Understanding the Lived Experience of People who Detransition in the United Kingdom: An Interpretative Phenomenological Analysis

By

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A thesis submitted to the University of Birmingham for the degree of Doctor of Clinical Psychology

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August 2023

Thesis Overview

This thesis is comprised of a systematic literature review in the form of a meta-analysis, an original empirical research study, and a press release for each. The meta-analysis investigated the internal consistency of the Gender Minority Stress and Resilience Measure (GMSRM; Testa et al., 2015) through the aggregation of Cronbach's alpha coefficients. The study found support for the internal reliability of the GMSRM, however there were risk of bias concerns identified.

The empirical paper explored the lived experiences of six adults who detransitioned their gender in the United Kingdom. The study employed a qualitative methodology for data collection and analysis and six group experiential themes and 11 subthemes emerged. Clinical and research implication are discussed, in addition to future research recommendations.

Dedication

This thesis is dedicated to Sheila. Away, but never gone.

Acknowledgements

I would like to firstly thank each individual who participated in this study, without whom this thesis would not have been possible. It really was a privilege to meet you and hear about your experiences.

I am extremely grateful to my research supervisor Dr Ruth Howard for believing in this research from the very beginning and for the warm conversations, kindness, and guidance from that point onwards. I would like to also thank Dr Andrew Fox and Professor Chris Jones for the additional supervision that supported this research, and for sharing their wealth of expertise in research methodology that helped me to grow as a researcher.

Thank you to Dr Teresa Madurai for her continued reassurance and support throughout my clinical psychology training. I feel so fortunate to have had Dr Madurai alongside me for the last three years.

I would like to thank the entire Clinical Psychology Doctorate course team who work so hard with incredible diligence.

Completing my thesis would not have been possible without my caring friends and family who have been there for me through the highs and lows of life over the last three years. Your emotional and practical support has meant more to me than I can ever describe using words. I will always remember it.

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What is the Internal Consistency of the Gender Minority Stress and Resilience Measure?

Abstract

Introduction: The Gender Minority Stress and Resilience Measure (GMSRM; Testa et al., 2015) is a psychometric assessment designed to measure gender-related minority stress, and a set of resilience factors. Whilst it is recommended that gender minority stress is accounted for as part of a comprehensive psychological assessment and formulation for transgender and gender nonconforming (TGNC) individuals accessing psychological services, elucidating the psychometric properties of available assessments is important for clinical rigour within this process. This meta-analysis will therefore examine the internal consistency of the GMSRM.

Method: A systematic literature search and screening process identified 30 studies from which Cronbach's alpha coefficients were extracted. The methodological quality of studies was inspected using an adapted risk of bias tool. Notably, 15 studies suffered from high performance bias, followed by reporting (8), detection (6), selection (5), and generalisation bias (1).

Analysis: Random effects models were used to estimate the overall meta-analytic effects. The influence of small study and publication bias was examined using a trim and fill procedure (Duval & Tweedle, 2000), and subgroup analysis by study design was performed. Each of the composite and subdimensions of the GMSRM yielded a weighted average alpha coefficient which exceeded the minimum $\alpha = 0.70$ (Cronbach, 1951) convention for acceptable internal consistency.

Conclusion: The GMSRM has good internal consistency. However, further research is required to elucidate other components of internal reliability, such as the stability of the GMSRM. Study limitations and recommendations for future research are discussed.

Introduction

The terms ‘transgender’ and ‘gender nonconforming’ (TGNC) are used to describe individuals whose gender identity differs from that which aligns with their sex registered at birth, and typical binary gender conventions (American Psychological Association, 2013; Richards et al., 2016). The 2021 Census in England and Wales determined that there are approximately 262,000 people living in England and Wales aged 16 years and older who identify with a gender other than that which is congruent with their sex registered at birth (Office for National Statistics, 2023). TGNC individuals are a minority group who are more likely than the cisgendered[1] majority to experience social hostility and suffer poorer mental and physical health. This can, in part, be explained through gender minority stress (Barr et al., 2022; Castellini et al., 2023; Helminen et al., 2022; Meyer, 2015; Testa et al., 2015; Timmins et al., 2017). In essence, minority stress occurs when chronically harsh and hostile social-environmental conditions and stressors – such as repeated discrimination and stigma – operate to inflame stress responses in the minority group, and not the majority. Recently, researchers have endeavoured to capture and quantify the minority stress experienced by TGNC individuals through the development of a psychometric test named the Gender Minority Stress and Resilience Measure (GMSRM; Testa et al., 2015). Hitherto, no meta-analytic findings exist which examine the internal consistency of the GMSRM. Thus, in the current meta-analysis we address the question of whether the GMSRM is adequately internally consistent for use with TGNC individuals.

In a study of 871 TGNC individuals in Britain, 28% had experienced domestic abuse, 25% had experienced homelessness, and 41% of transgender and 31% of non-binary

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[1] Cisgender is a term used to describe individuals whose gender identity corresponds with the sex they were assigned at birth (Rioux et al., 2022).

individuals had experienced a hate crime related to their gender identity in the prior 12 months (Bachmann & Gooch, 2018). Existing evidence indicates that transgender individuals experience lower quality of life in comparison to the general population (Nobili et al., 2018), and systematic reviews, meta-analytic, and population-based findings yield compelling evidence to suggest an increased prevalence of mental health disorders in TGNC adults in various parts of the world compared with cisgendered individuals (Borbogna et al., 2018; Dhejne et al., 2016; Lin et al., 2021; Pinna et al., 2022). For instance, internalised transphobia predicted body uneasiness in individuals with gender dysphoria one year following the commencement of gender affirming medical treatment (Castellini et al., 2023). Furthermore, suicidality is higher in transgender individuals (Bränström et al., 2021), and in a sample of 575 transgender individuals, structural equational modelling demonstrated that anti-transgender bias and non-affirmation of gender identity was linked to posttraumatic stress, even after controlling for other experienced traumatic events (Barr et al., 2022). This kind of evidence supports the idea that adversities and 'daily hassles' experienced by minority groups can potentially be cumulatively traumatic in themselves (Meyer, 2015).

Despite this, individual and collective strengths can amalgamate to cultivate resilience in the service of 'bouncing back' from potentially traumatic events or adversity (Meyer, 2015). Recent strengths-based models have been developed with aim of synthesising the factors which make a difference to the wellbeing of TGNC individuals. These include the Transgender Resilience Intervention Model (Matsuna & Israel, 2018) and the Minority Strengths Model (Perrin et al., 2020). In an ethnically diverse sample of 317 LGBTQ individuals, path analysis determined that social support and community connectedness were both directly and indirectly influential on mental health and physical health when community pride, resilience and self-esteem were stronger (Perrin et al., 2020).

The development of stress theory can be linked back to the work of Selye (1956) who instigated what would become a vast body of research illuminating the negative influence of environmental stress on physical health (Cohen et al., 2019; Pacella et al., 2013; Schneiderman et al., 2005). Furthermore, since Goffman (1963) introduced preliminary conceptualisations of stigma in the context of social identity, there now exists a wide-ranging literature which identifies the important contribution of stigma to our understanding various circumstances. These include particular health diagnoses such as HIV (Earnshaw & Chaudoir, 2009), to social class and ethnic minority groups (Tyler & Slater, 2018), to medication adherence (Rintamaki et al., 2006; Sirey et al., 2001). Minority stress theory (Brooks, 1981) is constructed with the stress literature in mind, in addition to the literature on coping and resilience in the face of adversity (Meyer, 2003; Meyer, 2015). Expanding upon the work of Brooks (1981), Meyer (1995) examined minority stress factors and mental health outcomes in gay men, however since then the stressors explicated within the minority stress framework have been shown to apply to TGNC individuals also (Chodzen et al., 2019; Hendricks & Testa, 2012; Testa et al., 2015; Thoma et al., 2021).

As can be seen in Figure 1, the gender minority stress framework is comprised of two connected dimensions (distal and proximal stress), and an additional set of resilience factors which serve as a buffer against undesirable mental and physical health outcomes on the distal-to-proximal continuum (Mayer, 2015; Testa et al., 2015).

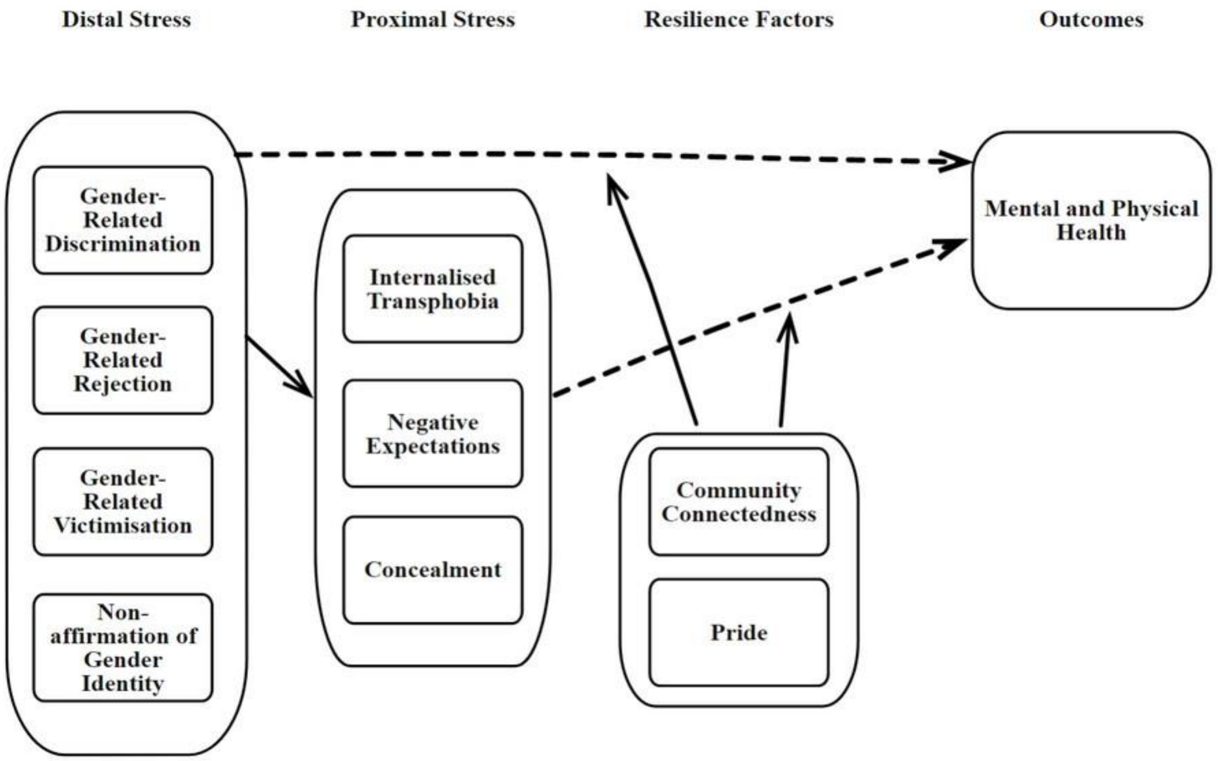

Figure 1: The Gender Minority Stress and Resilience Model (Testa et al., 2015)

Distal stress is defined as originating from events external to the person such as gender-related discrimination (e.g., barriers accessing healthcare), rejection (e.g., rejection within interpersonal, community, or institutional contexts), victimisation (e.g., through harassment or violence), and non-affirmation of gender identity (e.g., being misgendered) (Testa et al., 2015). Proximal stress is described as the intrapersonal subjective experience resulting from distal stressors which manifests through cognitive mechanisms (Meyer, 2015). These include internalised transphobia (e.g., resenting one's TGNC identity), negative expectations for the future (e.g., expressing one's gender identity will result in unemployment or negative appraisals from other people), and non-disclosure of gender identity (e.g., concealing aspects of oneself such as ways of speaking, dress sense, or body parts) (Testa et al., 2015). Lastly, the gender minority stress model postulates resilience as a moderating factor in thwarting the impact of minority stress on mental and physical health outcomes in TGNC individuals. Specifically, having pride in one's gender identity in addition to having community connectedness with individuals who share TGNC identities may result in an ability to 'bounce back' through the reappraisal of distal and proximal stress (Meyer, 2015; Testa et al., 2015).

Some transgender individuals may experience gender dysphoria and seek gender-affirming medical or surgical intervention in healthcare settings. Gender dysphoria is broadly defined as the experience of psychological distress resulting from an incongruence between one's felt gender and their sex registered at birth. In the United Kingdom, it has been standard practice to confer a diagnosis of gender dysphoria prior to being referred for physical or medical intervention (Cass, 2022). There is debate over existing conceptualisations of gender dysphoria, and recent research has suggested that gender dysphoria itself should be considered a continuous construct, and located within the minority stress framework as a proximal stressor (Galupo et al., 2020; Lindley & Galupo, 2020). In contrast to this, the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-V; APA, 2013) contains a set of discrete criteria used to confer a diagnosis of gender dysphoria. Although a discussion is beyond the scope of the current endeavour, the way in which gender dysphoria is conceived and measured (e.g., shifting from a position of pathology and diagnosis to one which places social context in the spotlight) could have significant implications for clinical practice (Lindley & Galupo, 2020).

The Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 (Coleman et al., 2022) highlight the importance of accounting for gender related minority stress in supporting TGNC individuals. Moreover, in their guidelines for working with gender, sexuality and relationship diversity in adults, the British Psychological Society (2019 pp. 7-8) state: *"Psychologists should have an understanding of the adverse effects of social stigmatisation on clients' identities and the distress caused to individuals who are seen as different. Assessments, formulations and interventions should acknowledge this explicitly".*

Considering the evidence that gender minority stress and resilience factors are important for TGNC individuals, it is important for clinicians to be in a position of being able to account for and assess the needs of this population. And in doing so, the availability of reliable psychometric measures to support clinical assessment is fundamental. Without evidencing adequate internal consistency within a psychometric test, we vastly attenuate the degree to which we can be confident in what we are truly measuring, and limit our ability to predict outcomes (Kline, 2000).

To overcome the limitations (e.g., research biases and small sample sizes) often associated with considering research studies in isolation, we elected a meta-analytic approach to address the research question. The meta-analytic approach brings an individual study outcome into the context of all other study outcomes. This way, the extent to which effect sizes are consistent across the universe of study outcomes can be examined, and statistical procedures applied to estimate the robustness of this consistency (Borenstein et al., 2009). Conversely, in the presence of between-study inconsistencies, the meta-analytic approach allows for the quantification of the extent of variation and, as such, to explore the implications (Borenstein et al., 2009). Using this methodology, we endeavour to ask how reliable the GMSRM is?

Method

Identifying Primary Studies

Search Strategy

A literature search of the APA PsycInfo, Medline, and APA PsycArticles databases took place between June 2022 and November 2022. Additional articles were identified through both examining the articles which had cited Testa et al., (2015), and references within them. The aim was to identify articles that had used and reported reliability coefficients for the GMSRM

(Testa et al., 2015) to scrutinise the extent to which the measure performs reliably across studies. The search terms included general terms related to the aim and topic of the meta-analysis, and the inclusion criteria. These were: {"gender minority stress and resilience"} AND {"gender non?conform$" OR trans$ OR LGBT$} AND {"internal consistency" OR alpha OR "cronbach$" OR reliability OR test-retest}.

Inclusion Criteria

As can be seen in Figure 2, the initial database search retrieved 52 records, and an additional 28 through other sources. When duplicate records were removed, 59 records were screened for eligibility using the inclusion and exclusion criteria (Table 1).

Data Extraction

Data extraction was completed by the lead author. The academic supervisor provided supervision on articles where ambiguity existed in relation to the inclusion criteria. Decisions on the retention or exclusion of an ambiguous article were made by consensus following the examination and discussion of the article.

Both descriptive and numerical data were extracted from each paper. The extracted data consisted of the author, year of publication, sample demographics, number of participants, study design, the number of items in each scale and subscale, and Cronbach’s alpha coefficient (Cronbach, 1951).

Table 1: Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria	Rationale
At least 50% of the study sample are over the age of 18 years of age.	The sample size consists predominantly of individuals under the age of 18 years of age.	Developmental factors could place limits on the conclusions drawn from the study.
Articles published in the English language between 2015 and 2022.	Articles published in a non-English language.	The authors were constricted by time and resource, preventing article translation.
Peer-reviewed articles reporting new empirical data	Meta-analytic / review papers, books / book chapters, studies reporting internal consistency coefficients from past studies, and literature which has not been peer-reviewed (e.g., unpublished theses or dissertations).	A meta-analysis requires original data for statistical inference-making. This exclusion criterion reflects this principle.
The study sample reflects the population for which the GMSRM was designed and intended.	The study sample were not transgender or gender non-conforming.	The GMSRM was developed to measure minority stress and resilience factors in transgender and gender non-conforming individuals (Testa et al., 2015).
The GMSRM and its subscales are administered in the way in which they were designed, and translated versions have been approved by the developer/s of the GMSRM.	The GMSRM was not used in its original or translated (and approved) form.	The aim of this meta-analysis is to examine the internal consistency of the GMSRM in line with the original scale development and validation. Therefore, only approved versions of the measure were included.
Appropriate statistical reporting of a minimum of one type of reliability coefficient for the GMSRM.	Studies which do not report reliability coefficients for the GMSRM.	The focus of this meta-analysis is to examine the reliability of the GMSRM. Thus, to meet this objective, it is required that studies report reliability coefficients.

Defining Problematic Variance

A study level effect is considered heterogeneous if it presents with variation from the meta-analysis synthesis that cannot be attributed to true variation in the distribution of effect in the population. Heterogeneity can result from methodological variation in the studies, measurement error or uncontrolled individual difference factors within the body of literature. Higgins I^2 is a commonly used measure of heterogeneity, with greater values of I^2 indicating variation in effect that cannot be attributed to true variation in the distribution of effect in the population (Higgins & Thompson, 2002). As there is considerable variation in methodologies of the primary studies that was used to calculate the meta-analytic synthesis, problematic heterogeneity was defined as a Higgins I^2 value greater than 75%. Where unacceptable or problematic heterogeneity is observed then the focus of the subsequent analyses will be upon the identification of the sources of heterogeneity between the estimates of effect in the primary studies.

Statistical Analysis

The data was analysed using the R programming language. To produce the main effects, the tau^2 statistic was derived using the DerSimonian-Laird random effects method (DerSimonian & Laird, 1986) for the Distal, Proximal and Resilience scales separately. Tau^2 is an estimate of the standard deviation the true effect sizes. Pooled estimates of effect and 95% confidence intervals were calculated. It was considered appropriate to use a random effects model to examine the effect sizes. This was because variability in effect sizes was anticipated in the included studies based on the sampling and methodological procedures selected within the studies. Thus, there was reason to assume that the true effect size would not be the same across all studies and that, consequently, there would be variability in the true effect size.

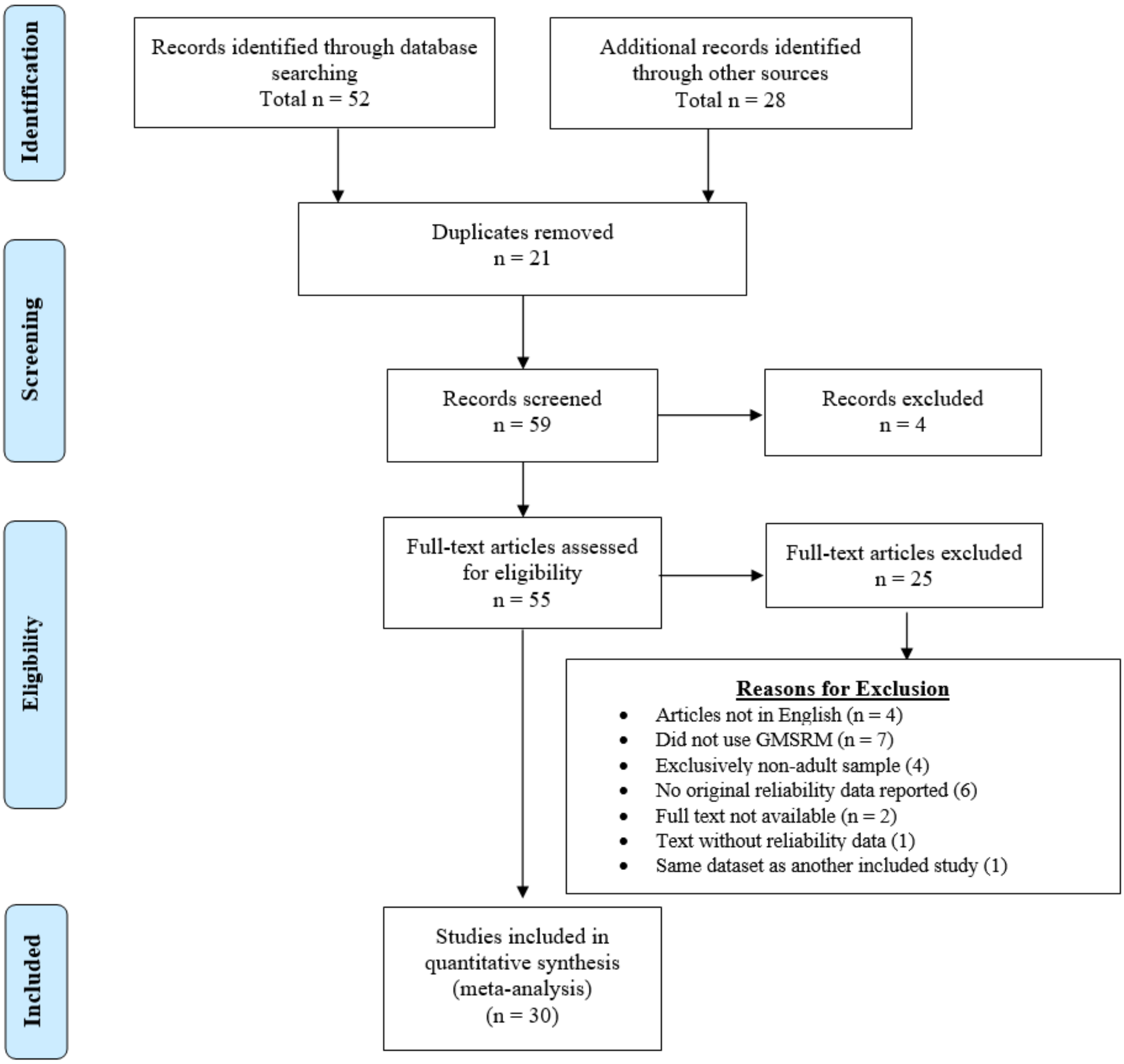

Figure 2: Prisma Flow Diagram for Literature Search

Heterogeneity was examined using the Higgins I^2 statistic (Higgins & Thompson, 2002) to yield the percentage of total variation across studies that is due to heterogeneity. Publication bias was assessed using the 'Trim and Fill' procedure and the data was inspected visually through funnel plots (Duval & Tweedie, 2000). The iterative 'Trim and Fill' procedure removes the most extreme small studies from the positive side of the funnel plot and the effect size is recalculated with each iteration until symmetry is observed around the arrived-at effect size (Borenstein et al., 2009).

Risk of Bias of Assessment

To mitigate against the impact of artefactual influences on the study effect sizes (Borenstein et al., 2009), a set of quality criteria were developed to assess any risk of bias within this literature. The quality criteria were adapted from existing risk of bias frameworks, including The Cochrane Collaboration Risk of Bias Tool (Higgins et al., 2011) and the Risk of Bias Assessment Tool for Nonrandomised Studies (Kim et al., 2013). The current framework assesses risk of bias in seven domains: selection bias, performance bias, detection bias, statistical bias, reporting bias and generalisation. The risk of bias in the six domains and the criteria for Low, Unclear or High risk is described in Table 2 and the application of these criteria are reported in Table 3. The risk of bias criteria were rated by the primary author. However, where articles presented with ambiguity, a process of consultation with the academic supervisor supported decision-making in categorising articles.

Selection Bias

As can be seen in Table 3, this domain had the highest number of studies considered to be unclear in the extent of bias. Of the 30 studies included in the analysis, selection bias was considered unclear in 24 studies (80%), whilst five were high risk, and one study low risk. The high-risk studies (Huit et al., 2022; Muratore et al., 2022; Powell et al., 2022; She et al., 2020; Watson et al., 2018), suffered from predominantly target sampling procedures, a high non-response rate, or used a clinical sample. Those with unclear risk used predominantly convenience sampling.

Table 2: Quality Assessment Framework with Risk of Bias Criteria

Domain	Details	Risk of Bias (example indicator)
Selection Bias	Are there systematic differences between the characteristics of those selected for the study and those who are not?	High Risk: (i) Includes an unacceptable level of non-response rate (reporting less than 30% of the data). (ii) Target sampling was used. The sample were of a clinical population (e.g., recruited due to having a mental health diagnoses). (iii) The characteristics of the study population are not reported. Unclear Risk: (i) Non-response rate is not reported. (ii) The characteristics of the study population are not clearly reported. For example, the country, setting, location, population demographics were not adequately reported. (iii) The recruitment process/ sampling method of individuals are unclear or has not been reported. (iv) Convenience sampling was used. Low Risk: (i) The characteristics of the study population are clearly described and without evidence of bias. (ii) Non-response rate is reported and of an acceptable level (set at 50%). (iii) The source population is well described, and the study reports the characteristics of the sample e.g. the study details subgroups. (iv) The recruitment method is clearly reported and well defined. (v) The article provides some reassurance that there is no selection bias
Performance Bias	What is the extent to which participants are differentially motivated to complete the study?	High Risk: (i) Responses are not confidential or anonymous. (ii) Participants were rewarded for their participation in the study. (iii) Participants were told which condition/ what questionnaires they were completing and why and any proposed hypotheses. Unclear Risk: (i) The study does not report levels of confidentiality and anonymity. (ii) It is not clear if participants were rewarded for their participation (e.g. motivation to respond in a certain way). (iii) It is unclear how much information was provided to the participant prior to taking part in the study. Low Risk: (i) Study reports level of confidentiality and anonymity. (ii) Participants were not rewarded for their participation in the study. (iii) Information and procedures are provided in a way that does not differentially motivated participants.
Detection Bias	Based on the administration of the GMSRM in a study, to what extent are the reported psychometric characteristics of the GMSRM generalisable to the administration of the GMSRM outside of the specific study setting?	High Risk: (i) Non-standard administration of the GMSRS. (ii) Reduced item administration. Unclear Risk: (i) Unclear administration procedure or the GMSRS is implemented inconsistently across all participants. (ii) Unclear if translated. (iii) Unclear if full item administration was administered. Low Risk: (i) The administration of the GMSRS is clearly described and is implemented consistently across all participants. (ii) Complete item versions of subscales and total scores are reported.
Statistical Bias	To what extent is the statistical treatment of the data appropriate?	High Risk: (i) Unclear what statistical test was used. or Reliability coefficients were not reported. Unclear Risk: Reports internal reliability coefficient that can be transformed into Cronbach's alpha (i.e., mean interitem correlation). Low Risk: Appropriate internal reliability coefficient is reported (i.e., Cronbach's alpha).
Reporting Bias	Is there evidence of selective outcome reporting? E.g., reporting internal reliability coefficients as a range?	High Risk: (i) Internal reliability is reported for subgroups only. (ii) Subscale reliabilities reported as a range. Unclear Risk: Concern regarding the reporting of internal reliability. Low Risk: Internal reliability is reported on the entire sample.
Generalisation	Can the research findings be applied to settings other than that in which they were originally tested? Are there any differences between the study participants and those persons to whom the review is applicable?	High Risk: (i) Small sample with or without idiosyncratic feature. (ii) The sample size is not adequate to detect an effect (N<25). Unclear Risk: (i) Sufficient sample for generalisation but with some idiosyncratic features. (ii) Sample size is not optimised to assess internal reliability (i.e., 25<N<50). Low Risk: (i) Sufficient sample for generalisation and representative of target population. (ii) The sample size is adequate to assess internal reliability (N>50).

Table 3: Study Level Risk of Bias Ratings

Study Name	Year	Selection Bias	Performance Bias	Detection Bias	Statistical Bias	Reporting Bias	Generalisability	Quality Index
Brennan et al	2017	🟨	🟩	🟨	🟩	🟩	🟩	45%
Budge et al	2020	🟨	🟩	🟨	🟩	🟩	🟨	41%
Cogan et al	2020	🟩	🟩	🟨	🟩	🟥	🟩	41%
Cusack et al	2021	🟨	🟩	🟨	🟩	🟩	🟩	45%
Flynn & Bhambhani	2021	🟨	🟩	🟨	🟩	🟩	🟩	45%
Fuller & Riggs	2018	🟨	🟩	🟨	🟩	🟩	🟩	45%
Huit et al a	2022	🟥	🟥	🟩	🟩	🟥	🟨	23%
Huit et al b	2021	🟨	🟥	🟩	🟩	🟥	🟩	11%
Holt et al	2019	🟨	🟥	🟩	🟩	🟥	🟩	32%
Jäggi et al	2018	🟨	🟨	🟥	🟩	🟨	🟩	32%
Kaplan	2019	🟨	🟩	🟩	🟩	🟩	🟩	50%
Kolp et al	2020	🟨	🟥	🟩	🟩	🟩	🟩	41%
Lee et al	2020	🟨	🟩	🟥	🟩	🟩	🟩	41%
Lett et al	2022	🟨	🟥	🟩	🟩	🟩	🟩	41%
Lindley & Galupo	2020	🟨	🟩	🟩	🟩	🟥	🟩	41%
Lloyd et al	2019	🟨	🟩	🟩	🟩	🟩	🟩	50%
Muratore et al	2022	🟥	🟥	🟩	🟩	🟥	🟩	27%
Pease et al	2022	🟨	🟥	🟩	🟩	🟥	🟩	32%
Poteat et al	2019	🟨	🟥	🟥	🟩	🟩	🟨	27%
Powell et al	2021	🟥	🟩	🟨	🟩	🟩	🟨	36%
Rabasco & Andover	2021	🟨	🟥	🟩	🟩	🟩	🟩	41%
Rimmer et al	2021	🟨	🟨	🟨	🟩	🟥	🟩	32%
Scandurra et al	2019	🟨	🟥	🟥	🟩	🟩	🟩	77%
She et al	2020	🟥	🟥	🟨	🟩	🟩	🟩	32%
Testa et al	2015	🟨	🟩	🟩	🟩	🟩	🟩	95%
Tebbe et al	2021	🟨	🟥	🟩	🟩	🟩	🟩	41%
Tebbe et al	2018	🟨	🟨	🟩	🟩	🟩	🟥	36%
Valente et al	2020	🟨	🟥	🟥	🟩	🟩	🟩	32%
Watson et al	2018	🟥	🟥	🟩	🟩	🟩	🟨	32%
Zhang et al	2021	🟨	🟥	🟥	🟩	🟩	🟨	27%

Performance Bias

This domain had the largest number of high-risk studies across all six domains. Performance bias was considered to be high in 15 studies (50%), whilst 12 studies (40%) were low, and three unclear (10%). High-risk studies used incentives or rewards for participation in the research, and unclear bias pertained to ambiguous detail regarding the anonymity of participants, rewards for participation, and information shared with participants prior to study participation.

Detection Bias

Detection bias was considered low in 15 (50%) studies, unclear in nine studies (30%), high in six studies (20%), as can be seen in Table 3. Half of the studies reported administering the GMSRM in ways consistent with how it was developed, whilst those studies which were unclear or high in risk were ambiguous in their detail of adaptations to the GMSRM (e.g., purport to have adapted a subscale for administration without an explanation for how or what was adapted), omitted items from a subscale, or administered the GMSRM differently across participants (e.g., paper versus online administration).

Statistical Bias

All of the included studies were considered to be low in statistical bias, meaning that appropriate statistical procedures were used and adequately reported in each study.

Reporting Bias

For reporting bias, 21 studies were considered to be low risk (70%), eight studies (27%) were considered high risk, and one unclear. The unclear and high-risk studies suffered from either concern over the reporting of subscale alpha coefficients, or reporting most or all coefficients in a range, which prevented the exact coefficients from being extracted. In order to include data in the meta-analysis from studies reporting a range of coefficients, it was decided to extract the midpoint within the range.

Generalisability

Risk of bias was predominantly low in this domain. Generalisability bias was considered to be low in 23 studies (77%), unclear in six studies (20%), and high risk in one study. For those studies unclear in the extent of bias, they used sample sizes with more than *N* = 25, but less that *N* = 50. The study with high risk of generalisability bias had sample idiosyncrasies (e.g., sample lacked diversity of characteristics) which lowered the representativeness of the sample.

Summary

The overall risk of bias within the 30 included studies was varied. As can be seen in Table 3, there were eight studies which did not achieve high risk categorisation in any domain, and eight which achieved a high-risk categorisation in only one domain. All 30 studies were low in statistical bias, whilst generalisability bias was second lowest with 23 low-risk studies, reporting bias with 21, detection bias with 15, performance bias with 12, and selection bias containing just one low risk study. High-risk studies were most frequent in performance bias (15 studies), whilst the second highest count of high-risk studies was in reporting bias (eight studies), followed by detection bias (six studies), sampling bias (five studies), and generalisation (one study). Unclear bias was most evident in selection bias (25 studies), followed by detection bias (nine studies), generalisability (six studies), performance bias (three studies), and reporting bias (one study).

Since reliability estimates are influenced by various aspects of the environment (Klein, 2000), it is expected that these established patterns of bias will influence the meta-analytic outcomes. Thus, a prudent interpretation of them if encouraged. With that said, these studies are representative of the existing literature at the time of writing and are included in the analysis.

Results

Three meta-analytic models were developed to estimate the internal consistency of the three GMSRM dimensions separately. We first examined the Distal dimension which is, as aforementioned, comprised of the Discrimination, Rejection, Victimisation and Non affirmation subdimensions (Testa et al., 2015).

The Internal Consistency of the Distal Dimension

Selection of the meta-analytic model

The distribution of primary study effects is shown in Figure 3. The between studies variance (tau^2) was calculated using the DerSimonian-Laird estimate estimator.

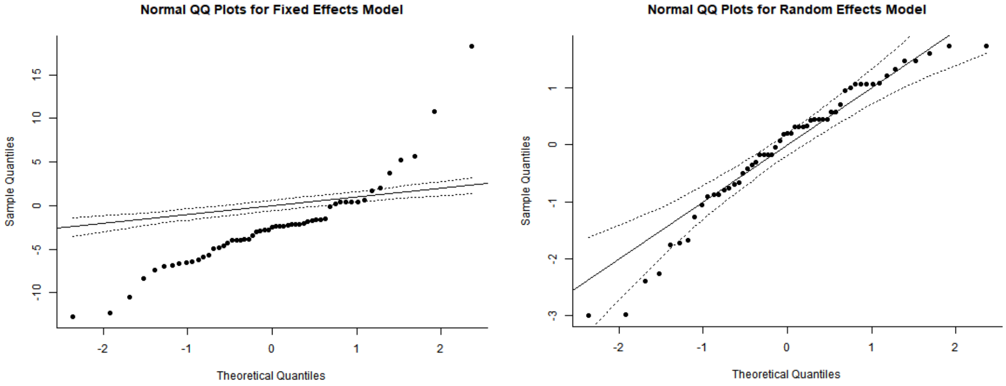

Figure 3: QQ plot of the distribution of internal consistency of the Distal Subdimensions

As can be seen from Figure 3, there is clear evidence of non-linearity in the distribution of alpha coefficients when using the fixed effects model, however, this non linearity is substantially absent in the random effects model. Therefore, this indicates that the use of the random effects model in which between studies variation is calculated using the DerSimonian-Laird estimate is an appropriate method for the calculation of weighted average internal reliability coefficient.

The omnibus test

The alpha coefficients reported in the included studies are reported in Table 4. Across all of the Distal subdimensions, there were 15 studies in a total of 7571 participants.

Table 4:Study level alpha coefficients for the Distal Subdimensions

Study	Scale	Alpha	Std.Er	CI_Lower	CI_Upper	Weight(random)
Brennan et al 2017	Discrimination	0.73	0.047434	0.637	0.823	114.83
Fuller & Riggs 2018	Discrimination	0.65	0.029881	0.5914	0.7086	136.03
Huit et al b 2021	Discrimination	0.745	0.027956	0.6902	0.7998	138.12
Holt et al 2019	Discrimination	0.78	0.023834	0.7333	0.8267	142.32
Jäggi et al 2018	Discrimination	0.48	0.069241	0.3443	0.6157	88.87
Lett et al 2022	Discrimination	0.73	0.021729	0.6874	0.7726	144.29
Lloyd et al 2021	Discrimination	0.6	0.021296	0.5583	0.6417	144.67
Muratore et al 2022	Discrimination	0.88	0.01989	0.841	0.919	145.9
Pease et al 2022	Discrimination	0.65	0.035947	0.5795	0.7205	129.02
Rabasco & Andover 2021	Discrimination	0.72	0.033183	0.655	0.785	132.28
Rimmer et al 2022	Discrimination	0.83	0.018332	0.7941	0.8659	147.18
Scandurra et al 2019	Discrimination	0.51	0.054647	0.4029	0.6171	105.88
Testa et al 2015	Discrimination	0.61	0.021251	0.5683	0.6517	144.72
Tebbe et al 2021	Discrimination	0.85	0.013716	0.8231	0.8769	150.45
Zhang et al 2021	Discrimination	0.89	0.009179	0.872	0.908	152.84
Brennan et al 2017	Nonaffirmation	0.9	0.017213	0.8663	0.9337	148.04
Budge et al 2020	Nonaffirmation	0.69	0.113196	0.4681	0.9119	51.89
Fuller & Riggs 2018	Nonaffirmation	0.91	0.007528	0.8952	0.9248	153.49
Huit et al a 2022	Nonaffirmation	0.88	0.033941	0.8135	0.9465	131.4
Huit et al b 2021	Nonaffirmation	0.745	0.027391	0.6913	0.7987	138.72
Holt et al 2019	Nonaffirmation	0.78	0.023353	0.7342	0.8258	142.78
Jäggi et al 2018	Nonaffirmation	0.82	0.023484	0.774	0.866	142.65
Kolp et al 2020	Nonaffirmation	0.88	0.013522	0.8535	0.9065	150.57
Lett et al 2022	Nonaffirmation	0.74	0.020501	0.6998	0.7802	145.37
Muratore et al 2022	Nonaffirmation	0.88	0.019488	0.8418	0.9182	146.23
Pease et al 2022	Nonaffirmation	0.87	0.013082	0.8444	0.8956	150.84
Rimmer et al 2022	Nonaffirmation	0.83	0.017961	0.7948	0.8652	147.47
Scandurra et al 2019	Nonaffirmation	0.92	0.008742	0.9029	0.9371	153.02
She et al 2020	Nonaffirmation	0.81	0.020971	0.7689	0.8511	144.96
Testa et al 2015	Nonaffirmation	0.93	0.003737	0.9227	0.9373	154.5
Tebbe et al 2018	Nonaffirmation	0.91	0.0106	0.8892	0.9308	152.19
Brennan et al 2017	Rejected	0.75	0.043033	0.6657	0.8343	120.33
Fuller & Riggs 2018	Rejected	0.69	0.025931	0.6392	0.7408	140.23
Huit et al b 2021	Rejected	0.745	0.027391	0.6913	0.7987	138.72
Holt et al 2019	Rejected	0.78	0.023353	0.7342	0.8258	142.78
Jäggi et al 2018	Rejected	0.82	0.023484	0.774	0.866	142.65
Lett et al 2022	Rejected	0.72	0.022079	0.6767	0.7633	143.97
Muratore et al 2022	Rejected	0.88	0.019488	0.8418	0.9182	146.23
Rimmer et al 2022	Rejected	0.83	0.017961	0.7948	0.8652	147.47
Scandurra et al 2019	Rejected	0.64	0.039338	0.5629	0.7171	124.91
Testa et al 2015	Rejected	0.71	0.015483	0.6797	0.7403	149.29
Zhang et al 2021	Rejected	0.79	0.01717	0.7563	0.8237	148.07
Brennan et al 2017	Victimisation	0.81	0.032705	0.7459	0.8741	132.83
Fuller & Riggs 2018	Victimisation	0.82	0.015057	0.7905	0.8495	149.58
Huit et al b 2021	Victimisation	0.745	0.027391	0.6913	0.7987	138.72
Holt et al 2019	Victimisation	0.78	0.023353	0.7342	0.8258	142.78
Jäggi et al 2018	Victimisation	0.82	0.023484	0.774	0.866	142.65
Lett et al 2022	Victimisation	0.84	0.012616	0.8153	0.8647	151.11
Muratore et al 2022	Victimisation	0.88	0.019488	0.8418	0.9182	146.23
Rabasco & Andover 2021	Victimisation	0.84	0.018579	0.8036	0.8764	146.98
Rimmer et al 2022	Victimisation	0.83	0.017961	0.7948	0.8652	147.47
Scandurra et al 2019	Victimisation	0.76	0.026225	0.7086	0.8114	139.93
She et al 2020	Victimisation	0.72	0.030905	0.6594	0.7806	134.89
Testa et al 2015	Victimisation	0.77	0.012279	0.7459	0.7941	151.3
Tebbe et al 2018	Victimisation	0.81	0.022379	0.7661	0.8539	143.69
Zhang et al 2021	Victimisation	0.93	0.005723	0.9188	0.9412	154.05
Brennan et al 2017	Total Distal	0.83	0.027313	0.7765	0.8835	138.8
Pease et al 2022	Total Distal	0.8	0.018786	0.7632	0.8368	146.81
Powell et al 2022	Total Distal	0.76	0.054872	0.6525	0.8675	105.6

A random effects models was calculated using the generic inverse variance method. The weighted average alpha coefficient for the Distal subdimensions are reported in Table 5.

The 95% confidence interval for the discrimination subdimension did not exceed the minimum interpretable value of alpha = 0.70, although the weighted average alpha coefficient (alpha = 0.7172) was just above the minimum interpretable value. All of the remaining Distal subdimensions evidenced a 95% confidence interval of the weighted average alpha coefficient that exceed the minimum interpretable value of α=0.70.

Table 5: Weighted Average Alpha coefficient for the Distal Subdimensions

	k	**ARAW**	**95%-CI**	**tau^2**	**tau**
Distal - Discrimination	15	0.7172	[0.6570; 0.7774]	0.0131	0.1145
Distal - Rejected	11	0.7625	[0.7224; 0.8027]	0.004	0.0629
Distal - Victimisation	14	0.8127	[0.7724; 0.8531]	0.0055	0.074
Distal – Non-affirmation	16	0.8555	[0.8299; 0.8810]	0.0022	0.0474
Total - Distal	3	0.806	[0.7768; 0.8352]	0	0

The individual study level effects as well as the random effects model weighted average alpha coefficient are reported in the forest plot in Figure 4.

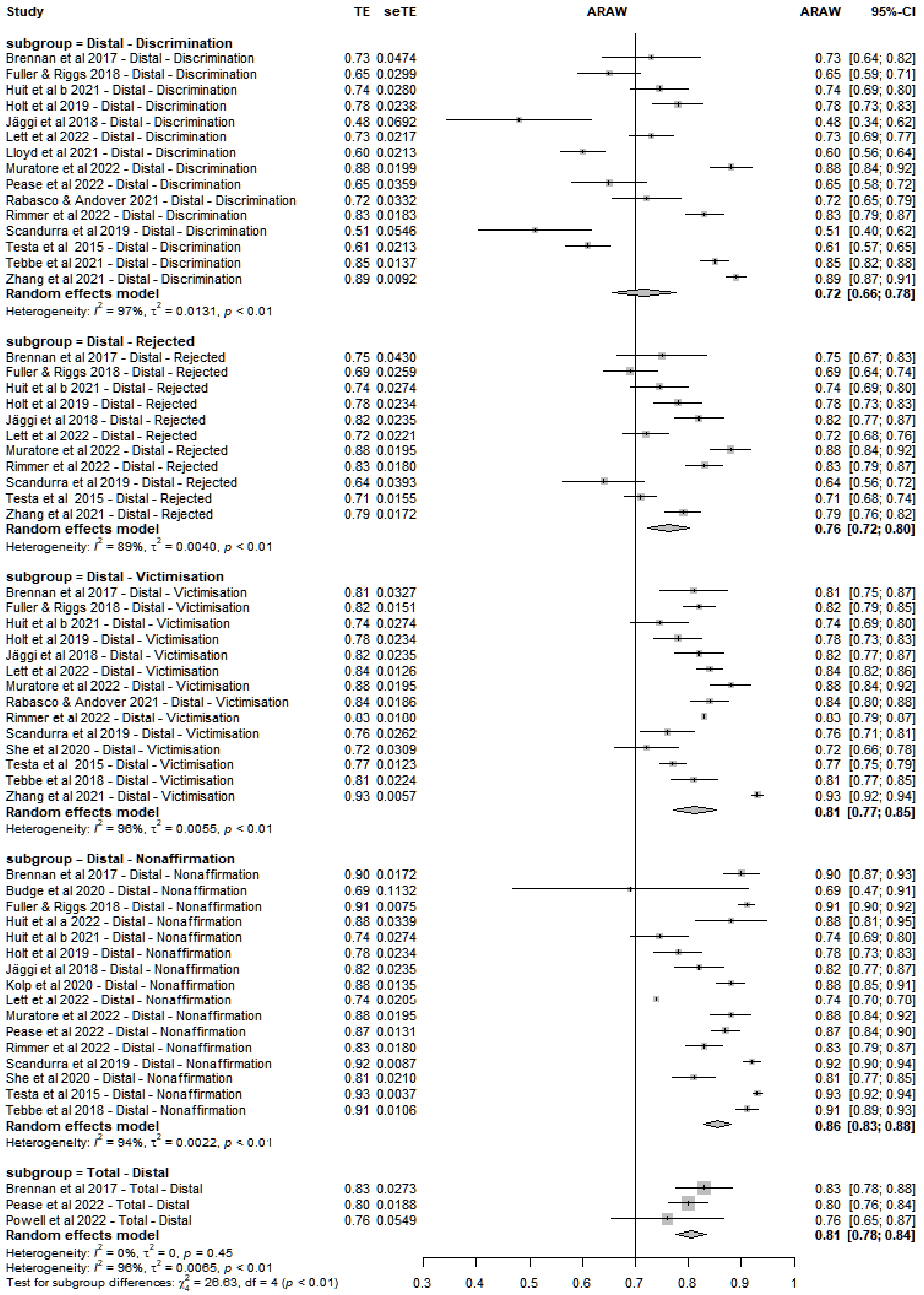

Figure 4: Forest plot of alpha coefficients for each of the Distal Subdimensions

A high level of heterogeneity in the studies was observed in the Discrimination, Non-affirmation, Rejected, and Victimisation subdimensions (Higgin I^2 values reported in Table 5 and Figure 4), suggesting that the estimates of internal consistency may be biased by the presence of uncontrolled or confounding factors (such as methodological artefacts and uncontrolled individual difference factors). Therefore, the focus of the subsequent analyses will be upon the identification of the sources of heterogeneity between the estimates of internal consistency in the included studies.

The impact of influential primary studies

The impact of disproportionately influence studies was assessed using a "leave-one-out" analysis, in which the random effects model was calculated with each of the primary studies removed in turn and change in weighted average effect size (i.e., influence) and the change in heterogeneity (i.e., discrepancy) was recorded. The result of this "leave-one-out" analysis is presented on the Baujat plot (Baujat, Pignon, & Hill, 2002) in Figure 5.

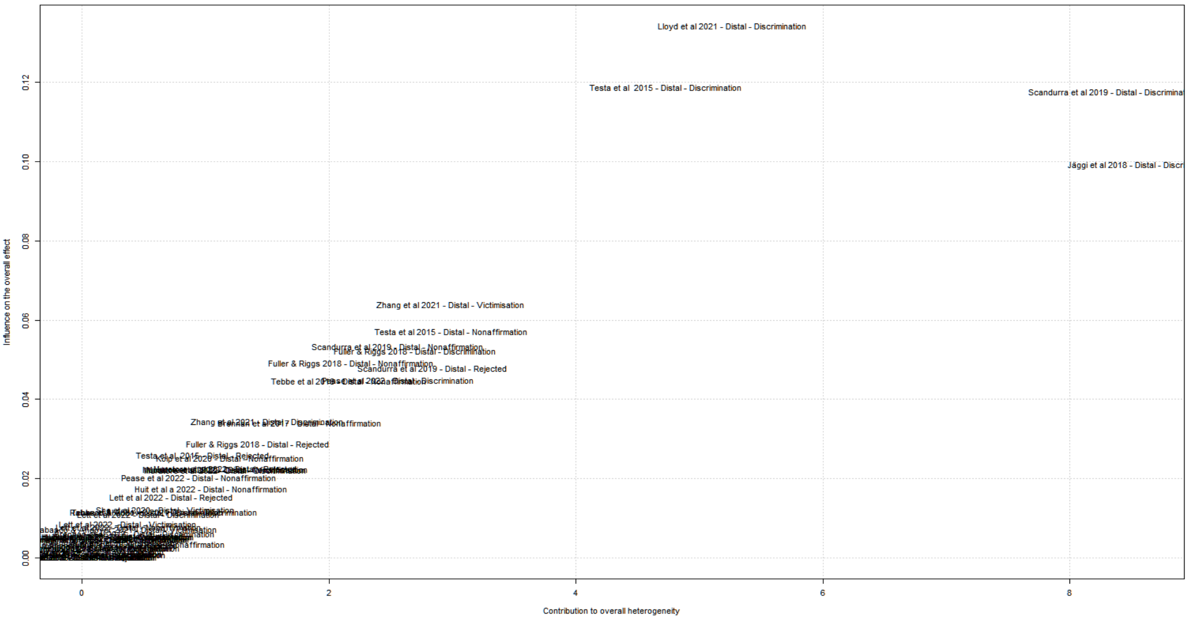

Figure 5: Baujat diagnostic plot of sources of heterogeneity. The vertical axis reports the influence of the study on the overall effect and the horizontal axis reports the discrepancy of the study with the rest of the literature

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The Baujat plot depicted in Figure 5 identified four study level effects as being influential and discrepant from the existent literature (Jaggi et al., 2018, Lloyd et al., 2021, Scandurra, 2019 and Testa et al., 2015), each reporting alpha coefficients from the Discrimination subdimension. The random effects model for the Discrimination subdimension was recalculated with the four studies showing disproportionate influence removed. The corrected random effects model reported a statistically non-significant increase (X^2=0.57, p= 0.45) in the weighted average alpha = 0.7508 (95% CI 0.6879 to 0.8136) for the discrimination subdimension. This change in alpha coefficient between the uncorrected model and the corrected model is shown in Figure 6.

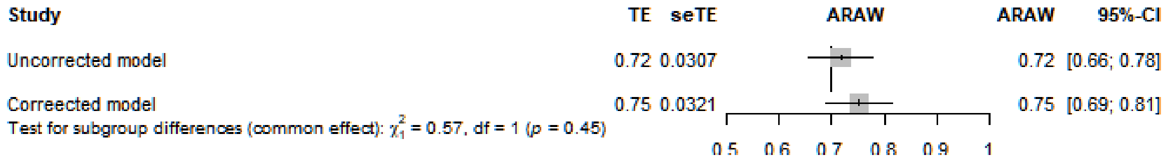


Figure 6: Comparison of the original omnibus weighted average alpha and the estimate that was obtained following the removal of influential and discrepant studies

The four influential and discrepant studies were critically reviewed with a view to removing them from subsequent analysis if marked risk of bias or threats to internal validity could be identified. As no marked risk of bias could be identified these four studies were retained in subsequent analysis.

The effect of risk of bias in the primary studies

In order to assess the impact of study level risk of bias upon heterogeneity, a series of subgroup analysis were conducted on the Distal subdimensions for the risk of bias ratings of “low risk” and “any risk” (i.e., unclear risk and high risk of bias combined) for each of the six types of methodological bias.

Table 6: Differences in weighted average alpha coefficients as a function of risk of bias in each of the Distal Subdimensions

		k	Alpha	Lower 95% CI	Upper 95% CI	tau^2	X^2	P
Discrimination Subdimension								
Selection Bias	Low risk							
	Any risk	15	0.7172	0.6570	0.7774	0.0131	-	-
Performance Bias	Low risk	4	0.6336	0.5909	0.6762	0.0011		
	Any risk	11	0.7496	0.6959	0.8034	0.0073	10.98	0.0009
Detection Bias	Low risk	9	0.7304	0.6576	0.8031	0.0118		
	Any risk	6	0.6933	0.5848	0.8018	0.0166	0.31	0.5782
Statistical bias	Low risk	15	0.7172	0.6570	0.7774	0.0131		
	Any risk	-	-	-	-	-	-	-
Reporting bias	Low risk	9	0.702	0.6133	0.7907	0.0175		
	Any risk	6	0.7445	0.6689	0.8200	0.0078	0.51	0.4749
Generalisation	Low risk	14	0.7045	0.6452	0.7638	0.0117		
	Any risk	1	0.89	0.8720	0.9080	-	-	-
Rejected Subdimension								
Selection Bias	Low risk							
	Any risk	11	0.7625	[0.7224;	0.8027]	0.004	-	-
Performance Bias	Low risk	3	0.7087	0.6838	0.7336	0		
	Any risk	8	0.7803	0.7370	0.8237	0.0033	7.9	0.0049
Detection Bias	Low risk	5	0.7671	0.7007	0.8335	0.0053		
	Any risk	6	0.7588	0.7053	0.8123	0.0037	0.04	0.8489
Statistical bias	Low risk	11	0.7625	0.7224	0.8027	0.004		
	Any risk	-	-	-	-	-	-	-
Reporting bias	Low risk	6	0.7203	0.6801	0.7605	0.0018		
	Any risk	5	0.8133	0.7701	0.8566	0.0019	9.54	0.002
Generalisation	Low risk	10	0.7592	0.7136	0.8047	0.0047		
	Any risk	1	0.79	0.7563	0.8237	-	1.14	0.2857
Victimisation Subdimension								
Selection Bias	Low risk							
	Any risk	14	0.8127	0.7724	0.8531	0.0055	-	-
Performance Bias	Low risk	3	0.7973	0.7594	0.8351	0.0008		
	Any risk	11	0.8164	0.7713	0.8615	0.0054	0.41	0.5239
Detection Bias	Low risk	7	0.8109	0.7768	0.8449	0.0017		
	Any risk	7	0.8151	0.7511	0.8790	0.0069	0.01	0.9095
Statistical bias	Low risk	14	0.8127	0.7724	0.8531	0.0055		
	Any risk	-	-	-	-	-	-	-
Reporting bias	Low risk	9	0.8129	0.7590	0.8668	0.0064		
	Any risk	5	0.8133	0.7701	0.8566	0.0019	0	0.9901
Generalisation	Low risk	12	0.8046	0.7802	0.8290	0.0014		
	Any risk	2	0.872	0.7544	0.9895	0.0069	1.21	0.2713
Non-affirmation Subdimension								
Selection Bias	Low risk	-	-	-	-	-		
	Any risk	16	0.8555	0.8299	0.8810	0.0022	-	-
Performance Bias	Low risk	4	0.9143	0.8929	0.9356	0.0003		
	Any risk	12	0.8408	0.8075	0.8742	0.0031	13.21	0.0003
Detection Bias	Low risk	7	0.8647	0.8296	0.8998	0.0017		
	Any risk	9	0.8487	0.8075	0.8899	0.0036	0.34	0.5615
Statistical bias	Low risk	16	0.8555	0.8299	0.8810	0.0022		
	Any risk	-	-	-	-	-	-	-
Reporting bias	Low risk	9	0.8769	0.8486	0.9052	0.0015		
	Any risk	7	0.8305	0.7952	0.8657	0.0018	4.05	0.0441
Generalisation	Low risk	13	0.8512	0.8222	0.8802	0.0025		
	Any risk	3	0.886	0.8279	0.9440	0.0014	1.1	0.2943

For the Discrimination subdimension a significant risk of performance bias was observed, with the presence of risk being associated with an increase in reported alpha coefficients. For the Rejection subdimension and the Non-affirmation subdimension a significant risk of performance bias and reporting bias was observed, with the presence of risk being associated with an increase in reported alpha coefficients. For the Victimisation subdimension, none of the risk of bias categories were significantly associated with different estimates of internal consistency.

The impact of study design

To further explore the impact of overall study design upon internal consistency, a subgroup analysis was conducted in which the included studies were categorised as ‘psychometric studies’ (i.e., studies designed to assess psychometric properties with greater than 20 participants) or ‘non-psychometric’ studies (i.e., a study that reports psychometric properties of the GMSRS but is optimised to address another question or a psychometric study and/or with less than 20 participants). This subgroup analysis is depicted in Figure 7.

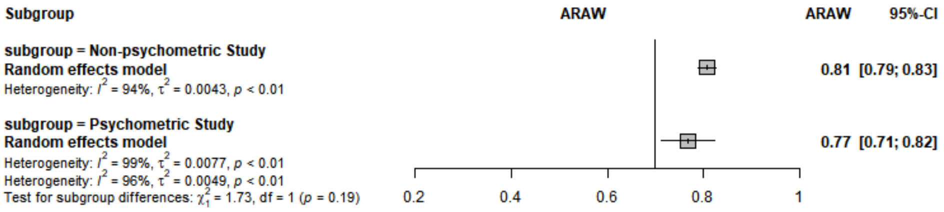


Figure 7: Subgroup analysis of study design

The non-psychometric studies reported a greater degree of internal consistency than did the psychometric studies, however, the difference between the study designs did not reach the threshold for statistical significance ($X^2 = 1.73$, $p = 0.19$).

The impact of publication and small study biases

Publication bias is caused by the tendency for statistically significant results to be published and the reticence to publish papers with non-significant results. Small study bias is the tendency for studies with smaller sample sizes to show greater variability in their measurement of internal consistency. These biases can be identified in a funnel plot, which plots the magnitude of the study’s alpha coefficient (i.e., the importance of the study within the synthesis) estimate the studies deviation from the meta-analytic average (i.e., the discrepancy between the study and the rest of the literature). If there is an absence of publication bias, the effects from the studies with small sample sizes which show greater variability will scatter more widely at the bottom of the plot compared to studies with larger samples at the top which will lie closer to the overall meta-analytic effect, creating a symmetrical funnel shape. If there is an absence of studies in the area of the plot associated with small sample sizes and non-significant results, then it is likely there is some publication bias leading to an overestimation of the true effect. The funnel plot of alpha coefficients is presented in Figure 8.

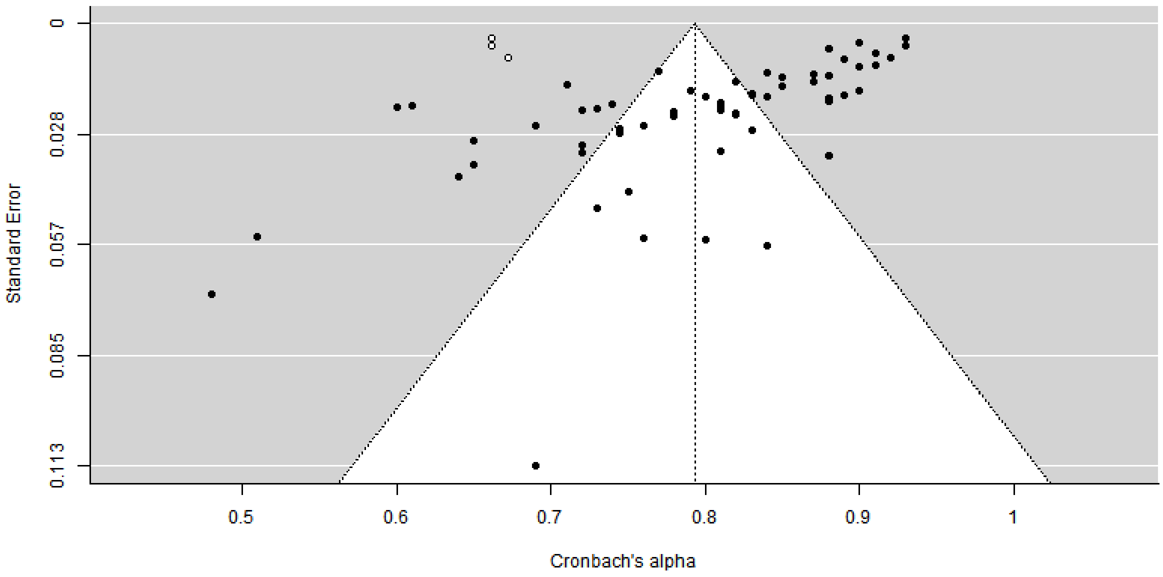


Figure 8: Funnel plot of the EFFECT. The 95% confidence interval of the expected distribution of alpha coefficients is shown as an inverted "funnel". Study level effects are shown in black, and effects imputed by the trim and fill procedure

As can be seen from Figure 8, there is clear evidence of the previously noted heterogeneity, however the distribution of small studies in the area of the forest plots associated with null effects does not indicate publication bias. Nevertheless, the effect of publication bias was simulated using a trim and fill procedure (Duval & Tweedle, 2000). The trim and fill procedure builds on the assumption that publication bias would lead to an asymmetrical funnel plot. Trim and fill procedure uses an iteratively removes the most extreme small studies from the side of the funnel plot associated with positive effects, re-computing the effect size at each iteration until the funnel plot is symmetric about the (corrected) effect size. While this trimming yields the adjusted effect size, it also reduces the variance of the effects, resulting in biased and narrow confidence interval. Therefore, the original studies are returned into the analysis, and the procedure imputes a mirror image for each on the side of the funnel plot associated with negative effects.

In the above funnel plot, the observed studies are shown as dark circles. The omnibus estimate of the effect size is 0.8021 (95% CI 0.7848, 0.8193). The imputed studies are shown as empty circles, and the imputed estimate is 0.7929 (95% CI 0.7671, 0.8186). The adjusted point estimate represents a -1.1488 % decrease relative to the original omnibus analysis, and does not change the overall conclusions of this analysis.

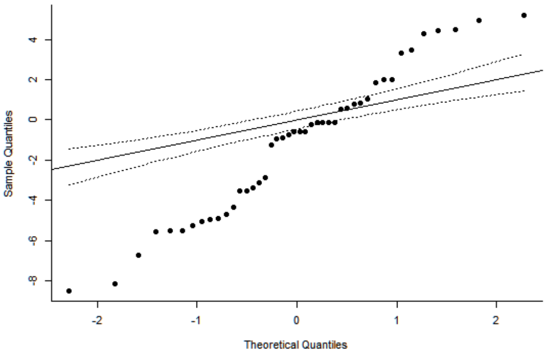
Orwin (1983) describes the calculation of a failsafe number which calculates the number of with non-significant results which would need to be included in the meta-analysis for the overall effect to be reduce to a minimally interpretable value. This procedure suggests that 42 studies with an average effect size of alpha=0.5 would be required to reduce the weighted average coefficient to below the minimally interpretable value of 0.7, suggesting that the observed weighted average alpha coefficient is robust to studies missing due to publication bias.

The Internal Reliability of the Proximal Dimension

Next, we estimated the internal consistency of the Proximal dimension, which is comprised of the Internalised Transphobia, Negative Expectations, and Non-disclosure subdimensions (Testa et al., 2015).

Selection of the meta-analytic model

The distribution of primary study effects is shown in Figure 9. The between studies variance (tau^2) was calculated using the Restricted maximum-likelihood estimator. The Restricted Maximum Likelihood estimator as the appropriate method for the calculation of the variation of the difference between studies, as this estimator has been shown to be more robust to deviations from normality (Banks, Mao, & Walters, 1985).



Fixed Effects Model

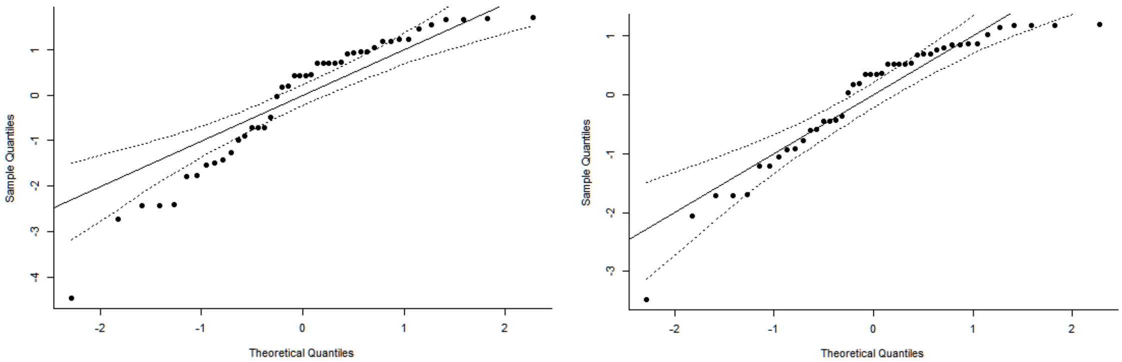


Figure 9: QQ-plots of the distribution of alpha coefficients within the included studies

REM (DerSimonian-Laird estimator) *REM (Re ML estimator)*

As can be seen from Figure 9, there is clear evidence of non-linearity in the distribution of alpha coefficients when using the fixed effects model, however, this non linearity is substantially reduced in the random effects model using the DerSimonian-Laird estimator and is largely absent in

Table 7: Study level alpha coefficients for the Proximal Subdimensions

Study	**Effect**	**Std.Er**	**CI_Lower**	**CI_Upper**	**REM Weight**
Internalised Transphobia					
Brennan et al 2017	0.93	0.01176	0.907	0.953	565
Budge et al 2020	0.91	0.03207	0.847	0.973	376
Flynn & Bhambhani 2021	0.92	0.00605	0.908	0.932	599
Huit et al a 2022	0.93	0.01932	0.892	0.968	499
Huit et al b 2021	0.745	0.02673	0.693	0.797	426
Holt et al 2019	0.78	0.02279	0.735	0.825	465
Jäggi et al 2018	0.82	0.02292	0.775	0.865	464
Kolp et al 2020	0.93	0.0077	0.915	0.945	591
Lee et al 2020	0.88	0.01267	0.855	0.905	558
Lindley & Galupo 2020	0.89	0.00968	0.871	0.909	580
Lloyd et al 2021	0.91	0.00458	0.901	0.919	605
Muratore et al 2022	0.88	0.01902	0.843	0.917	502
Rimmer et al 2022	0.83	0.01753	0.796	0.864	516
Scandurra et al 2019	0.9	0.01066	0.879	0.921	573
Testa et al 2015	0.91	0.00469	0.901	0.919	605
Tebbe et al 2021	0.9	0.00874	0.883	0.917	585
Watson et al 2018	0.89	0.00868	0.873	0.907	586
Negative Expectations					
Brennan et al 2017	0.9	0.01667	0.867	0.933	524
Huit et al a 2022	0.91	0.02465	0.862	0.958	447
Huit et al b 2021	0.745	0.02652	0.693	0.797	428
Holt et al 2019	0.78	0.02261	0.736	0.824	467
Jäggi et al 2018	0.93	0.00884	0.913	0.947	585
Lindley & Galupo 2020	0.89	0.00961	0.871	0.909	580
Muratore et al 2022	0.88	0.01887	0.843	0.917	503
Rimmer et al 2022	0.83	0.01739	0.796	0.864	517
Scandurra et al 2019	0.91	0.00952	0.891	0.929	581
Testa et al 2015	0.89	0.00569	0.879	0.901	601
Tebbe et al 2018	0.91	0.01026	0.89	0.93	576
Watson et al 2018	0.86	0.01096	0.839	0.881	571
Non-disclosure					
Brennan et al 2017	0.87	0.02284	0.825	0.915	464
Flynn & Bhambhani 2021	0.82	0.01423	0.792	0.848	545
Huit et al 2022	0.83	0.04907	0.734	0.926	248
Huit et al 2021	0.745	0.02796	0.69	0.8	414
Holt et al 2019	0.6	0.04334	0.515	0.685	285
Jäggi et al 2018	0.71	0.03862	0.634	0.786	320
Lindley & Galupo 2020	0.89	0.01013	0.87	0.91	577
Lloyd et al 2021	0.81	0.01012	0.79	0.83	577
Muratore et al 2022	0.88	0.01989	0.841	0.919	493
Rimmer et al 2022	0.83	0.01833	0.794	0.866	508
Scandurra et al 2019	0.79	0.02342	0.744	0.836	459
Testa et al 2015	0.8	0.0109	0.779	0.821	571
Watson et al 2018	0.8	0.01651	0.768	0.832	525
Total Proximal					
Brennan et al 2017	0.93	0.01126	0.908	0.952	569
Powell et al 2022	0.87	0.02975	0.812	0.928	397

the random effects model using the Restricted Maximum Likelihood estimator. Therefore, this indicates that the use of the use of the random effects model in which between studies variation is calculated using the Restricted Maximum Likelihood estimator is an appropriate method for the calculation of weighted average internal reliability coefficient.

The omnibus test

The alpha coefficients reported in the included studies are reported in Table 7. Across all of the Proximal subdimensions. There were a total of 5357 participants.

A random effects models was calculated using the generic inverse variance method. The weighted average alpha coefficient for the Proximal subdimensions are reported in Table 8. All of the Proximal subdimensions evidenced a 95% confidence interval of the weighted average alpha coefficient that exceed the minimum interpretable value of α=0.70.

Table 8: Weighted Average Alpha Coefficients for the Proximal Subdimensions

	k	ARAW	95%-CI	tau^2	tau	Higgins I^2
Proximal - Internalised Transphobia	17	0.8872	0.8732 to 0.9011	0.0006	0.0255	88%
Proximal - Nondisclosure	13	0.8064	0.7772 to 0.8355	0.0023	0.048	89%
Proximal - Negative Expectations	12	0.8747	0.8538 to 0.8955	0.0011	0.0334	89%
Total - Proximal	2	0.9063	0.8488 to 0.9638	0.0013	0.036	72%

The individual study level effects as well as the random effects model weighted average alpha coefficients are reported in the forest plot in Figure 10.

A high level of heterogeneity in the studies was observed in the Discrimination, Non-disclosure, and Negative Expectations subdimensions (Higgin I^2 values reported in Figure 10), suggesting that the estimates of internal consistency may be biased by the presence of uncontrolled or confounding factors (such as methodological artefacts and uncontrolled

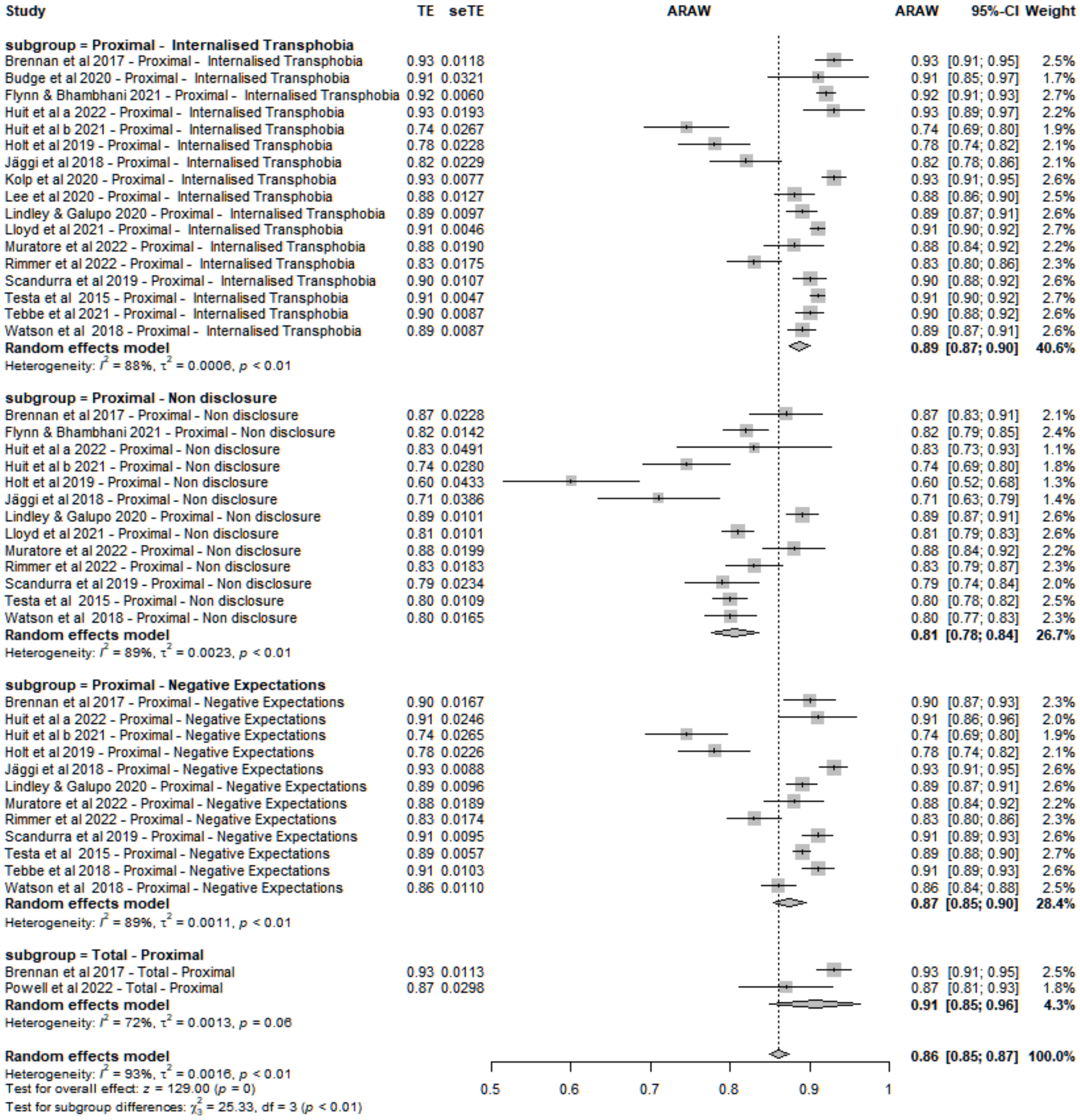


***Figure 10**: Forest plot of alpha coefficients for each of the Proximal subdimensions*

individual difference factors). Therefore, the focus of the subsequent analyses will be upon the identification of the sources of heterogeneity between the estimates of internal consistency in the included studies.

The impact of influential primary studies

The impact of disproportionately influence studies was assessed using a “leave-one-out” analysis and presented on the Baujat plot in Figure 11.

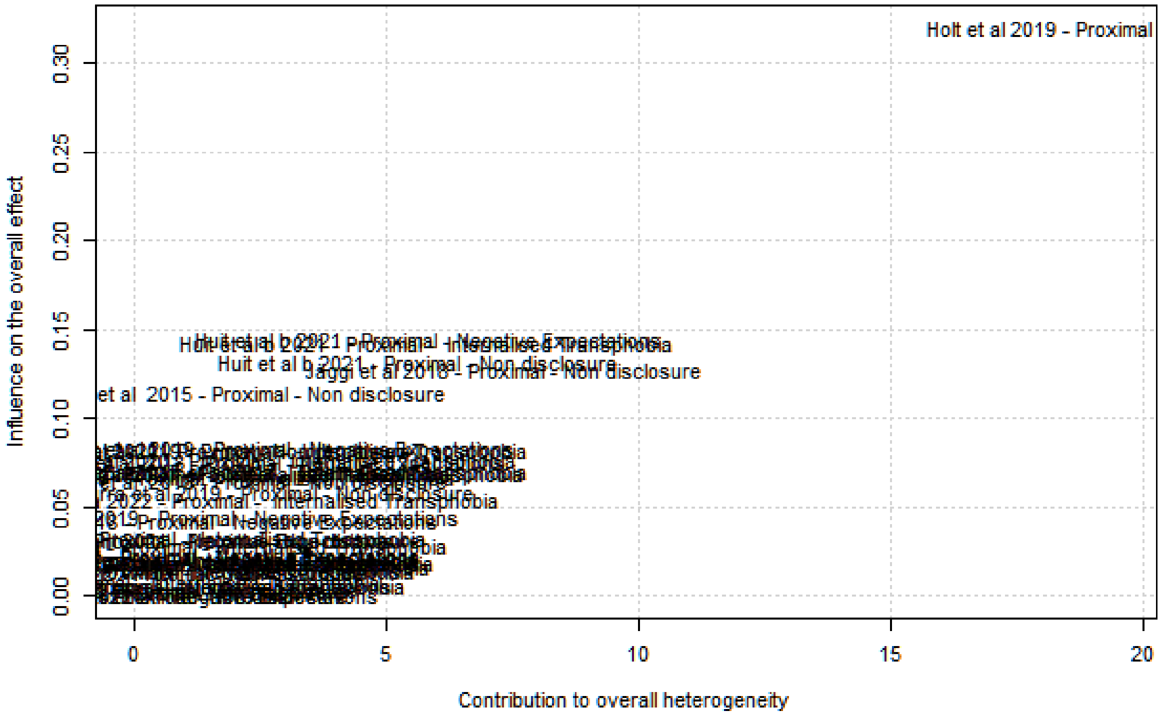


Figure 11: Baujat diagnostic plot of sources of heterogeneity. The vertical axis reports the influence of the study on the overall effect and the horizontal axis reports the discrepancy of the study with the rest of the literature

The Baujat plot depicted in Figure 11 identified Holt et al (2019) alpha for the non-disclosure subdimension as being influential and discrepant from the existent literature. The random effects model for the non-disclosure subdimension was recalculated with this study removed. The corrected random effects model reported a statistically non-significant decrease of approximately 5% in the weighted average alpha = 0.8187 (95% CI 0.7923 to 0.8451) for the non-disclosure subdimension. Accordingly, the removal of Holt et al (2019) did not result in any substantial or meaningful change in the overall conclusions of this numerical synthesis.

The effect of risk of bias in the primary studies

In order to assess the impact of study level risk of bias upon heterogeneity, a series of subgroup analyses were conducted on the Proximal subdimensions for the risk of bias ratings of “low risk” and “any risk” (i.e., unclear risk and high risk of bias combined) for each of the six types of methodological bias.

Table 9: Differences in Weighted Average Alpha Coefficients as a Function of Risk of Bias in Each of the Proximal Subdimensions:

		k	Alpha	Lower 95% CI	Upper 95% CI	tau^2	X^2	p
Internalised Transphobia								
Selection Bias	Low risk	-	-	-	-	-		
	Any risk	17	0.8872	0.8732	0.9011	0.0006	-	-
Performance Bias	Low risk	7	0.9085	0.8989	0.9181	<0.0001		
	Any risk	10	0.8654	0.8371	0.8936	0.0018	8.01	0.0046
Detection Bias	Low risk	10	0.8866	0.8689	0.9044	0.0006		
	Any risk	7	0.8867	0.8598	0.9136	0.0010	0.00	0.9962
Statistical bias	Low risk	17	0.8872	0.8732	0.9011	0.0006	0.00	-
	Any risk	-	-	-	-	-	-	-
Reporting bias	Low risk	10	0.9091	0.9091	0.9176	0.0001		
	Any risk	7	0.8417	0.7989	0.8845	0.0029	9.16	0.0025
Generalisation	Low risk	14	0.8830	0.8674	0.8987	0.0007		
	Any risk	3	0.9050	0.8774	0.9326	0.0003	1.85	0.1743
Negative Expectations Subdimension								
Selection Bias	Low risk	-	-	-	-	-	-	-
	Any risk	12	0.8747	0.8538	0.8955	0.0011	0.00	-
Performance Bias	Low risk	3	0.8908	0.8816	0.9000	0.00	-	-
	Any risk	9	0.8653	0.8329	0.8976	0.0022	2.21	0.1373
Detection Bias	Low risk	8	0.8638	0.8378	0.8898	0.0011	-	-
	Any risk	4	0.8948	0.8592	0.9304	0.0011	1.90	0.1680
Statistical bias	Low risk	12	0.8747	0.8538	0.8955	0.0011	0.00	-
	Any risk	-	-	-	-	-	-	-
Reporting bias	Low risk	5	0.8938	0.8769	0.9107	0.0003	-	-
	Any risk	7	0.8548	0.8111	0.8985	0.0031	2.67	0.1025
Generalisation	Low risk	9	0.8680	0.8418	0.8942	0.0014	-	-
	Any risk	3	0.8914	0.8534	0.9294	0.0009	0.99	0.3202
Non-disclosure Subdimension								
Selection Bias	Low risk	-	-	-	-	-	-	-
	Any risk	13	0.8064	0.7772	0.8355	0.0023	0.00	-
Performance Bias	Low risk	5	0.8370	0.7987	0.8753	0.0017	-	-
	Any risk	8	0.7792	0.7319	0.8266	0.0038	3.46	0.0630
Detection Bias	Low risk	8	0.8026	0.7608	0.8443	0.0030		
	Any risk	5	0.8122	0.7757	0.8487	0.0012	0.12	0.7330
Statistical bias	Low risk	13	0.8064	0.7772	0.8355	0.0023	-	-
	Any risk	-	-	-	-	-	0.00	-
Reporting bias	Low risk	6	0.8120	0.7956	0.8283	0.0002	-	-
	Any risk	7	0.7899	0.7273	0.8525	0.0062	0.45	0.5040
Generalisation	Low risk	11	0.8050	0.7723	0.8377	0.0026	-	-
	Any risk	2	0.8030	0.7724	0.8337	0.00	0.01	0.9313

With regard to internalised transphobia, the risk of performance ($X^2 = 8.01$, $p = 0.0046$) and reporting bias ($X^2 = 9.16$, $p = 0.0025$) showed statistically significant differences in estimates of alpha coefficients, with the low-risk studies reporting higher alpha values. The forest plots of performance and reporting bias are shown in Figure 12 and 13. The Negative Expectation Scale and the Non-Disclosure Scale did not evidence significant differences in alpha estimates for any of the domains of risk of bias.

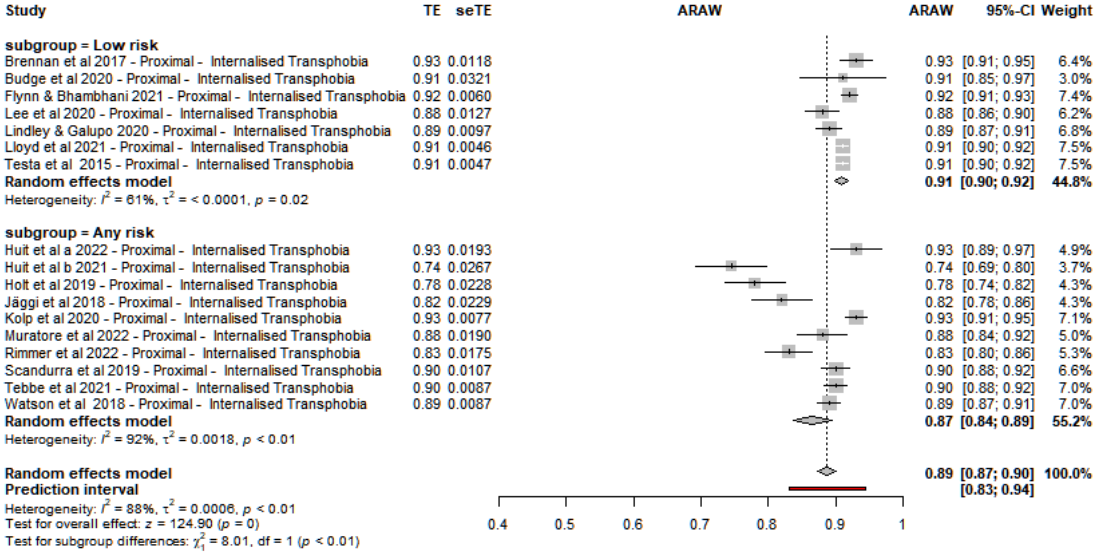


Figure 12: Forest plot of performance bias

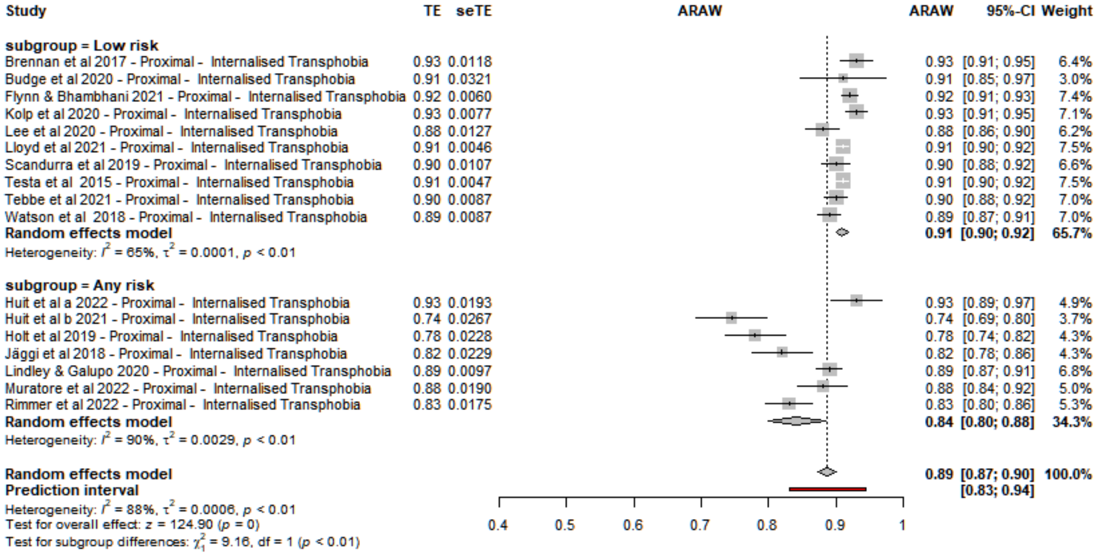


Figure 13: Forest plot of reporting bias

The Impact of Publication and Small Study Biases

The funnel plot of alpha coefficients is presented in Figure 14. As can be seen from Figure 14, there is clear evidence of heterogeneity, however the distribution of small studies in the area of the forest plots associated with null effects (marked in blue) does not indicate publication bias.

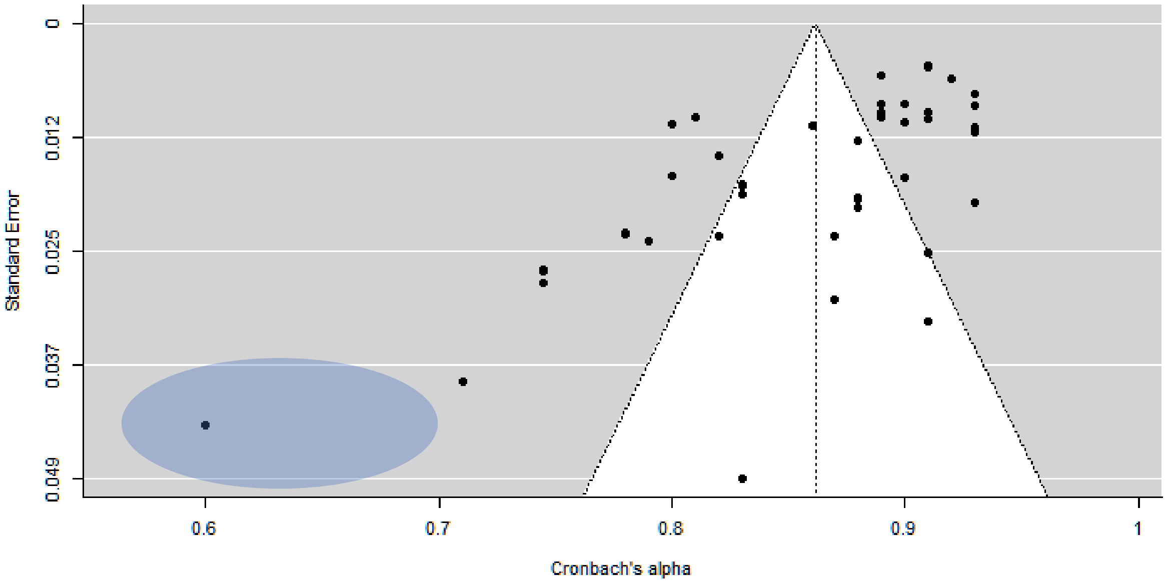


Figure 14: Funnel plot of the effect. The 95% confidence interval of the expected distribution of alpha coefficients is shown as an inverted "funnel. The area of the forest plots associated with null effects is marked in blue

.

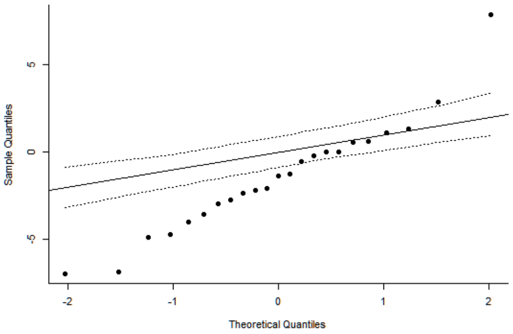
Orwin's (1983) failsafe procedure was used to calculate the number of studies with non-significant results which would be needed for the overall meta-analytic effect to be reduced to a minimally interpretable value. This procedure suggests that 36 studies with an average effect size of alpha=0.5 would be required to reduce the weighted average coefficient to below the minimally interpretable value of 0.7, suggesting that the observed weighted average alpha coefficient is robust to studies missing due to publication bias.

The internal reliability of the Resilience Scale

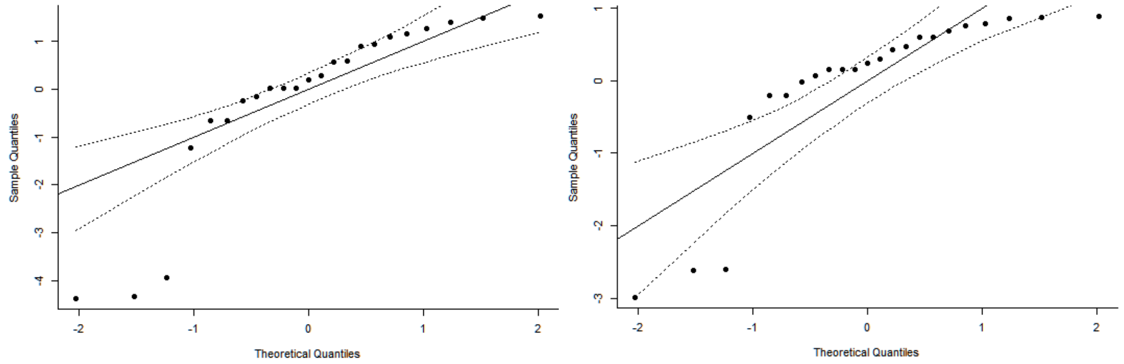
Finally, we examined the internal consistency of the Resilience scale of the GMSRM which is comprised of the Community Connectedness and Pride subdimensions (Testa et al., 2015).

Selection of the meta-analytic model

The distribution of primary study effects is shown in Figure 15. The between studies variance (tau^2) was calculated using the Restricted maximum-likelihood estimator. The Restricted Maximum Likelihood estimator as the appropriate method for the calculation of the variation of the difference between studies, as this estimator has been shown to be more robust to deviations from normality (Banks, Mao, & Walters, 1985).



Fixed Effects Model



REM (DerSimonian-Laird estimator) *REM (ReML estimator)*

Figure 15: QQ-plots of the distribution of alpha coefficients within the included studies

As can be seen from Figure 15, there is clear evidence of non-linearity in the distribution of alpha coefficients when using the fixed effects model, however, this non linearity is substantially reduced in the random effects model using the DerSimonian-Laird estimator and is reduced further in the random effects model using the Restricted Maximum Likelihood estimator. Therefore, this indicates that the use of the use of the random effects model in which between studies variation is calculated using the Restricted Maximum Likelihood estimator is an appropriate method for the calculation of weighted average internal reliability coefficient.

The omnibus test

The alpha coefficients reported in the included studies are reported in Table 10. Across all of the resilience subdimensions there were 13 studies and a total of 3709 participants.

A random effects model was calculated using the generic inverse variance method. The weighted average alpha coefficient for the resilience subdimensions are reported in Table 11. All of the Proximal subdimensions evidenced a 95% confidence interval of the weighted average alpha coefficient that exceed the minimum interpretable value of α=0.70.

Table 10: Study level alpha coefficients for the Resilience Subdimensions

Study	Effect	Standard Error	95% Confidence Interval	Weight (random)
Community				
Brennan et al 2017	0.83	0.029866	0.7715 to 0.8885	73.06
Budge et al 2020	0.86	0.052175	0.7577 to 0.9623	64.44
Huit et al a 2022	0.89	0.031754	0.8278 to 0.9522	72.44
Huit et al b 2021	0.48	0.057009	0.3683 to 0.5917	62.32
Holt et al 2019	0.48	0.056336	0.3696 to 0.5904	62.62
Jäggi et al 2018	0.82	0.023968	0.7730 to 0.8670	74.79
Kaplan 2019	0.85	0.007906	0.8345 to 0.8655	77.77
Kolp et al 2020	0.78	0.025302	0.7304 to 0.8296	74.43
Muratore et al 2022	0.34	0.109394	0.1256 to 0.5544	40.38
Rabasco & Andover 2021	0.82	0.021332	0.7782 to 0.8618	75.47
Pride				
Brennan et al 2017	0.89	0.018478	0.8538 to 0.9262	76.12
Budge et al 2020	0.84	0.057016	0.7283 to 0.9517	62.32
Huit et al a 2022	0.8	0.055205	0.6918 to 0.9082	63.12
Huit et al b 2021	0.745	0.026731	0.6926 to 0.7974	74.02
Holt et al 2019	0.78	0.02279	0.7353 to 0.8247	75.1
Jäggi et al 2018	0.82	0.022918	0.7751 to 0.8649	75.07
Kaplan 2019	0.9	0.00504	0.8901 to 0.9099	78
Kolp et al 2020	0.9	0.010997	0.8784 to 0.9216	77.42
Muratore et al 2022	0.88	0.019018	0.8427 to 0.9173	76
Poteat et al 2019	0.81	0.020363	0.7701 to 0.8499	75.7
Rabasco & Andover 2021	0.87	0.014731	0.8411 to 0.8989	76.85
Total Resilience				
Brennan et al 2017	0.87	0.021262	0.8283 to 0.9117	75.49
Powell et al 2022	0.9	0.023274	0.8544 to 0.9456	74.98

Table 11: Weighted Average Alpha coefficient for the Distal Subdimensions

	k	Alpha	95%-CI	tau	tau^2	Higgins I^2
Pride	11	0.8446	0.8118 to 0.8773	0.0494	0.0024	88.20%
Community	10	0.7281	0.6147 to 0.8415	0.1769	0.0313	91.90%
Total Resilience	2	0.8836	0.8529 to 0.9144	0	0	0.00%

The individual study level effects as well as the random effects model weighted average alpha coefficient are reported in the forest plot in Figure 16.

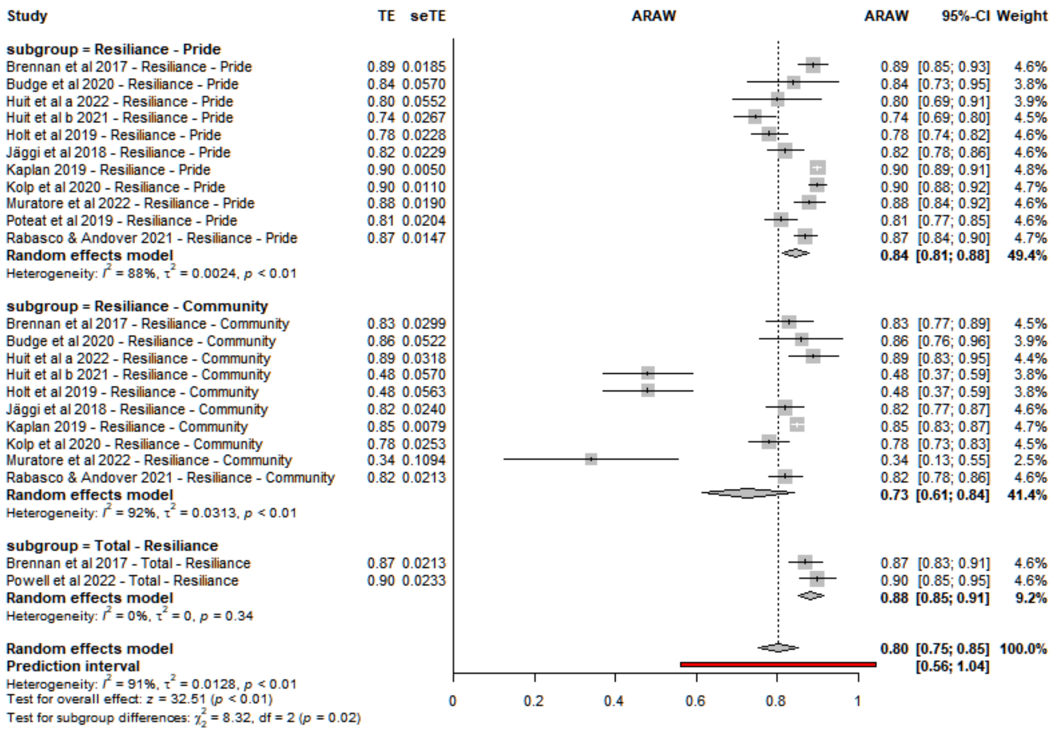


Figure 16: Forest plot of the Resilience Subdimensions

A high level of heterogeneity in the studies was observed in the Pride and Community subdimensions (Higgin I^2 values reported in Figure 16 and Table 11), suggesting that the estimates of internal consistency may be biased by the presence of uncontrolled or confounding factors. Therefore, the focus of the subsequent analyses will be upon the identification of the sources of heterogeneity between the estimates of internal consistency in the included studies.

The impact of influential primary studies

The impact of disproportionately influence studies was assessed using a "leave-one-out" analysis and presented on the Baujat plot in Figure 17.

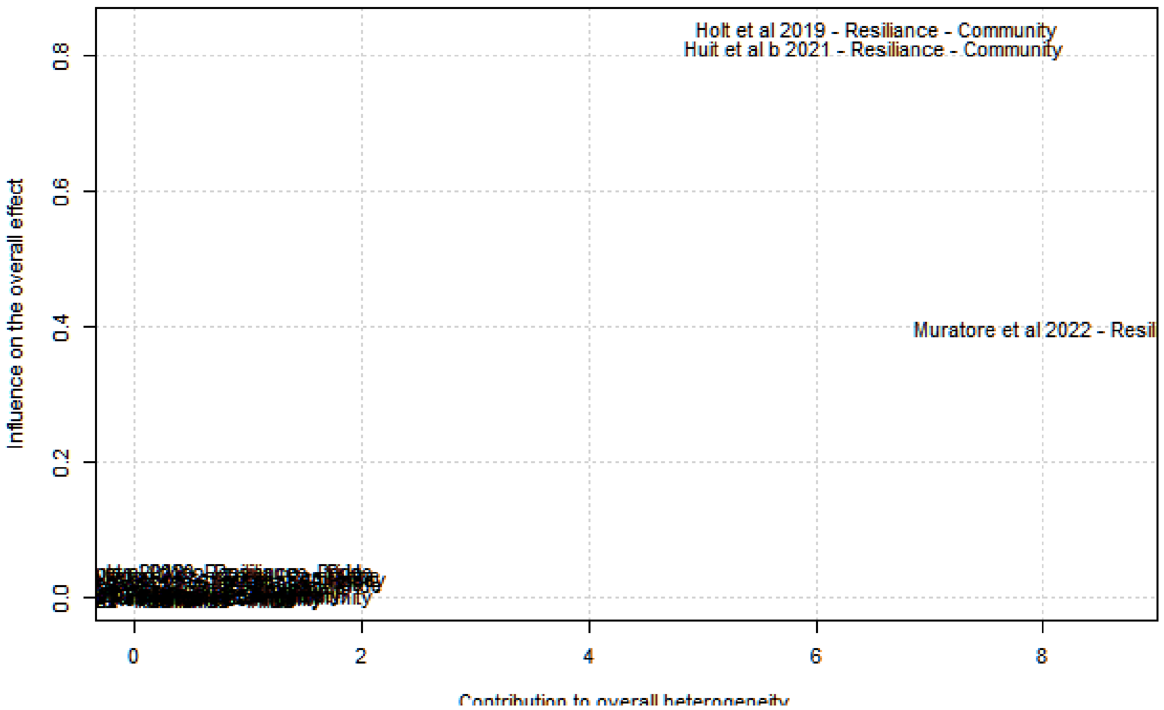


Figure 17: Baujat diagnostic plot of sources of heterogeneity. The vertical axis reports the influence of the study on the overall effect and the horizontal axis reports the discrepancy of the study with the rest of the literature

The Baujat plot depicted in Figure 17 identified Holt et al (2019), Muratore et al (2022) and Huit et al (2021) alphas for the Community subdimension as being influential and discrepant from the existent literature. The random effects model for the Community subdimension was recalculated with these studies removed. The corrected random effects model reported a statistically non-significant ($X^2 = 3.18$, $p = 0.07$) increase of approximately 13.7% in the weighted average alpha = 0.8335 (95% CI 0.8098 to 0.8572) for the Community subdimension. A comparison of the original estimate of the Internal reliability of the community scale and the corrected estimate (having removed Holt et al (2019), Muratore et al (2022) and Huit et al (2021) is shown in Figure 18.

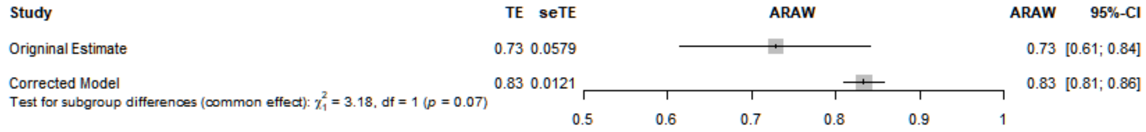


Figure 18: Comparison of the original estimate of the internal reliability of the community scale and the corrected estimate having removed Holt et al (2019), Muratore et al (2022) and Huit et al (2021).

The removal of these discrepant studies results in a weighted average alpha coefficient which is more consistent with the other Resilience subdimensions.

The Effect of Risk of Bias in the Primary Studies

In order to assess the impact of study level risk of bias upon heterogeneity, a series of subgroup analyses were conducted on the Resilience subscales for the risk of bias ratings of “low risk” and “any risk” (i.e., unclear risk and high risk of bias combined) for each of the six types of methodological bias. Unfortunately, it was not possible to undertake a risk of bias analysis for the composite Resilience scale due to the small number of studies reporting alpha coefficients.

Table 12: Differences in Weighted Average Alpha Coefficients as a Function of Risk of Bias in Each of the Resilience Subdimensions

		k	Alpha	Lower 95% CI	Upper 95% CI	tau^2	tau	X^2	p
Community Subdimension									
Selection Bias	Low risk								
	Any risk	10	0.7281	0.6147	0.8415	0.0313	0.1769	-	-
Performance Bias	Low risk	3	0.8489	0.8341	0.8637	0	0		
	Any risk	7	0.6718	0.5176	0.8261	0.0407	0.2016	5.02	0.0251
Detection Bias	Low risk	7	0.8280	0.7935	0.8625	0	0		
	Any risk	3	0.6762	0.5188	0.8336	0.0425	0.2061	3.41	0.0647
Statistical bias	Low risk	10	0.7281	0.6147	0.8415	0.0313	0.1769		
	Any risk	-	-	-	-	-	-	0.00	0.0
Reporting bias	Low risk	5	0.8281	0.7998	0.8564	0.0005	0.0221		
	Any risk	5	0.6137	0.4055	0.8219	0.0527	0.2295	4.00	0.0455
Generalisation	Low risk	8	0.6895	0.5566	0.8225	0.0345	0.1858		
	Any risk	2	0.8819	0.8287	0.9351	0	0	6.93	0.0085
Pride Subdimension									
Selection Bias	Low risk	-	-	-	-	-	-		
	Any risk	11	0.8446	0.8118	0.8773	0.0024	0.0494	-	-
Performance Bias	Low risk	3	0.8989	0.8894	0.9084	0	0		
	Any risk	8	0.8301	0.7913	0.8688	0.0025	0.0504	11.43	0.0007
Detection Bias	Low risk	7	0.8449	0.7977	0.8921	0.0035	0.0592		
	Any risk	4	0.8411	0.7977	0.8845	0.0012	0.0350	0.01	0.9072
Statistical bias	Low risk	11	0.8446	0.8118	0.8773	0.0024	0.0494		
	Any risk	-	-	-	-	-	-	0.00	0.999
Reporting bias	Low risk	6	0.8751	0.8462	0.9040	0.0009	0.0307		
	Any risk	5	0.8073	0.7580	0.8566	0.0023	0.0484	5.41	0.0201
Generalisation	Low risk	8	0.8513	0.8117	0.8909	0.0029	0.0541		
	Any risk	3	0.8120	0.7764	0.8475	0.00	0.00	2.10	0.1469

For the Community subscale, studies with low or any risk of performance bias, reporting bias and generalisation bias showed statistically significant differences in the estimates of coefficient alpha, with lower risk of bias being associated with higher alpha coefficients. The forest plots of performance, reporting, and generalisation bias are shown in Figures 19 to 21.

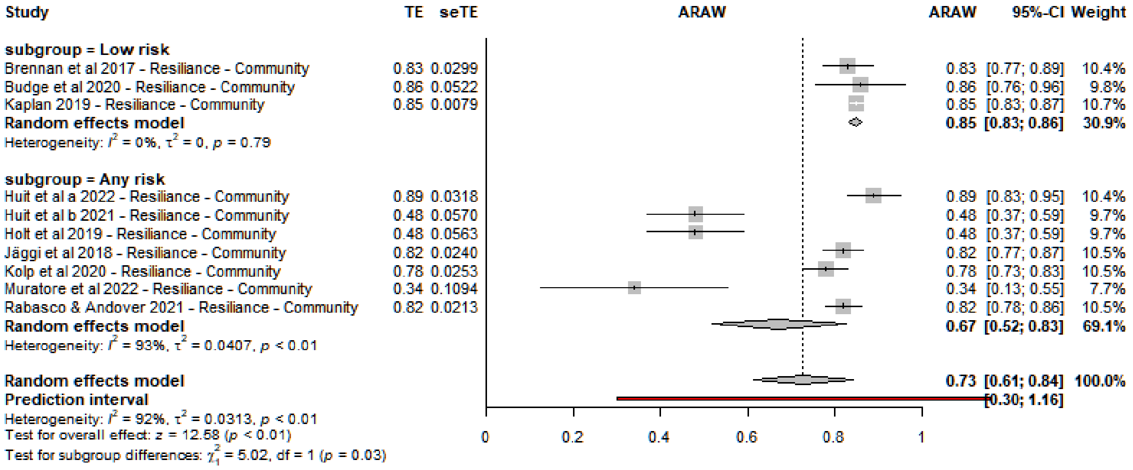


Figure 19: Forrest plot of Performance Bias on the Community Subscale

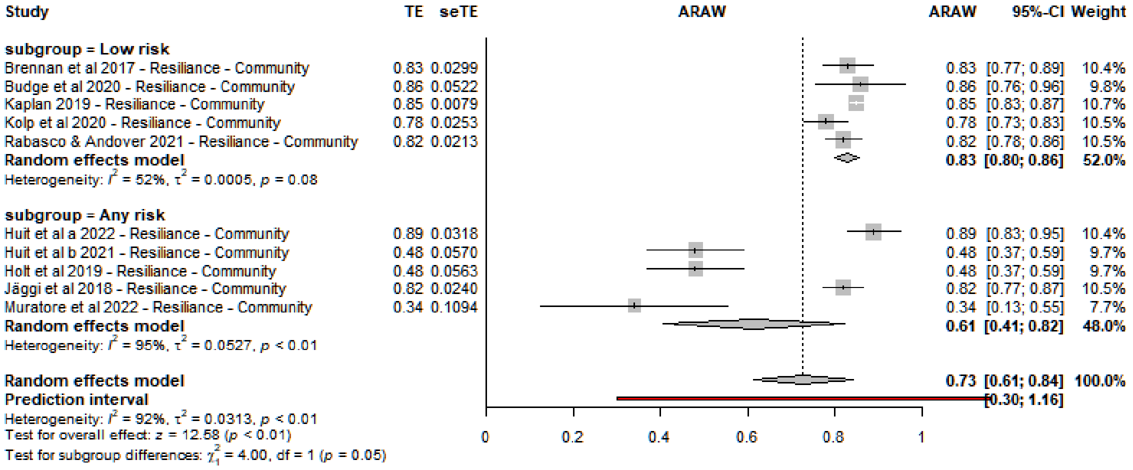


Figure 20: Forest plot of reporting bias on the Community Subdimension

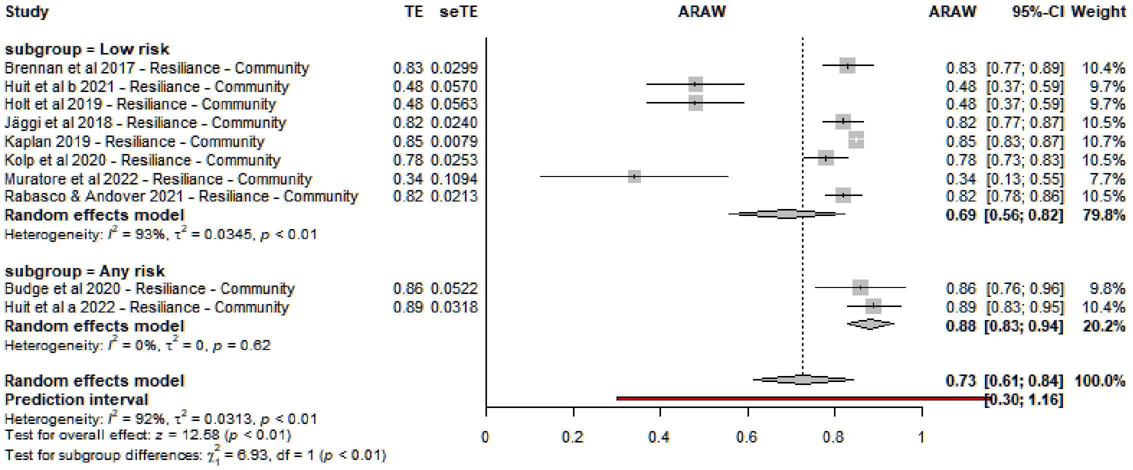


Figure 21: Forrest plot of generalisation bias on the Community Subscale

Similarly, for the Pride subdimension the summary effects for studies showing low or any risk of performance or reporting bias showed statistically significant differences in the estimate of coefficient alpha, with lower risks of bias being associated with higher average alpha coefficients. The forest plots for performance and reporting bias are shown in Figures 22 and 23.

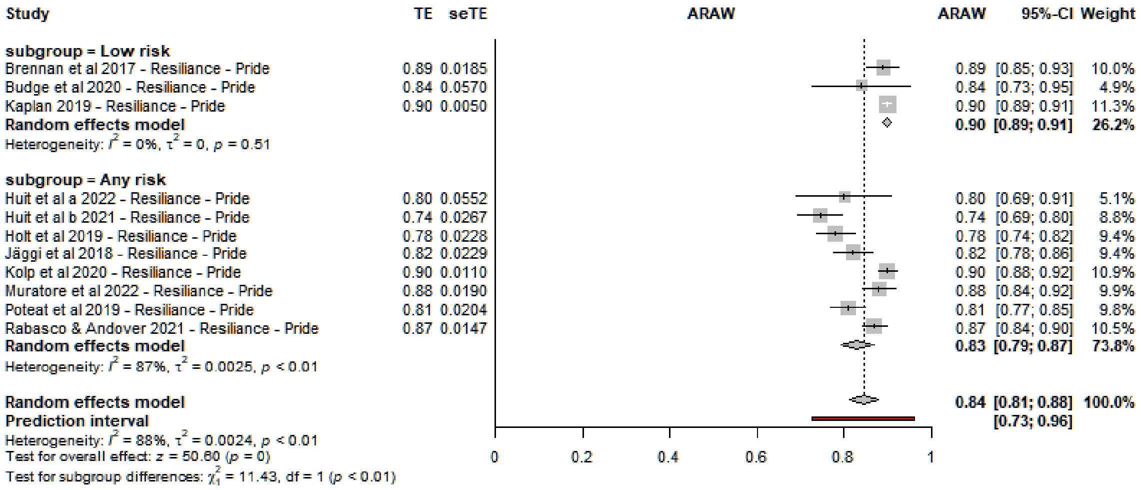


Figure 22: Forest Plots of Performance Bias on the Pride Subscale

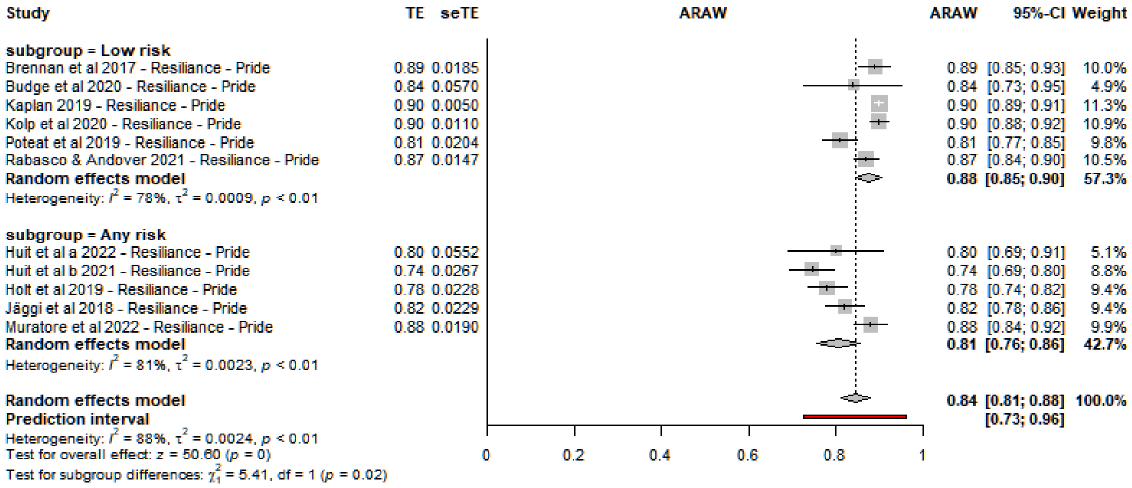


Figure 23: Forest Plots of Reporting Bias on the Pride Subdimension

The impact of publication and small study biases

The funnel plot of alpha coefficients is presented in Figure 24.

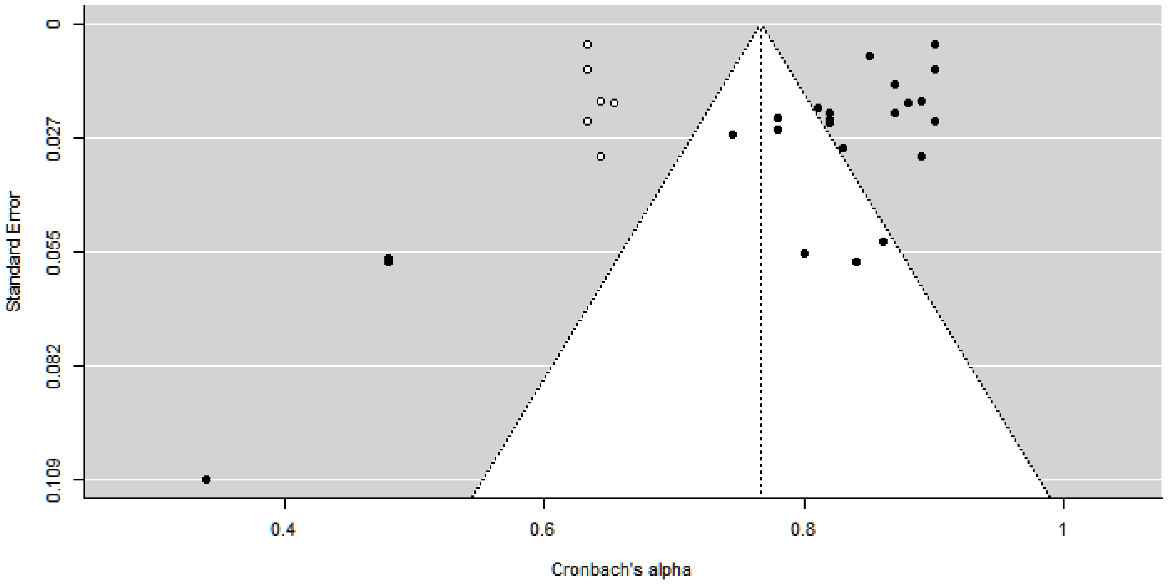


Figure 24: *Funnel plot of the EFFECT. The 95% confidence interval of the expected distribution of alpha coefficients is shown as an inverted "funnel". Study level effects are shown in black, and effects imputed by the trim and fill procedure (Duvall & Tweedle, 2000)*

As can be seen from Figure 24, there is clear evidence of heterogeneity, as previously identified. However, the distribution of small studies in the area of the forest plots associated with null effects does not indicate publication bias. Nevertheless, the effect of publication bias was simulated using a trim and fill procedure (Duval & Tweedle, 2000). The trim and fill procedure builds on the assumption that publication bias would lead to an asymmetrical funnel plot. Trim and fill procedure uses an iteratively removes the most extreme small studies from the side of the funnel plot associated with positive effects, re-computing the effect size at each iteration until the funnel plot is symmetric about the (corrected) effect size. While this trimming yields the adjusted effect size, it also reduces the variance of the effects, resulting in biased and narrow confidence interval. Therefore, the original studies are returned into the analysis, and the procedure imputes a mirror image for each on the side of the funnel plot associated with negative effects.

In the above funnel plot, the observed studies are shown as dark circles. The omnibus estimate of the effect size is 0.8032 (95% CI: 0.7548, 0.8516). The imputed studies are shown as white circles, and the imputed estimate is 0.7666 (95%,CI: 0.7197, 0.8136). The adjusted point estimate represents a 4.5 % decrease relative to the original omnibus analysis.

Orwin's (1983) method of calculating a failsafe number of studies with non-significant results which would be required for the overall effect in the meta-analysis to be reduce to a minimally interpretable value was employed here. This procedure suggests that 12 studies (i.e., equivalent to 57% of the existent literature) with an average effect size of alpha=0.5 would be required to reduce the weighted average coefficient to below the minimally interpretable value of 0.7, maybe somewhat susceptible to the effects of publication bias, but, as previously noted, the effect of simulating, the missing studies, does not result in any substantive change to the weighted, average, alpha coefficient, and does not change the overall conclusions for the Pride subscale.

Discussion

This meta-analysis quantified the internal consistency of the GMSRM by extracting Cronbach alpha coefficients (Cronbach, 1951) from the existing literature to establish the extent to which items in the GMSRM are measuring the same construct. Of the 55 studies assessed for eligibility, 25 were excluded (see Figure 2), leaving 30 studies reporting alpha coefficients to be included in the final meta-analytic review. Each of the studies were assessed for risk of bias, and the extent to which the literature was influenced by publication bias, or a disproportionate number of statistically positive results.

Main Findings

The random effects models for the Distal and Proximal dimensions, and Resilience scale of the GMSRM showed that each of the subdimensions yielded a weighted average alpha coefficient which exceeded the minimum α = 0.70 (Cronbach, 1951) convention for acceptable internal consistency, as did each of the composite dimensions.

Taking the Distal dimension first, the alpha coefficient for the Discrimination subdimension was α = .072 (CI: 0.66-0.78), Rejected α = 0.76 (CI: 0.72-0.80), Victimisation α = 0.81 (CI: 0.77-0.85), and Non-affirmation α = 0.86 (CI: 0.83-0.88), whilst the composite Distal dimension was α = 0.81 (CI: 0.78-0.84). Secondly, the alpha coefficients for the Proximal dimension subdimensions were α = 0.89 (CI: 0.87-0.90) for Internalised Transphobia, α = 0.81 (CI: 0.78-0.84) for Non-disclosure, α = 0.87 (CI: 0.85-0.90) for Negative Expectations, and α = 0.91 (CI: 0.85-0.96) for the composite Proximal dimension. Lastly, the alpha coefficients for the Resilience scale was α = 0.84 (CI: 0.81-0.88) for the Pride subscale, α = 0.73 (CI: 0.61-0.84) for the Community Connectedness subscale, and α = 0.88 (CI: 0.85-0.91) for the composite Resilience scale.

The methodological design of included studies was examined to identify the extent to which ‘psychometric’ versus ‘non-psychometric’ studies influenced the internal consistency of the GMSRM. The results showed that although ‘non-psychometric’ studies reported higher proportions of internal consistency, there was no statistically significant difference between the two.

How much internal consistency is necessary for the reliability of a psychometric test? The alpha coefficient developed by Cronbach (1951) is considered the best estimation of good test internal consistency, and internal consistency reliability is essential for a useful psychometric test (Kline, 2000). In contrast to tests low in internal consistency, a highly internally consistent test will be lower in measurement error, yield largely consistent true scores on a test over time, and ultimately demonstrate predictive validity with other constructs (Kline, 2000). However, whilst Cronbach’s (1951) .70 threshold is an accepted marker of adequate internal consistency, other researchers have suggested different thresholds depending on the context a test is utilised in. Nunnally (1967; 1978) suggested three minimum alpha acceptability thresholds; .70 for early-stage research, .80 for use in empirical research, and .90 for use in clinical contexts. On the contrary, it has been argued that alphas over .90 likely represent test items which are too narrow and specific in what they are measuring, and risk redundancy (Klein, 2000; Streiner, 2003). In addition, tests which have less than 10 items and which are highly internally consistent may warrant further item inspection since these too may be too specific (Klein, 2000). In sum, it is suggested that caution is used when alpha's below .70 or higher than .90 are identified. In the current meta-analysis, all subdimensions and dimensions of the GMSRM reached adequate internal consistency, however the Negative Expectations subdimension ($\alpha = .90$) and the overall Proximal dimension ($\alpha = .91$) did surpass the .90 alpha threshold and may warrant closer scrutiny in future research. However, each dimension and subdimension of the GMSRM surpasses the minimum acceptable scientific convention of $\alpha = .70$ for adequate internal consistency, suggesting it is reliable in its underlying psychometric structure and suitable for use with TGNC individuals.

Study Limitations and Recommendations for Future Research

There are several limitations to this meta-analysis. A series of subgroup analyses was conducted to examine the influence of the six categories of bias on the heterogeneity of study effects. All subdimensions except Victimisation, Non-disclosure, and Negative Expectations were significantly associated with risk of bias. The Internalised Transphobia subdimension showed statistically significant risk for reporting and performance bias, where higher alpha estimates were apparent in low-risk studies. In the Rejection and Non-affirmation subdimensions there was also a statistically significant risk of performance and reporting bias, whereby increasing risk of bias was associated with an increase in alpha estimates. In the Discrimination subdimension, a statistically significant relationship was found between lower risk of performance bias and increasing alpha estimates. For the Resilience scale, there was a statistically significant association between lower risk of performance, reporting and generalisation bias with higher alpha estimates in the Community subscale. In the Pride subscale, there was a statistically significant association between lower risk of performance and reporting bias with higher alpha estimates.

As can be seen above, the statistical data extracted from the existing literature suffers the influence of performance and reporting bias predominantly, however also generalisability bias in the case of the Community subdimension. To avoid misperceiving the outcomes of this meta-analysis, it is important to be cognisant of the influence of bias on one's interpretation of the internal consistency of the GMSRM based on the existent literature; these sources of bias can attenuate the degree to which we can draw firm conclusions (Higgins et al., 2011; Kim et al., 2013; Lilienfeld et al., 2014).

Furthermore, there were questions of reliability that could not be addressed as part of this meta-analysis. Firstly, we examined internal consistency, however we did not explore the stability of the GMSRM over time due to the absence of research examining this property of the GMSRM. This is another important component for establishing the reliability of a psychometric test (de Souza et al., 2017), and this is suggested as an area of focus for future research. Secondly, it is notable that there were fewer studies reporting composite scale internal consistency statistics for the GMSRM. Including these in future studies would provide broader coverage on the internal consistency of the entire GMSRM, and each of the dimensions separately. Lastly, this meta-analysis used data from adults only. It would be considered fruitful to inspect the psychometric properties of the adolescent extension of the GMSRM (Hidalgo et al., 2019) in future research to sufficiently support the increasing number adolescents accessing gender identity healthcare services (Kaltiala et al., 2019).

Clinical Implications

Gender minority stress is a contributing factor to both mental and physical health outcomes for TGNC individuals, and as such, it is recommended that clinicians consider it as part of a psychological assessment and formulation with TGNC individuals accessing healthcare services (BPS, 2019; Coleman et al., 2022). In doing so, clinicians can measure and monitor gender related minority stress, elucidate clinical symptomatology, and establish targeted interventions accordingly. Additionally, in terms of clinical utility the GMSRM could invite sensitive conversations about minority stress and support TGNC populations to articulate and put into context their experiences, which can could have added therapeutic benefit. This meta-analysis contributed to the certainty that the subparts of the GMSRM are homogenous and measure the same construct, and that therefore, the measure is sufficiently internally consistent for administration with TGNC individuals in both healthcare and research contexts.

Conclusion

To determine the internal consistency of the GMSRM (Testa et al., 2015) the current study extracted Cronbach's alpha coefficients from the existing peer-reviewed literature and performed a meta-analysis. Although there are limitations in the literature included in this meta-analysis, the GMRSM appears to be a reliable measure of minority stress and resilience factors in TGNC individuals and is thus fit for use in clinical and research contexts. It is hoped that, firstly, this study will contribute to the provision of culturally informed therapeutic support which elucidates the social context and clinical presentations of TGNC individuals. Secondly, these findings will hopefully prompt further research into the psychometric properties of the GMSRM to enhance certainty and understanding around other aspects of its psychometric properties.

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Exploring the Lived Experience of People Who Detransition in the United Kingdom: An Interpretative Phenomenological Analysis

Abstract

Introduction: Some people who undergo gender transition will pause, stop, or reverse the changes conceived during their gender transition, and this is known as gender detransition (Jorgenson, 2023). Research with people who detransition is in its infancy, however existing studies indicate that this population have multiple unmet social, psychological, and physical health needs (MacKinnon et al., 2023; MacKinnon et al., 2022a; Expósito-Campos et al., 2023), and little is known about how to meet the clinical needs of this group (Butler & Hutchinson, 2020). The aim of the current study is to explore how people make sense of their lived experience of detransitioning in the United Kingdom.

Method: Semi-structured interviews were conducted online with six adults who had started and stopped at least one medical intervention for gender transition in the UK. Participants were recruited online through social media and the qualitative method of Interpretative Phenomenological Analysis (IPA; Smith et al., 2022) was employed to analyse the data.

Results: Six group experiential themes (GETS) and 11 subthemes emerged from the data. These captured how participants made sense of their detransition experiences at various points in time across different contexts, ranging from the point of realising a desire to detransition, to adjusting to ambiguous feelings following detransition, to finding meaning and contentment in their current circumstances.

Conclusion: Participants in this research experienced a range of distressing psychosocial difficulties combined with barriers to healthcare services, to name a few. The findings are discussed along with clinical and research implications.

Introduction

Gender transition is often undertaken in the service of enhancing the wellbeing of people experiencing a felt incongruence between their gender identity and their sex registered at birth (Coleman et al., 2022). Transitioning gender may involve undertaking one or more steps, including social transition where the person presents as a different gender (e.g., changing pronouns, clothing, hair and/or makeup), legal transition (e.g., acquisition of gender recognition certificate), medical transition (e.g., hormone therapy), or surgical transition (e.g., mastectomy or vaginoplasty) (Winter et al., 2016). In addition, complimentary interventions may be undertaken such as speech and voice communication therapy and mental health support (Coleman, et al., 2022). Recent census data has shown that out of the 59.6 million people living in England and Wales, less than 0.5 per cent identified with a gender other than that which was registered at birth (Office for National Statistics, 2023).

Gender Dysphoria (GD) is a psychiatric diagnosis in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychological Association, 2013) which captures the experience of a marked disparity between a person's perceptions of their gender and their physical sex characteristics (American Psychiatric Association, 2013). In the UK a diagnosis of GD or gender incongruence (GI; in the case of International Classification of Diseases 11th Edition; World Health Organisation, 2022) is used to justify access to gender affirming healthcare (Cass, 2021). Although gender transition is often undertaken to reduce the emotional distress associated with GD or GI, there is variance in both the intensity of experienced GD (Meyer-Bahlburg, 2010), and need for gender affirming healthcare interventions (Beek et al., 2015). The prevalence of GD is thought to vary by geographical location, however a large national cohort study over 43 years in the Netherlands yielded rates of 3.64 per 10,000 for those registered male at birth, and 1.93 per 10,000 for those registered female at birth (Wiepjes et al., 2018). Whilst these estimates of the prevalence of GD exist, they are predicated on the assumption that all individuals living with GD-consistent difficulties turn to health care services. To illustrate this point, in a general population sample of 8,064 individuals, 0.6% of men and 0.2% of women reported GD-consistent experiences (Kuyper et al., 2014). The implications of this are such that estimates of GD based on clinical samples are likely to underrepresent the true prevalence of GD in the general population. Related to that, since people in the general population also report GD-consistent difficulties (Åhs et al., 2018; Kuyper et al., 2014), authors have questioned the validity of existing GD conceptualisations (Galupo et al., 2020; Indremo et al., 2021; Lindley & Galupo, 2020). In the UK interventions for GD or GI are available through the publicly funded National Health Service (NHS), however many people also access gender affirming medical interventions through privately funded gender care providers, or receive their gender care in a different country, or self-medicate (Boyd et al., 2022; Mepham et al., 2014). In one study 23% of individuals referred to a gender care clinic had already been using HRT, and 70% of those individuals sourced HRT through the Internet (Mepham et al., 2014). This has been suggested to make more complicated for clinicians the provision of gender in the NHS (Wren, 2021).

Transgender and gender non-conforming (TGNC) individuals are vulnerable to disparities and discrimination in accessing healthcare in the UK, reporting distress due to waiting lists, a perceived lack of clinician competence, gender stereotyping from professionals, and feeling unheard (Carlisle, 2020). In comparison to cisgender individuals, TGNC individuals are more vulnerable to experiencing chronic elevated stress in response to socio-environmental hostility, including gender-based discrimination and victimisation (Testa et al., 2015). In a large sample of 514,000 participants, Warrier et al.,

(2020) compared cisgender individuals with TGNC individuals and reported disproportionately higher rates of neurodevelopmental and mental health difficulties in TGNC individuals. With that said, direct comparisons between cisgender and TGNC individuals negates the diversity of experiences, identities and backgrounds which could compound such findings. For instance, Robertson et al., (2021) applied an intersectional lens to examine the prevalence of frequent mental distress and chronic depression at the intersections of gender identity, race, and ethnicity. The findings showed that in comparison with cisgender White adults, transgender American Indian or Alaska Native individuals were 8.06 times more likely to experience frequent mental distress, whilst transgender adults of other/multiple racial identities or ethnicities and transgender White adults were 3.15 and 1.81 times more likely to experience frequent mental distress. A similar trend followed for chronic depression, with transgender American Indian or Alaska Native individuals 3.61 more likely to experience chronic depression, and transgender adults of other/multiple racial identities or ethnicities and transgender White adults showing rates of 2.37 and 2.07 (Robertson et al., 2021). Furthermore, evidence suggests that rates of personality disorder (Anzani et al., 2020), substance use (Nuttbrock et al., 2014), and risk of suicide and self-harm (Hanna et al., 2019; Wiepjes et al., 2020) are elevated in TGNC populations. There is growing evidence to show a link between GD/GI and autism, and although more research is warranted to make clearer this association, recent meta-analytic findings have shown there to be an estimated prevalence rate of 11% in the autism and GD/GI overlap (Kallitsounaki & Williams, 2022). In contrast, some racial and ethnic minority groups are largely excluded from the scientific literature on autism (Diemer et al., 2022). With that said, research has shown that most people who undergo gender affirming surgery will report positive psychological and sexual wellbeing at least one-year post-surgery (Javier et al., 2022). This demonstrates that TGNC people may present with multiple and differing mental health symptoms and diagnoses within clinical services, demonstrating the importance of full and comprehensive assessment to guide treatment.

There is a growing awareness that, following transition, gender identity and related care needs may fluctuate over time, and some individuals may subsequently decide to stop transitioning, and detransition (MacKinnon et al., 2021). Gender detransition typically involves taking action to pause or terminate the transition progression to reverse the changes achieved during transition either partially or entirely to realign the person's gender identity with the sex registered at birth, or with another identity (e.g., non-binary identity) (Expósito-Campos, 2021; Jorgenson, 2023). The true rate of detransition remains unknown, and the empirical literature hitherto has suffered from methodological challenges, including definitional inconsistencies, sampling weaknesses, and short-term follow-up and loss to follow-up limitations (Cohn, 2023). This diminishes the confidence with which any firm conclusions can be made about detransition rates. Considering this, in their Swedish sample Dhejne et al., (2014) reported a detransition rate of 2.2%, in the USA Turban et al., (2021) report 13.1%, Roberts et al., (2022) report up to 30%, and in the UK, discrepantly, Hall et al., (2021) reported at least 6.9% and Richards & Doyle (2019) less than 1%. Detransition is often conflated with regret (Huckins, 2023), and although there is overlap between detransition and regret, people who detransition also report an appreciation for their transition experiences and view it as part of their personal developmental trajectory (Littman, 2021; Pullen Sansfaçon et al., 2023; Tang et al., 2022).

There exists a stigma towards people who detransition (MacKinnon et al., 2022b; Vandenbussche, 2021). MacKinnon et al., (2022b) propose that in the sociopolitical context of cisnormativity and transnormativity, detransition stigma (or 'detransphobia') can comprise a number of transgressions which negatively impact the wellbeing of detransitioned people. Those experiencing detransphobia may conceal their detransitioned status, experience delegitimisation, person misrecognition, non-affirmation of gender identity, rejection from others, and internalised stigma (MacKinnon et al., 2022b). Existing research has found that individuals who detransition can experience judgement and rejection from healthcare services and the LGBTQ+ community, healthcare avoidance, an absence of connection with detransitioned peers, and live with unmet physical and mental health needs (MacKinnon et al., 2023; MacKinnon et al., 2022b; Vandenbussche, 2021). In many cases, people do not inform healthcare providers of their decision to detransition due to detransition stigma, barriers to finding competent professionals, a lack of information, or mistrust in medical or mental health services (Expósito-Campos et al., 2023).

Although not everyone will require ongoing professional support, a number of those who detransition are likely to require assistance to safely stop hormone replacement therapy, and access psychological support for existing mental health difficulties, and to process the residual anxiety, shame or regret which might accompany detransition (Expósito-Campos, 2021). Moreover, some individuals who detransition are likely to benefit from counselling on how to navigate the detransition disclosure, receive advice on what to expect from reversing physical changes, make sense of the role GD has played in their lives, process worries about both past and future interventions on the body, and the potential for future identity reconfigurations, to name a few (Expósito-Campos, 2021; MacKinnon et al., 2023; Pullen Sansfaçon et al., 2023).

More recently the rate and demographic landscape of those attending gender care services has changed internationally (Aitken et al., 2015, Churcher Clark & Spiliadis, 2019; Expósito-Campos et al., 2023; Gender Identity Development Service, n.d.). In England, the number of referrals made to the child and adolescent Gender Identity Development Service

(GIDS) rose from a total of 138 in 2010-2011 to 2748 in 2019-2020. In 2020 to 2021 over twice the number of people registered female at birth (1512) were referred to GIDS in comparison to people registered male at birth (704), and the sex of 167 referral was unknown – a trend in the opposite direction to a decade earlier (Gender Identity Development Service, n.d.).

The politicolegal context surrounding gender care in several parts of the world, including the UK, America and Sweden has resulted in heightened media attention (Brooks, 2023; Orange, 2020; Robinson, 2021). In the UK, a lawsuit against the Tavistock and Portman NHS Foundation Trust initiated by a young person who detransitioned resulted in the Divisional Court placing restrictions on young people's ability to consent to puberty blockers (Bell v. Tavistock, 2020), however this was later overturned. Previous to this lawsuit, an independent review of gender services for children and young people was commissioned and recommended a more 'fit for purpose' service model of gender care (Cass, 2022). The recommendations subsequently received endorsement by the Association of Clinical Psychologists in the UK (ACP-UK; Association of Clinical Psychologists, n.d.). However, in an open letter response, clinicians criticised the position statement from the ACP on the grounds that the voices of clinical psychologists were absent in the development of this position piece (Open Letter to the ACP-UK, 2022).

Considering the international rise in gender transition in gender identity clinics, the number of individuals who detransition is expected to rise (Irwig, 2022). Whilst some authors have positioned detransition as an outcome of immense clinical failing, calling on collaboration between clinical and research professionals to diminish the possibility of detransition (Jorgensen, 2023b), others have opined value in extended clinical assessment for those with gender identity difficulties (Churcher Clark & Spiladis, 2019). However, predictors of detransition have hitherto shown to be difficult to identify, suggesting that detransition could be a clinically unavoidable outcome for some people (MacKinnon et al., 2021). Furthermore, some people who detransition retrospectively report an inability to have predicted their detransition at the time of assessment and transition (Littman, 2021; MacKinnon et al., 2021).

Our understanding of the clinical needs of people who have detransitioned in the United Kingdom (UK) is of yet rudimentary, and there is a growing acknowledgement that, as the numbers of people inevitably rises, clinicians have an obligation to focus their research endeavours and adapt their services appropriately to meet the psychosocial needs of this population (Butler & Hutchinson, 2020; MacKinnon et al., 2023). To the best our knowledge, no peer-reviewed qualitative research has yet examined how people make sense of their experiences living as somebody who has detransitioned in the UK. Therefore, here, we aim to explore this question with the application of Interpretative Phenomenological Analysis (IPA; Smith et al.,2021).

Methodology

Design and Theoretical Rational for IPA

The data collection and analysis for this project was guided by IPA (Smith et al., 2021). IPA adopts an epistemological stance concerned with phenomenology, hermeneutics and idiography to arrive at nuanced understandings of the meanings people attribute to their lived experiences (Nizza et al., 2021; Tuffour, 2017). The approach is idiographic in the sense that a detailed picture of each individual's experience is developed, and personal experiential themes are identified which encapsulate the main experiential concerns reported by the individual. Despite its idiographic nature, IPA also enables the development of themes across a group of interviewees following careful and iterative analysis of each individual case. In doing so, particular significance is attributed to the double hermeneutic in IPA; here, the researcher is actively involved in making sense of how the interviewee has made sense of their experience, acknowledging the subjectivity of experiential reporting and the interpretations derived (Nizza et al., 2021; Smith et al., 2021). Whilst the principles of IPA are considered optimal for exploring the experiences of people who detransition, IPA is also optimal for interpreting the experiences of under-researched groups and phenomena (Smith et al., 2021).

In line with best practice, Table 13 explicates how each of the criteria necessary for conducting high quality IPA research have been met in the current study (Tracy, 2010).

Table 13: The Eight Quality Criteria for Assessing Qualitative Research

Quality Criteria	Means and practices for achieving quality criteria
Worthy topic	• Topic is relevant with regard to priorities in the empirical literature, clinical practice, and contributing to a more inclusive society.
Rich rigour	• The interviews were comprehensive, and the researcher became highly immersed in the data. • Data was abundant and complex. • The process of data collection and analysis was clearly described. • Researcher received monthly supervision. • Excerpts from the transcripts and drafts of the themes were shared and discussed in research supervision. • Excerpts from the transcripts were brought to a series of IPA peer workshops led by experienced IPA researchers which helped to deepen the analysis.
Sincerity	• A reflexive diary was maintained throughout the research. • Open dialogue with the supervisor and peers helped enhance self-reflexivity. • A reflexive position has been shared for transparency around personal, methodological and theoretical views. • There is acknowledgement of the study limitations.
Credibility	• Rich quotations and descriptions are provided as much as is appropriate. • The researcher became fully immersed in the data by following the IPA protocol in Smith et al., (2021).
Resonance	• The findings are evocative and compelling in content, and likely prompt a compassionate and empathic reaction in the reader. • The findings are transferable and are fitting with existing literature.

Significant contribution	• The findings could contribute to the development of a theory of detransition. • In terms of the practical contribution, clinical recommendations have been made available for clinicians and services to consider. • The findings promote inclusive communities and services for people who detransition. • The research has developed avenues for future research to explore.
Ethics	• The study was reviewed by the ethics board at a reputable university. • The researcher was available to be contacted with any queries regarding the research. • Time and space was provided before and after the interview for the participant to speak with the researcher. • A debrief form was provided to the participant. • A non-binary person provided consultation on the development of the interview schedule. • The data was carefully managed to protect the identity of participants. • Caution has been advised around the interpretation of the study findings where appropriate.
Meaningful coherence	• The methodological approach and analysis are in line with IPA standards. • The aims of the study, empirical literature, data and interpretations are brought together in meaningful coherence.

Reflexivity Statement:

IPA acknowledges the double hermeneutic process whereby the researcher makes interpretations of the interviewee's interpretation of their lived experience. Thus, IPA invites the interviewer to consider their own subjective cognitions and emotional and physical reactions which might bias the interpretations made (Berger, 2013). In this instance I, the researcher, am a cis-gendered, gay, White Irish male who is increasingly developing the confidence to comment on matters of social justice. I have been shaped to hold an intellectual curiosity about the world, and to think and feel feelings as a consequence of, but not limited to, my past and present cultural surroundings, including personal and professional experiences. I am on a journey towards learning how to hold difficult conversations on sensitive topics for multiple audiences. Just as with the aspects of my own identity which have been brashly misunderstood and misrepresented in history, I like to think there is more complexity and nuance to the controversy and politically charged discourses which exist in society with regard to the experiences of those who detransition or adopt a gender non-conforming identity. I have never worked in gender care services, and my reasons for conducting this research are multifarious in nature. However, one reason dates back to when I worked in Her Majesty's Prison Service and there was an emerging workplace discourse that all transgender prisoners were likely to abandon their transgender identity beyond their release, which was justification for some to further stigmatise transgender people in prison. However, for this and various other reasons, I was motivated to understand what it might be like to detransition, and contribute in some way to helping a group I believed would suffer marginalisation in the community. I endorse a position of critical realism, whereby I believe individual and social experiences can be empirically examined to generate knowledge with a degree of confidence, but with fallibility also.

It is noteworthy that I have chosen to terminologies which are commonly used within the literature at present (e.g., hormone replacement therapy over cross-sex hormones or gender-affirming hormone treatment; sex registered at birth over sex assigned at birth) to aide communication and maintain consistency within the scientific literature. Whilst I am aware that this language may feel appropriate for some individuals, it may not feel appropriate for everyone.

Ethics

The research was approved by the Psychology Research Ethics Committee at University of Birmingham, United Kingdom (ERN_21-1459; see Appendix C). To honour the labour for minoritised groups taking part in research, participants were given a £20 online shopping voucher as a token of gratitude, in line with ethical recommendations for related groups (Vincent, 2018).

Participants and Recruitment Procedure

Purposive sampling was used to recruit participants who had experience of detransitioning in the United Kingdom. The main study advertisement was hosted on 'Call for Participants' (www.callforparticipants.com) and shared on a Twitter account established specifically for the study, and on the Detransition Subreddit (>48,000 members) https://www.reddit.com/r/detrans/. This forum and social media platform were used due to the potential reach to participants matching the study inclusion criteria. Participants were redirected by weblink to ‘Call for Participants’ (see Figure 25) to read about the study and opt in should they choose to, and if they met the inclusion criteria (see Table 13). At no point did the researcher contact people on the platforms to participate in the study. When participants indicated their interest, the researcher was alerted in an email account specifically developed for this study, and a

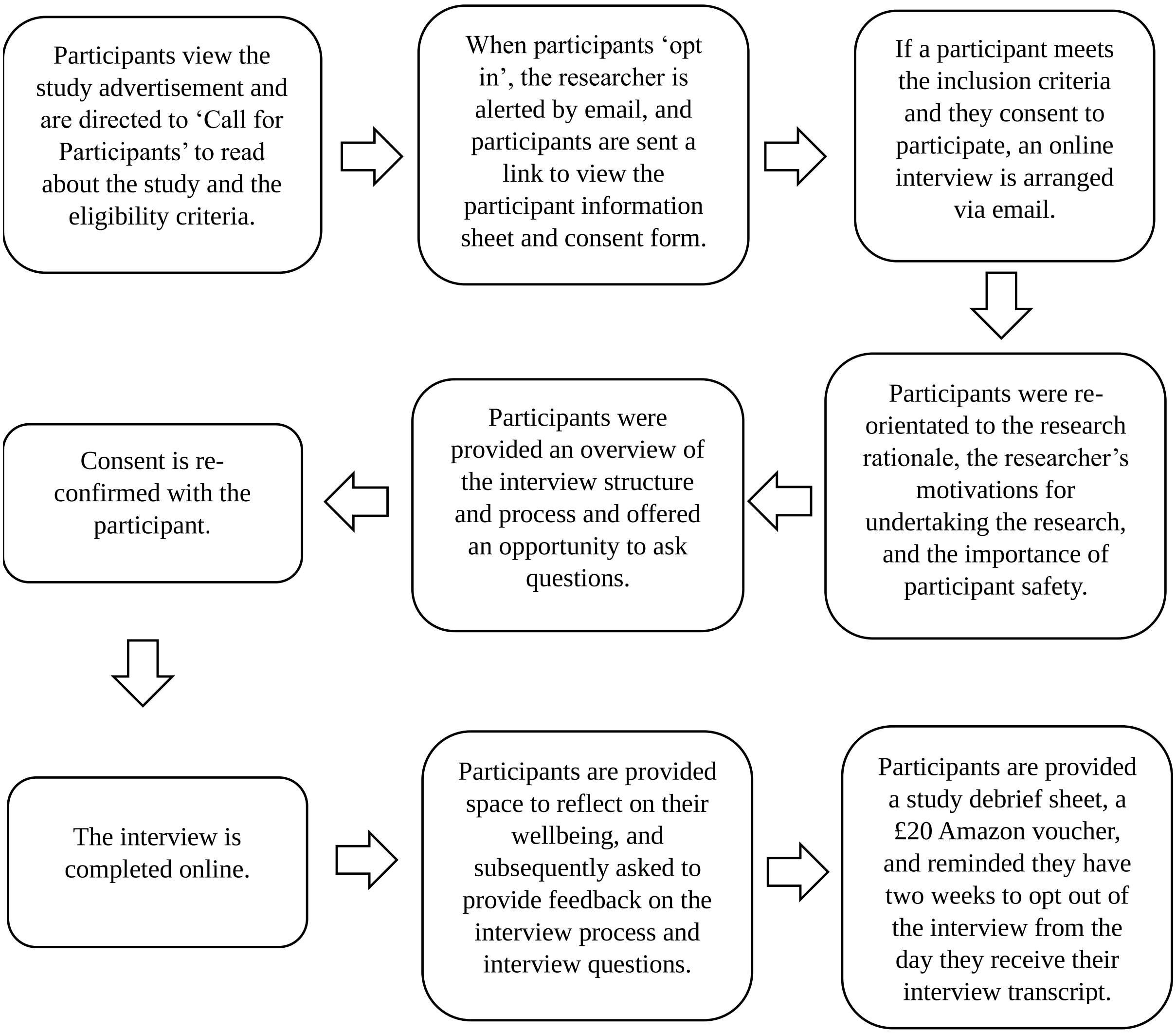

Figure 25: Study Procedure

link was sent to participants containing the study information and consent form and demographics questionnaire. Interviews were conducted remotely on Zoom and recorded using an inbuilt audio-only recorder. These were deleted following a two-week transcription period. The names of participants were

Table 14: Inclusion / Exclusion Criteria

Inclusion Criteria	**Exclusion Criteria**	**Rationale**
Adult – Over 18 years of age		This is necessary in order for the individual to consent to participant in the study autonomously, and at a developmental stage synonymous with others in the study.
Began at least one medical intervention for transitioning and stopped (for example, hormone replacement therapy; gender affirming surgery)		This was proposed to capture those individuals who would likely present with an elevated threshold of severity in both clinical and personal difficulties which may not be experienced by social transition alone.
Transitioned and detransitioned in the United Kingdom		This was to minimise the cultural, legal and systemic variation in participants' experiences of transitioning and detransitioning.
Speak English to a standard that allows you to understand and respond to the interview questions	Requirement for a translator	A core tenet of the IPA approach is that the researcher makes interpretations of the interviewees account of their experiences. The involvement of a translator could preclude the closeness of the researcher from the interviewee's experiences, diminish the quality and rigour of IPA, or obfuscate the study outcomes.
Have access to Zoom or Microsoft Teams through an electronic device (e.g., a computer or smartphone)		This was chosen to maximise our reach to participants in an economical and practically accessible way.

changed at the point of interview transcription and subsequently throughout this research to protect their identity. The study advertisement and recruitment closed at the point at which the commencement of data analysis was necessary for the thesis submission date. Participants were given a £20 shopping voucher as a token of gratitude for the time, emotional and intellectual labour involved in their participation.

Six participants (some participant information is broadly summarised to protect identities) provided informed consent and volunteered to participate in the study, and their ages ranged from between 22 and 28 years of age. In terms of racial identity, one participant was Black, African, Caribbean or Black British – African, and the five other participants were White – English, Welsh, Scottish, Northern Irish or British. The length of time since the commencement of detransition ranged from between six months and five years. All of our participants reported having previously had a diagnosis of gender dysphoria conferred upon them, with the exception of one who had received a diagnosis of gender incongruence. All participants self-reported having at least one psychiatric diagnosis. These included borderline personality disorder, anxiety, depression, agoraphobia, and obsessive-compulsive disorder. Two participants had received a diagnosis of an autism spectrum condition, and three others suspected they are or may be autistic despite never receiving a diagnosis. Additionally, two participants had a diagnosis of attention deficit hyperactivity disorder. Four participants reported they had completed the detransition process despite three of these individuals reporting ongoing discomfort with physical differences associated with their previous transition, and two reported detransition was ongoing. Further information about the study participants can be seen in Table 14.

Interview Schedule

An interview schedule (Appendix B) was developed to be used in line with the semi-structured data collection model postulated in the IPA approach (Smith et al., 2021). It consisted of open-ended questions tapping into life experiences in different contexts (e.g., relationships, employment, health) of someone who has detransitioned. For example, *"How you would describe life currently as someone who has detransitioned?"*

Despite numerous efforts, it was not possible to have someone with experience of detransitioning to review the schedule ahead of its implementation. Two individuals with experience of detransitioning offered to support the development of the research for a £20 Amazon voucher, however for personal health reasons it was not the right time. However, gratitude is expressed to one non-binary individual who consulted with the researcher on the item development and gave tips on rapport building. Furthermore, all study participants provided positive feedback on their experience of the interview process and interview questions at the end of each interview.

Table 15: Participant Demographic Information

Pseudonym	**Ethnic Background**	**SRAB**	**Current Gender Identity**	**Plan to re-transition?**	**Sexual Orientation**	**Previous Gender Affirming Healthcare Intervention**	**Employment Status**	**Education Level**	**Relationship Status**
Morgan	Black, African, Caribbean or Black British – African	F	F	No	Heterosexual	HRT, Speech Therapy.	Self-employed	Unknown	Single
Cooper	White – English, Welsh, Scottish, Northern Irish or British	F	F	No	Bisexual	HRT Double Mastectomy.	Employed	College	Single
Carey	White – English, Welsh, Scottish, Northern Irish or British	F	F	No	Heterosexual	Double Mastectomy, HRT, Speech Therapy.	Employed	University	Single
Eli	White – English, Welsh, Scottish, Northern Irish or British	F	F	No	Bisexual	HRT, Double Mastectomy.	Employed	Some University	Single
Jesse	White – English, Welsh, Scottish, Northern Irish or British	M	M	No	Gay	HRT	Unemployed	Unknown	CR
Mel	White – English, Welsh, Scottish, Northern Irish or British	F	N-B	Unsure	Bisexual	HRT	Student	University	CR

Note: F = Female; M = Male; N-B = Non-binary; SRAB = Sex registered at birth; HRT = Hormone replacement therapy; CR = committed relationship

Analytic Method

Following interview transcription, the IPA framework developed by Smith et al., (2021) was utilised for data analysis.

Table 16: Stages of Analysis in IPA (Smith et al., 2021)

Step in Analysis	**Brief Description**
Step 1: Reading and Rereading	This involves taking time to become immersed in the participant's data, with the researcher noting down initial impressions of the participant's experience.
Step 2: Exploratory Noting	Exploratory noting involves holding continuous curiosity and commenting on the phenomenology of the participants experience, including the concerns or experiences of importance to the participant, such as relationships, processes, or events.
Step 3: Constructing Experiential Statements	Experiential statements are a construction bourn out of the exploratory notes and the original transcript. This step involves more of the researcher's interpretation. The statements are a synthesised interpretation of the main concerns articulated within a piece text. The whole text will inevitably influence each piece of text and vice versa.
Step 4: Searching for Connections across Experiential Statements	This iterative stage involves developing patterns of connection across each of the experiential statements. At this stage some experiential statements may be excluded depending on their pertinence to the research question.
Step 5: Naming and Organising Personal Experiential Statements (PETS)	Here, experiential statements are clustered together to develop PETs for each participant, highlighting the main concerns reported by each participant.
Step 6: Developing Group Experiential Themes (GETS) from PETS.	At this stage, PETs are examined to identify group-level similarities and differences. Here, we can see how it was each participant lived their experience, and identify connections across each of them.

To buffer the validity of the data, the earlier stages of the analysis was presented and discussed within regular IPA workshops, and during the later stages of analysis the cases and analysis were reviewed and discussed as part of the research supervision process. The researcher made efforts to journal and bracket their experience of the interview, the transcripts, and the data analysis, however some variation would be likely should other IPA researchers analyse this data. An invitation is extended to consider this with the reflexivity statement in mind.

Results

Overview of Themes

Figure 26 provides an overview of the GETs and subthemes generated from the data, whilst Table 16 show how participants endorsed each of the themes.

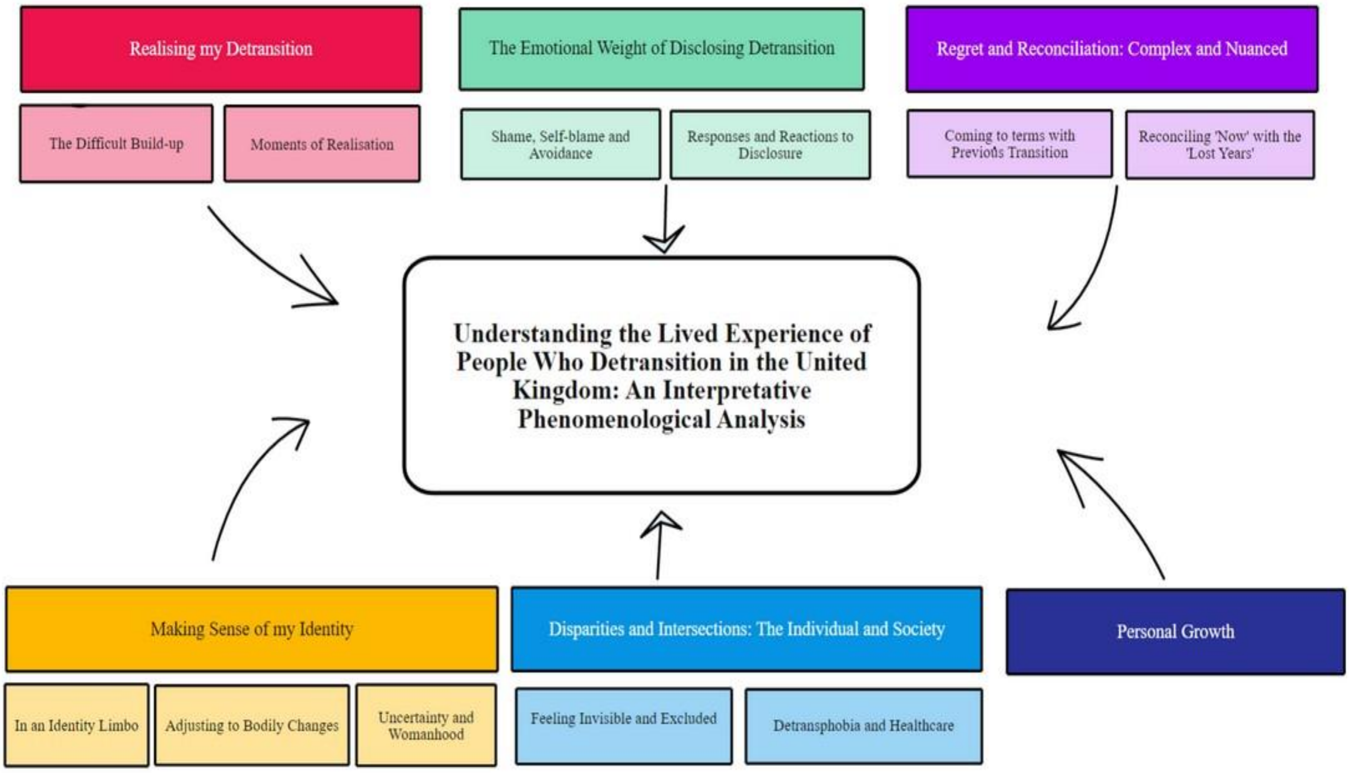

Figure 26: Table of Themes

Table 17: Participant Contributions Across Themes

Group Experiential Theme	Subtheme	Carey	Cooper	Eli	Jessie	Mel	Morgan
Realising My Detransition	The Difficult Build-up	❖	❖	❖	❖		
	Moments of Realisation		❖		❖	❖	❖
The Emotional Weight of Disclosing Detransition	Shame, Self-blame and Avoidance	❖	❖		❖		
	Responses and Reactions to Disclosure	❖			❖	❖	❖
Regret and Reconciliation: Complex and Nuanced	Coming to Terms with Previous Transition	❖	❖	❖	❖	❖	
	Reconciling 'Now' with the 'Lost Years'	❖	❖	❖	❖		
Making Sense of My Identity	In an Identity Limbo	❖	❖	❖	❖		
	Adjusting to Bodily Changes	❖	❖	❖	❖	❖	❖
	Uncertainty and Womanhood	❖	❖				
Disparities and Intersections: The Individual and Society	Feeling Invisible and Excluded	❖	❖			❖	
	Detransphobia and Healthcare	❖		❖	❖	❖	
Personal Growth		❖	❖		❖	❖	❖

Each theme is discussed below using illustrative direct quotations from the interview transcripts. Ellipses (…) represent the omission of words from the transcript for the sake of brevity.

Realising My Detransition

This GET has two subthemes, *'The Difficult Build-Up'* and '*Moments of Realisation'*. It refers to the gradual strengthening of distressing thoughts and feelings of anguish associated with the increasing desire to stop their gender transition. All participants described reaching a point of having to stop and pay attention to their suffering. Precipitating this, they described significant moments of realisation, such as noticing they felt alone, feeling shock from a glance in the mirror reflecting their physical changes, and realising they were embodying a *"persona"* and that the underlying need to be accepted was still unmet irrespective of gender.

The Difficult Build-Up

Whilst five participants found the decision to detransition difficult, four participants described a challenging build-up to this point. For instance:

> *Uhm, I think for months before I told anybody, I was having second thoughts. I had thoughts that slowly built up and I just couldn't really deny them anymore… It's quite a hard thing to like admit because I had been on this journey since I was about 13…*
>
> Carey: Page 12; Lines 326-331

This extract conveys the gradual strengthening of a desire to detransition over time to a point it could no longer be ignored, despite attempts to deny it. The struggle was concealed from others, and seemingly unspeakable, giving the impression that both shame and the time/years spent gender transitioning raised barriers to Carey's ability to share the decision. Moreover, the denial of detransition likely functioned to protect Carey from the fearful prospect of navigating life without the transgender identity which once brought comfort and relief. Similar conflicts were experienced by Cooper who described a two-year period wherein she used the strategies of thought stopping, minimisation, and keeping busy to cope with the realisation of detransition:

> *So I think I kind of, I was able to keep that unhappiness in the back of my mind for a couple of years, even after I knew it was that, because I was just keeping myself busy, I was like, no, no, don't, don't think about that, just go out for a couple of hours, and then go to work for another six hours, and just make yourself busy. Don't, don't think about it.*
>
> Cooper: Pages 13-14; Lines 336-342

Cooper describes a prolonged unhappiness which was avoided over time likely due to the emotional pain of confronting the underlying problem, thus perpetuating the underlying unhappiness. Both Jessie and Eli commented on their mental health during the build-up to deciding to detransition. Whilst Jessie shared that he entered a *"deep depression"*, Eli stated the following:

> *...it just kept eating away at me to be honest... how it built up and built up, I don't know, I think it would have really negatively impacted my mental health if I had kept going.*
>
> Eli: Pages 33-34; Lines 915-918

Eli conveys a sense of significant inner turmoil during the build-up to deciding to detransition. The use of the words *"it just kept"* indicates a driving persistence in the psychological turmoil, whilst *"eating away"* conjures up the presence of an all-consuming emotional distress. This experience was distressing enough for Eli to imagine a significant deterioration in her mental health had she not come to terms with her decision to detransition.

Moments of Realisation

Four participants provided a description of significant moments that contributed to the change in their gender transition trajectory. These ranged from realising they are alone, to discomfort and/or seeing no value in bodily changes due to HRT, and in Cooper's case, realising what they needed was to feel loved and accepted:

> *... and the transition was just kind of the different way of trying to cope with that…it was a persona… inside I didn't really care if I was a boy or a girl, but I just wanted to be loved. I guess I just wanted people to accept me, and to feel like I was enough, to feel like I was loved. And so that was like a really powerful kind of moment.*
>
> Cooper: Pages 15-16; Lines: 383-384, 394-399

Cooper describes a misalignment between her outward identity and her internal psychological needs, and curates a sense that her gender identity overshadowed the underlying need to be loved and accepted by those around her. It is as though her transgender identity was no longer enough, reflecting how she felt internally. This realisation struck Cooper in quite a significant way and made more concrete her decision to detransition. Cooper also stated that transitioning her gender became a coping mechanism which likely functioned to create hope for the resolution of her problems, as did Carey and Eli (see 'Coming to Terms with Previous Transition'). Mel's moment of realisation had to do with physical bodily changes:

> *I think it was when I was kind of looking in the mirror and I looked and I seen facial hair and things like that I was like oh this is a thing now, this is something I'm going to have to deal with for the rest of my life, and like it became very much like, this isn't me now or in my future self.*
>
> Mel: Page 11; Lines 305-309

Mel reports on an impactful moment of realising the reality of physical changes associated with HRT. Using the words *"deal with"* gives the impression this was a problem requiring a solution. Interestingly, once Mel's body began to transition, there was a sense of conviction in their knowledge that transitioning to live as a man was not in alignment with their sense of self currently or in the future. Jessie's account somewhat reflected this, stating his dissatisfaction with HRT, but also realising that living as a man and expressing his gender more femininely can co-exist:

> *I went long term sick with depression and anxiety and stuff and during that time I sort of really reflected... Am I happy with the body that these hormones are giving me, how's this been a positive influence on my life? And I came to the conclusion that, no, I don't really like having breasts. There is no benefit to that for me. And all of the other stuff is so superficial that it wasn't worth it… And then I continued to reflect and do lots of research and came to the whole, while there is butch woman out there, what am I interested in and why can't I do that just as a man.*
>
> Jessie Page: 7; Lines 170-177

In the context of experiencing poor mental health, Jessie stopped to pay attention to why he experienced a downturn in his emotional wellbeing, leading to the discovery of a broadened perspective on his gender identity and expression, and subsequently a more concrete desire to detransition. Jessie conveyed a sense of both relief and self-belief in his ability to navigate his gender identity thereafter.

The Emotional Weight of Disclosure

This GET consists of two subthemes, *'Shame, Self-blame, and Avoidance'* and *'Responses and Reactions to Disclosure'.* Five participants contributed to this GET and described a wealth of emotions and worries for the impact of their disclosure on their other people, the transgender community, and healthcare services. Participants also shared the range of reactions they, and others, had to the disclosure.

Shame, Self-Blame, and Avoidance

Cooper gives the impression that she blamed herself in order to protect her parents from feeling responsible for her gender transition, and that shame played a role in the disclosure:

> *I had found it like really stressful, and I guess emotionally it was just really hard to tell my parents and I felt like I had just kind of brought them on this big kind of journey with me unnecessarily... I just didn't want to kind of make them feel like they had done anything wrong, or that it wasn't something that anyone could have seen coming or changed, I guess.*
>
> Cooper: Page 25; Lines 638-647

The use of the words *"journey"* with *"unnecessary"* could indicate an assumption that gender transition is invalid if not linear, thus contributing to a sense of shame. Jessie echoed a sense of shame and self-blame associated with disclosing the decision to detransition in his personal relationships due to having persuaded others to adapt to his transgender identity over five years. Cooper reported she had avoided telling her gender care clinician of her detransition, stating she could never speak the words aloud to her clinician. Cooper feared that disclosing her detransition would impact negatively on access to gender healthcare for the transgender community, or impact negatively on clinicians and services, ultimately believing she deserved to detransition without support:

> I was worried that it would reflect badly on like their care. I know that if you treat like transgender people… if there was kind of a, there's a situation where someone is unhappy with their care or they regret their care, especially if they're like blaming the practitioner, I didn't want to, I didn't want to make things harder for either trans people in case that gender clinic

> that the GP got closed down, or if they got in trouble or something like that, I don't know… it really wasn't anyone else's like fault… no one had pushed me to transition, and so I felt like I should bear the brunt of detransitioning alone as well.

Cooper: Page 22-23; Lines 564-575

Here Cooper conveys a sense of psychological complexity in relation to disclosing her detransition to her gender care provider. The concealment and avoidance of sharing her detransition appeared to be driven by self-sacrificial beliefs and self-blame resulting in her detransition-related needs being concealed from clinicians supporting her. Adding to this complexity was a sense of power and catastrophe accompanying the vocalisation of the disclosure of detransition. From Cooper’s perspective, it likely felt too overwhelming for services to tolerate her decision, and that she would be held responsible for any subsequent ramifications, thus Cooper’s clinical needs remained unexplored.

Similarly, Carey reported taking time to disclose her detransition to her parents due to shame associated with having been supported by her family through her gender transition:

> *It was very shameful especially for like my family who had paid privately for like my surgery and everything that happened up until that point like when I went privately to get the testosterone. And all that cost money, so I was really shameful about telling them that I didn’t want to do it so it took a while to actually tell them.*

Carey: Page 8; Lines 221-225

Responses and Reactions to Disclosure

All participants reported positive responses from family members to their disclosure of detransition. However, responses were more mixed from friends and gender care clinicians. Morgan described feeling unsupported by queer friends:

> *You see they [queer friends] are not even asking me is there any cause, how can they support me, you know? I just came to realise now later on that actually, it was my call, I did not require validation from them…*
>
> Morgan: Page 22; Lines 439-442

Morgan suggests here that disclosing her decision to detransition with her queer friends was met with silence and lack of support, and in speaking about this experience, Morgan communicated a sense of shock, as though she felt unseen and/or abandoned. She eventually came to see those relationships as of less value in her detransition journey.

Each participant with transgender friends experienced a sense of loss associated with the change in their relationship quality (see 'Feeling Invisible and Excluded' below). Whilst all participants felt supported by family, there was variability in how their gender care clinicians responded:

> **…** *I basically said you know I'm thinking of deransitioning… And the doctors that I had spoken to, you would swear that I had just been diagnosed with cancer… after him they were all pretty supportive, you know. I would say that they were perhaps… not as enthusiastic as when I was transitioning.*
>
> Jessie: Page 7, 9; Lines 181-182, 231-232

Here, Jessie describes perceiving his gender clinician's response to detransition as one characterised by shock and likens it to having been diagnosed with a serious health concern.

There is a historical stigma associated with the word cancer, and Jessie uses it here in the context of disclosing detransition in a healthcare context, and may associate it with something unspeakable, or punishment and suffering. However, he did go on to experience an improvement in the support received. Carey echoed this, however with an observed physiological response as she spoke of her experience:

> *…I had my next appointment with the Tavistock adult services to confirm with them when I wanted to set the surgery date… I went into that appointment [pause] without really knowing what to say [breathing quickly]… I told the person in the Tavistock that I was seeing at the time, and I don't think they really knew what to do to be honest."*
>
> Carey: Page 8; Lines 211-217

It was evident this experience had a lasting impact on Carey by how her body responded to the recollection of the event. The description of going into the appointment, followed by a pause, conveyed a sense of re-experiencing a flood of anxiety, which could be felt in the interview. There was a perception that the professionals supporting her were unprepared to respond to her detransition-related needs, which likely increased a sense of fear. Conversely, Mel reported feeling that their gender care clinician was able to emotionally tolerate their disclosure, showing understanding, and an ability to move forward together:

> *I mentioned when I stopped testosterone to them and told them that I was feeling insecure about my gender identity and that I was worried that it was more body dysmorphia related rather than dysphoria…. she understood that entirely, and she offered different solutions to try to help to work it out…*
>
> Mel: Page 5; Lines 122-127

Regret and Reconciliation: Complex and Nuanced

Five of the six participants contributed to this GET, which consists of two subthemes. Participants described a process of coming to terms with their previous transition through the construction of a narrative which allows for both an appreciation of their gender transition experience, and an acknowledgement for that which has been lost.

Coming to Terms with Previous Transition

The relationship participants have with their previous transition could be considered emotionally ambivalent and nuanced. Most participants felt a sense of regret or sadness, but also viewed their transition as instrumental in becoming who they now are:

> *I think there is a part of me that does regret it and a part of me that doesn't... when I first started my transition and I was already in a bad place... I definitely have regrets but, it's just that I don't know what I would have done if it wasn't for like that belief that it was going to make my future better... for me it was just a way of coping.*
>
> Eli: Page 9; Lines 234-243

Eli experiences transition regret, however expresses an inability to imagine her life void of the hope that transitioning instilled in her, describing it as a way of coping with problems in her life. There appears to be an inner 'tug of war' with regret that possibly represents a residual dissonance following the shattering of a belief that transitioning was going to enhance her life. Cooper's account below demonstrates the coexistence of both sadness and appreciation for having transitioned, and frames transitioning as having contributed to a journey of self-discovery which ultimately ended well:

> *... it's strange, because in one sense I feel sad that things didn't work out differently... and that I, I don't regret my transition... I'm in such a good place now that I feel like things worked out okay in the end, and it was just part of, part of my own journey...*

Cooper: Page 44; Lines 1134-1140

Cooper reframes any transition-associated losses by bringing into context the satisfaction with life she currently has, helping her to honour and hold two seemingly opposing truths at once. Similarly, Carey described a battle with regret that she ultimately came to preside over through the use of cognitive strategies:

> *I think it was just trying to push it forward in my mind that well, you didn't, you don't really regret it, it's brought you where you are now, I am happy with the person that I am now. Just try... I didn't really feel like being regretful and that wouldn't have helped much. That wouldn't change much, you know?*

Carey: Page 20; Lines 532-537

Carey describes a process of trying to assimilate her experiences to make sense of what was likely to have been interpreted as an incoherent trajectory of circumstances and feelings. The account conveys a sense of initial 'tug-of-war' with regret, however Carey's appraisal of the situation in those moments helped her to overpower feelings of regret, see the personal value in her experiences, and move forward.

In addition, Mel shared that living as a transgender individual before detransitioning was fundamental to who they now are as a person:

> *The trans community and my experience as a trans person I think are very integral to who I am... I wouldn't change it.*

Mel: Page 11; Lines 298-300

Reconciling 'Now' with the 'Lost Years'

Four participants contributed to this subtheme, which explicates the sense-making behind the feelings of loss, sadness, or regret associated with their previous transition and detransition:

> *... it just feels like there is a massive gap in my life now because I, I've uhm, spent that much time transitioning and then detransitioning... it sort of feels like you have thrown seven years of your life away... It makes me feel sad but, uhm, there is nothing that I can do. I have pretty much caught up to where I would like to be anyway in myself now...*
>
> Carey: Page 9, 12, 38; Lines 246, 333, 1034-1035

Carey expresses a period of seven years in time which feels lost or discounted, and a sense of falling behind in terms of life progression. Although it feels sad, acceptance seems to have played a role in helping her to reach a more content sense of self. Related to this, Cooper reflected that she cannot help but think life would have been easier had she not been through the pain associated with transitioning:

> *Now I feel like things worked out okay in the end, and it was just part of part of my own journey. But at the same time, you know, all of the difficulties I've been through, and all of the heartache, and the, the pain and stuff it's... I think it's just human nature to kind of think things would have been a little bit easier if I didn't have to go through all of that.*
>
> Cooper: Page 45-46; Lines 1163-1168

Cooper uses the word "*Now*" to situate her ability to appraise and articulate with more clarity her previous transition and detransition. There is a poignancy to Cooper's reflections on her experiences and she uses the words *"heartache"* and *"pain"* to describe the strength of the emotional challenges in her life at that time. For Cooper, 'now' is different to 'back then' – 'now' represents a sense of evolution, security, and safety whilst 'back then' represents possible uncertainty and threat. Cooper communicates a sense of resolution with her past coupled with a sense of injustice for having experienced the pain associated with transition and detransition.

Eli described feeling on one hand *"failed"* by mental health services, but also suggests a sharing of responsibility for decision-making in her gender care:

> *I feel a bit failed by that. I also kinda feel like I was failed a bit by CAMHS and not trying to explore it a bit more I guess... it's kind of hard to say because I think at the time I probably would have like shot down any questioning of it anyway. So it is that thing of well, would it have gotten through to me?*
>
> Eli: Page 10; Lines 270-275

It is as though Eli carries some self-blame for her persistence in transitioning her gender. Jessie expressed a belief that transition was not inevitable and that more psychological support would have been preferable ahead of HRT prescription:

> *I don't think that it's something that I had to go through, and I don't think it was inevitable. In an ideal world I wouldn't have gone through that - therapy would have been mandatory, they would have helped me to figure out those answers before going on a medicine pathway. But I don't necessarily regret it…*

Jessie: Page 14; Lines 385-388

Above, Jessie looks back with a sense of injustice at an absence of psychological support at the time of accessing gender care for his gender transition. Jessie refers to an *"ideal world"* which might represent a 'just world', and in contrast, presumably a 'non-ideal' world or 'unjust world'. Despite Jessie expressing some difficulty reconciling these seemingly polarising beliefs, there appears to be an ability to conciliate his views and move forward without feeling regretful.

Others shared concerns about the lack of regular contact with gender care services, noting it to be a barrier to exploring their feelings during their transition. For instance:

> *…they [gender care appointments] were spread out between months so I might have one session and then I wouldn't have another one until five or six months down the road… So I wasn't really having any, any sessions with any other mental health services other than the [gender clinic name] at that time, so it just pushed me towards thinking well this must be what it is.*

Carey: Page 14; Lines 381-388

Carey attributes the frequency and intervals between meetings, along with a lack of opportunity for therapeutic support from a clinician, as having contributed to the conviction that transitioning was the appropriate next step for her. Carey suggests that more contact with a clinician to explore transitioning may have helped her on the journey to transition.

Making Sense of My Identity

All participants contributed to this GET, which consists of three subthemes representing participants' struggles to situate themselves socially in relation to their gender identity following detransition. Layers of compounding difficulties included adjusting to bodily changes, and having uncertainties about navigating life as a woman following detransition.

In an Identity Limbo

This subtheme was characterised by an experienced sense of identity confusion in relation to both gender identity and physical characteristics, both in the context of oneself and wider societal gender norms. Eli, who has medically but not socially detransitioned, described it as though playing a character, whilst others described it as an identity *"limbo"*, but for different reasons. For instance, Jessie used the word limbo in association with the wait for a surgical reversal intervention:

> *So I sort of have been stuck in limbo with that for [pause] since [date of detransition]… that will then be a two year wait. So, that's annoying…*
>
> Jessie: Page 9; Lines 237-239

Related to this, Carey described a type of 'limbo' in relation to a felt 'in-between' gender state:

> *… it does feel like a stuck in the middle because you can't really… I just want to live my life… But it is kind of hard to do that when you're still in this mid-transition and you are not really identifying with either party.*
>
> Carey: Page 30; Lines 827-829

Interestingly, although it had been a number of years since Carey started to detransition, she conveys a sense of feeling trapped and isolated as a function of her gender identity, stifling her ability to socially integrate. Related to this, Cooper shared her perspective of feeling alienated from both the cisgender and transgender communities, despite also feeling a sense of connection with both groups:

> *...You kind of feel like you're locked out of both worlds, I guess, I guess, even though you can relate to both, which is the really strange thing.*
>
> Cooper: Page 32; Lines 819-822

Cooper gives the impression there is a desire to be ‘let in’, but also that she has yet to make sense of why there is this consequence of being *“locked out”*. It is possible that this is experienced by Cooper as a punishment for detransitioning.

Adjusting to Bodily Changes

Participants shared a variety of converging and diverging experiences and perspectives on the adjustment to life as someone who has detransitioned, emphasising the residual impact of HRT, gender affirming surgery, and transitioning more generally. Cooper, Carey and Eli described a number of challenges associated with their physical appearance and sound of their voice following HRT cessation. For instance, Carey shared that the changes to her voice were of such emotional salience that she became depressed and attempted suicide, resulting in her presenting to a healthcare professional:

> *...my biggest problem was my voice... I was extremely depressed and tried to kill myself one day and I ended up at the GP and they made the decision to refer me back to the [name of gender care service] to try and get voice therapy.*

Carey: Page 16; Lines 427-431

For Carey, changes to her voice were so despairing and seemingly irreparable that the solution she chose was to attempt suicide, which illuminates the significance of Carey's distress, and the meaning of her voice for her own self-identity. Similarly, Cooper conveyed a sense that her voice holds significant psychosocial implications:

> *... the thing with my voice, I think cuts a little bit just because it's that old wound of like, I just worry that, you know, I'm not what people expect, and therefore they won't like me, or they won't accept me and that kind of thing, and that can hurt.*

Cooper: Page 54; Lines 1383-1386

Conversely, Mel shared that they felt fortunate their voice hadn't *"deepened too much"* and that other physical changes due to HRT were manageable:

> The hormone changes aren't entirely noticeable. Like my voice hasn't deepend too much so I can still get away with that fine, and obviously body hair and things is very easily hidden so I'm quite lucky in that respect that I don't have anything that makes it too difficult.

Mel: Page 33; Lines 890-894

This was paralleling with Jessie's experience of finding manageable solutions to conceal changes due to HRT, such as binding his chest and wearing loose clothing. Morgan and Cooper endorsed privately sought psychological therapy as a fundamental step in their finding self-love and acceptance following detransition. For example:

> *I had to undergo some therapy, and that is where I had to learn about self-love and self-acceptance, and to know there is no need for you to be*

> *verified by everyone. You have to love yourself as a person. Appreciate yourself as a person, and that is something I didn't grow up with. So, I think it also came from the childhood traumas that I had experienced earlier in life.*

Morgan: Page 5; Lines 98-104

In Morgan's account there was a sense that the views of other people had been important determinants in her evaluations of herself. She describes having a long history of not realising her own self-worth, and that this contributed to difficulties adjusting to life as someone who had detransitioned. Morgan spoke about therapy with pride and conveyed a sense that it was pivotal in her psychological adjustment following detransition.

Uncertainty and Womanhood

Two participants experiences comprised this subtheme, which explicates an uncertainty with knowing how to embody womanhood and having concerns for the future following detransition. Cooper shared the following:

> *I felt like really ashamed I didn't know how to kind of go on being like a woman after detransition.*

Cooper: Page 20; Lines 494-495

For Cooper there was a sense of shame associated with embodying a female gender identity following detransition. It is likely that both changes to Cooper's worldview and changes in her perceptions of her own body made the initial adjustment to an identity as a woman emotionally difficult.

Carey described how the impact of time and sense of mastery in her transgender identity made her adjustment to living as someone who had detransitioned more challenging:

> *…because I had years presenting as male… I knew how to do that… I didn't know how to do that as a female because I hadn't been presenting as that [cisgender female] since I was about 14…*
>
> Carey: Pages: 23-24; Lines 638-640

Both participants convey a sense of conflict with their gender roles, and that there would be a process of re-learning or figuring out for the first time how to comfortably navigate the world with a gender identity they did not previously identify with. Cooper shared feeling *"anxiety"* about one day becoming a mother, conveying a sadness at the prospect of her inability to breastfeed. She also shared worries about how her maternity experience might be responded to in the context of healthcare:

> *…I feel like, because I haven't had a super linear experience of womanhood, it, that brings me a little bit of anxiety - just kind of uncertainty - and how the nurses and the midwives and stuff will handle that. And you know, if, if they'll have ever met someone who has detransitioned prior to that.*
>
> Cooper: Page: 69; Lines 1781-1787

In addition to a potential grief over the possibility of breastfeeding, potentially leading to a feeling of inadequacy in her ability to be a mother. Cooper's concerns are compounded by the anticipation of a healthcare system unable to meet her needs in an understanding and compassionate way.

Disparities and Intersections: The Individual and Society

This GET consists of two subthemes wherein five participants spoke of innumerable experiences of judgement, exclusion, silencing and stigma resulting in both frustration and sadness, in the contexts of healthcare, relationships, and wider societal attitudes towards detransitioning.

Feeling Invisible and Excluded

The experiences expressed in this subtheme were varied, and they ranged from, firstly, feeling silenced or unable to talk about having detransitioned generally, to, secondly, feeling discounted, delegitimised, and excluded from the transgender community, and thirdly, feeling a widespread avoidance in acknowledging the existence of individuals who detransition. Carey shared her perspective below:

> *I feel like it is not encouraged to talk about, uhm, detransitioning. It is almost seen as like this failure for the person that does it.*
>
> Carey: Page 33; Lines; 899-90

Here Carey suggests having perceived the message that detransition is associated with a sense of individual failure and that detransitioning is thus somewhat unspeakable or taboo. Eli described frustration at the lack of understanding and tolerance for those who detransition, stating:

> *I just wished that people were just more understanding of it [detransitioning]... I feel like because it is seen as such a controversial subject but it is still people's like lived experience... and trying to just sweep it under the rug doesn't help anybody it is just going to hurt people.*
>
> Eli: Page 29; Lines 795-800

When Eli shared this perspective there was a sense of both sadness and injustice which was likely exacerbated by her still being in the process of detransitioning and struggling to access the resources she needs to complete her detransition. Eli uses the analogy *"sweep it under the rug"* to represent her perception of both how unacceptable detransition is in the eyes of others, and her feelings of isolation and exclusion.

Mel spoke about their relationship with the transgender community since they detransitioned to their non-binary identity:

> *... although I love the [trans] community and I adore being in it, I feel like I am not counted as being a part of it anymore... for a while I was referred to consistently as they/them but I see them slipping up more and more and it feels like my identity isn't really respected I suppose is the correct way to put it...*
>
> Mel: Page 29-30; Lines 797-804

Mel expresses a sense of exclusion from the trans community and positions the experienced non-affirmation of their non-binary identity as the means through which this is made known to Mel. It is possible that both Mel's detransition in addition to adopting a non-binary identity adds further layers of context to this feeling of exclusion. Furthermore, Mel perceives that their transgender friends now avoid discussing *"trans topics"* when they are together, also contributing to this sense of exclusion. Similarly, Cooper shared the following:

> *... he [transgender man, friend] kind of implied that I must have been faking being trans and or that I kind of, I transitioned but I kind of knew I wasn't trans the whole time... in fact, I really strongly believed I was trans...*
>
> Cooper: Page 58; Lines 1497-1501

Cooper conveys a sense of feeling her experience of gender transition is in some way delegitimised for having detransitioned, which conflicts with her own perspective and genuine lived experience. Such experiences could lead to a range of emotions, leading one to doubt or self-question the validity of their own self-perceptions, and/or lead to a sense of physical and emotional isolation from others.

Detransphobia and Healthcare

Five participants contributed to this subtheme which encompasses, with some exceptions, a clear dissatisfaction with the availability of both healthcare and community supports for individuals who detransition. Jessie and Cooper expressed a gratitude for the online detransition communities on Twitter and Reddit, stating that the inclusive climate facilitated conversations which were otherwise unspeakable in healthcare contexts:

> *Probably the reason that I'm doing so well today is literally because of a reddit community, and that was it. People who have detransitioned share their stories and they ask questions, and so other people could recommend things to them, and then sometimes people just want to vent that because it really felt like no one else kind of understood the issue that we were going through, because it was kind of like transition, but in reverse.*
>
> Cooper: Pages 20-21; Lines 511-522

Being within a community with relatable peers likely fostered a sense of belonging and connection for Cooper. Whilst Cooper felt satisfied with the peer-to-peer information sharing in online spaces, Eli was not active on these mediums and highlighted her dissatisfaction with the dearth of healthcare information and support:

> *I don't feel supported at all… it feels like the only time that ever is raised is to use it as a political football more than anything… I just feel like I am being left to my own devices at this point, you know? … it's just because it is considered something that is controversial or whatever, but I just want the resources that I need to just get on with my life or whatever.*
>
> Eli: Page 28; Lines 761-768

The use of the term *"political football"* communicates a sense that Eli feels they are part of a perpetual game of 'back and forth' and that the politicisation of detransitioning dehumanises her human needs. At the same time, Eli gives the impression she feels emotionally fed up and resigned to making her detransition journey alone. Eli also shared she perceives available detransition-related health information to be unregulated and saturated in *"propaganda",* diminishing her confidence to adequately care for her physical and mental health. Similarly, Mel shared the following:

> *…things like events or social groups… if there is events then they seem to be in kind of a negative light. I think it's a stigma that people have where it's like 'oh you made a mistake and now you have to pay for it'…*
>
> Mel: Page 33; Lines 904-908

Here Mel conveyed a sense of hopelessness at the perceived absence of helpful support services and events for individuals who detransition, stating that available supports appear to be framed in *"a negative light"*. Mel conveyed a desire to connect with other people who have experienced detransitioning, however they are also cautious and feared of being pulled into a situation wherein their values come into conflict. Mel does suggest that there are social events or groups in existence for people who detransition, however they gave an impression of feeling different, or 'independent of' others who attend them.

Below, Carey conveys a sense of experiencing a polarising tension in the context of naming and sharing her beliefs regarding her individual gender care needs. Interestingly, although Carey's beliefs appear to have changed since she detransitioned, when she initially transitioned her gender she also perceived efforts to rethink gender care processes as part of a hostile movement towards transgender individuals and gender care:

> *...you were just trying to say that some people just need more sessions because they have more problems and mental health issues than just their, just their gender. But if you bring that up it means like you are just gatekeeping, you are putting more barriers to getting, uhm, into surgery and stuff. I mean I felt the same way when I was first going into getting surgery in the UK...*
>
> Carey: Page 34; Lines 940-946

Similarly, Eli described an experience of feeling judged by a healthcare professional after deciding to detransition:

> *... she made a comment about like, you know some people fight really hard for that, and I was just a bit like, you know, taken aback... it was just a bit like, kind of like well yeah [laughs], I did too. It wasn't something that I had done for a laugh or had taken lightly or anything.*
>
> Eli: Page 17; Lines 455-461

The reaction Eli received from a healthcare professional could communicate to her that detransition is in some way not acceptable and/or that her previous transitioning experience was in some way different to that of others, thus explaining why she detransitioned. Experiencing this could lead Eli to feel invalidated and as though there is a sense of distance between her and the healthcare professional, or feel anger for having to justify herself, leading to a strained relationship with the healthcare environment.

Cooper expressed feeling stressed and irritated that healthcare professionals in accident and emergency insensitively questioned her bodily characteristics, resulting in her having to educate them on gender affirming surgery when she was already very physically unwell. In a similar context, Mel reported:

> *I feel like, in therapy, I have had CBT and I feel like I couldn't really talk about my anxiety due to gender issues. It is not something I feel that they are trained to talk about.*
>
> Mel: Page 37; Lines 1020-1023

Taken together, these experiences are likely to cultivate and reinforce a sense of stigma and preclude those who detransition from having their healthcare needs met in the same way as individuals who have not undergone transition and detransition.

Personal Growth

Five participants contributed to this GET. Despite the challenges faced as part of their detransitioning journey, participants shared a combination of feeling an appreciation for their current gender identity, contentment in life, an improvement in mental wellbeing, and an ability to use their experience to benefit themselves and others. Morgan stated:

> *Like, now it is up to me to choose to be happy, and I don't care so much what others say. And I believe I can make an impact to someone who is feeling like they are having some challenges.*
>
> Morgan: Page 15; Lines 306-309

Morgan appears to feel somewhat more agency in both her emotions and in the attributions made about the views of other people. She conveys a sense that overcoming previous intra-and-interpersonal obstacles has added to her ability to support others going through difficulties in their lives. Related to this, Cooper suggests she has found an ability to be more present where previously she was more threat-sensitive:

> *One of the biggest things is I've lost is the hypervigilance, I appreciate being a woman now, and I feel like comfortable being a woman because any kind of ideas I had about, you know, I don't fit in, I'm not good enough as a woman, as an adult, I now know that, like, women come in all different, like shapes and sizes…*
>
> Cooper: Page 43; Lines 1111-1117

In addition, Cooper describes a restoration in her relationship with her gender, and a shift towards acceptance of herself as a woman. It seems that Cooper's ability to see beyond gender and body cultural stereotypes has contributed to a sense of contentment. Carey echoed the experience of contentment, stating:

> *… it always felt like I was sort of always on this sort of journey [that] just felt like it was never going to end. Now that I have detransitioned I don't get that feeling and I don't have to worry as much about that. I have definitely gotten a grasp on my mental health situation compared to when I was still transitioning, I still had those problems, they didn't really go away.*
>
> Carey: Page 29; Lines 797-802

Carey reflected on how at the time of living as a transgender man she experienced a journey that seemed to have no foreseeable end or resolution – it felt enduring and exhausting. In contrast, currently Carey sees positive changes in her life and shared a sense of feeling proud for having gained control over the direction of her life and her mental health. It is as though the problems which *"didn't really go away"* when living as a transgender man have now become less problematic living as someone who has detransitioned.

Below, Mel views their detransitioning as enabling a new sense of freedom in their non-binary identity:

> *Detransitioning has allowed me to be in a unique position to kind of do whatever I want in regards to my gender identity whereas in the past I would have been staunchly like, I need to be masculine, rah, rah, rah. This has allowed me to kind of uniquely be myself. I have been allowed to take time and experience every different aspect of each gender.*
>
> Mel: Page 44; Lines 1200-1205

Mel describes a shift from a position of rigidity with their gender expression to a place where the parameters around their gender are unconstrained, allowing them to get in touch with their uniqueness as a person. It appears to have taken time to arrive at this point of liberation, however Mel perhaps conveys a sense of relief that they ultimately found resolution. Their use of the word unique in their self-description is perhaps indicative of their sense of pride in who they are.

Discussion

The aim of this study was to explore the experiences and perspectives of adults who have detransitioned their gender in the United Kingdom. In addition, it aimed to identify how people make sense of the detransition process, and how they respond and adjust to the world around them, considering the current sociopolitical environment. Interview data from six participants was analysed using IPA, and six GETs emerged from the data: *Realising My Detransition, The Emotional Weight of Disclosing My Detransition, Regret and Reconciliation: Complex and Nuanced, Making Sense of My Identity, Disparities and Intersections: The Individual and Society,* and *Personal Growth.* Findings will be discussed in relation to the study aims and existing literature, followed by an overview of the research and clinical implications, study limitations and future research recommendations.

The findings which emerged from the data showed a mix of thoughts, feelings and experiences about various aspects of life as someone who has detransitioned. The narrative began with most participants grappling with acknowledging and admitting to themselves and others they wanted to detransition. During this emotionally complex period, some participants found ways to cope with the dissonance surrounding detransition, whilst others experienced a deterioration in their mental health. Although existing studies have acknowledged the difficulties associated with disclosing detransition to others (Expósito-Campos, 2021; Vandenbussche, 2021), the experiences prior to this point are mostly absent in similar detransition research studies (e.g., Pullen Sansfaçon et al., 2021). Whilst participants elsewhere have described a similar journey with realising their detransition (MacKinnon et al., 2022a), participants in this study reported an emotionally isolating experience which had a concerning impact on their mental health.

Interestingly, participants recounted significant moments in which their decision to detransition was made concrete. These moments often reflected a change in participants' relationship with their transgender identity, viewing it as either no longer serving a helpful psychological function, seeing HRT changes as problematic, or realising a vision of gender that does not have to be binary, consistent with previous research (Expósito-Campos, 2021; Pullen Sansfaçon et al., 2021; Turban et al., 2021). Disclosing detransition was an emotionally taxing experience for participants in different ways and in different relationship contexts, leading to disclosure avoidance. For instance, concealment of their decision to detransition was associated with responsibility-taking and self-blame to protect people close to them, or their gender care provider. Often, the responses from family to the detransition disclosure left participants feeling supported; however, those who retained transgender friends experienced a feeling of loss when the relationship quality diminished. Of those who did disclose detransition to clinicians, two participants felt their clinicians struggled to tolerate the disclosure, whilst for another, sharing disclosure using different language was received well.

The findings on regret are mostly congruent with that found in other studies (MacKinnon et al., 2021; Littman, 2021; Pullen Sansfaçon et al., 2023; Tang et al., 2022). Whilst most participants felt varying intensities of regret or sadness, the framing of their previous gender transition as a helpful and often necessary journey of personal development and discovery appeared to act as a buffer to allow mixed feelings to co-exist. When participants experienced a sense of injustice associated with their previous gender transition, it was typically experienced in the context of healthcare services and associated with a lack of opportunity for gender identity exploration. The literature on regret illuminates the complexity of this phenomenon and the types of conditions (e.g., free versus forced choice, or positive versus negative outcome) which determine different affective responses following important decision-making (Matarazzo et al., 2021). For instance, when an individual has free choice over their decision-making, regret is suggested to be high only when the outcome is perceived to be negative (Matarazzo et al., 2021), which is congruent with the findings of this research. Moreover, in addition or alternatively to regret, people can experience a singular or combination of affective responses such as disappointment, anger towards oneself or one's circumstances, or satisfaction. This corresponds with the experiences of the people in this study, also.

The way in which participants made sense of their self-identity revealed several interesting descriptions and social implications. Across different points in time in the detransition process, participants used descriptions such as *"playing a character",* and described their identity as a *"limbo*" or *"mid-transition"* state which had both psychological and social costs. Participants reported feeling *"locked out"* of the cisgender and transgender communities, which raises questions about the availability of peer support for people who detransition. Considering this, community connectedness is known help sustain the wellbeing of minority groups and enhance a sense of belonging (Testa et al., 2015).

An unhappiness with physical changes as a result of gender transition is often reported as a reason for detransitioning (Vandenbussche, 2021). Half of participants described ongoing challenges due to the lasting physical changes associated with HRT and gender affirming surgery, whilst the others found solutions to overcome them. For instance, participants held fear of judgement and rejection over how their voice was perceived by others, and one participant found her voice so distressing that she previously attempted suicide. There was a sense that this is still an area of significant emotional salience for some participants, carrying significant psychosocial importance. People who have detransitioned have reported similar experiences elsewhere (Pullen Sansfaçon et al., 2023), however the impact and severity of living with undesirable lasting physical changes on mental health is yet under-researched.

Two participants shared interesting perspectives on the conflict of re-establishing a role as a woman and described anticipated concerns for the future. Whilst reinhabiting the role of a woman was difficult, it was accompanied by a sense of being ‘less than’, feelings of grief, and future worries about becoming a mother. This concern was coupled with worry that maternity professionals would respond insensitively to someone giving birth who had detransitioned. Social identity theory posits that group membership influences how individuals derive their self-concept (Tajfel & Turner, 1979), and through the process of embodiment, subjective experiences of one’s own body coupled with the integration of the surrounding social environment characterises how social identities are formed (Nagoshi et al., 2014; Nagoshi et al., 2023). Thus, the integration of a different identity following detransition could be partially explained through social identity theory and embodiment. Although this subtheme consisted of two out of a potential five participants, it was interpreted to carry unique emotional salience and meaning for these participants and therefore considered important in the capturing the intricacies of experience within IPA. In addition, these feelings and concerns in the context of maternity care have been echoed elsewhere in the detransition literature (Gribble et al., 2023).

Two participants felt an appreciation for inclusive online communities for people who detransition, stating they enabled peer-to-peer information sharing and conversations which could not take place in healthcare settings. Most participants felt unsupported to some extent by healthcare services, feeling dehumanised, shunned, and emotionally deflated because of the impact of clinician inexperience, and the politicisation and stigmatisation of people who detransition. There was a sense of mistrust regarding peer-lead healthcare information, and some healthcare professional interactions were experienced as invalidating, which contributed to a sense of tension in the helping relationship. The stigma attached to detransition is suggested to increase healthcare avoidance, mistrust in services, and make the disclosure of detransition more challenging (Expósito-Campos et al., 2023).

In terms of friendships with the transgender community, participants felt that the quality of their relationships had diminished, rejection was common, and the legitimacy of their previous gender transition was questioned. For one participant having a non-binary identity could have added a layer of complexity to this stigma. Taken together, these experiences can be understood in the context of minority stress theory (Mayer, 2015; Testa et al., 2015). Recently MacKinnon et al., (2022b) expanded the theory to capture the unique environmental stressors experienced by people who detransition in the context of cis-and-transnormative environments. Postulated within this model is 'detransphobic stereotyping', 'misrecognition and detrans unintelligibility' and 'non-affirmation of identity and rejection', which appear to be congruent with the experiences described by participants in this research.

Within the Personal Growth GET, participants described a contentedness within themselves despite the difficulties they experience. Participants found meaning in their circumstances despite ongoing mixed emotions about their previous gender transition experiences and current mental health struggles. Taken together, most participants experienced personal growth and empowerment, an improvement in social skills, and found acceptance, freedom, and pride in their current gender identity following detransition. This is congruent with existing research with people who detransition in other parts of the world showing regret did not preclude an ability to find positive meaning in challenging circumstances following detransition (Pullen Sansfaçon et al., 2023; Turban et al., 2021). These findings can also be understood through the phenomenon of growth following adversity, whereby growth can manifest as increased personal strength, a rejuvenated appreciation of life, spiritual growth, and an ability to recognise new life possibilities (Taube & Mussap, 2022). To the best of our knowledge research is yet to examine this theory with individuals who have detransitioned, however high rates of growth following adversity have been reported in both White TGNC and TGNC people of colour (Taube & Mussap, 2022).

Clinical Implications

There are several implications to consider for both service development and clinicians working with people who detransition. This research data suggests there is a stigma attached to detransitioning which may prevent the disclosure of detransition, possibly during a period of significant emotional need for some people. In addition, many participants report living with unmet psychological, social, and physical health needs and have a sense of invisibility or apprehension regarding healthcare contexts. Therefore, during and following detransition, people may wish to access support to make sense of their experience, determine the next steps in their care, find information, or explore ambiguous feelings, regret, or a different relationship with their gender/new self-identity. The clinical implications, which are largely congruent with those purported by Butler & Hutchinson (2020), suggest that clinicians could facilitate conversations exploring gender fluidity and evolving identities, develop appropriate therapeutic pathways which allow detransition visibility, capture the evolving needs of individuals accessing gender care, and adopt a 'both-and' service which does not place limits on service provision for TGNC or detransitioning individuals.

In line with the suggestions made by Butler & Hutchinson (2020), the findings from this study also highlight the need for services to take into consideration the systemic context surrounding the individual, and endeavour to influence systemic change through therapeutic intervention (e.g., by supporting friends and family to understand gender identity or detransition). Also, to combat the isolative experience of detransitioning, individuals who detransition should be offered the opportunity to access group therapeutic or peer support to connect with others who share relatable experiences or who have gender or sexual identity commonality to promote social connection and belonging (Butler & Hutchinson, 2020).

The evidence here is not to be interpreted as aiming to prevent gender transition, but to add to the support available to people exploring their gender. How it is that services for people who detransition are structured is likely to require further research to capture the views of this population. Lastly, it is important that primary and secondary healthcare in the UK promote an awareness of the needs of people who detransition, both to promote inclusivity and enhance the quality of the patient experience and the helping relationship.

Research Limitations and Recommendations

As an idiographic approach, IPA is suitable with a sample of six participants and can facilitate a deeper understanding of the phenomena under study (Brocki & Wearden, 2006). However, there are a number of limitations to this study, perhaps the most obvious being the use of purposive sampling. Many people who indicated their interest in participating ceased contact before arranging an interview. This meant that of all the eligible participants, the sample ultimately comprised of only those who were open to discussing their lived experience of detransition. In addition, the age of participants in this study ranged between 22 and 28 years of age, meaning that this research captured only the experiences of individuals of similar age. It would have been fruitful to explore how it is older adults experience detransitioning so that coverage is provided across the lifespan, for example. Other sampling limitations include the heterogeneity of the sample, and having very little representation from people who were registered male at birth, and people of minority ethnic backgrounds. With regards to sample heterogeneity, it is important to highlight that the intersections whereat aspects of identity such as neurodivergence, sexual orientation, gender identity, ability, and ethnic and racial identity, to name a few, were not examined. An intersectional analysis would have further elucidated disparities in the experiences of people who detransition (Abrams et al., 2020).

Importantly, participants reported accessing their gender care in different ways; three participants received the entirety of their gender care through the NHS, one accessed non-NHS care for their gender affirming intervention, and two received care through a combination of NHS and non-NHS services. It has been noted that NHS gender care staff have previously raised concerns regarding the complexity of working with families receiving both private and NHS gender care (Wren, 2021), which could be relevant in the interpretation of participants experiences here.

Whilst research on detransition is in its infancy, and researchers already recognise it as a complex and heterogenous phenomenon (Expósito-Campos et al., 2023), there are representational similarities in the experiences of the current sample and others in various locations (e.g., Cain & Velasco, 2021; Gribble et al., 2023; Pullen Sansfaçon et al., 2023; Turban et al., 2021). In addition, hopefully the broad range of experiences across time and context captured in this data contributes to developing an understanding or theory of detransitioning. In addition, IPA as a systematic qualitative approach is recognised as an optimal methodology for understanding new and emerging areas within healthcare research and under-researched populations.

The wider context surrounding this research is noteworthy for interpretation of the findings. Just before participant recruitment began in November 2022, in July 2022 it was announced that the GIDS NHS service would be closing, with high numbers of people remaining on waiting lists (Brooks, 2022). It is possible that these events influenced the information provided by participants.

Finally, there are significant methodological limitations to existing studies in transgender care outcomes, which has possibly added to the invisibility of people who detransition (Cohn, 2023). We echo the suggestion from MacKinnon et al., (2023) that long-term follow-up studies are warranted and should favour a focus on understanding those who disconnect from care, or who are lost to follow-up in research. Furthermore, research exploring the mental health needs of people who detransition and the factors which might predict who might require mental health support would help to inform service provision. For instance, does the amount of gender affirming intervention prior to detransition predict mental health outcomes?

Conclusion

This study aimed to explore the lived experience of people who detransition their gender in the UK in line with calls for clinicians and researchers to use their position to help to understand and respond to the needs of this population (Butler & Hutchinson, 2020). It is clear from the findings that detransition involves significant psychological and social challenges for many people, and clinical settings are currently perceived to be ill-equipped to support this population. There are implications for clinical practice to be considered, including the expansion of healthcare service provision, and increasing professional confidence in facilitating therapeutic space for those who detransition. Further, larger scale research is needed to understand the full extent of the issues faced by this population in order to better develop appropriate support services. It is believed that this is one of the first studies to apply a systematic qualitative research method to examine this phenomenon in the UK.

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Press Release: Literature Review

What is the Internal Consistency of the Gender Minority Stress and Resilience Measure?

Introduction:

The terms 'transgender' and 'gender nonconforming' (TGNC) refer to people whose gender identity doesn't match their sex registered at birth. These populations often face challenges due to societal hostility, which is known to affect mental and physical health. Minority stress theory helps foster an understanding of how repeated discrimination and stigma creates stress for minority groups, including TGNC individuals. A scientific questionnaire called the Gender Minority Stress and Resilience Measure (GMSRM) was developed to quantify these experiences of stigma, which includes questions about things which are known promote resilience in TGNC individuals, such as having community support. Sometimes clinical psychologists use questionnaires as part of a comprehensive clinical assessment, and having an evidence base demonstrating the utility of questionnaires is crucial for an accurate assessment. One way of examining this is to explore the ‘internal consistency’ of a questionnaire; this can tell us how well the questionnaire is measuring the experiences we are interested in assessing. Therefore, this research aimed to understand how reliable the GMSRM is by examining its internal consistency.

Method:

A systematic search of the scientific databases was completed and then compiled all the existing studies which have used the GMSRM, extracting the numerical internal reliability information from them. Each study was assessed for quality and rigour, and a set of inclusion and exclusion criteria. We then statistically analysed all of the numerical data together to look for patterns and trends across all of the studies combined, which is known as a meta-analysis.

Results:

A total of 30 studies were included in the meta-analysis, and following completion of the meta-analysis it was determined that the groups of questions that make up the GMSRM demonstrated adequate internal consistency. However, it was also determined that parts of the GMSRM could be vulnerable to different kinds of bias because of the limitations of the included prior studies which used the GMSRM. This could influence the extent to which we can be confident in the reliability of the GMSRM.

Conclusion:

This meta-analysis contributed to the certainty that the questions within the GMSRM all work together to measure the same outcome, and that therefore, the questionnaire is suitable for administration with TGNC individuals in both healthcare and research contexts.

Press Release: Empirical Paper

Understanding the Lived Experience of People Who Detransition in the United Kingdom: An Interpretative Phenomenological Analysis

Introduction: Some people experience emotional distress related to their gender when they perceive their sex characteristics to be misaligned with how they view and feel about themselves (Coleman et al., 2022). This distress can prompt some people to transition their gender from the one congruent with the sex they were assigned at birth to another gender, typically that of the opposite sex, to mitigate gender-related distress. Not everybody will seek medical or surgical interventions to support their gender transition, however some do, and report feeling less distressed and more content with their new transgender identity (Javier et al., 2022). Despite this, transgender individuals are more likely to experience a range of transgender-specific stressors in the community, along with mental health and neurodevelopmental difficulties compared with people whose gender aligns with their birth sex (Vandenbussche, 2021; Warrier et al., 2020). Internationally there has been an increase in the number of people referred to gender care services, accompanied by an observation that some people stop their gender transition at some point after they have started it, or following completion of it (Aitken et al., 2015; Expósito-Campos et al., 2023). This is known as 'detransitioning' - a process which involves taking steps to stop or reverse, temporarily or permanently, the changes associated with an initiated gender transition (Expósito-Campos, 2023). The lives of people who detransition is poorly understood, however this group of individuals are likely to face barriers to appropriate healthcare, face judgement and social rejection, and live with unmet physical and mental health needs, to name a few (MacKinnon et al., 2022a; MacKinnon et al., 2022b; Vandenbussche, 2021). Research with those who detransition is scant. The aim of this research was to understand how people make sense of their detransition experience in the UK amidst an emotionally charged legal, social and political landscape.

Method:

Six adult participants were recruited from online forums and met with a researcher remotely. Participants had to have started and then stopped at least one medical intervention for the purpose of transitioning their gender. The data collected was analysed using the qualitative research method of Interpretative Phenomenological Analysis (Smith et al., 2021)

Results:

Six group themes with 11 subthemes describing the experiences of participants were identified within the data. In the first group theme ‘Realising My Detransition’ participants found it challenging to accept their discontent with their gender identity and body and often resisted it, hoping that it would pass. However, this had a negative on some participants mental health. In the second group theme ‘The Emotional Weight of Disclosing Detransition’, opening up about the decision to detransition proved emotionally difficult for participants. Many felt hesitant due to shame and other thoughts and feelings. When they did share, responses varied: families were unexpectedly positive, friends showed mixed reactions, and healthcare professionals at times fell short in providing the needed emotional reassurance. The third group theme ‘Regret and Reconciliation: Complex and Nuanced’ participants had varied emotions about their past gender transition, including sadness and regret alongside appreciation for self-discovery, and balancing lost time with contentment. Motivation for self-acceptance and finding new meaning helped resolve these conflicts. In the next theme, ‘Making Sense of My Identity’, participants struggled to find their place in society with unique social, gender, and bodily characteristics. They felt in a state of "mid-transition" or identity "limbo", isolated from both transgender and those who identify with their sex registered at birth. In the fifth theme ‘Disparities and

Intersections: The Individual and Society', participants experienced stigma-related stressors feeling as though certain groups and institutions largely ignored and failed to support their existence. Despite these challenges, online detransition communities provided valuable peer support that was appreciated by some participants. Lastly, in the theme 'Personal Growth' participants conveyed a sense of resilience and a drive to create the life they desire. Many found a sense of contentment and reduced emotional burden through detransition, leading to improved life satisfaction and improved well-being.

Conclusion:

This was a small-scale study to help gain an understanding of how people make sense of living in the UK as someone who has detransitioned. It is clear from the findings that detransition involves significant psychological and social challenges for many people, and clinical settings are currently perceived to be ill-equipped to support this population. There are implications for clinical practice to be considered, including the expansion of healthcare service provision, and increasing professional confidence in facilitating therapeutic space for those who detransition. Further, larger scale research is needed to understand the full extent of the issues faced by this population in order to better develop appropriate support services.

Appendix A: Participant Information Sheet and Consent Form

Exploring the Lived Experience of People who Detransition in the United Kingdom

PARTICIPANT INFORMATION SHEET

Central University Research Ethics Committee Approval Reference: [Insert]

General information

My name is Michael O'Donnell and I am a Trainee Clinical Psychologist at the University of Birmingham. I am inviting you to take part in a research project for my doctorate qualification. Before you decide whether to participate or not, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take the time to decide whether you wish to take part.

Why is this research being conducted?

Research has shown that the process of transitioning one's gender is a positive experience for many individuals, and many who do transition go on to live a life content with both the decision to transition, and the outcome of it. On the other hand, there is an increasing awareness that some people who transition their gender decide to reverse or stop this process and detransition. In the United Kingdom it is unclear what it is like to live as someone who has detransitioned, and we need research to help to enhance the visibility of individuals with these experiences and to increase our understanding of what it is like to live as someone who has de-transitioned. It is hoped that this research will build on existing knowledge, and inform society and clinical practice.

Why have I been invited to take part?

As researchers, we are inclusive of all gender expressions, gender identities, people without a gender identity, non-binary individuals, and all sexual orientations (if any). Up to 10 adult individuals will be invited to take part in this study. In order to take part, each individual must meet the criteria below:

Adult (over 18 years of age)

Began at least one medical intervention and stopped (for example, hormone replacement therapy; gender or sex affirming surgery)

Transitioned and detransitioned in the United Kingdom

Speak English to a standard that allows you to understand and respond to the interview questions

Have access to an electronic device (e.g., a computer / smartphone) and Zoom / Microsoft Teams

Do I have to take part?

No. It is up to you to decide whether or not to take part. You can withdraw yourself from the study, without giving a reason by advising me of this decision. However, the deadline by which you can withdraw any information you have contributed to the research will be three weeks from the time of the completed interview. By this time the researcher will have turned the audio recordings into written word documents that will no longer have your personal details associated with them. After two weeks from the completion of the interview, the researcher will send you a copy of the information you shared during the interview for you to read, and from that point you have seven more days to withdraw from the study should you wish to. If you decide to withdraw within three weeks of being interviewed, your data will be deleted and disposed of securely.

What will happen to me if I take part in the research?

This research will be conducted online through Zoom or Microsoft Teams. A link to the meeting will be sent to you in advance of the research meeting. Participation in the research will involve one individual interview with the researcher which will last for up to two hours.

Before taking part in the research interview, a link will be sent to you through email which will ask you to read through an online information and an online informed consent form. If you are happy that all your questions have been answered, you can then decide if you would like to participate in the research by indicating this on the webpage. After that, you will be asked some questions about you, such as your age, gender identity, and occupational history.

The interview will involve asking you a little bit about your journey towards deciding to detransition, however it will mainly focus on what it is like to currently live as someone who has de-transitioned in the United Kingdom. The questions will ask about what it is like to live with changes which may have come about in your life since de-transitioning, and how you view them and manage them.

Participants can ask to stop or pause the research interview at any time.

With your consent, I would like to audio record the interview so that I can have an accurate record of our conversation. No video footage of participants will be recorded. This audio recording will be used to transcribe the interview word-by-word, and after this is completed, the audio recording will be securely deleted two weeks from the interview date. If you do not consent to be audio recorded you will not be able to participate in this research.

There will not be any follow-up research meetings after the interview. However, if you wish, a summary of the research findings can be provided to you when the data has been analysed.

What are the possible disadvantages and risks in taking part?

The interview will involve asking questions about your personal life experiences, including your thoughts and feelings, as someone who has de-transitioned in the United Kingdom. It is understandable that this could be a discussion of sensitivity for some individuals. You can ask to pause or stop the interview at any time.

The researchers will never share participants personally identifiable information and your safety is of the highest importance to us. It is important to be aware that excerpts from the interview will be included in the final research paper. However, you will not be identifiable from the excerpts used and your name will be replaced with a pseudonym to protect your identity. You will have the chance to read the transcript two weeks after your interview. At this stage, you will not be able to change the transcript since it will have been transcriber verbatim, however you can withdraw your data completely from the study and it will not be used.

Are there any benefits in taking part?

While there are no immediate benefits for people participating in the project, it is hoped that this research will lead to increased visibility for people who detransition in the United Kingdom, and contribute to better awareness, understanding, and care for this population of people. It is anticipated that the research will help both clinicians and researchers alike, and will also inform society in general. This research could be used to support clinicians' understanding of the emotional and practical needs of people who detransition and the obstacles they may have to overcome in their lives or highlight any positive aspects of an individual's journey. This way, we can work towards establishing the best ways to support people who de-transition in clinical settings, such as gender identity services, and the wider NHS. The research will help to kickstart an evidence base that is unique to people who de-transition in the United Kingdom. It will contribute to research in the area of gender dysphoria and help to build a more comprehensive understanding.

Expenses and payments

You will receive a £20 online shopping voucher for your participation in this study. As the research interview will be conducted online, no other expenses or payments will be offered.

What information will be collected and why is the collection of this information relevant for achieving the research objectives?

The data we will collect that could identify you will be age, sex / gender identity, occupation, ethnicity, relationship status, educational achievements, and the interview audio recording. Your IP address (from your computer or mobile device) will not be stored. The file containing the interview data (including consent data) will be stored the University of Birmingham's Research Data Store and subsequently archived for ten years in line with the General Data Protection Regulation and University of Birmingham guidelines. The interview recording will be deleted three weeks following the interview.

The researcher and the research supervisor will have access to the research data.

Will the research be published? Could I be identified from any publications or other research outputs?

The findings from the research will be written up in a thesis and examined for my Clinical Psychology Doctorate. The research may also be published in an academic journal, and presented at a conference. Where interviews are used for qualitative data analysis, written quotations from the original interviews are included in the write-up of the study to serve as evidence for the themes identified in the interviews. As a result of this, it will be important to make a choice over what you share in the interview. The demographic data collected about participants will be summarised and never linked to any one study participant. Your safety is of the highest importance to us.

A copy of the research thesis will be deposited both in print and online in the University of Birmingham Research Archive where it will be publicly available to facilitate its use in future research.

We would like your permission to use direct quotations, however, no identifying information will accompany these quotes. The researchers will never share information which could knowingly identify a participant in our study.

Data Protection

The University of Birmingham is the data controller with respect to your personal data, and as such will determine how your personal data is used in the study. The University will process your personal data for the purpose of the research outlined above. Research is a task that is performed in the public interest. Further information about your rights with respect to your personal data is available at https://www.birmingham.ac.uk/privacy/index.aspx

Who has reviewed this study?

This study has received ethics approval from a subcommittee of the University of Birmingham Central University Research Ethics Committee. (Ethics reference: **xxxxx).**

Who do I contact if I have a concern about the research or I wish to complain?

If you have a concern about any aspect of this study, please contact Michael O'Donnell (Principal Researcher at detransitionproject@contacts.bham.ac.uk or Dr Ruth Howard (Research Supervisor) by email R.A.Howard.20@bham.ac.uk and we will answer any queries you may have. We will acknowledge your concern within 10 working days and give you an indication of how it will be dealt with. If you remain unhappy or wish to make a formal complaint, please contact the Chair of the administrative lead for research integrity matters you can contact Dr Brigit Whitman (Head of Research Governance and Integrity on +44 (0) 7814 650 003.

Further Information and Contact Details

If you would like to discuss the research with someone beforehand (or if you have questions afterwards), please contact:

Michael O'Donnell (Principal Researcher)
University of Birmingham
University email: detransitionproject@contacts.bham.ac.uk

Thank you ever so much for reading this information sheet and for considering taking part in this study

[click next]

Consent to Participate in the Research Project:

Exploring the Lived Experience of Those who Detransition in the United Kingdom

Name of Principal Researcher: Michael O'Donnell

Name of Research Supervisor: Dr Ruth Howard

Please indicate your consent by clicking on either 'Yes' or 'No'.

I confirm that I have read the information sheet on the previous web page for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	Yes / No
I understand that my participation is voluntary and that I am free to withdraw at any time up until two weeks from the interview completion date.	Yes / No
I agree to the interview being audio recorded (only)	Yes / No
I understand that the research may be published in a scientific journal and presented at conferences, and I agree to this	Yes / No

I understand that excerpts of the interview data will be quoted in the research output and that I have a choice about what I share in the interview.	Yes / No
I understand that I will be asked questions about my personal life, thoughts, and feelings.	Yes / No
I understand that the researchers will hold all information and collected data securely in an encrypted electronic database for a minimum period of ten years.	Yes / No
I understand I can contact the researcher or the research supervisor if I wish to make a complaint if I think I have been treated unfairly or unreasonably.	Yes / No
I confirm that I have read the information sheet on the previous web page for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	Yes / No
I confirm I am 18 years or older.	Yes / No
I give my consent to take part in this study.	Yes / No

We would be pleased to hear from you if you would like to be sent a summary of the research results before they are published, please contact the researchers in September 2023 at the following email address detransitionproject@contacts.bham.ac.uk

Appendix 2: Interview Schedule

Interview Schedule

1. Please could you let me know a bit about your journey towards transitioning in the first instance?

   (Exploration prompt: At which point in your life did your sense of your own gender become something more conscious to you?; How did you express your gender growing up?; When did you begin to get a sense you were transgender?; How did you cope / deal with this?)

2. What were the factors which led you to decide to detransition? *(NB: share that the focus hereafter will not be on factors which led to detransitioning, rather the experience of living as someone who has detransitioned)*

   (Exploration prompt: What were your thought processes at the time?;How did this make you feel at the time?;What supports did you have around you at the time?; Who did you share the decision with?; Who could you confide in? How did you go about sharing your decision with people around you?)

3. What were the stages involved in detransitioning?

   (Exploration prompt: what feelings came up during this time?; What might have been running through your mind during this process? What would the people around you have noticed in you, if anything? What support did you have at each stage?)

4. What differences or changes were there in (a) you and (b) in your life after you decided to detransition / had detransitioned?

   (Exploration prompt: What was the decision process like e.g., slow, quick, complicated, straightforward?; How did you feel? What changes, if any, did you notice in how you were thinking about yourself, others, the world?;In what ways did your sense of your gender change?;How would you describe your sense of your own gender identity living as someone who has detransitioned?

5. How you would describe life currently as someone who has detransitioned?

   (Exploration prompt: How has this impacted your emotional wellbeing?; How do you feel when you wake up in the morning?;How is work, education, family, social connectedness, Can you tell me a bit more about your experience?)

6. What are the main things that are different about life after having detransitioned compared to life before having detransitioned?

   (*Exploration prompt: How has this impacted your emotional wellbeing?; Can you tell me a bit more about your experience?; What were the changes to work, family, education, social circles / groups including LGBTQ+, relationships, confidence, social experiences, sense of self, if any?)*

7. What are the things that go well for you on a day-to-day basis as a result of living as someone who has detransitioned?

(Exploration prompt: What helps you? What makes the difference? How does this make you feel?; How do you experience this?)

8. What are the pressures / difficulties / challenges / problems which arise for you in everyday life as someone who has detransitioned, if any?

   (Exploration prompt: For instance, Public spaces such as bathrooms, supermarkets; Name; Pronouns; Clothing; Situations; How does this make you feel?; How do you get through this?)

9. How do others react to you on a day-to-day basis?

   (Exploration prompt: E.g., how do family, friends, LGBTQ+ community, colleagues, educators, strangers and so on react to you? How visible do you feel? How does this make you feel?; Why do you think this is the case?)

10. How supported do you feel living in society as someone who has detransitioned?
    (Exploration prompt: For instance, in charity and third sector organisations, healthcare settings, education, workplace, on the streets etc?; Can you tell me more about that?; How does this impact your emotional wellbeing? What are your views on this?)

11. How well do you think other people understand detransitioners?
    (Exploratory prompt: E.g., family, friends, romantic partner, work colleagues, professionals, society; How does this impact your emotional wellbeing?; Why do you think this might be the case?; What are your views on this?)

12. How do you think other people think about you as someone who has detransitioned?
    (Exploration prompt:E.g., family, friends, romantic partner, work colleagues, professionals, society as a whole?; How does this make you feel?; Why do you think this is the case?)

13. What are your relationships like with other people now (e.g., romantic and non-romantic; family; friends; professionals)?
    (Exploration prompt: How does this make you feel?; Why do you think this is the case?)

14. What are your experiences of finding employment / being in employment since you have detransitioned?
    (Exploration prompt: How does this make you feel?; Why do you think this is the case? What do you believe the main barriers or facilitators are to finding employment?; What makes a workplace experiences positive?; What are your views on this?)

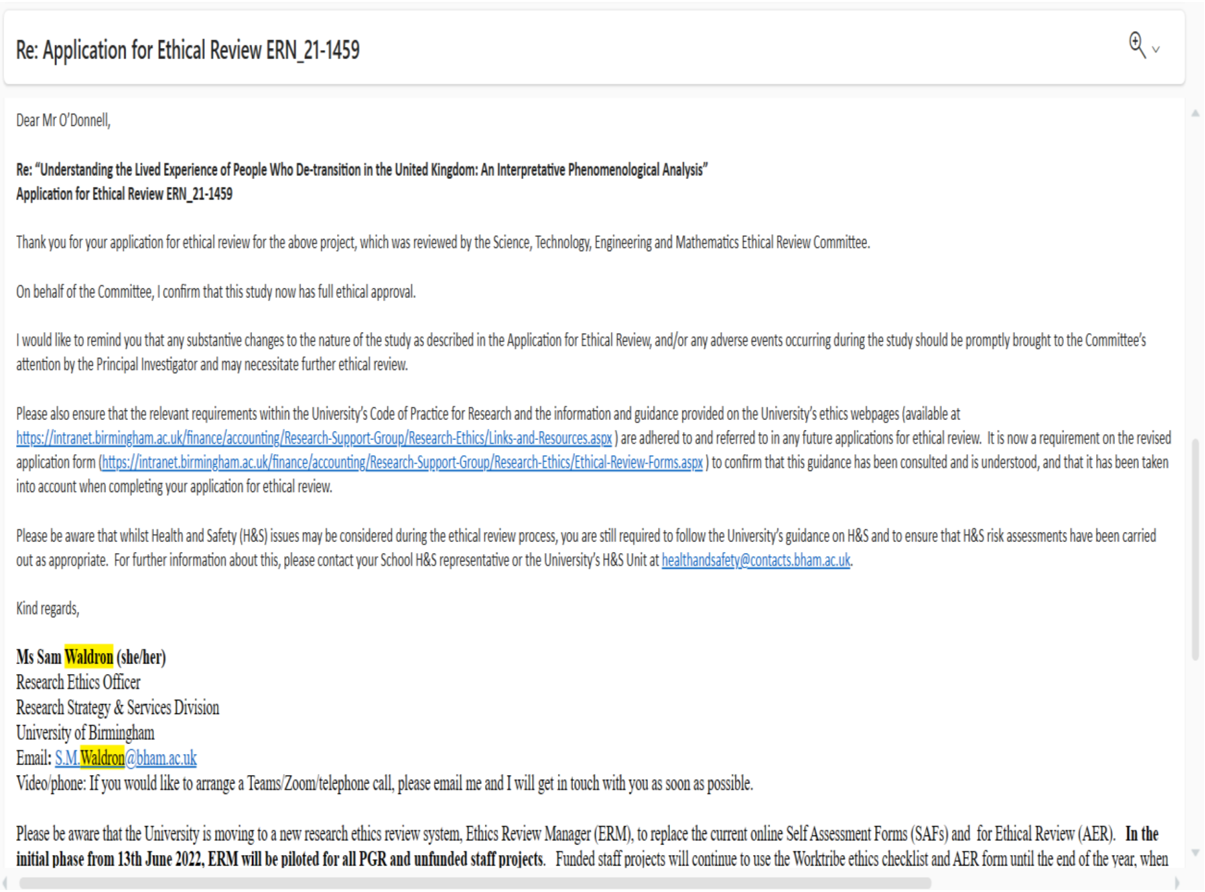
15. How do you think transitioning / detransitioning has impacted your physical health?
    (Exploration prompt: How does this make you feel?; Why do you think this is the case?)

16. How do you think transitioning / detransitioning has impacted your emotional health?
    (Exploration prompt: How does this make you feel?; Why do you think this is the case?)

17. What are your experiences of healthcare since you have detransitioned?
    (Exploration prompt: How accessible has it been? What sort of support did you receive? What went well, and not so well? How did this make you feel?; Why do you think this is the case?)

18. How do you think life would be different if you had not detransitioned?
19. What, if anything, might you want to add which has not been asked or covered?

Appendix C: University of Birmingham Notice of Ethics Approval



Re: Application for Ethical Review ERN_21-1459

Dear Mr O'Donnell,

Re: "Understanding the Lived Experience of People Who De-transition in the United Kingdom: An Interpretative Phenomenological Analysis"
Application for Ethical Review ERN_21-1459

Thank you for your application for ethical review for the above project, which was reviewed by the Science, Technology, Engineering and Mathematics Ethical Review Committee.

On behalf of the Committee, I confirm that this study now has full ethical approval.

I would like to remind you that any substantive changes to the nature of the study as described in the Application for Ethical Review, and/or any adverse events occurring during the study should be promptly brought to the Committee's attention by the Principal Investigator and may necessitate further ethical review.

Please also ensure that the relevant requirements within the University's Code of Practice for Research and the information and guidance provided on the University's ethics webpages (available at https://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Ethics/Links-and-Resources.aspx) are adhered to and referred to in any future applications for ethical review. It is now a requirement on the revised application form (https://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Ethics/Ethical-Review-Forms.aspx) to confirm that this guidance has been consulted and is understood, and that it has been taken into account when completing your application for ethical review.

Please be aware that whilst Health and Safety (H&S) issues may be considered during the ethical review process, you are still required to follow the University's guidance on H&S and to ensure that H&S risk assessments have been carried out as appropriate. For further information about this, please contact your School H&S representative or the University's H&S Unit at healthandsafety@contacts.bham.ac.uk.

Kind regards,

Ms Sam Waldron (she/her)
Research Ethics Officer
Research Strategy & Services Division
University of Birmingham
Email: S.M.Waldron@bham.ac.uk
Video/phone: If you would like to arrange a Teams/Zoom/telephone call, please email me and I will get in touch with you as soon as possible.

Please be aware that the University is moving to a new research ethics review system, Ethics Review Manager (ERM), to replace the current online Self Assessment Forms (SAFs) and for Ethical Review (AER). **In the initial phase from 13th June 2022, ERM will be piloted for all PGR and unfunded staff projects.** Funded staff projects will continue to use the Worktribe ethics checklist and AER form until the end of the year, when

Appendix D: Example of Transcript Analysis

Being transgender and part of the community provided insight into the stigma attached to people who detransition.	Yeah, so, yeah, like you said. I need that when I identified as trans me and my trans friends, we would have had conversations about people who detransition and we just kind of, there was very much the sense that, oh, they must have a political agenda or even if they were genuinely trans. They, you know, it was their own fault, and you know they have no one else to blame but themselves.	Detransition = threatening. Critical, judgemental. Questioning prior trans legitimacy. Blame.
	I: And all of this kind of thing might then feed into the stigma you mentioned towards detransition.	
Exposure to critical detransition attitudes contributed to self-stigma when detransitioning. Her efforts to connect with the transgender community are met with suspicion and mistrust. Efforts to connect with the transgender community are met with invalidation of gender.	**P:** I was going to say that. I internalised that. I had like this feeling of, well other people are gonna I think that I made a stupid choice, and that it's no one else's fault but my own and that kind of thing. Yeah, I think there is very much a feeling of discomfort with detransitioners within the trans community. And so, even if you are very supportive of trans people and you are a detransitioner or you talk about your experiences detransitioning… I've had experiences online, not in real life, but just like online where I don't know, I've just spoken about detransitioning and that I'm a woman who detransitioned from being a trans man, and people from within the trans community were kind of like... I suppose they must have felt… they must have felt that I had some kind of agenda like they just don't trust detrans people at all. But they would just kind of like say you're, you're, a woman now again, like you are cisgender. You don't need to talk	Self-stigma. Other people's attitudes contributed to self-blame. Detransitioners are feared, despite showing support. I am seen as a threat to the trans community. Binary notion of gender. Invalidation.

It can feel as though I am being silenced when I attempt to speak about my detransition experiences.

It is not possible to return to the life or body I had before, it is different now.

Although life and body is different now, circumstances are accepted.

As someone who has detransitioned I have unique experiences that make me different, others don’t understand. Feeling alienated from both the transgender and cisgender communities.

about any of this, and stop kind of acting as if you understand what trans people are going through, and, and there's very much this sense of like, we don't really want you to talk about your experiences detransitioning, and, and I think trans people they don't understand because they haven't been through it first hand, I guess. And because there's just like very little presence of detrans people, they just don't get that once you've detransitioned you don't really feel like you're, like you can't just go back to the life you had before. Like my, my body is like permanently changed from my transition. And even though I've kind of made peace with that, and to be honest, I don't, I don't regret my top surgery because it did help the dysphoria that I felt around my body. The testosterone especially, like you can't really reverse the effects that that has on like your voice, like you’re, I can't remember the proper name for it, like your voice box is permanently changed, and, and once you take testosterone for a while, like half follicles will start growing like on your face, and so you'll start growing facial hair. And that just kind of, you have these kind of experiences that cisgender women who have never been through transition, they just don't have those experiences. They just don't. They haven't had to deal with any of that. And so you do feel really alienated from cis-gendered women, and sadly from the trans community as well. And,

Now an outsider?
Rejected?

Silenced?

The trans community don’t understand.

Detransitioning means returning to a life different to the one you had before.

Bodily changes represent a different life.

Acceptance, not regret.

Gender affirming surgery served a purpose.

There is no going back – a different voice.

Voice is changed permanently - significant

Cisgender women don’t understand. Unrelatable.

Feeling alone / unaccepted / alienated

Having support from others who have detransitioned has many benefits and feels comforting.

Being around others who have detransitioned is powerful – it allows for exchanging information, offers validation, and abates loneliness.

and, I think that that's why the, like support group on [name of support group], it's like so important to me, because that's pretty much the only place where people kind of, people like, look like you, people have been through the same procedures as you, and you know women who detransitioned, who have facial hair, and they talk about, you know, like permanent hair removal like electronics and laser and they talk about their top surgery scars, and you know, if they've decided to get breast reconstruction, or if they're just happy as they are, and, and that kind of thing just. And just like, like I said, just seeing people that look like me, who have detransitioned bodies is incredibly powerful and like empowering because I feel like that. The only people that make me feel like I'm not alone and that I'm, yeah, I'm, I'm not alone in the, the journey that I've been through. Yeah.

A sense of community is important.

Access to others like me brings comfort.

Peer information / story telling seems important.

Detransition representation / sharing of experience is powerful and empowering.

Online detransition peer support feels inclusive. Comforting.