaching were appropriate." (E, 25-28)	BCDEFG

Table 3: Category 1, subcategory: Needing others to see what I see

This subcategory shows the inner turmoil participants appeared to have gone through. That is, it seemed participants were in need of some proof or validation, as if their own assessment was not enough. Perhaps due to the suspected difficulty of the process they were about to go through, they needed someone to tell them this was the right thing for them, and that there definitely was no other way of relieving them of their pain.

> "*I was only giving them how I felt. I was giving them all of that and thinking, "You use the calculator, and hopefully the equation should add up to what qualifies me to get through." Didn't care, because if it wasn't that, then what was it?*" (Fran, 408-412)

Fran states she does not care about the external approval, yet she says she hopes the information adds up to what qualifies her to get treatment. This indicates that this tendency is about receiving validation of what one is feeling and experiencing; for someone else to tell them this is valid and that they have the right to need treatment for it. Similarly, in table 3's example above, Ella knows she is trans, yet seeks out the psychiatrist's view on whether this is appropriate. This tendency frequently emerged in the data, and many participants expressed sympathy for their families or doctors, who did not accept or understand them straight away. It seemed as if they were all allowing others and the system to adjust, just as they had been doing in their own lives up until that point. As such, this stage also seemed to be a time of considering the reality of the transitioning process in more detail, and the potential impact it might have on close relations. One participant expressed his parental considerations in this way:

> "*(…) err, and so for me it was an enormous decision to take hormones. Enormous. And as such I put it off for several years. I didn't want to have to put my… from the point of view of a psychotherapist, I didn't want to have to put my children through, err, grieving for the loss of a mother, very young."* (Andy, 15-20)

It should be noted how early in the interview this statement is made, as indicated by the line numbers after Andy's name above. It seems as if one of Andy's very first considerations was: am I failing as a parent if I do this? Or even, have I failed as a parent by being trans? The implied guilt or self-blame here witnesses of an emotionally difficult decision-making process, alongside an appreciation for what this journey is like for both families and the professionals.

> "*They [GICs] haven't got no magic wand, which I imagined when I walked in that they did. But as you sort of sit there, then you realise there's another human being in front of you.*" (Fran, 212-215)

3.3.1.3 Subcategory: Having No Choice

Category	Subcategory	Focused code	Initial code	Core text	Participants
Identity frustration	Having no choice	Feeling so uncomfortable being mis-gendered that it triggers a physical reaction.	Feeling creeped out by female pronouns to the extent of physically cringing.	"Female pronouns creeped me out. Like, I just physically cringed if someone called me a girl and stuff." (B, 117-118)	ABEFG

Table 4: Category 1, subcategory: Having no choice

Towards the end of the first stage of the decision-making process, it was found that a point had been reached where the need to transition was so great, entertaining the idea of potentially not doing so seemed to have been eliminated. As one participant put it:

> "*Yeah, it's kind of accepting the inevitability of it, or (pauses) just… you can supress it, but that's only going to lead to mental problems. Err, and of course the other option is suicide.*" (Ella, 210-213)

This is also the point at which the fear of death begins appearing, as part of the realisation that one may not survive if treatment does not commence. As such, extensive studying of what such treatment will involve takes place in preparation. The example in table 5 above sees Ben describe the physical reaction he had to being mis-gendered, and as this example indicates, it seems the emotional struggle participants are experiencing is now reaching a sense of urgency, which was not previously there.

3.3.2 Category 2: Meeting the Gate-Kept World

> "*The whole time I was insistent that I wanted to start hormones, and I was really frustrated by waiting, like, three years before I finally got prescribed hormones in X (town). But I knew from the beginning that was exactly what I wanted. And everyone just kept telling me 'oh, you have to wait and like, make sure you're ready' and that kind of stuff.*" (Claire, 16-22)

The second stage of the decision-making process to begin hormone therapy bears themes of feelings of disappointment with and rejection by the system. The difficult emotional experience of waiting for treatment is also explored in great detail by the participants. As indicated above, participants seemed to get the feeling the system and clinicians in it did not want to help them, and a frustration and lack of understanding for this was thus expressed.

> "*But when I first went, I was a bit anxious that I'd say the wrong… you know, put my foot in it and get booted out, you know, because I wouldn't give the correct answer (…) I was thinking I really didn't want to say the wrong thing, you know. This person is the gatekeeper. And I've got to get past this person, so I've got to say the right things.*" (Danielle, 537-546)

As another participant indicates here, the hurt and frustration of being gate-kept is also accompanied by intense fear that treatment will be refused or denied, seemingly making communication and the development of a relationship with the system very difficult.

3.3.2.1 Subcategory: Nobody Understands

Category	Subcategory	Focused code	Initial code	Core text	Participants
Meeting the gate-kept world	Nobody understands	Wondering why the system would not help.	Thinking the idea behind the system delaying her transition was that it was because she was quite young.	"I think the idea was that it was because I was quite young." (C, 25-26)	ABCDEG

Table 5: Category 2, subcategory: Nobody understands

> "*They don't know how. So they'd rather do nothing than end up doing something wrong, but like, they're just so paranoid about doing something wrong that they're afraid to do what they already know is right. I know we've lost at least three trans men last month to suicide. I know that much. In this country. They're dying on the waiting list. They're killing themselves on the waiting list.*" (Gary, 601-609)

As one participant notes here, a realisation seems to take place at this stage that the system is not working as intended. Essentially, it was found that these processes which are in place within the health care system to help trans patients, feel unavailable or inaccessible, and that some trans patients are ultimately not able to make it through.

Moreover, it was found that when time and resources were available, these were spent on assessments and conversations that felt unnecessary to the participants, leaving them disappointed and no more supported than they felt before:

> "*It always seems like an interrogation when you go there. Like, two and a half hours of somebody sitting there asking you really inappropriate… like,*

> *personal questions. It’s like, I don’t like this. Don’t really want to open up about stuff to them.*” (Ben, 514-518)

It is as if the participants are beginning to feel the system does not want to help them, and they begin to wonder why that is. This in turn creates a felt disjointedness between the person and the system, as indicated by one participant here:

> “*You have to be mentally stable. So if you have depression, it has to have not changed in its magnitude for the last… random amount of time. An abstract amount of time*.” (Gary, 530-533)

In this quote, Gary is talking about the NHS requirements for transitioning, and particularly the requirement that all mental health problems have to be stable. He makes it clear that he finds this requirement hard to understand, and seems to have given up even trying to understand. It seem that when Gary, after years of agony, finally took the risk of opening up about his struggles to the system, he felt unsupported. This tendency was found to be very common, but is perhaps an unhelpful one, as it led participants to shut down, creating a disjointedness between them and the system, which could potentially provide treatment.

3.3.2.2 Subcategory: Me vs. Them

Category	Subcategory	Focused code	Initial code	Core text	Participants
Meeting the gate-kept world	Me vs. them	Worrying about being caught not cross-dressing.	Finding she made sure to cross-dress every day. Suspecting the psychology people know how one is living.	"I never did any cheating. I never went: "I'm not crossdressing today because nobody is looking at me." I put the clothes on. Those psychology people tend to know how you're living." (F, 248-215)	ACDFG

Table 6: Category 2, subcategory: Me vs. them

At this stage, disjointedness between the trans patients and the system intended to look after them appears to have been created. This seems to be happening partly due to the uncomfortable encounters they have each had with the system and the clinicians within it, and partly due to a felt need to ease emotional pain by lowering one's own expectations significantly.

> "*She's, err, she's the clinical at X (GIC), that I saw. So she's a doctor, a psychiatrist, whoever she is, whatever qualifications they feel they need to have.*" (Gary, 49-51).

This quote suggests an interest to even know what kind of clinician the participant is seeing is no longer present and additionally further emphasises the felt divide between the person and the system, which was previously indicated. It should be noted that Gary goes from wondering what qualifications this clinician holds, to even wondering who she is, which may be seen symbolically as him removing himself further and further from her as he is talking. This tendency is also seen in table 7’s example above, where the term “*those psychology people*” is another indication of this felt divide. What might also implicitly be said here is “how am I meant to know what these people expect of me, when I do not even know what they are?” and as such, a sense of injustice is also suggested.

A few of the participants do point out that they find the tendency to make an enemy of the system unhelpful, as noted by one participant below. It seems as if she wonders whether the system was not helping her, or whether she was not accepting their help.

> “*I didn’t want to be there, so I wasn’t really communicative at all. Like, I probably got in the way of my own treatment a little bit to be honest.*” (Claire, 268-270)

3.3.2.3 Subcategory: Experiencing Rejection

Category	Subcategory	Focused code	Initial code	Core text	Partici-pants
Meeting the gate-kept world	Experiencing rejection	Experien-cing a strong emotional response to feeling let down by the system.	Being told by his GP to bring his privately acquired hormones to be injected there. Experiencing being told NHS time could not be used on his injections, and crying as a result.	"(…) because my GP was like: 'yeah, it's fine, you can get this stuff from X (*private GIC*), bring it here and we'll do your injections here.' Fine, booked an appointment with the nurse, turned up with the box like: 'can you inject this please?' They were like: 'no, we can't use NHS time on this because you got it privately.' (…) I cried and cried and cried (…)" (G, 69-77)	ABCDEG

Table 7: Category 2, subcategory: Experiencing rejection

A theme of felt rejection was present across many areas of life, however, the two most prominent ones appeared to be a felt rejection by one's family and a felt rejection by the system. When familial rejection was brought up, it was either accompanied by an expression of understanding for that family member and a recognition of the difficult nature of what they must have been going through, or it was accompanied by a notion that these people were not important anyway, and that the fall-out was probably for the best. This suggests a slight avoidance of engaging with the difficult feelings that may be associated with the experienced rejection.

A similar trend was found regarding feelings of systemic rejection, predominantly demonstrated with an action of disjointedness from the system. An example of such experienced rejection by the system is shown in table 8 above. Here, the participant describes how he went into his meeting with the system, almost blasé about it, blindly expecting the system to help him, and then having this experience of having the door slammed in his face at such a very critical and fragile moment. Note also the lack of understanding there seemed to be for what this must have been like to hear. In Gary’s experience, the clinician just gave him the information that they could not help him, and sent him away. The intense emotional distress that followed experiences of rejection, and the felt loneliness with that distress was common throughout the data.

3.3.2.4 Subcategory: Waiting

Category	**Subcategory**	**Focused code**	**Initial code**	**Core text**	**Participants**
Meeting the gate-kept world	Waiting	Expressing frustration of knowing what would help the emotional struggle and being asked to wait a long time for it.	Experiencing having to wait three years for hormones as frustrating.	“(…) the whole time I was really insistent that I wanted to start hormones, and I was really frustrated by waiting, like, three years (…)” (C, 16-18)	ABCDFG

Table 8: Category 2, subcategory: Waiting

> “*So all of that time was an existential limbo (laughs), err, and it was nine months. And I’m aware that that’s not forever, but it felt like it. It certainly felt like a gazillion years. Have you seen Titanic? You know when she starts*

> *in the beginning, she says: 'it's been 84 years,' (laughs). It felt like that, definitely. Forever and ever, never going to end.*" (Gary, 695-702)

The fragile emotional state one appears to be in upon seeking out hormone therapy has been touched on in previous categories above, but this quote captures nicely how to some extent, it does not actually matter how long the wait was, because the *felt* experience was so intense. This is further suggested by another participant, who described his experience of being told to wait in this way:

> "*I think the strongest emotional response I had was when I initially went to see the GP. Now, bearing in mind that I'd spent several years agonising over this, finally coming to the conclusion that it was unavoidable, finally coming to the conclusion that I had to ask for help, finally getting to see my GP, and then I'm told I've got to wait two years. That was heart breaking. That moment was really emotionally devastating.*" (Andy, 311-318)

The most prominent theme within this subcategory was how intensely agonising the process of waiting was. It was found that the participants were experiencing a sense of urgency upon seeking hormone therapy, because they were already stretched as thin as they could be, emotionally. As such, it appeared a 'crisis' state was being entered, which needed immediate attention, hence the strong emotional response upon learning that was not going to happen.

3.3.2.5 Subcategory: Learning a Script

Category	Subcategory	Focused code	Initial code	Core text	Participants
Meeting the gate-kept world	Learning a script	Feeling it necessary to be cautious about disclosing gender identity in fear of having treatment delayed.	Deciding to tell the gender clinic that he identifies only as male due to having heard that doing otherwise may delay treatment.	"I've heard stuff that being non-binary… that if you say you're non-binary, like, it'll take longer for surgery and stuff. So like, I've only told them I identify as male." (B, 521-524)	ABCDEG

Table 9: Category 2, subcategory: Learning a script

> "*It's a tick boxing exercise all the time*." (Ben, 542)

Following the harsh realisation that the system does not work as intended, or that it is not what one had hoped for, various tactics appeared to be implied as a coping mechanism or strategy for navigating through this system. One such tactic was found to be the act of 'learning the script.' Participants reported gaining knowledge, either by their own experiences or by the experiences of trans peers, of what they would need to tell clinicians in order to obtain the treatment they needed.

> "*You always worry about what you tell them because you know what you want to achieve, and it doesn't matter how many people tell you otherwise, you'll always think that maybe they'll find a reason for not giving me what I want."* (Ella, 404-407)

As indicated in this quote, it seems a feeling has developed that one can never be too careful, and that it does not actually matter whether the information given to the clinicians is true or not, it just matters that it is the right information for the purpose.

As such, participants did not necessarily report that they directly lied to the clinicians, rather, many of them reported having lied by omission and left information out that they felt might complicate matters.

> "*Err, so for example, a classic one, very well-known now, is trans women, just before surgery they choke the chicken just the once. It's a standing joke because you're just about to lose it. It's almost, err… it's not an urban legend, it happens. It's like, just the once, just to see, you know? But you can't confess that to the clinic, because they'll say 'Ahh! So you do enjoy it. That's it, cross, you're not having it.' So it's like one of those things that's a known secret. You know, it's ridiculous.*" (Andy, 701-709)

The 'known secret' in the quote here shows the aforementioned tendency, but is also important because it indicates just how far removed this participant feels the system's understanding of what it means to be trans is from what it actually means to be trans. Whilst the ridiculousness of this was sometimes talked about with humour as above, an urgent need for better psychological support was expressed throughout the data. That is, aside from more supportive staff who are assessing medical needs, psychological support on a deeper level was found to be both missing and missed.

> "*Err, but I did feel a little bit like… partly like the GP hadn't maybe ever encountered this before, and partly like he was trying to understand on a personal level why I would want to transition at all. Like, he seemed to want me to justify exactly why I felt that way. But, like, I was not interested in talking about that at all."* (Claire, 33-38)

With the need for understanding and support unmet and instead the continuous experiences of being asked the wrong questions, participants appeared to employ a variety of mechanisms for surviving the journey. These mechanisms formed a category, as explored in the next section.

3.3.3 Category 3: Survival Mechanisms

As the category of survival mechanism is broached, it is worth nothing that this was the category found to be most emphasised and most prominent throughout the data. Arguably, all the categories and subcategories explored so far have all had a theme of 'survival' in them, as will the remaining ones. It seems that this decision making process at its essence is a process by which already fragile individuals enter a world of further struggle and challenge. As such, at the heart of this process seems to be the strategies and mechanisms these individuals employ to survive it.

3.3.3.1 Subcategory: Activism

Category	Subcategory	Focused code	Initial code	Core text	Participants
Survival mechanisms	Activism	Focusing on the struggles of others as her own became too difficult to manage.	Finding that helping others took her mind off herself.	"Carried on with what I was doing. Put myself out there, working out there, doing everything I could do and helping others, which takes you off yourself." (F, 284-286)	AEFG

Table 10: Category 3, subcategory: Activism

The first survival mechanism identified was ‘activism,’ as most of the participants had devoted their career to helping and supporting trans peers. One participant even implied having devoted his own transition to this cause:

> “*I did seriously contemplate going private because I was very tired of fighting it. But I also had, err, I also felt it was really important to fight to be able to have it, the top surgery, without hormones, because there were going to be people coming after me who would want the top surgery without hormones, and I thought: if I give up, they’re going to have to do the fighting instead.*” (Andy, 420-426)

In this quote, Andy is talking about the fact that he wanted his breasts surgically removed before starting hormone therapy, and the fact that he generally finds it to be an issue that within the NHS, transitioning is a static process not tailored to the individuals going through it. Andy waited seven years for hormones, which in his experience was a direct consequence of wanting to transition in this order. Honourable as fighting for this on behalf of others coming after him is, the tendency to act as an activist in support of the trans cause was understood to be a survival mechanism due to the soothing nature doing so had for the participants themselves. As Fran notes in the example in table 11, supporting and helping other trans people acted as a helpful distraction from one’s own struggles. Arguably, it could therefore also be seen as a form of displacement, as being angry with or hurt by the system on behalf of a client or a colleague may feel easier than being so on behalf of oneself. I also wonder whether the subconscious aim of this tendency is to be the person for somebody else that nobody was for them.

3.3.3.2 Subcategory: I guess it Could Have Been Worse

Category	Subcategory	Focused code	Initial code	Core text	Participants
Survival mechanisms	I guess it could have been worse	Avoiding addressing the pain of parental rejection by focusing on the supportive aunt.	Finding transitioning would have been a lot harder, had he not had his aunt and college.	"And because I had a lot of support from my aunt and college, it would have been a lot harder." (B, 443-446)	ABCDEFG

Table 11: Category 3, subcategory: I guess it could have been worse

As seen with the tendency to act as an activist, various other defences were found to act as survival mechanisms throughout the process. These other defences or tendencies included the use of humour when talking about difficult material, rationalising, placing emphasis on the few kind or helpful encounters experienced, and lastly, but perhaps most prominently, noting the fact that it could always have been worse, and that other people do go through worse.

An example of the emphasis on good experiences is seen in table 12, where instead of commenting on the parental rejection Ben experienced, he instead continuously mentions the support he felt at school and from his aunt. Another participant offers an example of rationalisation, as she describes scientifically how a person becomes trans in the quote below.

> "*And of course we now know that during foetal development, there's a flow of testosterone at six weeks. All foetuses start as female, and that then changes those with XY chromosomes to male. But we also know that there's*

> *a genetic influence of how susceptible a foetus is to the effects of testosterone.*" (Ella, 138-143)

The notion is phrased almost as if others do not believe this, and think it is her own fault, but one could also wonder whether she implicitly worries herself that she somehow caused this, or that it could have been avoided. In line with that, she then uses scientific knowledge to emphasise to me, or perhaps to herself, that this was not her fault.

Finally, an example of the use of humour as a survival mechanism shows a participant mocking the process at the GIC. In this way, he makes this potentially very emotionally difficult process easier to talk about by making it funny when he points out how ridiculous it all was. As such, he avoids talking about the pain and even the fear of not surviving that he may have experienced at the time.

> "*I'm coming up to three years now, so yeah. Nearly two years to actually get my hormone levels right, because they were just like 'no, we need to put you through the thing, to do this step and this step and that step, and then we will do this.' And then they took a century to send the letter to my GP to say: 'yes, do prescribe the hormones please.'*" (Gary, 745-751)

3.3.3.3 Subcategory: Building Up to a Contest

Category	**Subcategory**	**Focused code**	**Initial code**	**Core text**	**Participants**
Survival mechanisms	Building up to a contest	Needing to brace self and concentrate to not let anyone get in the way.	Finding she was warned by trans peers not to listen to anyone, but to just keep her head down.	"I was warned ahead of time by trans people, like: "you don't have to listen to any of that stuff, like, just put your head down and get through it," and that kind of thing." (C, 275-277)	ABCEFG

Table 12 Category 3, subcategory: Building up to a contest

> "*So my life for 20 years was discipline. All I needed to do was implement that. Exactly what I'd taught myself then. I suppose I looked at it like I was building up to a contest. The contest would be to get on that table and have reassignment surgery. That's what I wanted, that's what I've always wanted."* (Fran, 437-442)

The final survival mechanism identified was the implementation of strength and self-discipline. As noted by Fran here, who used to be in competitive sports, a pattern appeared in which participants would talk about the times in their lives they had had to be the strongest, and try to create the same mind-set for themselves in order to survive the process. This tendency seemed to have its base in a fear one would not survive the process, which is also indicated in the example provided in table 13. Here, it is as if the participant fears that if she does not keep her head down and stay focused, she will slip and not survive.

It seems that due to the great emotional distress a person is already in once this process commences, they are way past the point of having the headspace to consider whether mocking the process or making an enemy of it is helpful in the longer run. Rather, all efforts appear to be put towards the here-and-now. As such, it seems a point of being in a state of identity crisis is reached, and starting to escalate, leading to the development of category 4.

3.3.4 Category 4: Escalating identity crisis

> "*They have reached a point where no matter what the fear, no matter what the terror, the insecurity, the shame… no matter what, they've reached a point where they're prepared to sit in from of a GP and say: 'I'm transgender. I need help.' They're in crisis. And at that point, they're told that have to wait two years. So I think, you know, bearing in mind that all transgender clients, once they get to see the GP and say 'I'm transgender,' they need urgent care. Not to be put on a waiting list of two, or you know, however long.*" (Andy, 597-606)

Employing an earlier identified survival mechanism of talking about the issues of trans peers, rather than one's own, Andy here captures the state of being in crisis, which is at the heart of this category. It should be noted that he begins to give the example waiting time of two years specifically, which was the exact time he himself had to wait for his first GIC appointment. He then stops himself, and goes back to making it a broader, systemic issue. It feels noteworthy that talking about the crisis itself is so difficult, a defence or survival mechanism needs to be employed to do it.

3.3.4.1 Subcategory: Point of No Return

Category	Subcategory	Focused code	Initial code	Core text	Participants
Escalating identity crisis	Point of no return	Experiencing an unbearable disconnect between lived and felt gender.	Feeling unable to live as a gender she did not identify with anymore. Feeling living as male was just not her.	"(…) as I said, in the end I was getting up in the morning thinking: "I can't do this anymore. It's just not me." (E, 168-169)	ACDEFG

Table 13: Category 4, subcategory: Point of no return

It was found that at the beginning of each person entering the stage of escalating identity crisis was a point of no return. At this point, something would switch inside that person's head. For some, this just would be a sudden 'aha' moment of having had enough; for others, a specific experience would be remembered and retold in detail.

> "*I remember a day we were going shopping somewhere and, well my house is towards the end of a fairly long cul-de-sac, and I was looking out of the door for anyone to see me getting into the car, and I suddenly thought: "I'm 63 years old, why am I still hiding?" Like, "why am I still hiding? I'm a grownup! What do I care what people think anymore!" It was that that prompted me to phone the doctor*." (Danielle, 171-177)

In this example, it seems that for Danielle, looking out the door to check if the coast was clear was a regular occurrence, and that the peculiarity of it was never questioned until this very moment, in which a sudden, irresistible urge to never encounter it again came over her. Another participant experienced a similar moment. Here, it was triggered by a comment:

> “*Err, I had a kind, pleasant young man, a waiter in a restaurant, while I was suited and booted, feeling like the king of the world, beautiful woman on my arm, you know, pulling out the chair for… seated her, sat down. And he said: ‘so what can I get you ladies?’ And that was like the last straw. I literally looked at him and thought: I’m going to have to go on hormones*” (Andy, 60-64)

Again, being mis-gendered in this way was likely a regular occurrence, however at this particular time he had had enough. This example also highlights the need for the inside to match the outside, which several participants also reported to become greater and greater with time.

3.3.4.2 Subcategory: Nothing Else Matters

Category	**Subcategory**	**Focused code**	**Initial code**	**Core text**	**Participants**
Escalating identity crisis	Nothing else matters	Expressing happiness about the physical pain because of its outcome.	Feeling fine about having to inject himself for the rest of his life because he gets to grow a beard.	“I have to stab myself 15 days of the year for the rest of my life, and I am fine with that. That is just fine. Because I get to grow a beard.” (G, 374-376)	ABDEFG

Table 14: Category 4, subcategory: Nothing else matters

As the point of no return has been reached, it seems participants are no longer willing or able to negotiate with themselves or anybody else. The fact that they need treatment is no longer negotiable, and neither is the time scale. It has become clear that this is necessary to their continued existence, and as such, no risk or consequence is great enough anymore to call that into question.

> "*Well, I have had a heart attack, and the [hormone] tablets have kind of contraindicated that if you have heart problems… But I'd rather have the attack. I saw the GP and he said: 'you do realise that it isn't a good idea to be on these tablets? You know, it's not really brilliant,' he said, and then he said: 'but you're not going to stop, are you?' And I said: 'no.'* (Ella, 100-106)

> "*I had no fears about what was happening to me, no fears that his hand might slip, or any of the things they quite rightly tell you could happen. I wasn't afraid of any of those. I was afraid (giggles) that it would be delayed."* (Danielle, 338-342)

For both of these participants their accounts were told with such calmness. One even giggled throughout, suggesting an awareness of how extreme this may sound. It just does not seem to matter. In fact, one participant even expressed a sense of pride or satisfaction with the health risks he was facing, as these seemed to make him feel more like the felt gender, and as such, he identified with them:

> "*(...) and being on hormones increases your risk of heart disease. And I'm like 'it increases to the male range.' I don't really care that I increase to the same as a cis male, like, it's like now I'm in the right category of heart disease and heart problems*." (Ben, 397-401)

3.3.4.3 Subcategory: Fearing Death

Category	Subcategory	Focused code	Initial code	Core text	Participants
Escalating identity crisis	Fearing death	Feeling overwhelmed by distress to the point of contemplating suicide.	Thinking that jumping out from the 12th story would be the end of her problem.	"I was living in a tower block at the time, and looked out at the 12 stories down and thought, 'well, that would be the end of the problem.'" (E,190-192)	ACEFG

Table 15: Category 4, subcategory: Fearing death

In the final subcategory of the 'escalating identity crisis' stage, a fear of death was identified. It is important to emphasise here, that this is *not* a fear of the medical risks associated with transitioning, but rather, it is a fear of dying if the medical transition does not take place.

> "*Because I needed control over it. Because it's my body, and I needed to do what my body needed me to do in order to keep it going*." (Gary, 268-271)

This participant is talking about the symbolic importance to him of doing his own injections. It is almost as if he is saying "I was dying, and nobody was trying to save me, so I had to do something to try and save myself." This stage of fearing that one might actually not survive comes at the tail end of a long and agonising process. The anxiety and distress of this experience feels important to highlight in order to understand the emotions, behaviours and mechanisms implemented in it.

3.4 Conclusion

As explored in this chapter, the category of realising and accepting one's own trans identity was found to be the first stage in the decision-making process to take hormones. It appeared the acceptance however is not a product of coming to terms with who one is, and being truly non-judgemental of that. Rather, the acceptance relates to the inevitability of it all. It seems there almost was not time to really accept oneself, due to the urgency for emotional relief. This felt important for how fragile a person can then feel, going forward in this process, and entering a system which may feel flawed and unhelpful, and the strategies one implements for surviving that. When meeting the gate-kept world after having sought out treatment, it appeared that ultimately it did not really matter whether it was a lack of knowledge, because they are learning, because they are busy, or because they do not care. It seems that regardless, this apparent systemic problem seemed to lead to great emotional distress, as indicated in this quote:

> "*It's like, I got a new neurologist, and the nurse there started asking me really inappropriate… well, not quite inappropriate, but like questions about transitioning, and like, how I peed and in which bathroom, since she found out I was trans. And I'm like 'why do you need to know that?' 'Oh, it has to go on your medical notes.' And I'm like 'what's that got to do with my ears?'*'" (Ben, 370-379)

The problem here is that regardless of the reasons for the clinician asking these questions, it has left the patient feeling inappropriately treated, widening this gap between the clinicians and the patients. In this way, what the category of "meeting the gate-kept world" implies overall, assuming the aim is to ensure people receive the correct treatment, is that gate keeping does not work, because this treatment is not experienced as helpful. Interestingly, one participant, who is talking about her use of online peer support as a survival mechanism, does point out the potential unhelpfulness of behaviours which widen the gap between trans people and their professionals, however; as the word choice in ‘from a survival point of view’ suggests, it felt necessary for her survival at the time.

> “*Err, I think it was helpful to me just from a survival point of view, whereas I was, you know, really desperate for something that I had to wait a long time for. It was nice to just have that solidarity of, you know: ‘if you keep trying, you will eventually get there’ – kind of thing. And then from another point of view, maybe not as much, in that I think it discouraged me from trying to work with the professionals I was seeing.*” (Claire, 292-298)

It seemed participants entered a state of “escalating identity crisis,” which could only be resolved once hormone treatment commenced. Within this decision making process, obstacles were encountered and survival mechanisms implemented and it seems as if the decision to continue the pursuit of hormones was made over and over, until this final stage, where the decision to take hormones was ultimately made.

Chapter 4: Discussion

4.1 Reflections

In the first reflexive statement of this study, I asked myself to stay aware of whether this work has any value to the good of humankind (Blakemore et al., 2009). I think it does, and it is my hope that by the end of this chapter, it will be clear to the reader exactly why, as well as how we as counselling psychologists can benefit from knowing that.

I also noted in the beginning of this study that this research might influence my understanding of gender as a concept, and it most definitely has. Moreover, it has influenced my understanding of the clinical impact of this understanding. That is, when I now hear colleagues ask clients on the phone what gender dysphoria is, or when the receptionist calls to let me know a client has arrived, and uses the wrong pronoun, I think extra hard about what that must be like for the client. I think about what it must be like for somebody who is already in crisis.

A reflection that has been on my mind since this study commenced, is the notion that I can never truly understand what it is like to be trans, and the question has been that if I can never truly understand, how can I help? What I have realised in relation to this is that clients often want to know whether I am like them in a way that is relevant to what they are talking about. They ask me if I have children like them, or if I am married like them. This idea that sameness ensures some understanding is not unique to trans people.

In the beginning of this study, I mentioned guilt about not being trans, and about being a part of a system or profession that does not understand trans people. But perhaps that is exactly why *I* needed to do this study. That is, I used to be one of the many people who think they know, but who truly do not. To an extent, I still am that person; the difference is just that now I am aware of it, and throughout this work I have learned just how important this awareness is. On this note, I have found that I used to implement surviving or coping mechanisms similar to those of my participants. Mechanisms to help me cope with my lack of knowledge about what it is like to be trans, and with the guilt I felt for that lack of knowledge and for not feeling that pain. This led me to an important part of my motivation for this project to begin with. Perhaps my taking such an interest in this population, a population that "has it worse than me," is me implementing a survival mechanism myself. When discussing the subcategory "activism," it was noted that this behaviour might ease a person's emotional distress both because it might be easier to address someone else's pain rather than one's own, and because it can be a mode of distraction from that pain. Jung (1951) coined the term *wounded healer,* and suggested that people are motivated to become psychological therapists because of their own wounds. The concept of the wounded healer seems to fit nicely with what might be going on for the participants of this study who employed activism, and certainly those who had gone into psychological therapies themselves. Upon reflection, I also think it fits what was going on for me, because as well as accidentally stigmatising others myself, I also know what it is like to be accidentally stigmatised; whether it be because of my nationality, my sexuality, my age, or my gender. In this way, I think the choice to do this study was motivated, in part, by wanting to focus on someone else's pain to perhaps ease my own. I wanted to fight for better understanding of minority populations, but on behalf of a specific minority I do not belong to; one whose struggles seem even more difficult than my own, additionally implementing the survival mechanism “I guess it could have been worse.”

4.2 Summary of Findings

Based on the data collected in this study, a model of the different stages of deciding to begin hormone therapy was developed. The first of such stages captured early experiences of being aware of one’s identity. This stage included both an active effort to hide or supress this identity, and the development of a need for it to be shared with the world. This need then led to a meeting with the system, and subsequent feelings of being rejected by the system as a whole, and by individual clinicians working within it acting as gatekeepers. Following these experiences of being misunderstood and not receiving the necessary or adequate help, survival mechanisms were developed. These various mechanisms were found to help individuals get though the emotional struggles of this process; however, due to long wait for treatment and the system being perceived as unhelpful and unwilling to help, an escalating identity crisis stage was found to occur. At this stage, individuals felt that there was no going back and that beginning hormones would be necessary now for their continued survival.

All participants also expressed reaching a stage of emotional relief once hormone therapy commenced. A point had been reached where the outside and the inside now matched, the emotional distress was eliminated, and one’s survival was no longer under threat. It seemed easier for some participants to talk about the distress they encountered when it was phrased as something that was no more. A pride of being trans was expressed relating to taking ownership of one’s own journey, and changing it in the narrative from being a problem, to being a solution. Within the subcategory “needing others to see what I see," many also expressed understanding for the fact that this is a learning process for everyone involved. It was emphasised that this treatment was much better than no treatment at all; it was almost as if they wanted to ensure it was known that they were not ungrateful. I wondered whether this expression of gratitude could also be understood as a survival mechanism in itself. Indeed, it does arguably bear resemblance to the subcategory "I guess it could have been worse." However, here it is phrased not only as a need to minimise one's own emotional suffering, but also as an almost unwillingness to remember how difficult it was. The literature does suggest a vast decrease in emotional suffering and increase in quality of life once treatment commences (e.g. Haas et al., 2011; Gorin-Lazard et al., 2012; Tucker et al., 2018).

As this research set out to understand the decision making process of beginning hormone treatment, how participants felt afterwards is somewhat irrelevant to the research question, and "relief" was therefore not included as a category in the analysis. However, its presence should be noted as it is relevant for my overall understanding of the implications of these findings.

4.3 The Decision to Take Hormones as a Stage Theory

As discussed in chapter one, some of the epistemological issues faced by a homosexual individual may also be faced by a trans individual (Merryfeather, 2011). I want to be careful here not to shoehorn or suggest there is a clear distinction between which aspects of this theory apply to a trans person and which do not. Yet, thinking about social constructivist principles of using what is useful only (Blakemore et al., 2009), Cass' (1979) findings on the formation of a homosexual identity are worth mentioning here for comparison purposes. Comparing the current findings to the Cass (1979) model of the formation of a homosexual identity, *identity confusion* and *comparison* can be seen as alike “identity frustration,” and *identity tolerance* and *acceptance* as alike “meeting the gate-kept world.” In particular *identity acceptance* seems a crucial point here as this is where the need for the survival mechanisms arguably arises because one is trying to enter *identity pride* and *synthesis*, but is unable to do so because of all the barriers, which leads to the crisis. This also shines a light on an important difference between the formation of a homosexual identity and the decision-making process to begin hormone therapy in that for trans people there are external barriers. A clinician or ‘gatekeeper’ does not need to “approve” a homosexual identity and there is no need for specialist external help or treatment for the identity to fully form. Regarding this particular comparison, this might also explain the addition of an *escalating identity crisis* stage in the decision-making to take hormones, which does not take place in homosexual identity formation.

It should be noted that Cass’ (1979) theory has been criticised for being out-dated, and for seemingly operating under the assumption that one knows very little about homosexuality initially (e.g. Lipsitt, 2014; Svetina, 2014). For both gay and trans people, this is arguably true for some and not others, depending on many factors such as generation and culture. Some participants did mention having no idea what being trans was, and knowing no other trans people whose experiences they could draw on. The criticism is worth noting though, and the point here is merely to point out the similar stage-like process in this theory.

Another stage theory which can be compared to the decision-making process to start hormone treatment is Kübler-Ross’ (1969) five stages of grief, which are *denial, anger, bargaining, depression*, and *acceptance*. While this model was initially developed to characterise the process of dealing with being dying or the death of a loved one, it has emerged into a popular model of personal change (Kübler-Ross & Kessler, 2005). With the established model of this study in mind, the stage of *bargaining* is seemingly relevant here. Yet, this should not necessarily be viewed as a stage in this instance, but almost as a survival mechanism, in which individuals are trying to retain some control over things in a process where so much is out of their control.

Zandvliet (2000) described transitioning as a process of migration that individuals are not always prepared for, and as such, a sudden sense of loss and a subsequent grieving process takes place. Grief within the family has been suggested in the literature (e.g. Emerson, 1996; Norwood, 2012), but it was not possible to find any studies addressing the potential grief the trans person themselves may be experiencing. McAlearney et al. (2015) found the five stages of grief to apply when a life change occurs in which knowledge is lost. In this instance, trans individuals may grow up with the idea of themselves living their lives as the assigned gender, but once the point of no return has been reached, they are stripped of that idea and now have to adjust thoughts and plans for the future. However, this time it is without preparation or the experiences of people like their parents to mirror.

Within "knowing from an early age," an initial refusal of the trans identity was expressed, with one participant stating that she felt only freaks transition, and that she was not a freak. Thinking about Kübler-Ross' (1969) stages, initial *denial* was implied here. In the category "I have been trans for as long as I can remember," several participants described a sense of fighting the inevitable. In this way, parallels can be drawn to Kübler-Ross' *bargaining* stage again, in that people are trying to negotiate with a non-negotiable fate. I wonder whether this tendency, at least in part, is encouraged by society. We have constructed the idea that there is a certain way of being, and that it is better to be in this way, and that differing from the norm should be avoided where possible. In this way there may be an almost unconscious first response in a trans individual of feeling this is something they need to fight, similar to how the first response to the concept in society being that it was something that needed to be fought (e.g. Milton, 2015: Murjan & Bouman, 2015).

Finally, as participants expressed a sense of relief once hormone therapy had commenced, this could be viewed as akin to *identity pride* (Cass, 1979) and *acceptance* (Kübler-Ross, 1969).

4.4 A Big Deal

As established above, the prospect of transitioning was considered very life altering by all participants, and many difficult considerations took place. These were considerations of the perceived stigma held by others but perhaps also by self, and of the impact this would have on one’s life as well as loved ones, particularly for those who had children. It was both established in the literature (e.g. Zandvliet 2000; Yarhouse, 2015) and clear from the collected data that the decision to begin hormone treatment was huge. In the category “identity frustration,” an understanding was expressed for the fact that everyone is learning and that this is a big transition for everyone. This was somewhat surprising, as the literature suggests that feeling angry or frustrated towards those who do not understand would be more likely (e.g. Poteat et al., 2013; Lyons et al., 2015). The participants in this study also expressed such feelings, but they were expressed alongside an understanding of why there was a lack of support or knowledge. This was perhaps due to the ability to relate to being in a state of ‘bargaining’ with the inevitable themselves, as discussed above.

It seemed the anger and frustration only came later, once the decision to seek out hormones was made, but the process was being slowed down by external factors, such as waiting times and NHS requirements. Once participants learned that they had no choice in the matter and moved towards the earlier identified "point of no return," an eagerness was expressed, and potential consequences were discarded. Several participants expressed a direct disregard for potential physical health risks associated with hormone therapy, and one even expressed a sense of identification or belonging with an increased risk of heart disease, as this was considered *more male*, and thereby aligned with the felt gender. It seemed most of the emotional distress in the early stages of this decision-making process was caused by this friction; a friction between worries that one had failed as a parent, spouse or child, and the intense need to be who they truly were.

4.5 Problems Identified

4.5.1 Coming In By the Van-Load, Already in Crisis

Throughout the data, it appeared, for reasons established above, that hormone treatment was not sought until it felt like the absolute last resort. Being at this point of crisis, it seems participants were turning up to the GICs with little fight left in them, but at this point, their emotional struggles clashed with a systemic one. That is, as one participant put it, people are coming to the GICs "by the van-load." In the year between 2016 and 2017, the UK saw a 55.35% increase in referrals (Westcott, 2018), so this study by no means wants to suggest that the GICs are not doing everything they can. However, as noted by Westcott (2018), despite repeated pledges to get the GIC waiting times down, these are still on the rise. It therefore seems this systemic problem will not be resolved anytime soon, and as the results of this study demonstrate, whilst the reasons why urgent support cannot be provided may be good, the reality is that these people need it.

As noted by Backmann and Gooch (2018) in chapter one, it is a common fear amongst trans people that they will not be able or strong enough to make it through the excessive waiting times. Lemma (2012b) mentioned experiencing a countertransference response of feeling this sudden sense of urgency and an acute appreciation of how much this person is struggling when working with trans clients. According to Bouman and Arcelus (2018), professionals should be aware of that and of what trans people have already gone through psychologically before accessing care, and be mindful of that when interacting with them. They also note that unnecessary questioning of people's readiness to move forward and the subsequent delays this may cause only serves to damage professional relationships. It should be noted here that one participant of this study had de-transitioned, and interestingly, when looking back at that time, she still felt the delays and excessive questioning at the time did not change anything, but merely made her more frustrated and distressed. This finding is supported by Murjan and T'sjoen (2018), and suggests that the good intention to ensure transitioning is right for that individual merely increases distress and has little impact on the outcome.

The notion that people are already in a state of crisis when seeking out treatment is also supported by research regarding the tendency to self-prescribe hormones. Studies showed that 25-30% of people attending their first appointment at a GIC reported already self-prescribing hormones (e.g. Rotondi et al., 2013; Benothsch et al., 2013). Similar statistics were found for the UK, where this number was reported as 23% (Mooney et al., 2017). It should be noted that none of the participants of this study reported any self-prescribing, though they all expressed understanding for why people do it, and one participant did seek out hormones privately whilst waiting for his GIC appointment. As the results of this study indicated, it seems people reach a point where they are so desperate for this treatment that the risks of things like liver failure and death (e.g**.** Bouman & Arcelus, 2018; Garofalo et al., 2006) no longer matter. This disregard of risks to one's life may not initially indicate an eagerness to survive; however, what the current findings indicate is that that is exactly what it is. It seems people are just not rating the risk of dying by liver failure as great as dying by suicide if treatment is delayed any further. Indeed, studies show trans people to be at significantly greater risk of suicide than the general population (e.g. Wolford-Clevenger et al., 2018; McNeil et al., 2012).

4.5.2 Being Misunderstood

The participants of this study frequently expressed a general feeling of being misunderstood or even stigmatised by health professionals. APA (2015) points out that just because a person is trans, it should not be assumed that their mental health difficulties are related to that, and Arcelus & De Cuypere (2018) note that undue attention should not be paid to one's trans identity upon addressing other health difficulties. Yet, one participant seemed to get the impression that all his health difficulties, both physical and mental, were being attributed by professionals to be related to his transition. As quoted in chapter three, a noteworthy example of this is when he reportedly attended an appointment regarding his ears, and was asked which bathroom he pees in.

The literature suggests feeling uncomfortable and scrutinised by professionals in this way is not unique to the participants of this study and highlights the unhelpfulness of this tendency (e.g. Bradford et al., 2013; Murjan & T'Sjoen, 2018). Moreover, Clements-Nolle et al. (2006) found the high rates of suicidal ideation to be linked, amongst other factors, with gender-based discrimination. This finding is also supported by the minority-stress model, suggesting that distress is more likely amongst minorities due to stigma and discrimination (Meyer, 2003); non-disclosure and negative expectations of how helpful the system would be are thought to be significant contributors for this minority (Testa et al., 2017). This research is very relevant to this study because it highlights the important role of the system and the professionals working in it, and the detrimental impact of how we come across can have on people.

Following difficult experiences with the system and an acknowledgement of the reality of how it works, participants seemed to experience a shift from telling their clinicians how they felt to telling them what they thought they needed to say in order to progress with treatment. This tendency led to the construction of the subcategory "learning a script," and is supported by the literature. In fact, Metastasio et al. (2018), who noted that clinicians need to gain a much better understanding of what trans people are going through emotionally, even argued that the current system is forcing trans people to self-prescribe hormones.

An "us" and "them" divide seems to have been created with the system on one side, and the people trying to make it through on the other. The participants of this study reported mainly finding support from other trans people via online forums, in which shared difficulties and suggestions as to how to overcome these were discussed. This has been argued to be unhelpful, not only because it widens the gap between patients and clinicians by, for example, encouraging people to lie or leave out certain details (Mesastrasio et al., 2018), but also because it can work as a communal way of disregarding potential risks associated with self-medicating (Littlejohn, Baldacchino, Schifano &

DeLuca, 2005; Valeriani et al., 2015). In this way, the system and the clinicians in it seem to become another hoop to jump through, rather than a source of support.

4.5.3 Gatekeeping and the Gap between Professionals and Individuals

The NHS guidelines, the questions clinicians ask and the judgements and decisions they make are presumably all in good faith. Nobody wants to give medical treatment to somebody for whom that treatment is not right, nor does anyone intend to deny treatment when it is right. However, the data in this study indicates that when decisions are made by professionals, which make no sense to the patient, a belief is created that the professional is somebody that does not want to help. One participant noted that GPs are actually able to prescribe hormones and according to Metastrasio et al. (2018), this notion is true. So when GPs do not prescribe hormones, it seems to create a perception in the eyes of the patient that even though they have the means, they do not want to help.

There appeared to be a consensus among the participants that the need to lie to clinicians came not only from a lack of desire on the clinicians' part to speed treatment along, but also from the fact that clinicians' understanding of what it means to be trans tends to differ from the reality. Several examples of this tendency were given in the interview, including flaws in clinicians' understanding of trans sexual behaviour and even of how gender identity itself was understood. One participant noted that they would not disclose their non-binary gender identity to their clinicians out of fear that this would complicate or delay treatment. Another mentioned not disclosing occasionally wearing tights, as this might compromise the clinicians' understanding of his male identity. Indeed, Hembree et al. (2018) noted in chapter one that in today's society, it is very difficult to get gender-affirming treatment if you do not identify with a binary gender and further emphasise the urgent need for clinicians to stop putting trans people in a box in this way. Arguably, a societally constructed understanding of gender has formed the basis of the way we medically treat trans people, and as the current study suggests, this understanding is problematic.

As discussed in chapter one, there is much research to suggest that a tendency to change or withhold certain information when speaking to a professional involved in one's treatment would be likely to appear in the data. As such, this tendency and the complicating impact it might have on the treatment was suspected. However, the anger and frustration accompanying this tendency was less so. This study found a real sense of resentment towards clinicians claiming to think they knew how to treat a trans person, but who were getting it wrong. Upon reflection, this is perhaps not surprising, and leads to an understanding of the gate-keeping factor as a two-way thing, where trans people appear to give the professionals less and less information and the professionals in turn make more and more assumptions and get it more and more wrong. According to Moody et al. (2015), this felt inability to be honest with clinicians is compromising for both mental wellbeing and suicide prevention, yet it seems that in the current environment, the gap between trans individuals and the professionals working with them keeps on widening.

In chapter one we saw Bouman and Arcelus (2018) suggest that clinicians ask trans people upon the first meeting with them if they are self-prescribing and if so, where they obtained the hormones. However, the results of this study suggests doing so carries a consequence of patients feeling they are being interrogated and thus widening the gap between trans clients and the professionals working with them. Questions like these, as well as the ways in which the system attempts to establish whether somebody would benefit from gender-affirming treatment may be counterproductive because of the gap it creates. As Metastasio et al. (2018) point out; people who have a good relationship with their clinician are more likely to tell them if they are, for example, self-prescribing hormones, suggesting the opposite is true when the relationship is not good. It could thus be argued that the issues and gaps identified here ultimately have a cost both to the trans person's mental and physical health.

4.6 Surviving the Crisis

Following the notion that the system's understanding of gender identity issues is problematic, the results of this study suggest the needs of trans people are not treated with an appropriate sense of urgency. According to Lemma (2013), trans people pursue medical treatment to relieve their intensely painful emotional incongruence, a notion which is clearly supported in the data of this study. In this way, asking people to wait several years for treatment is arguably, essentially asking them to live in intense pain for all that time, and it was therefore perhaps not surprising to find that a variety of complex coping mechanisms were implemented by the participants to survive it.

"Survival mechanisms" was the first category constructed in this study. Although the objective was to investigate the process, and not how it is survived, the presence of these mechanisms was so striking. Knowing what I know now, however, it seems impossible to understand the decision making process to take hormones without this aspect. According to Willig (2001), understanding how people make sense of and manage difficult situations is symptomatic of qualitative research, and that is exactly what "survival mechanisms" helps us to do.

4.7 Findings in Relation to the Research Questions

At the beginning of this research, four research questions were set. The first two questions asked how trans individuals decide to begin hormone therapy and what factors influence this decision. With regards to these questions, the model drawn shows this decision making process, and within it the factors influencing the process, such as feared rejection both clinically and personally, were discussed. The latter two research questions asked about the extent to which waiting time is regarded as a distressing part of the process and how health professionals are viewed. In answering these questions some systemic issues were identified, and this is arguably where the important implications for clinical practice lie. Bluntly put, it seems clinicians are not people whom trans individuals want to confide in. Whether it be about their physical or psychological health, a systemic understanding that it is best not to tell was found, and this sadly confirms the suspected gatekeeper issue.

When discussing the de-transitioned participant in this study, I suggested her story implies that systemic efforts to ensure transitioning is right for the individual before proceeding do not work. This is of course based on the account of one person only, however, it feels important to note because it taps into a wider issue. That is, it triggers the question of whether transitioning even can be looked at as the *right* or *wrong* thing for a person, because arguably gender is not binary and is internally experienced.

4.8 Implications for Counselling Psychology Practice

The findings of this study suggest that lack of trans knowledge amongst professionals working with trans people is a core issue. This finding is supported by the research, where Snelgrove et al. (2012) found that physicians themselves feel they do not know how to best provide care for trans people. Additionally, Murjan and T'Sjoen (2018) note that even if we wanted to, there is no clear pathway for clinicians wanting to specialise in working with this population.

As noted in section 4.3, trans people are arguably in a uniquely difficult position because of their need for clinicians to approve their medical transition. As such, a medicalisation of their identity takes place, which brings about some unique practice dilemmas. Both the cited research and the findings of this study has indicated that the persistent checking and 'ensuring' hormone therapy is appropriate for a person is neither necessary nor helpful. As such, it seems way the system fundamentally is designed needs to be changed. Based on the findings of this study it is argued that trans clients need to have more of a say in how they are attended to as an attempt to minimise this medicalisation of their identity. Bluntly put, a need is suggested here for listening to the trans clients and changing the procedures accordingly if we want them to be more open with us.

A need is also suggested for an increase in awareness of stigma and misunderstandings by professionals working with trans clients, such as misassumptions and wrong use of pronouns. As the findings of this study indicate, the continual misunderstanding of the trans population by professionals is problematic for several reasons. Not only can it add emotional distress to an individual already in crisis, but it may also further feed the 'us and them' divide and the gatekeeper tendency. It is therefore suggested that guidelines should be put in place around monitoring the assumptions we as professionals make. These guidelines should keep in mind that the point of us as clinicians is to help relieve the emotional crisis, not worsen it, and to implement this focus more effectively.

Furthermore, the gap between trans clients and the professionals working with them implicates a need for greater awareness of risk factors. The commonness of the tendency to self-prescribe hormones was suggested both in the literature and by the participants of this study. As noted earlier, this carries some serious potential health risks, both mentally and physically. Aside from these, and perhaps most importantly, the risk of suicide among the trans population was abundantly clear from both the previous and current findings. It is thus suggested that we as professionals are aware of that, and of the fact that the potential gap between us and our trans clients may limit the extent to which suicidal thoughts are shared with us.

As previously discussed, this study has taught me that I as a practitioner and as a person overestimated my own understanding of this population. Now, if I overestimated my understanding, and most of the clinicians my participants spoke to seem to potentially have overestimated theirs, it can be assumed this may not be a coincidence. At a recent conference I attended, it was advised that therapists and practitioners have a trans flag up in their practice to signal their friendliness towards this population. I think this is an important step in the right direction, but I also think it has to go further than that. As practitioners, we need to think about what we mean when we say we are trans friendly, and then live up to that. We need to be aware of the assumptions we make about our trans clients, and work to minimise their impact on our practice.

The society we live in seems to expect people to “pick a gender” to identify with so that we can understand it; it might be easy for therapists to fall into the trap of wanting clients to do so (Desmarais & Gray, 2014). However, this lack of creative validation is clinically unhelpful (Rachlin et al., 2008). As counselling psychologists, we need to remember our understanding of the client as the expert of their own life, and that if a person sits in front of us saying they are a trans person in crisis, then there should be no question about that. As Zandvliet (2000) points out in chapter one, the gatekeeper function - whether it is actual or imagined - is problematic because it is in direct conflict with the non-judgemental stance at the core of counselling psychology philosophy (Woolfe et al., 2013). It is therefore irrelevant whether the clinician working with the trans client actually has a gatekeeping role or not; the problem is that they may be considered as part of this institutional system, which is anticipated to be judgemental and gatekeeping. In practice, we need to be mindful of suggestions by researchers like Yarhouse (2015) and Zandvliet (2000) and work affirmatively with a client rather than trying to fit them into a box.

4.9 Limitations and Suggestions for Further Research

Recent research suggests suicidal ideation and attempts within the trans population are still on the rise (e.g. Haas et al. 2014; Bouman & Arcelus, 2018) and that further research into the mental wellbeing of this population is needed. The present study was small, and the abbreviated version of grounded theory was used because the sample was smaller than desired. As such, perhaps unsurprisingly, the main suggestion for further research is a similar study, but with a larger sample size. Moreover, this model suggests a linear decision making process to take hormones. As with all stage models, all stages or one specific order of stages is not going to apply to everyone, and this should therefore be understood as a suggestion of how the process might look, rather than a blueprint of how it should always look.

Regarding recruitment, a strict ethical ruleset was set in this study to ensure no one would feel pressure to take part. The only people who were interviewed were therefore those who had approached me themselves after reading the research ad. Upon reflection, however, this may have meant all the participants of the study, whilst expressing dislikes for the system, were still willing to negotiate a collaborative solution because they still wanted to talk to me, a potential perceived member of this system, about it. In this way, I might have lost the possibility of hearing from people who had truly given up on this system altogether, because surely these people would just not have come forward. Similarly, by enforcing a requirement of interviewee PHQ-9 and GAD-7 scores below *moderate*, I might have lost the possibility of hearing from people who were severely distressed in this process. I wonder whether, had I not had this requirement, I might have gotten a rawer picture and one that was truer to reality.

Based on the findings of this study, more research into how this population can be best supported is suggested, and finally, it is encouraged that this research is done by asking trans people themselves, rather than their families or clinicians.

4.10 Epilogue and final reflections

The aim of this study was to get an increased understanding of the process by which trans individuals decide to take hormones. In investigating this, several issues were identified, and suggestions for improvements were made, regarding both further research and clinical practice. If the findings of this study were to be summed up in one sentence, it would be that trans people seeking hormones are already in emotional crisis, and due to lack of knowledge and resources, clinicians are not providing them with the best possible support.

Throughout this research, my assumptions have changed, both as a person and as a clinician. I have come to understand my personal identification and sexual orientation to be very relevant to this work. That is, I now feel that my previous denying of its importance kept me within the assumption that there is no reason how I, who am not trans, should not be able to understand trans issues properly. This assumption is arguably problematic because it does not align with the humanistic counselling psychologist values and minimises appreciation of the fact that their pain is unique to them.

I am more acutely aware of the agony that comes of needing external help and ‘approval’ to be who one is. My positioning regarding what I think I know about the struggles a person or client sitting in front of me is going though is thus more humble now. I am more aware of the position I as a clinician hold and how this might be viewed because of potential negative experiences of ‘the system.’

Despite the fact that this study shows, to an extent, the multifaceted difficulties trans people face, it is hoped that it will raise awareness for the various service providers along the way. The participants themselves, even through the tough processes they have been discussing, have maintained a sense of hope, optimism, and resilience. In fact, I was struck by just how strong this group of participants were. Given the issues and emotional struggles highlighted in this study, it was clear incredible strength would be necessary to survive it, but the strength displayed here seemed to go beyond just surviving. The interviews showed that for these participants, after having built up so much anger, hurt, and resentment, when it came down to it, they were still able to pick up on each kind moment and victory they encountered along the way. None of them were asked about how good it felt when treatment began, but they all told me about it anyway. Perhaps this ability to shine a light on even the darkest experiences in life is really the greatest survival mechanism of them all.

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Appendix A: Research Ad

Trans* participants needed

**Any individual who identifies with a gender identity different to the sex assigned at birth.*

Would you like to take part in a study **on the decision-making process of beginning hormone therapy**, partake in an interview lasting approximately one hour, and receive a **£10 Amazon voucher** in exchange for your participation?

I am interested in learning about the decision to begin hormone therapy for my doctoral research. This is because I believe a better understanding of this process may help mental health professionals provide better care for the people going through it.

If your gender identity differs from the biological sex assigned at birth, and you have made the decision to begin hormone therapy (regardless of where in the process you are), you may be eligible to **take part in this study**. If you would like to know more, or think you might want to take part, please contact me on: [redacted]

Thank you,

Loa Sofie Wamsler

Appendix B: Protocol to follow if participants become distressed during participation

This protocol has been has been devised to deal with the possibility that some participants may become distressed and/or agitated during their involvement in the present research study on transgender individuals' decisions to begin hormone therapy. Such participants may have experienced some form of psychological or emotional difficulty in relation to their gender identity. Loa Sofie Wamsler is a trainee counselling psychologist at London Metropolitan University and has training in managing situations where distress occurs.

There follows below a three step protocol detailing signs of distress that the researcher will look out for, as well as action to take at each stage. It is not expected that extreme distress will occur, nor that the relevant action will become necessary. This is because the participants will have been given PHQ-9 and GAD-7 questionnaires assessing their levels of depression and anxiety prior to the interviews commencing, and excluded if their scores in these were concerning. However it is included in the protocol, in case of emergencies which could not be foreseen.

Mild distress

Signs to look out for:

1) Tearfulness

2) Voice becomes choked with emotion/ difficulty speaking

3) Participant becomes distracted/ restless

Action to take:

1) Ask participant if they are happy to continue

2) Offer them time to pause and compose themselves

3) Remind them they can stop at any time they wish if they become too distressed

<u>Severe distress</u>

Signs to look out for:

1. Uncontrolled crying/ wailing, inability to talk coherently

2. Panic attack- e.g. hyperventilation, shaking, fear of impending heart attack

3. Intrusive thoughts of a traumatic event or part experience- e.g. flashbacks

Action to take:

1. The researcher will intervene to terminate the interview/experiment.

2. The debrief will begin immediately

3. Relaxation techniques will be suggested to regulate breathing/ reduce agitation

4. The researcher will recognise participants' distress, and reassure that their experiences are normal reactions to abnormal and distressing events

5. If any unresolved issues arise during the interview, the researcher will accept and validate their distress, but suggest that they discuss with mental health professionals and remind participants that this is not designed as a therapeutic interaction

6. Details of counselling/therapeutic services available will be offered to participants

Extreme distress

Signs to look out for:

1. Severe agitation and possible verbal or physical aggression

2. In very extreme cases; possible psychotic breakdown where the participant relives a traumatic incident or event and begins to lose touch with reality

Action to take:

1. Maintain safety of participant and researcher

2. If the researcher has concerns for the participant's or others' safety, they will inform them that they has a duty to inform any existing contacts they have with mental health services, such as a Community Psychiatric Nurse (CPN) or their GP.

3. If the researcher believes that either the participant or someone else is in immediate danger, then they will suggest that they present themselves to the local A&E Department and ask for the on-call psychiatric liaison team.

4. If the participant is unwilling to seek immediate help and becomes violent, then the Police will be called and asked to use their powers under the Mental Health Act to detain someone and take them to a place of safety pending psychiatric assessment. (This last option would only be used in an extreme emergency).

Appendix C: Participant Information Sheet

I am a counselling psychologist trainee at London Metropolitan University currently carrying out research to discover more about trans people’s decision to begin hormone therapy.

Little is known about this topic, but the Gender Identity Clinic’s (GICs) waiting times after referral are long, and little support appears to be in place for the people waiting. Arguably, long waiting times combined with the distressing nature of the transitioning process (regardless of where on the trans spectrum one falls) may evoke emotional difficulty in the people going through it. Equally, very limited research has been conducted in this area, and trans individuals do not appear to be receiving adequate therapeutic care.

My hope is that by carrying out this research we will be able to gain a better understanding of trans people’s decision to begin hormone therapy so that this population can be better supported by mental health professionals.

I am writing in the hope that you will be interested in helping me in this endeavour and share your experience of deciding to begin hormone therapy by participating in an interview. The interview would last approximately one hour and will be voice recorded. Data from your interview will be used for my Doctoral level counselling psychology project.

Participation is entirely voluntary. If you choose to participate, you are free to withdraw at any time up to the interview and up to four weeks after the interview. Interviews will be voice recorded, transcribed, and kept strictly confidential. All recordings will be kept securely and destroyed once the project is completed.

Before you decide to participate it is important that you understand that the interview will be discussing an emotive topic and therefore may evoke some distressing and difficult feelings for you. In line with this it is also important that you are older than 18 years of age, and that you have completed and returned the PHQ-9 and GAD-7 sheets sent out to you. You will have the opportunity to discuss any feelings evoked at length post interview with the researcher and be given information on sources of support if you would like this.

Thank you so much for your time; if you have any further quires please do not hesitate to ask either by phone: [redacted] or email: [redacted]

Yours Sincerely,

Loa Sofie Wamsler

Appendix D: Participant Consent Form

Title of research: Understanding the Decision-Making Process to Begin Hormone Therapy for Trans Individuals: A Grounded Theory Study.

Description of procedure: In this research you will be asked a number of questions regarding your experience of deciding to begin hormone therapy.

☐ I understand the procedures to be used.

☐ I understand I am free to withdraw at any time up to the interview and up to four weeks after the interview. However, all data will be aggregated after this time; therefore, if I wish to withdraw it has to be done before the interview, or within four weeks after.

☐ I understand that participation in this study is anonymous. My name will not be used in connection with the results in any way, a pseudonym will be used on the digital voice recording and all information that may otherwise identify me (e.g. address, friends' names) will be changed prior to transcription. There are limits to confidentiality however; confidentiality will be breached if any information is disclosed that indicates a risk to the safety of myself or of anybody else.

☐ I understand that the results of the study will be accessible to others when completed and that excerpts from my interview (except from explicit identifying information) may be used within the study.

☐ I understand that I may find this interview upsetting and that it may evoke a number of difficult and distressing feelings for me. I will be offered support and the opportunity to discuss these feelings at length post interview with the researcher. The researcher will also give information on further support available if required.

☐ I understand that I have the right to obtain information about the findings of the study and details of how to obtain this information will be given in the debriefing form.

☐ I understand that the data will be destroyed once the study has been assessed.

Signature of participant:……………... Print name:………………… Date: …….………

Signature of researcher:……………… Print name:………………… Date: .……………

Appendix E: Interview schedule version 1

1. First of all, could you tell me about your experiences with hormone therapy so far?

Probe: whether it has begun yet, duration of hormone therapy, practical aspects of it.

Prompt: How were your hormones obtained? Were there any difficulties with this?

2. In as much detail as possible, could you tell me about what sort of thoughts went through your head when you began to consider hormone therapy?

Probe: for/against evaluation of the idea, perhaps stigma, family influences/support.

Prompt: Did it feel like the process would be straight forward/difficult? Did you worry you might regret it later? Did it take you long to decide or did you feel eager to get started? What factors influenced this decision making process?

3. How have you experienced/are you experiencing levels of support throughout this process?

Probe: doctor, family, possible therapist, friends.

Prompt: Do you have a therapist? Have you ever had one? Did the levels of support meet your expectations, exceed them, or disappoint?

4. What role has waiting time played, if any?

Probe: length of waiting time, whether they are currently waiting, pleasantly surprised/disappointed, what their expectations of this were based on and whether they were met.

Prompt: Did you feel you had to wait long? How long? In your experience, how did your waiting time compare to that of others you know? What was waiting for this like? Did you feel supported throughout?

5. What is your understanding of counselling psychologists?

Probe: perhaps let the researcher define what it is. A broader understanding of mental health professionals overall.

Prompt: What do you understand a counselling psychologist to be? Are mental health professionals helpful for people in your situation? Have they been helpful for you? Did you ever worry about their evaluation of you (gatekeeper function)?

6. Before we finish, is there anything you would like to add?

Probe: Whether their experience was conveyed properly, whether the researcher has understood.

Prompt: Have you got any questions for me? How has this interview been for you?

Appendix F: Participant debrief sheet

Thank you for taking part in this research study. This is part of a Doctoral project that the researcher is conducting.

If you are interested in the results of the study, or if you have any questions about this study, or if you wish to withdraw, please contact the researcher on the following email address: [redacted] Emails will be checked regularly.

Please remember that if you wish to withdraw your data from this study it should be done within four weeks after this interview, as it may not be possible at a later stage.

Equally, if you have any questions or concerns you are more than welcome to address them now. If you have any complaints regarding any aspect of the way you have been treated during the course of the study please contact my research supervisor Dr Angela Ioanna Loulopoulou on: [redacted]

If participation has raised any concerns or issues that you wish to discuss further, a number of agencies can provide advice and support in confidence.

- **MindOut** is a mental health service run by and for lesbians, gay men, bisexual, trans and queer people. They provide help and guidance in finding the mental health support a person needs. Call them on: 01273 234839 or email them on: info@mindout.org.uk. Alternatively, visit their website: http://www.mindout.org.uk/

- **The Gender Trust** supports all those affected by gender identity issues. It is a support and information centre for anyone with questions or concerns regarding their gender identity. Call them on: 07000 790347 or visit their website: http://gendertrust.org.uk/

- **Beaumont Society** is an established transgender UK support group with a support network for Transgender (TG), Transvestite (TV), Transsexual (TS) and Cross Dressing (CD) communities. Their 24 hour helpline phone number is: 01582 412220. Or visit their website: http:// www.beaumontsociety.org.uk

- **The Samaritans** offer confidential support for suicidal thoughts, and feelings of distress or despair. This service is available for everybody, regardless of age, race or gender. The national 24 hour helpline phone number is: 08457 90 90 90. Alternatively, you can visit their website: http://www.samaritans.org.uk/ or email them: jo@samaritans.org

- In an emergency, always call the police on 999.

Appendix G: Interview schedule version 2

1. First of all, could you tell me about your experiences with hormone therapy so far?

Probe: whether it has begun yet, duration of hormone therapy, practical aspects of it.

Prompt: How were your hormones obtained? Were there any difficulties with this?

2. In as much detail as possible, could you tell me about what sort of thoughts went through your head when you began to consider hormone therapy?

Probe: for/against evaluation of the idea, perhaps stigma, family influences/support.

Prompt: Did it feel like the process would be straight forward/difficult? Did you worry you might regret it later? Did it take you long to decide or did you feel eager to get started? What factors influenced this decision making process?

3. How have you experienced/are you experiencing levels of support throughout this process?

Probe: doctor, family, possible therapist, friends.

Prompt: Do you have a therapist? Have you ever had one? Did the levels of support meet your expectations, exceed them, or disappoint?

4. What role has waiting time played, if any?

Probe: length of waiting time, whether they are currently waiting, pleasantly surprised/disappointed, what their expectations of this were based on and whether they were met.

Prompt: Did you feel you had to wait long? How long? In your experience, how did your waiting times compare to that of others you know? What was waiting for this like? Did you feel supported throughout?

5. Before we finish, is there anything you would like to add?

Probe: Whether their experience was conveyed properly, whether the researcher has understood.

Prompt: Have you got any questions for me? How has this interview been for you?

Appendix H: Interview schedule version 3

1. First of all, could you tell me about your experiences with hormone therapy so far?

Probe: whether it has begun yet, duration of hormone therapy, length and experience of waiting time.

Prompt: How were your hormones obtained? Were there any difficulties with this? Were you expecting to wait as long as you did? Has the experience generally met your expectations?

2. In as much detail as possible, could you tell me about what sort of thoughts went through your head when you began to consider hormone therapy? What was the decision making process like?

Probe: for/against evaluation of the idea, perhaps stigma, family influences/support.

Prompt: Did it feel like the process would be straight forward/difficult? Did you worry you might regret it later? Did it take you long to decide or did you feel eager to get started? What factors influenced this decision making process? Were things like waiting times and practicality of hormones considered?

3. How have you experienced/are you experiencing levels of support throughout this process?

Probe: doctor, family, possible therapist, friends, online forums, peers.

Prompt: Do you have a therapist? Have you ever had one? Did the levels of support meet your expectations, exceed them, or disappoint? If psychological support/therapy had been available to you during the waiting time, do you think that would have been helpful?

4. Before we finish, is there anything you would like to add?

Probe: Whether their experience was conveyed properly, whether the researcher has understood.

Prompt: Have you got any questions for me? How has this interview been for you?

Appendix I: An excerpt from the recorded memos

03.03.17. Last summer I went to the BPS conference and there was this talk about working with trans clients, and the speaker said that so many people think that they understand, but they don't actually understand what it's like to be trans. I wondered whether I am one of those people, and what I can do to avoid being one of those people. I wonder whether the speaker meant that people who are not trans can never understand. Following this conference, I also received some feedback on the poster I presented, and it became clear to me that the way it was presented might come across as offensive. I think I thought I understood this population better than I do, and I think this was a very important moment in my research.

23.03.17. Although I did not ask for my participants to be in the mental health sector, all of the participants who have come forward so far appear to be in the mental health field one way or another. This has made me wonder about their motivation for coming forward, and has made me question to an extent whether this project also feel relevant and important to trans people out of the mental health sector. Moreover, I now wonder whether I need to rethink what talks about the gatekeeper effect will be like. That is, perhaps there will be themes of more understanding of difficulties faced by health professionals than there might have been, had the participants not been involved with it themselves. Then again, I suppose this has brought an assumption to my attention I did not know I held; that participants will not be understanding of the difficulties faced by health professionals.

24.03.17. I am now in the process of recruiting participants, and though I was initially worried about how to phrase the blurb, I actually feel I have gotten some really positive responses really quickly. They’re spread all over, so I’ll have to do a lot of travelling, but I’m quite determined that this is the better way to do it; that it should be the people that want to talk about it that I do interview, rather than the people that are convenient. My current problem is that as I have now been in touch with a few interested people, they have started to send back the PHQ-9 and GAD-7 questionnaires that I sent them. And all but one came back really low, so it wasn’t even questionable. But then I reviewed this one email from somebody seeming very, very interested, but then their questionnaires came back above ‘moderate’ scores. I just hate that I have to exclude somebody who wants to take part so badly. It feels to me like I’m saying “I want to know about your experiences, because I want things to be better for you, assuming there is improvement to be made,” and then I send a questionnaire, and then if you’re too unhappy with the situation that I’m presuming is not great, and that I want to help better, then I won’t hear your story. It makes me feel like a hypocrite. I know that ethically it’s the right thing to do, but right now, I’m just feeling like I’m excluding a really potentially important voice, and also wondering what it might be like for that person to have been excluded. By that I mean that if they have to wait for hormone treatment, and that perhaps they haven’t received adequate psychological support while doing that, and now I have one person who indicates to me that they have actually really struggled throughout this process, and then I won’t hear them out.

07.05.17. I wonder whether participants in a mental health profession will answer the interview questions as a health professional or as a trans person first and foremost. I also wonder if it is even possible to distinguish, for me or for them. Perhaps I need to re-think where I advertise the study throughout continuous recruitment if I wish to interview a wider selection of professions.

12.07.17. It feels like Ella is emphasising the reasons why she had to go on hormones, and which professionals agreed with that conclusion and why it was all necessary. I wonder what this is about; perhaps she worries I might think it was unnecessary. Or perhaps it is to emphasise these things to herself, potentially due to previous internalised transphobia, causing her to need to remind herself that the psychiatrist did also reach the same conclusion, so it was not just her.

12.07.17. *Early thoughts about the analysis* – themes of feeling lucky or fortunate. One participant said to the doctor when initially phoning them that she needed an appointment, but that this was not important or urgent. Remarks like this one suggest a feeling that *any* transition was better than no transition, and as such, an expression of gratitude for the fact that transitioning was even possible. Certainly not that one is entitled to treatment, more that they thought it would be impossible.

13.07.17. Ella is remembering a lot of details about her treatment, like specific dates and dosages.

17.07.17. Fran states that her teenage years were awful, and follows it up by stating straight away that most people's teenage years were awful. Perhaps she is belittling her own struggle here. Why? Perhaps it hurts less to think about the teenage years in this way; that it was the same for everyone, because this indicates the struggles could not have been avoided. Maybe this is also about not wanting to seem ungrateful or like she is complaining about her upbringing.

27.10.17. I have now just finished transcribing my first interview, and am now starting to think about what analysis is going to be like, and how I'm going to analyse the data. I really enjoyed the interviews. It's been really, really interesting what people have had to say. It definitely feels like there is a gap where I thought there was one. And I'm really happy that the people I've interviewed so far are people who have contacted me, despite my potentially very narrow participant criteria. I've still managed to only interview people so far who actually wanted to take part, and who have contacted me because they wanted to take part. And I don't know if it does or it doesn't, but it definitely make me feel like it adds to the data. I've just been so reminded of why I'm doing all of this when I hear these participants talk, and hearing about their experiences and why **they** think what I'm doing is important. I am also feeling a lot of anxiety about the work right now because I want to do a good job for the participants. I want to do them justice. I feel I need to do something good with all of this data that they're giving me. I think that is a lot more anxiety provoking than having done quantitative work in the past, because there wasn't the same aspect of feeling like I want to or need to do my participants justice. But I really feel that now.

14.03.18. Possible categories: coping styles/active or inactive coping styles. Coping resources. Survival. Strategies of surviving. Some participants seem to compliment the decision making of the health professionals a lot. Is this a coping mechanism? The idea that it could not have been easier or better.

27.06.18. Do the participants want to make sure it's known they worked hard for everything they got?

02.07.18. A sense of injustice amongst the trans population seems to appear. Sometimes it is expressed in relation to the rest of the LGBT population, and sometimes it is in relation to the general population. Perhaps this is what naturally gave rise to a theme of 'activism.'

Appendix J: PHQ-9 and GAD-7 questionnaires given to participants

PHQ-9 Questionnaire

Over the last two weeks, how often have you been bothered by any of the following problems? (*Use ✓to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure – or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3

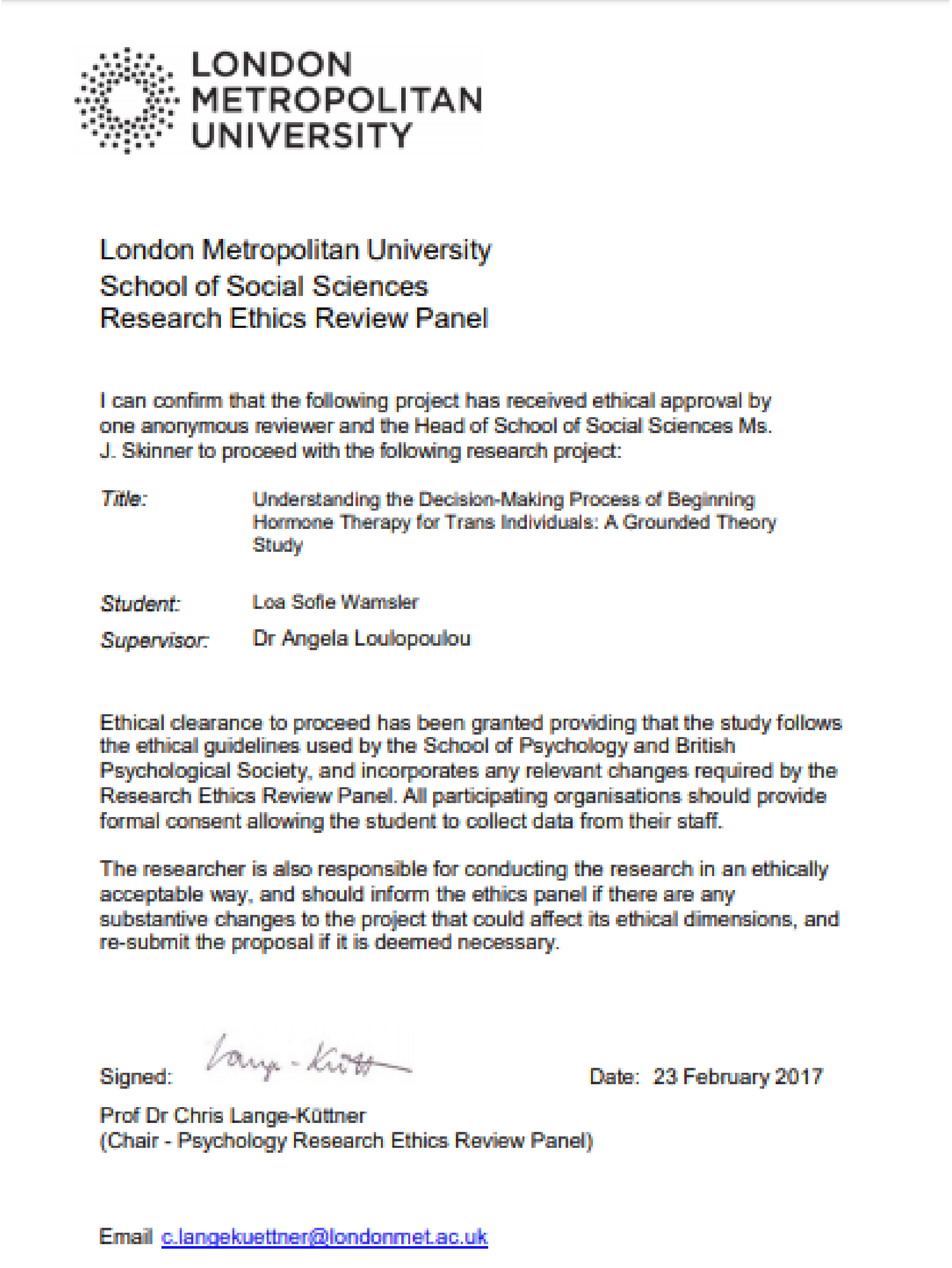
Questionnaire retrieved from: Kroenke, Spitzer & Williams (2001)

GAD-7 Questionnaire

Over the last two weeks, how often have you been bothered by any of the following problems? (*Use ✓to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

Questionnaire retrieved from: Williams (2014)

Appendix K: Certificate of ethical approval



LONDON
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London Metropolitan University
School of Social Sciences
Research Ethics Review Panel

I can confirm that the following project has received ethical approval by one anonymous reviewer and the Head of School of Social Sciences Ms. J. Skinner to proceed with the following research project:

Title:	Understanding the Decision-Making Process of Beginning Hormone Therapy for Trans Individuals: A Grounded Theory Study
Student:	Loa Sofie Wamsler
Supervisor:	Dr Angela Loulopoulou

Ethical clearance to proceed has been granted providing that the study follows the ethical guidelines used by the School of Psychology and British Psychological Society, and incorporates any relevant changes required by the Research Ethics Review Panel. All participating organisations should provide formal consent allowing the student to collect data from their staff.

The researcher is also responsible for conducting the research in an ethically acceptable way, and should inform the ethics panel if there are any substantive changes to the project that could affect its ethical dimensions, and re-submit the proposal if it is deemed necessary.

Signed: Date: 23 February 2017

Prof Dr Chris Lange-Küttner
(Chair - Psychology Research Ethics Review Panel)

Email c.langekuettner@londonmet.ac.uk

Appendix L: Tables of categories and subcategories

Category	Subcategory	Focused code	Initial code	Core text
Identity frustration	Knowing from an early age	Experiencing self as always different from and potentially less ‘correct’ than other mothers.	Experiencing self to never having been a Laura Ashly mother.	“(…) you know, I was never a Laura Ashley mum (*laughs*)” (A, 336-337)
		Envying trans peers from an early age.	Feeling a desire to be like his school friend, who came out aged 13.	“Cause he came out when he was 13. So I saw him. (…) And I thought: you are how I want to be.” (B, 136-141)
		Taking pride in the ability to supress trans identity, due to the pain it was expected to cause.	Finding she has been trans for as long as she can remember. Supposing she managed to supress her trans identity very well.	“I’ve been trans for as long as I can remember, but I wasn’t actively so. I’ve managed to supress it very well until about 20 years ago I suppose.” (D, 4-6)
		Wondering what made her wait so long to transition, when she knew all along.	Finding one is subjected to all sorts of conditioning growing up.	“But then during when you’re growing up, you’re subjected to all sorts of conditioning, (…)” (E,147-159)
		Needing to take action to minimise internal suffering from a very young age.	Remembering crossdressing aged seven and experiencing it to have a calming effect.	“And then it came to crossdressing at a very early age. Probably about seven, which I found actually calmed what was going on inside.” (F, 65-67)

		Knowing early that a sex change would be necessary for emotional contentment.	Remembering promising himself from a young age that he would grow up and have a sex change.	“I’d waited until I was 23 to actually do something about it, but I’d been promising from a really young age, like: I will grow up and I’ll have that sex change. I’ll do that for myself. (G, 6-9)
	Needing others to see what I see.	Valuing a professional agreeing with his own gender identity.	Being told by the psychiatrist that he was quite clearly trans.	“So I went to them, and then after like 20 minutes of appointment, they were like: ‘yeah, no you are quite clearly trans.’” (B, 71-73)
		Appreciating the struggle her parents encountered whilst also feeling rejected.	Experiencing her parents as supportive although they took time to come around.	“They kept telling me to be more patient and that kind of stuff. So they were very supportive, but it took them a while to come around and really understand it from my point of view.” (C, 46-49)
		Expressing a desire to have this treatment in the way her clinician saw fit.	Finding she was asked to wait to book an appointment although she felt ready then. Thinking retrospectively that it was good she was asked to wait.	“They wouldn’t let me make an appointment then, after which I think was a good thing. I said… well, I had gone with my diary and said ‘right, OK, so when are you going to do it then?’” (D, 449-452)

		Seeking confirmation own gender identity.	Thinking she would have to go see if the psychiatrist felt her conclusion that she was trans was appropriate.	“My first thought was that I would go and see X (*psychiatrist*), (…) to see whether he felt the conclusions I was reaching were appropriate.” (E, 25-28)
		Expressing openness to an alternative explanation other than being trans.	Wondering what might be going on if she was not trans like she thought	“I didn’t care because if it wasn’t that, then what was it?” (F, 411-412)
		Feeling impatient with clinician’s lack of knowledge.	Finding that some medical professionals still do not know what the word ‘transgender’ means, as it takes the profession time to catch up with culture.	“Err, still! Still, still, *still* people don’t know what this word means. I think, with medicine, it takes more time to catch up with culture.” (G, 505-507).
	Having no choice	Experiencing a realisation that seeking out a transition would be necessary for his wellbeing or even survival.	Finding he had spent years agonising over being trans. Concluding finally that transitioning was unavoidable.	“Now, bearing in mind that I’d spent several years agonising over this, finally coming to the conclusion that it was unavoidable” (A, 313-315)
		Feeling so uncomfortable being mis-gendered that it triggers a physical reaction.	Feeling creeped out by female pronouns to the extent of physically cringing	“Female pronouns creeped me out. Like, I just physically cringed if someone called me a girl and stuff.” (B, 118-118)

		Giving up trying to fight what was becoming inevitable.	Reaching the conclusion that she would have to transition.	“I finally realised I had to go through with it, regardless of the consequences.” (E, 169-171)
		Feeling unable to continue trying to contain trans identity.	Feeling pushed by trans identity to the point of being unable to contain it.	“Absolutely, yeah. It just… it really pushed me. Everything was… it really pushed me. I could contain it, but this time… So I told my wife.” (F, 142-144)
		Experiencing an urgent need to transition.	Deciding to seek hormones due to feeling a need to change his face right away.	“I was like, OK, hormones are for sure. Because I need to change this face, like, right away. Right away.” (G, 12-13)

Category	**Subcategory**	**Focused code**	**Initial code**	**Core text**
Meeting the gate-kept world	Nobody understands	Feeling unnecessarily checked and evaluated.	Finding the psychiatric evaluation unnecessary.	“You shouldn’t be required to go through *that* in my opinion” (A, 681)
		Feeling unsupported by the system due to their lack of knowledge.	Finding he had to educate his community psychiatric nurse, as she did not know much about transitioning.	“When I first met the CPN [community psychiatric nurse], like, she didn’t really know anything about transitioning or anything. It was sort of a lot more over time me educating her.” (B, 359-361)

		Wondering why the system would not help.	Thinking the idea behind the system delaying her transition was that it was because she was quite young.	“I think the idea was that it was because I was quite young” (C, 25-26)
		Feeling her sincerity was unjustly doubted by the system.	Wondering about the purpose of repeatedly asking her the same questions. Feeling like her sincerity was being checked.	“They didn’t ask the *same* questions. The same questions in a different way, so I don’t know if they were taking notes, just checking the answers were the same each time. I can only speculate, but that’s how it felt like to me.” (D, 44-47)
		Fearing complete openness and honesty would impact negatively on her transition.	Thinking trans people should not *just* see clinicians controlling their treatment. Thinking trans people should be able to talk about their issues without it impacting on their treatment.	“I think all trans people shouldn’t *just* go and see the psychiatrist who’s controlling their treatment. They should also have counselling so that they can talk about their issues, err, without that impacting on their treatment. (E, 337-341)

		Experiencing the system to not care.	Thinking there is a need for more trans people in health care, as the sympathy and empathy currently is not there.	“I think there needs to be more trans people looking after trans people in health care. Err, the empathy isn’t there. I don’t think the sympathy particularly is either.” (G, 795-797)
	Me vs. them	Feeling the system tries to catch him out to deny him treatment.	Finding there is a need to know the right boxes to tick in order to access transitional help.	“You have to know the right boxes to tick to get help.” (A, 712-713)
		Using resentment to help find the strength to survive the process.	Finding it easier to view the gender clinic as an enemy to struggle against.	“Yeah, totally. It gave me someone to see as a kind of enemy (*laughs*), that I could be, like, struggling against.” (C, 308-309)
		Expressing a divide between how she and the clinic each take care of her.	Finding the determination of the right form of hormones has nothing to do with her.	“I don’t know. That’s *their* thing.” (D, 72-73)

		Worrying about being caught not cross-dressing.	Finding she made sure to cross-dress every day. Suspecting the psychology people know how one is living.	“I never did any cheating. I never went: ‘I’m not crossdressing today because nobody is looking at me.’ I put the clothes on. Those psychology people tend to know how you’re living.” (F, 248-215)
		Feeling inferior to gender clinic clinicians.	Experiencing gender clinic clinicians as terrifying. Finding clinicians are put on a pedestal by trans people.	“They have so many letters after their damn names. They’re terrifying to people who don’t know what they mean. And then trans people put these people on, like, a pedestal, like they’re all knowledgeable, all this, all that.” (G, 619-622)
	Experiencing rejection	Experiencing parental rejection as a perceived direct consequence of transitioning.	Experiencing his father was unable to deal with the transition.	“My father and I no longer have a relationship. He couldn’t deal with it at all. Really quite violently not at all.” (A, 92-94)

	Experiencing the family as so rejecting that moving out felt necessary.	Leaving home due to lack of acceptance from half of his biological family.	“Because half my biological family do not accept me whatsoever. And they still don’t accept me, so I left home at 18.” (B, 82-83)
	Finding the waiting time unreasonable.	Experiencing the waiting times for the gender clinics as really crazy.	“(…) you know, really crazy waiting times for the clinics.” (C, 395)
	Experiencing parental invalidation.	Finding her mother found her being trans to be stupid.	“I mentioned it to my mother, and she startled and went: ‘don’t be so stupid.’” (D, 113-115)
	Experiencing feared and actual rejection by loved ones.	Worrying about losing her daughter. Expecting a lack of understanding from her mother, due to her views.	“My daughter, well there was a risk that I’d lose her (…) I knew my mother’s views on transvestism and transsexualism and they weren’t positive, so I knew that would be an issue.” (E, 182-185)

		Experiencing a strong emotional response to feeling let down by the system.	Being told by his GP to bring his privately acquired hormones to be injected there. Experiencing being told NHS time could not be used on his injections, and crying as a result.	“(…) because my GP was like: ‘yeah, it’s fine, you can get this stuff from X [private GIC], bring it here and we’ll do your injections here.’ Fine, booked an appointment with the nurse, turned up with the box like: ‘can you inject this please?’ They were like: ‘no, we can’t use NHS time on this because you got it privately.’ (…) I cried and cried and cried (…)” (G, 69-77)
	Waiting	Feeling unprepared for the devastation of having to wait.	Thinking he was finally going to get help, but being told to wait two years.	“I thought: ‘I’m finally going to get help!’ And then I’m told to go and come back in two years” (A, 321-322)
		Expressing guilt about feeling the wait is too long as others wait even longer.	Noting his three years of waiting would objectively be found to be quick.	“Yeah, it’s like I’ve been seen quick, but it’s still been three years.” (B, 287-288)

	Expression frustration of knowing exactly what would help the emotional struggle and being asked to wait a long time for it.	Experiencing having to wait three years for hormones as frustrating.	“(…) the whole time I was really insistent that I wanted to start hormones, and I was really frustrated by waiting, like, three years (…)” (C, 16-18)
	Finding the wait for treatment unbearably long.	Experiencing the waiting as frustrating. Feeling like the wait lasts forever.	“Of course that’s the frustrating thing I haven’t mentioned; everyday it seems you are waiting for the next appointment. It seems to last forever.” (D, 267-269)
	Experiencing the long wait for the gender clinic as a growing problem.	Experiencing her wait for the gender clinic as long. Imagining people now wait even longer than she did.	“(…) cause there’s an awfully big waiting list. Cause, you know, mine was long enough, it’s going to be even longer now.” (F, 197-19)

		Feeling pushed to engage in risky behaviour by the system for making the wait so long.	Experiencing the waiting time for the gender clinic as so damn long that people start to do dangerous things.	“Err, it’s so damn *long*! People will do anything. Dangerous things! Injecting myself without being taught by a nurse is obviously dangerous!” (G, 567-569)
	Learning a script	Experiencing learning a script as a necessity to access help.	Finding one must speak a script to access help. Experiencing having to know the right words to say as ludicrous.	“… ‘the script’ that you *must* speak to access the help. I mean, it’s ludicrous, you have to know the right words to use. You have to know the right boxes to tick to get help.” (A, 710-713)
		Feeling it necessary to be cautious about disclosing gender identity in fear of having treatment delayed.	Deciding to tell the gender clinic that he identifies only as male due to having heard that doing otherwise may delay treatment.	“I’ve heard stuff that being non-binary… that if you say you’re non-binary, like, it’ll take longer for surgery and stuff. So like, I’ve only told them I identify as male.” (B, 521-524)

	Feeling it necessary to be wary of disclosing information to the system out of fear it would lead to denial of treatment.	Thinking the fact that she did not want any complicating factors influenced what she disclosed to clinicians.	“I think it might have been a factor that I didn’t want any sort of complicating factors, I saw it as a kind of obstacle course, you know?” (C, 368-371)
	Attempting to avoid feared denial of treatment.	Supposing she viewed the gender clinic psychiatrist as a hoop to jump through.	“Err, if I’m honest I suspect I saw it as just a hoop to jump through.” (D, 509-510)
	Contemplating dishonesty to ensure vital treatment is not denied.	Worrying about what she tells clinicians due to knowing what she wants to achieve.	“You always worry about what you tell them because you know what you want to achieve (…)” (E, 404-405)
	Feeling a need for preparation to ensure not saying the wrong thing.	Finding he never wanted to rock the boats of the gender clinic. Knowing what the gender clinic looked for, and that he would have to play a game.	“I never wanted to rock those boats. Never, ever, ever. I knew that I’d have to play a game, because with all the psychology, I read everything that would happen, and… I knew what they’d be looking for (…)” (G, 471-475)

Category	**Subcategory**	**Focused code**	**Initial code**	**Core text**
Survival mechanisms	Activism	Needing to make a point of fighting on behalf of all trans people.	Finding that if he did not fight, others would have to.	“I thought: if I give up, they’re going to have to do the fighting instead. So it was in part a little bit of activism for me to stick at it until I got it” (A, 423-427)
		Shifting focus from own suffering onto that of others.	Finding she was providing support rather than receiving it. Noting she became chairperson of the support organisation.	“But I found I was giving the support rather than getting the support. I’ve found that’s always been the case. And in fact, I became chair of the organisation for quite a few years (*giggles*).” (E, 226-229)
		Focusing on the struggles of others, as her own became too difficult to manage.	Finding that helping others took her mind off herself.	“Carried on with what I was doing. Put myself out there, working out there, doing everything I could do and helping others, which takes you off yourself.” (F, 284-286)
		Seeking out trans peers through work, due to potential feelings of loneliness.	Feeling motivated by own struggles to do his job due to feeling he could not possibly be alone.	“*That* experience has motivated me to do X [job], because I can’t possibly be alone.” (G, 247-249)

	I guess it could have been worse	Minimising own devastation by suggesting it could have been worse.	Feeling better equipped to deal with own devastation than most other people in his position.	“So I felt I was a lot better off than probably most people in my position. I was nevertheless devastated, but I was probably better able to cope with it” (A, 323-327)
		Avoiding addressing the pain of parental rejection by focusing on the supportive aunt.	Finding transitioning would have been a lot harder, had he not had his aunt and college.	“And because I had a lot of support from my aunt and college, it would have been a lot harder.” (B, 443-446)
		Searching for alternative explanations for loss of close ones to minimise feelings of rejection.	Thinking she fell out of touch with her university friends because they graduated and do not have much in common anymore.	“I think it’s partly because I graduated I’m not in touch with any of my uni friends anymore, basically. But err, that might have contributed to it a little bit. I don’t know. I just suppose we don’t have that much in common anymore.” (C, 192-196)
		Minimising own expectation of familial rejection.	Felling fortunate not to have been rejected. Thinking her lack of familial rejection is the exception rather than the rule.	“And I think I’ve been very fortunate now because while I haven’t, I think it’s very important to remember that I might be the exception rather than the rule.” (D, 423-426)

	Scientifically explaining the development of her trans identity, emphasising to self it was not her fault.	Finding it to be known that a foetal flow of testosterone determines the lack or presence of transsexualism.	“We know that, that flow of testosterone can be weaker or stronger, shorter or longer than average and that’s going to have an impact on the extent to which the brain is reprogrammed. And I’m *convinced* that that is the fundamental cause of transsexualism.” (E, 143-147)
	Implementing early survival strategies to minimise emotional suffering.	Finding it pretty clever how she used to cross-dress as soon as her family left the house.	“I’d be sitting with myself, quite happily getting on with my homework, and then when I heard the door go, I’d get up and do it. And it was like, pretty clever when I look back at it now.” (F, 77-80)
	Minimising the feeling of lacking control by finding control within it.	Finding he has always done his own injections. Feeling a need for control over his injections, as he can never manufacture the hormone on his own.	“I did it myself that next day, and I’ve been doing it ever since. No one else has ever done my injections. (…) And that was my way of grasping control of my hormones. I needed control of it, desperately, because I will never be able to manufacture testosterone on my own.” (G, 79-87)

	Building up to a contest	Finding it necessary to be strong and intelligent in order to obtain treatment.	Feeling thankful to be intelligent and articulate enough to be taken seriously.	“Err, you know, thankfully I’m sort of articulate and intelligent enough that they took me seriously.” (A, 27-29)
		Feeling a need to push himself in order to make it through the transition.	Experiencing his aunt to help him out by pushing him.	“My aunt helped me out. She sort of pushed.” (B, 128-129)
		Needing to brace self and concentrate not to let anyone get in the way.	Finding she was warned by trans peers not to listen to anyone, but to just keep her head down.	“I was warned ahead of time by trans people, like: ‘you don’t have to listen to any of that stuff, like, just put your head down and get through it,’ and that kind of thing.” (C, 275-277)
		Finding the strength to beat suicidal ideation.	Experiencing self as too bloody minded to commit suicide.	“But I’m just too bloody minded to do something like that.” (E, 193-194)
		Drawing on own greatest strengths to survive.	Feeling a need to implement the discipline she had spent 20 years learning.	“So my life for 20 years was discipline. All I needed to do was implement that.” (F, 437-438)
		Needing to eliminate bad habits in order to survive.	Finding hormones made him hungry. Feeling he had to resist the hunger as he had needed to lose weight before the surgery.	“It does make you hungry. But if you can just ignore it, then yeah… I lost a bunch of weight, yeah, before surgery, because I’d been… I was fat.” (G, 416-419)

Category	Subcategory	Focused code	Initial code	Core text
Escalating identity crisis	Point of no return	Finding it emotionally unbearable to be confused for the former presenting gender any longer.	Experiencing being called a lady as the last straw.	“And he said: ‘so what can I get you ladies?’ And that was like the last straw.” (A, 63-64)
		Experiencing a sudden realisation of needing hormones.	Thinking the documentary she watched aged 15 was what made her decide to seek hormones.	“I think when I was about 15, I saw a documentary about a teenager who transitioned female to male, and that’s what made me decide, like, not long after that.” (C, 4-7)
		Feeling a sudden inability to carry on hiding.	Wondering suddenly why she was still hiding.	“(…) and I suddenly thought, ‘I’m 63 years old, why am I still hiding?’” (D, 174-175)
		Experiencing an unbearable disconnect between the gender she was and the gender she was living as.	Feeling unable to live as the wrong gender anymore. Feeling living as male was just not her.	“(…) as I said, in the end I was getting up in the morning thinking: ‘I can’t do this anymore. It’s just not me.’” (E, 168-169)

		Experiencing a sudden inability to continue living as the wrong gender.	Remembering seeing herself and wondering what she had done. Realising living as male was not right and was not her.	“And I remember seeing myself in the mirror, thinking: this isn’t me. And I started to swear: what have I done? And at that point I realised this wasn’t right. This wasn’t me.” (F,130-133)
		Experiencing emotional distress to the point of feeling unable to carry on.	Experiencing hitting a point where he needed to do something right away.	“I hit a point where I was like ‘OK, I need to do something right away.’ Like, I’m crying every single day because nothing is happening (…)” (G, 203-205)
	Nothing else matters	Expressing a willingness to sacrifice close relationships to pursue transition.	Possessing awareness that taking hormones might cost him his relationship with his father.	“I was fully aware that that chances were I would lose my relationship with my father” (A, 242-243)
		Happily suffering physical pain in order to relieve emotional pain.	Finding he did not care about having to have injections.	“No. Cause I wanted T, so I didn’t really care how.” (B, 234-235)

	Needing the emotional relief of the surgery more than life itself.	Fearing only that she or the surgeon would be ill. Experiencing no fears about the risks of the surgery.	“I mean that was my only fear about the surgery. It was that either I’d be ill or the surgeon would be ill. I had no fears about what was happening to me.” (D, 337-339)
	Expressing a preference of risking death over stopping the transition.	Feeling she has got to be on oestrogen. Finding she had to risk either breaking bones or having a heart attack.	“Err, and I don’t want testosterone, so (*giggles*) it’s got to be oestrogen. So I either run the risk of a lot of falling over and breaking hips, or of a heart attack.” (E, 117-120)
	Expressing a willingness to lose her spouse in order to transition.	Experiencing the need to be a woman so great that she would leave her wife if she could not accept it.	“It wasn’t a problem then to the point where I’d walk out and leave her, if she couldn’t accept it, which I was quite willing to do then.” (F, 148-150)

		Expressing happiness about the physical pain because of its outcome.	Feeling fine about having to inject himself for the rest of his life because he gets to grow a beard.	“I have to stab myself 15 days of the year for the rest of my life, and I am fine with that. That is just fine. Because I get to grow a beard.” (G, 374-376)
	Fearing death	Feeling unable to continue fighting.	Contemplating going private due to being tired of fighting.	“So I did seriously contemplate going private because I was very tired of fighting it” (A, 420-421)
		Experiencing an intense low point.	Thinking the experience of seeking out the transition was ultimately horrible.	“You know, I think ultimately… it was horrible. It really was.” (C, 401-402)
		Feeling overwhelmed by the distress to the point of contemplating suicide.	Thinking that jumping out from the 12th story would be the end of her problem.	“I was living in a tower block at the time, and looked out at the 12 stories down and thought, ‘well, that would be the end of the problem.’” (E,190-192)

	Realising she would not survive if she continued attempting to defeat her trans self.	Feeling unable to hold trans self in anymore. Experiencing anxiety attacks and finding she could not defeat trans self.	“But there just came a point where I couldn’t hold it in anymore. It became anxiety attacks and that, and I thought, this time I’m not going to defeat it. I’m not sure I can defeat it.” (F, 135-138)
	Feeling an intense inability to continue living in the wrong body.	Experiencing bawl crying to his mother, stating he needed to do something about his gender, as he felt awful all the time.	“But I just, you know, I just bawled cried, like, I was like: ‘I need to do something about this. I can’t do anything. I can’t go out in public. I feel just awful all the time.’”(G, 30-32)