What is the experience of adults with a diagnosis of gender incongruence at an NHS GIC (Gender Identity Clinic) in England who have sought treatment, but decided to detransition, or retransition during the treatment pathway?

By

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Thesis Overview

Part One: A meta-ethnography which explores the experience of ATGD (Autistic Transgender and Gender Diverse) people. Database searches identified eight qualitative research articles. Following the meta-ethnography process outlined by (Noblit & Hare, 1988) this resulted in three main themes. These included: 1. Autism acts as a barrier to gender transition; 2. Autism acts as a facilitator to being your authentic self; 3. There is a need for support and adaptations to mitigate external and internal factors. Minor themes included: Supportive relationships are necessary, The impact of the environment/other people can hinder wellbeing, There is a need for support in gender transition, and Adaptations to services are needed to support ATGD people in accessing them. Conclusions include clinicians developing more specialist knowledge and Gender Identity Clinic's (GIC's) making adaptations for ATGD people.

Part Two: The empirical paper explores the experience of people who have attended an NHS (National Health Service) GIC to access support regarding their experience of gender incongruence (International Classification of Diseases 11th Revision; ICD-11, 2017), and who have begun gender transition to align with their gender identity but have then paused or stopped transition. Five people were interviewed, with transcripts analysed using IPA (Interpretative Phenomenological Analysis: Smith et al., 2021). This resulted in four main themes: 1. A sense of difference since childhood; 2. Gender transition is challenging in multiple ways; 3. Conflicts are experienced; and 4. Stopping transition has challenges and benefits. We conclude that further research is needed but recommend further support for participants transitioning gender identity, regardless of their individual trajectory.

Dedication

I would like to thank the participants who gave up their time to contribute to this research study and to the EBE (Experts by Experience) Alex. S, and Chrissy. M who supported the project; I could not have done this without your support. I hope you feel that the output from this is a useful contribution to a growing body of research.

Thank you to Dr George Johnson for taking a chance on me and supporting this project, without your support and expertise I would have ended up doing something else, and it would not have been as good! Thank you to Dr Andy Fox for your specialist qualitative support, I hope this was an interesting project to be involved in. Also thank you to Dr Liz Kent for your support over the last three-years, your kind words of wisdom have kept me going.

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I would like to express thanks to all the placements I have had during the doctorate and the supervisors who have provided helpful support and advice at various junctures.

I could not have got this far without the support of my family and friends. To my mum, thank you for all your support and for making me copious concoctions from your allotment to keep me going. Thank you to my uncle who has absolutely no idea what I do, despite being told many times but has nevertheless been more than happy to have emergency trips to the ice cream parlour.

Finally, to my partner, thank you for supporting my career for over a decade, you have put up with numerous job changes, the highs, the lows, moving halfway across the country and the living in constant suspicion that you are being psycho-analysed!

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Abbreviations

A/ND (Autism/ Neurodiversity)

ASD (Autism Spectrum Disorder)

ATGD (Autistic and Transgender and Gender Diverse)

CASP (Critical Appraisal Skills Program)

CBPR (Community-Based Participatory Research)

DSM (Diagnostic and Statistical Manual of Mental Disorders)

EBE (Experts by Experience)

GD (Gender Dysphoria)

GETs (Group Experiential Themes)

GIC (Gender Identity Clinic)

GIDS (Gender Identity Development Service)

GIH (Gender Identity Healthcare)

HRA (Health Research Authority)

HRT (Hormone Replacement Therapy)

ICD (International Classification of Diseases)

IPA (Interpretative Phenomenological Analysis)

IRB (Institutional Review Board)

NHS (National Health Service)

NICE (National Institute for Health and Care Excellence)

P (Participant)

PETs (Personal Experiential Themes)

Pt (Parent)

R/P (Researcher/ Participant)

TCC (Trans Community Connectedness)

TERF (Trans Exclusionary Radical Feminist)

TGD (Transgender and Gender Diverse)

TNG (Transgender, non-binary, and gender-diverse)

YP (Young people)

Language

I note within this thesis identity first language is used as much as possible. For example, I will use autistic person, as opposed to person with autism, and TGD (Transgender and Gender Diverse) person rather than person who is transgender and/or gender diverse. I use the term TGD as an umbrella term to encompass all transgender including non-binary and gender diverse identities, as used within 'The World Professional Association for Transgender Health guidance' (WPATH; 2022), unless specifically stated on occasion. In respect of people who are both autistic and transgender and gender diverse I use the abbreviation ATGD.

I use the term autism as opposed to ASD (Autism Spectrum Disorder; ICD-11, 2023), and being TGD or experiencing symptoms of Gender Incongruence (ICD-11, 2017) rather than Gender Identity Disorder as used in the DSM (Diagnostic and Statistical Manual of Mental Disorders; American Psychiatric Association, 2013) or Gender Dysphoria (NHS England, 2013) unless referring specifically to the diagnostic guidance.

I do not stipulate that a clinical diagnosis for autism be given to validate identity as many autistic people have advocated for self-diagnosis (there are wider arguments regarding the need and function of diagnosis). There are multiple barriers to accessing Specialist Autism Assessment Services, and currently the waiting list for adults in my local service is four-years.

In the same way I do not stipulate that for a TGD gender identity to be valid a person must have received a diagnosis, as I note not all TGD people claim a transgender identity. However, I must point out that in the empirical research it was necessary to stipulate the need for a diagnosis. This was to ensure all our participants had received the same experience within a GIC, and for the purpose of having standardisation in experiences and, to provide validity and reliability for the results this was important.

The Lived Experience of Autistic Transgender and Gender Diverse (ATGD) People: A Meta-Ethnography

Abstract

Background

Warrier et al. (2020) reported that TGD people were 3.03 to 6.36 times as likely to be autistic than cisgender people. At present this co-occurrence is poorly understood although research studies into this phenomenon have begun to emerge with various theories posited, and qualitative studies providing a rich insight into this experience have been published. This literature review sought to explore the lived experience of ATGD people.

Methods

Databases were searched to find research articles which utilised qualitative methodologies to explore the experience of ATGD people. These were analysed using the meta-ethnographic approach developed by Noblit and Hare (1988).

Results

Eight studies were identified for review, and analysis resulted in three main themes: 1. Autism acts as a barrier to gender transition; 2. Autism acts as a facilitator to being your authentic self; 3. There is a need for support and adaptations to mitigate external and internal factors.

Discussion

The synthesis concludes that there are unique challenges to being an ATGD person. Clinicians can support people to access services such as considering the sensory impact of the environment and adapting their communication style. Providing groups where people can

meet people with similar experiences can also be a helpful way of supporting people to develop social connections.

Introduction

Research has suggested that TGD people are more likely to be autistic (de Vries et al., 2010; Pasterski et al., 2014; Warrier et al., 2020). At present this phenomenon is poorly understood. Historically experiencing incongruence between assigned sex at birth and gender identity; and experiencing social and communication difficulties have accrued formal diagnosis (ICD-11, 2017; ICD-11, 2023). However, increasingly people are self-identifying as both transgender (Zamman, 2019) and autistic (Lewis, 2016). A lack of research has meant that although clinicians are aware of some of the needs of both TGD and autistic people, the needs of those who identify as both are poorly understood.

TGD is an umbrella term used to describe a range of gender identities where a person does not feel that their gender is the same as, or is congruent with, their assigned sex at birth (Stonewall, n.d.; WPATH, 2022). The research literature is increasingly focusing on people who identify with a TGD identity and who are also autistic, as the incidence of co-occurrence is considered higher than expected within the neuro typical population (Coleman-Smith et al., 2020).

Diagnostic Criteria

Currently the term 'Gender Incongruence' is used as an accepted diagnostic term for adults, and the diagnostic criteria states that there must be a persistent incongruence between a persons' experience of their gender and assigned sex at birth. The guidelines stipulate that behaviour or preferences that may be seen as non-conforming are not sufficient for providing a diagnosis (ICD-11, 2017). Not all TGD people will experience gender incongruence or wish to seek a formal clinical diagnosis. Recent changes to the diagnostic classification of symptoms of gender incongruence has led to some criticism, in part due to this being classified under conditions related to sexual health rather than mental health (Winter et al., 2016).

The diagnosis of ‘Gender Incongruence of Adolescence and Adulthood’ is characterised by the same criteria as outlined above. However, it notes that the experience of gender identity and assigned sex not being congruent can lead to a person to want to ‘transition’ to align their gender identity and sex through interventions. Interventions can include hormonal treatment, surgical intervention and by accessing services such as hair-removal to align their body to their gender identity (ICD-11, 2017).

The diagnosis ‘Gender Incongruence of Childhood’ pertains to difficulties experienced in childhood due to incongruence between gender identity and assigned sex in pre-pubertal children. This can include wish for their gender identity to be different to their assigned sex, a dislike of their anatomical sex characteristics, and a desire for sex characteristics which align with their gender identity. They may prefer or engage in activities culturally typical of their gender identity as opposed to their assigned sex. For a diagnosis to be given, the incongruence between gender identity and assigned sex must have been present for around two-years and at diagnosis they must be over the age of five-years-old (ICD-11, 2017).

Autism referred to in the diagnostic manual (ICD-11, 2023) as ‘Autism Spectrum Disorder’ is classed as a neurodevelopmental disorder, characterised by persistent deficits in social interaction such as difficulty in initiating and sustaining reciprocal communications. People may have restricted, repetitive, or inflexible patterns of behaviours or interests/activities. These may be atypical or excessive in respect of the persons’ age or culture. Autism typically occurs during early childhood however it may not become noticeable until later in a persons' development. The deficits caused by impairments in social functioning must be sufficiently severe to cause difficulty across all areas of life including occupational, personal, and social settings. There can be large variances in intellectual functioning and language abilities in those presenting with autism, some people may also meet the clinical criteria for a diagnosis of a learning disability (ICD-11, 2023). Due to diversity in how autism can present in different people, it can be considered an umbrella term covering a range of traits and sensory profiles.

People do self-diagnose as autistic (Lewis, 2017). This is problematic as it means data pertaining to prevalence are unlikely to capture a true picture. People who self-diagnose may not receive appropriate support, or intervention. Oftentimes co-morbid diagnoses are identified, and in those who self-diagnose these may also be left unsupported (Abdallah et al., 2023).

Prevalence

Around 9.8 per 1,000 adults in England are estimated to have autism (Brugha et al., 2011). In children this is estimated to be 157 per 10,000 (Baron-Cohen et al., 2018). It has been suggested that variance in diagnosis of autism between age groups may be due to factors such as assessments now being more accessible to younger generations (O'Nions, et al., 2023).

In the results of the 2021 Census in England and Wales 45.7 million people aged 16 years or over answered the question "*Is the gender you identify with the same as your sex registered at birth?*" 262,000 people answered "*No*". Of these 118,000 did not specify their gender identity, 48,000 identified as a trans man, 48,000 identified as a trans woman, 30,000 reported a non-binary gender identity, and 18,000 provided a different gender identity to those outlined above (Office for National Statistics, 2023).

In the *'NHS Standard Contract for Gender Identity Development Service (GIDS) for Children and Adolescents'* (NHS England, 2015) data are reported from an unpublished study which suggests an incidence in children and adolescents aged 4-15 years presenting to NHS services of 1.6 per 100,000 in the UK. These data only include those who have presented to an NHS service and therefore the actual figure may be higher. Incidence in children and adolescents is thought to be harder to establish as experiences of gender incongruence may not continue into adulthood, and their identity may evolve or have been a precursor to a lesbian, gay or bisexual sexual orientation (NHS England, 2015).

Being TGD either as a child or an adult is rare in England and Wales, as is being autistic; it is also likely that people experiencing both is an even more rare phenomenon. It is however important to understand this experience so that healthcare professionals can offer tailored support to meet clinical needs.

Co-occurrence of Autism and Gender Incongruence

Of those who present to a GIC with symptoms of gender incongruence, some may also be autistic. In a study of children and adolescents referred to a GIC 7.8% were autistic (de Vries et al., 2010). In a separate study of adults receiving support at a GIC 5.5% had autistic traits (Pasterski et al., 2014). A larger study reported that TGD people were 3.03 to 6.36 as likely be autistic than cisgender people (Warrier et al., 2020). Prevalence data are useful in giving an estimate of the rate of co-occurrence; however developments in how autism is understood and therefore recognised will have an impact on the accuracy of these data. Autism in women has become more recognised, and therefore diagnosed. Younger generations are also more likely to receive a diagnosis suggesting there are adults who would meet criteria but may have never received a diagnosis (O'Nions, et al., 2023).

A study of children and adolescents conducted in Australia found that although there was an increased prevalence of co-occurrence of being both TGD and autistic in referred and non-referred groups, this was not specific to autism but may be due to other developmental factors (May et al., 2017). It is however unclear why there is a higher incidence of TGD people who also meet diagnostic criteria for autism, and further studies are needed to understand the prevalence rates and factors relating to this phenomenon.

At present there is a lack of research to draw conclusions about the co-occurrence of being ATGD, and it is considered best practice to follow clinical guidelines when a diagnosis is given, partly as there is currently no reason to suggest that gender incongruence is ‘caused’ by autism (Turban & van Schalkwyk, 2018).

Accessing Support for Gender Incongruence

Currently anyone who experiences gender incongruence can access support provided by the NHS (if they wish) and meet diagnostic criteria. However, there are long waits to access support and often people do not feel adequately supported by local clinicians such as GP’s (Vincent, 2018). Indeed, it has been found that TGD people report negative experiences of healthcare providers, and this may be a cause of distress and a barrier in accessing services (McNeil, 2012).

In adult GIC's all care plans follow the 'NHS England Interim Gender Dysphoria Protocol and Service Guidelines' (NHS England, 2013). TGD people may wish to access a range of interventions including psychological support, medical interventions, speech and language interventions and referral for laser hair removal (NHS England, 2013).

Within the GID's young TGD people can also access psychological support but limited medical interventions. At present due to a lack of high-quality research pertaining to evidence-based practice in services for young TGD people, GIDS has come under increasing pressure with the new 'Interim specialist service for children and young people with gender incongruence' guidance (NHS England, 2023) put in place to restrict services. For example, clinicians only being able to refer young TGD people for medical interventions from around the age of 16. More recently there has been an independent report into the GIDS (The Cass Review, 2022), which was requested due to a significant increase in referrals, as well as young people and their guardians facing long waiting lists and concerns about the treatment pathway that young people were following, particularly those who are autistic. The interim report has suggested that a new service model, across different departments within the health service, would better meet the needs of young people, particularly at a more local level, involving specialists collaborating to provide tailored support and intervention.

Mental Health, Suicidality and Self-Harm

A review of literature pertaining to the mental health of TGD people found that pre-assessment levels of psychopathology and psychiatric disorders are higher compared to non-TGD people; however for many these symptoms can improve significantly post medical intervention (Dhejne et al., 2016). Although a more recent review reported that TGD people have a lower quality of life pre-treatment with only some evidence that this improved post-intervention (Nobili et al., 2018). A systematic review and meta-analysis found that co-occurring mental health difficulties were higher in autistic populations. For example there were pooled estimates of 20% for anxiety disorders and 11% for depressive disorders (Lai et al., 2019).

Research suggests that young TGD people are at higher risk of suicide compared to their non-TGD peers (de Graaf et al., 2022). Being autistic (whether child or adult) is associated with being more likely to self-harm or experience suicidal ideation (Blanchard et al., 2021). This is further supported by a study conducted in Australia reporting that young ATGD people aged 14-25 are at higher risk of self-harming, suicidal behaviours and poorer mental health compared to young non-ATGD people (Strauss et al., 2021). In a study of adults by Clements-Nolle et al. (2006) reported that nearly 32% of TGD adults have attempted suicide, compared to around 6.1% of cisgender men (6.1%) and cisgender women (6.6%) (Kirakosian et al., 2023).

Impact of autism

Findings within the current research give insight into how being autistic can have an impact across various aspects of a persons' life. The lived experience for autistic people can be challenging, not least due to social and communication difficulties, with this having an impact across the lifespan including challenges at school and in the workplace. Being autistic can negatively affect confidence, the feeling of being different to peers, and experiencing frequent anxiety. Finding people and environments that fit with a persons' needs and interests can lead to a more positive experience although some may find it easier to make social connections online through support groups (DePape & Lindsay, 2015).

Autistic people can experience communication difficulties and barriers when accessing healthcare (Nicolaidis et al., 2015), including a lack of therapists with specialist knowledge to meet their needs (Adams & Young, 2021). Parents of young autistic people report numerous barriers to advocating for their child (Boshoff et al., 2016). These barriers to accessing healthcare may be a factor in why some people self-diagnose, as well as questioning the need for a formal diagnosis to access support (Lewis, 2016).

Minority Stress

A recent study suggests the co-occurrence of being TGD and being autistic leads to health inequalities (Hall et al., 2020). Research studies have also noted that being part of a minority can cause increased stress on a person and lead to them needing to develop coping strategies such as concealing their identity to mitigate their distress (Meyer, 2015). The connection with other TGD people is linked to some positive outcomes such as improved mental health and supported exploration of sexual and gender identities, and connection with others could reduce the impact of minority stress (Sherman et al., 2020). Autistic people's perceptions of low social support have been linked to poorer psychosocial outcomes (Zimmerman et al., 2018). Further suggesting there is an important role for social support in the exploration of identity.

Autism and Gender

A meta-synthesis exploring the experience of autism and gender found that the discourse surrounding autism restricted gender identities (Moore et al., 2022). For example, theories pertaining to the 'extreme male brain' were considered to exclude those with female identities and invalidate their autistic identity (Baron-Cohen, 2002). Masking narratives were also felt to be providing the assumption that because someone is female, they should inherently be better at hiding their autistic traits (Milner et al., 2019). Being autistic was also felt to invalidate TGD identities making it difficult for people to feel authentic (Moore et al., 2022). As research has emerged, the way that autism is understood has evolved with less focus on boys/men and binary genders instead considering a broader definition of gender identity.

Nevertheless, being autistic can be a barrier to accessing social spaces and communicating, however some report finding online communities helpful and validating (Miller et al., 2020). Studies have begun to understand how autism and gender identity interact such as Moolchaem et al. (2015) who found that for TGD people finding spaces that are inclusive of neurodiversity can be a helpful way of supporting people to gain social interaction.

Aims of the Review

To describe and gain a richer understanding of the experience of ATGD people to inform and guide healthcare clinicians in identify and meeting needs. The meta-ethnography is also intended to act as a foundation for future research endeavours.

Rationale

Currently few studies have examined the experience of ATGD people. This meta-ethnography aims to explore themes across studies to determine common experiences. Meta-ethnography was chosen for this review as through its approach it transcends the data to allow new insights into people's experiences; this is done through the interpretations made by the meta-ethnographer. This can have important theoretical implications as it has the ability to generate hypotheses, reconcile consensus and contradictions within each qualitative study and can also derive new knowledge and generate formalised evidence to support evidence-based practice

(Sattar, 2021; Soundy & Heneghan, 2022). This could support clinicians in understanding the nuances within this population and make adaptations to support people in accessing services.

Methodology

The SPIDER tool (Cooke et al., 2012) was used to frame the question: For autistic people who have been diagnosed or self-identify (Sample), what is their experience of being ATGD (Phenomenon of Interest/ Evaluation) in their narrative (Study Design) according to qualitative research findings (Research Type). I note here that within the meta-ethnography we include those who are TGD and/or are experiencing gender incongruence; this is due to people not necessarily identifying with both terms.

Positionality Statement

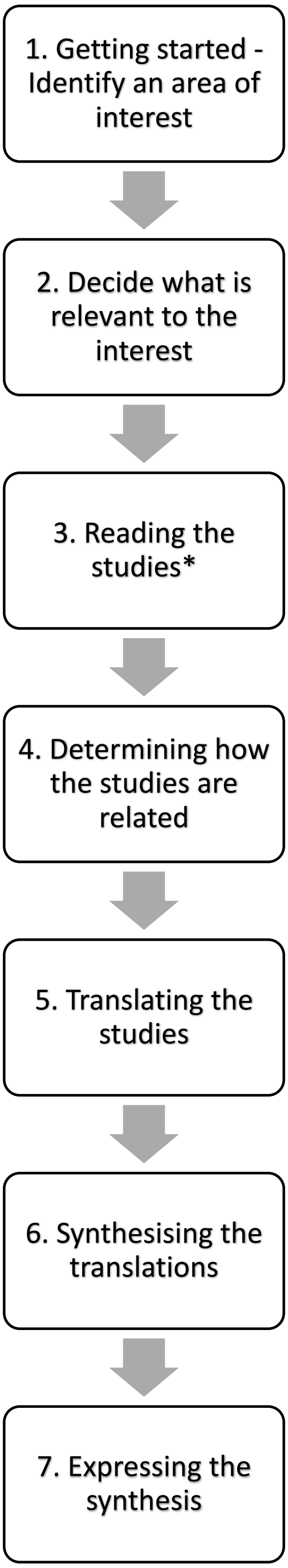
The author is a non-autistic cisgender woman; she has worked as a Senior Assistant Psychologist in an NHS GIC, and more recently as a Trainee Clinical Psychologist in a Specialist Autism Assessment Service. The author was supervised by a Clinical Psychologist acting as an Academic Supervisor, and by a Clinical Psychologist working in a GIC as Clinical Supervisor. She attended specialist meta-ethnography workshops. The author received regular supervision throughout the project. She also attended specialist workshops to share and reflect with others, and to aid in exploring positionality, beliefs, and potential biases and the impact of these when synthesising using the meta-ethnographic approach. The author took a critical realist epistemological and ontological position when undertaking the meta-ethnographic approach (Danermark et al., 2002), in keeping with expectations of systematic reviews and meta-ethnography (Smith & Eatough, 2007; Barnett-Page & Thomas, 2009; Sim & Mengshoel, 2022).

Synthesis Methodology

This meta-synthesis follows the meta-ethnographic approach as proposed by Noblit and Hare (1988). This approach synthesises the literature by critically examining multiple accounts and generating new interpretations through comparison and analysis. The steps are summarised in Figure 1, and in Table 1 which provides a detailed account of each phase.

Figure 1

A Flow Diagram of the Meta-Ethnographic Approach (adapted from Noblit & Hare, 1988)



**Completed after the PRISMA protocol* (Page et al., 2021) *was followed.*

Table 1

An Outline of the Meta-Ethnographic Phases (adapted from Noblit & Hare, 1988)

Step	Phase	Description
1	Getting started - Identify an area of interest	This step involved identifying an area of interest and determining whether a review of the literature is necessary and/or valuable.
2	Decide what is relevant to the interest	In this step the researcher determined what was relevant and developed justifiable reasons for the inclusion and exclusion of studies.
3	Reading the studies*	This step involved reading and re-reading studies, making notes on the content, and extracting key concepts.
4	Determining how the studies are related	In this step the researcher moved to begin determining how the studies were related, how key concepts 'fitted' or 'jarred', and initial assumptions were made regarding the relationship between the studies.
5	Translating the studies	This step involved maintaining central metaphors and concepts in one account whilst determining how they translated into other accounts.
6	Synthesising the translations	In this step the researcher began to determine whether the translations across studies could be encompassed together to create something more than the component parts.
7	Expressing the synthesis	The last step involved sharing the information generated with the intended audience.

**Completed after the PRISMA protocol* (Page et al., 2021) *was followed.*

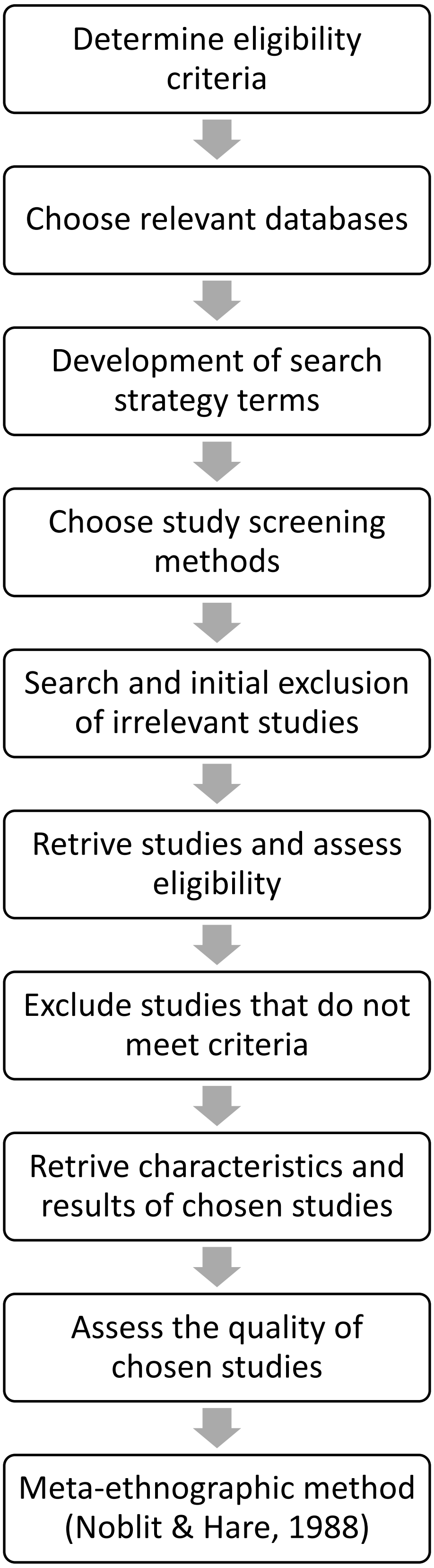
Phases 1 and 2

Initially the area of interest was identified. The lived experience of ATGD people was identified due to being a relatively new area of study, and synthesising the existing research presented the opportunity to "*…advance our interpretive understanding of social phenomena*" (Noblit & Hare, 1988: pp 9). At present there has not been a review of this area of research. It was therefore decided that only studies including participants who were both ATGD would be relevant, as opposed to including studies only focusing on either characteristic and synthesising these together. This was because it would miss any nuances that could be only attributed to people who experience both, as opposed to general crossever between the two. Only qualitative studies were included due to their richer data content.

A pre-planned search strategy was developed, and discussed with a Specialist University Librarian to ensure a comprehensive search strategy was completed and to ensure all relevant studies were included in the review. A summary of this is displayed in Figure 2.

Figure 2

A Flow Diagram Summarising the Search Strategy (adapted from Page, et al., 2021)



Determine Eligibility Criteria:

To be included the study had to be a) original primary research utilising a qualitative methodology exploring the experience of ATGD people; b) articles involving research with adolescents and adults, and c) studies focused directly on the experience of being an ATGD person. If a study captured the perspectives of others, they were included if the experience of ATGD people was sufficiently separated.

Studies were excluded if they: a) were a case report, a mixed-methods study (unless significant focus on qualitative aspect), grey literature including dissertations, solely quantitative studies, opinion pieces, and review articles; b) articles solely focusing on individuals not directly or personally affected by the issue studied; c) studies only pertaining to an autistic or TGD identity, and d) if the sample only included young children under the age of 12 as it was felt developmentally they would be too different from adolescents and adults. It was decided that dissertations would not be included in the review due to differences in the peer-review process which would provide less standardisation between the final selected papers. I note here that some articles included in the review were based on their respective author's masters' and doctoral research; however their peer-reviewed article is included as opposed to their dissertations due to the added quality assessment involved in the peer-review process.

The exclusion of grey literature has implications and limitations. For example, some studies are not published due to publication bias, or in quantitative studies (particularly) may not be published if effects are low or insignificant (Hopewell et al., 2007). However, unpublished studies may in themselves be an unrepresented sample, or of lower quality (Egger et al, 2003). Although some authors have argued for its inclusion, in part to reduce the aforementioned biases, they note the idiosyncratic approach often needed to search for and identify relevant grey literature, and the increasingly broad definition of what would constitute an appropriate paper to include (Adams et al., 2016).

Choose Relevant Databases

Searches of relevant databases were conducted in September 2023. The databases included: AMED, APA, CINAHL Plus, Embase, EBSCO Discovery, EBSCO host, OVID Medline, PsychInfo, ProQuest, PubMed, and Scopus.

Development of Search Strategy Terms

Key search terms are included in Table 2. The reference lists of short-listed studies were reviewed to ensure no papers were missed. The authors of shortlisted studies were contacted to enquire as to whether they would be publishing any further papers, none were. All authors contacted had at least a month to respond.

Table 2

A Table of Key Search Terms

Terms Related to Neurodiversity	Terms Related to TGD	Terms Related to Research Methodology
Autis*	Transgender	Qualitative
Asperger*	Transsexual	Themes
Neurodiver*	Gender identity	Phenomenol*
ASD	Gender incongru*	Grounded
ASC	Gender divers*	Thematic
Aspie	Gender fluid	Discours*
	Non binary/ non-binary	Focus Group
	Transma*	Ethno*
	Transfem*	Interview*
	Trans woman	Narrative
	Trans women	IPA
	Trans men	
	Trans feminine	
	Trans female	
	Trans masculine	
	Trans man	
	Trans male	
	Gender queer	
	Enby	
	Gender dysphori*	

The search strategy resulted in the following data being inputted into each database:

((((((Autis*) OR (Asperger*) OR (Neurodiver*) OR (ASD) OR (ASC) OR (Aspie))))))

AND

(((((((((((((((((((((Transgender) OR (Transsexual) OR (Gender identity) OR (Gender incongru*) OR (Gender divers*) OR (Gender fluid) OR (Non binary) OR (Non-binary) OR (Transma*) OR (Transfem*) OR (Trans woman) OR (Trans women) OR (Trans men) OR (Trans feminine) OR (Trans female) OR (Trans masculine) OR (Trans man) OR (Trans male) OR (Gender queer) OR (Enby) OR (Gender dysphori*)))))))))))))))))))))

AND

(((((((((((Qualitative) OR (Themes) OR (Phenomenol*) OR (Grounded) OR (Thematic) OR (Discours*) OR (Focus Group) OR (Ethno*) OR (Interview*) OR (Narrative) OR (IPA))))))))))).

Boolean operators AND/OR in combination with free text terms were applied. A year limit was not applied as research into being ATGD is a new phenomenon, and therefore this was deemed unnecessary. Limits relating to research design were not felt to be needed due to the search terms utilised.

Study Screening Methods

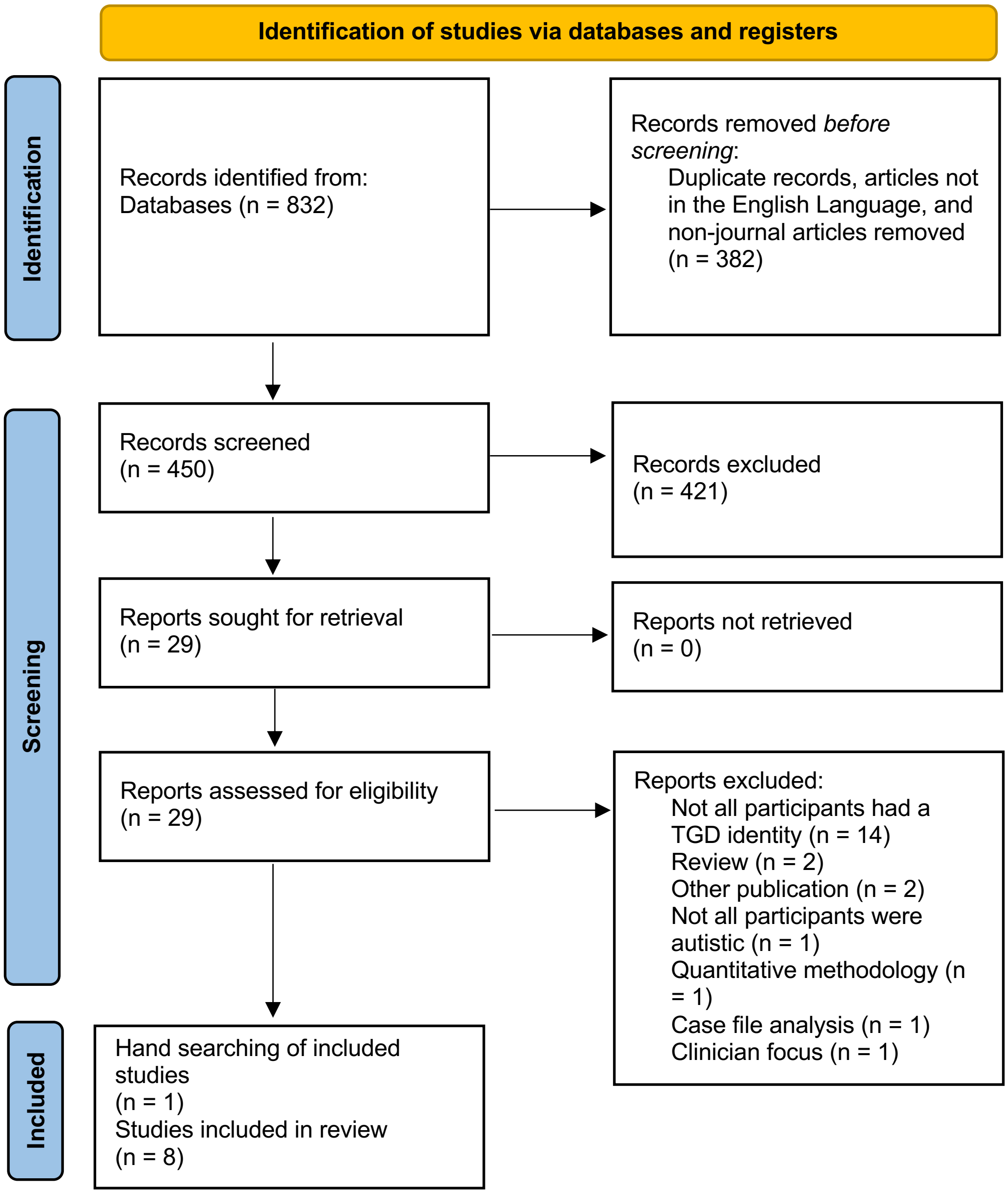
The titles and abstracts of studies were screened using the pre-set inclusion and exclusion criteria. Short-listed studies were retrieved and reviewed with those not meeting the pre-set criteria excluded.

Searches, Initial Exclusion of Irrelevant Studies, Retrieval of Studies and Assessment of Eligibility, and Exclusion of Studies that did not Meet Criteria

Database searches were conducted entirely by hand. Therefore, during the identification stage, when databases were searched the author removed duplicates. Additional duplicates were removed during the screening stage as some papers were found in multiple databases. The searches initially resulted in 832 papers being identified. Where possible; results were restricted to journal articles and screened to remove duplicates and articles not in the English language. This removed 382 articles. The titles and abstracts of 450 papers were screened using the pre-set inclusion and exclusion criteria. 421 papers were excluded due to not meeting inclusion criteria. Of these 130 were excluded either due to being a duplicate or not relevant to the review question. 119 were excluded due to being another type of publication such as a review or protocol. 92 were excluded due to not having a focus on both TGD and autistic identities. 32 case studies were also excluded. 30 papers exploring the perspectives of parents and clinicians were removed. 18 quantitative studies were also excluded. 29 papers were retrieved and screened. Of the 29 papers screened by the author to assess whether they met the review criteria, 22 were removed due to not meeting inclusion criteria. Seven papers remained. Hand-searching of the remaining papers identified another study. This paper was identified during the initial review search in the Web of Science database, however when the searches were re-run the author no longer had access to this database and substituted it for another. Eight studies were included in the final review reporting the experiences of 167 people. The identification of studies is outlined in Figure 3.

Figure 3

Flow Diagram of the Identification of Studies for Review (adapted from Page et al., 2021)



14 papers were discounted due to not all the participants being TGD, these were by: Penwell Barnett and Maticka-Tynedale (2015), Penwell Barnett (2017), Kourti and MacLeod (2019), Hall et al. (2020), Hillier et al. (2020), AnderSon et al. (2022), Cohen et al. (2022), Folta et al. (2022), Koffer Miller et al. (2022), McAuliffe et al. (2022), Crehan et al. (2023), Putnam et al. (2023) and Steinberg et al. (2023). A paper by Carlile (2020) was removed due to not all the participants being autistic. A further paper by Strang et al. (2018a) was removed due to all participants being clinicians.

On closer inspection papers by Jack (2012) and Oswald et al. (2021) were literature reviews and therefore excluded. A paper by de Vries et al. (2010) was excluded due to utilising a quantitative methodology. A case file analysis by Kaltiala-Heino et al. (2015) was also excluded as were discussion pieces by Pyne (2021) and Strang et al. (2019).

Phase 3

Retrieve Characteristics and the Results of Chosen Studies

The shortlisted studies are outlined in Table 3, and further information pertaining to the design and methods are outlined in Table 4. Five of the included studies had adult participants and three had young people. There was slight variation in ethnicity in the UK studies, if these data were recorded in the study, and in the studies conducted in the USA the participants were mostly identified as ‘white’ however, there was more variability in this characteristic.

Table 3

Table of Research Study, and Participant Information

	Authors	Year	Country	Title	Participants (P)	Autism	TGD	Ethnicity	Age
1	Bruce et al.	2023	Global	Exploring the Experiences of Autistic Transgender and Non-Binary Adults in Seeking Gender Identity Health Care	17 Adults	Formal diagnosis or self-identified	Self-identified TGD	1 African American, 2 Mixed, 14 White	18-46
2	Coleman-Smith et al.	2020	UK	'Conflict versus congruence': A Qualitative Study Exploring the Experience of Gender Dysphoria for Adults with Autism Spectrum Disorder	10 Adults	Met DSM/ICD10 criteria	Met related DSM/ICD-10 Criteria	Not recorded	18-65
3	Cooper et al.	2022a	UK	The lived experience of gender dysphoria in autistic young people: a phenomenological study with young people and their parents	17 Young people (YP) and 16 parents (Pt)	Clinical Diagnosis verified by viewing diagnostic report	All identified as transgender and had experience of gender dysphoria	15 White British, 2 Mixed	YP 13-17, Pt 42-55
4	Cooper et al.	2022b	UK	The lived experience of gender dysphoria in autistic adults: An interpretative phenomenological analysis	21 Adults	Clinical diagnosis verified by viewing diagnostic report	All identified as transgender and had experience of gender dysphoria	20 White British, 1 Mixed	18-51

5	Cooper et al.	2023	UK	Phenomenology of gender dysphoria in autism: a multiperspective qualitative analysis	Adults 18-51, YP 13-17	Formal diagnosis	Sought professional help due to experience of gender dysphoria	Adults 20 White British, 1 mixed. YP 14 White British, 1 Mixed.	Adults 18-51, YP 13-17
6	Maroney and Horne	2022	USA	"Tuned into a different channel": Autistic transgender a dults' experiences of intersectional stigma.	13 Adults	Most had a diagnosis, one p was seeking, one P had self-identified	Three diagnosed with gender dysphoria, remaining self-reported TNG	7 White, 1 Asian, 1 Latina, 2 Hispanic/ White, 1 Multiracial, 1 Latinx	18-29
7	Strang et al.	2018b	USA	"They Thought It Was an Obsession": Trajectories and Perspectives of Autistic Transgender and Gender-Diverse Adolescents	22 Young People	ASD met diagnostic criteria DSM	Gender dysphoria mostly met diagnostic criteria DSM	2 Asian, 18 White, 2 Other	12.9-20.76
8	Strang et al.	2022	USA	A Clinical Program for Transgender and Gender-Diverse Neurodiverse/ Autistic Adolescents Developed through Community-Based Participatory Design	31 Young people and 46 parents	ASD met diagnostic criteria DSM	Gender dysphoria met diagnostic criteria DSM	26 White non-Hispanic/ Latinx, 1 White Hispanic/ Latinx, 2 Asian non-Hispanic/ Latinx, 1 Mixed-race non-Hispanic/Latinx, 1 Mixed-race Hispanic/Latinx	YP 12-19, Pt ages not given

*There are variances in how presentations consistent with autism, TNG (Transgender, non-binary, and gender diverse), TGD and/or gender incongruence are characterised, and the diagnostic label utilised. For example, experiences of the symptom of gender dysphoria in the ICD-11 has the label Gender Incongruence (ICD-11, 2017), and autism the label Autism Spectrum Disorder (ICD-11, 2023). For the purpose of the review we try to use the language used by the individual studies authors due to nuances and changes in meaning when translated.

Table 4

Reviewed Study's Research Design and Methodology

Study	**Study Authors/ Year**	**Aim**	**Use of EBE***	**Ethical Approval**	**Data Collection Method**	**Data Analysis Method**
1	Bruce et al. (2022)	To explore the experiences of trans and/or non-binary autistic adults who have accessed, or tried to access, GIH* to help understand the challenges they face and what changes can be made to positively impact their experiences	No	University Ethical Approval	Interview	Reflexive Thematic Analysis
2	Coleman-Smith et al. (2020)	Aimed to answer the questions: How does autism impact on the ways in which people understand and address GD*? How is this shaped by the social environment?	Some	University and NHS Research Authority	Interview	Grounded Theory
3	Cooper et al. (2022a)	Aim to answer the questions: How do autistic young people experience gender dysphoria? How do young people and parents perceive the intersection of autism and gender dysphoria?	Yes	NHS HRA	Interview	IPA
4	Cooper et al. (2022b)	Aim to answer the question: what is the phenomenology of gender dysphoria in transgender autistic adults?	Yes	NHS HRA	Interview	IPA
5	Cooper et al. (2023)	To generate robust findings about the phenomenology of gender dysphoria in autism by identifying converging and diverging viewpoints on this intersection	Yes	NHS HRA	Interview	Multi-perspectival IPA
6	Maroney and Horne (2022)	To explore the intersectional experience of being both TNG and autistic, and resistance strategies	No	University IRB*	Interview	Critical-Constructivist Grounded

7	Strang et al. (2018b)	Aimed to: (1) characterize the short-term gender trajectories of adolescents with the co-occurrence and (2) identify salient themes in these young people’s lives	Stakeholder Research Methodology	IRB	Interview	Theory Framework Analysis
8	Strang et al. (2022)	Aimed to: identify care and support needs and develop clinical care techniques for A/ND*- GD adolescents using a CBPR* framework.	Stakeholder Research Methodology	Children's National IRB	Interview and assessment	Framework Analysis

* GIH (Gender Identity Healthcare)

*GD (Gender Dysphoria

*IRB (Institutional Review Board)

* A/ND (Autism/ Neurodiversity)

* CBPR (Community-Based Participatory Research)

In the study conducted by Bruce et al. (2023), they recruited participants from the UK and from across the globe. They had a predominantly White sample (*n* = 14); however, they also captured the experience of one African American and two 'Mixed' race people. Participant's characteristics of being ATGD were self-identified, with only some of the sample having a formal diagnosis of autism. They interviewed 17 people and analysed the transcripts using reflexive thematic analysis (Braun & Clarke, 2019). The authors received ethical approval from a university, and they note that they did not formally use EBE, they did however reflect on the lived experience of the first author who is non-autistic and cisgender and how they had supported a TGD person who was denied GIH (Gender Identity Healthcare) and how this led them to be inspired to conduct the research. The second author is an autistic non-binary researcher and the third is an autistic cisgender researcher. The experiences of the research team informed the study by bringing multiple perspectives.

In the study conducted by Coleman-Smith et al. (2020) in the UK they interviewed 10 adults aged 18-65 about their experience of gender dysphoria (gender incongruence) and autism. The authors were keen to identify how autism impacted on how they understood and addressed feelings of gender incongruence, and how this was shaped by their social environment. Participants had to have met accepted diagnostic criteria and have received a diagnosis for both autism and gender incongruence. The mandating of diagnosis may have been a factor in having a smaller sample. Although requesting formal diagnosis as an inclusion criterion is helpful for increasing the validity of a study, current long-waiting lists and a propensity in people wishing to self-diagnose may render it a limitation particularly if studies miss capturing their experiences. The ethnicity of participants was not recorded. The study received ethical approval from a university and from the NHS HRA. The authors report the use of EBE in the process although it is not clear if they were involved formally, or directly informed the decision making on aspects such as methodology. They used a qualitative methodology with grounded theory analysis and note that due to their small sample they did not achieve data saturation which limited the robustness of the final conceptual model (Glaser & Strauss, 1967).

Cooper et al. (2022a) in their study explored gender dysphoria (incongruence) and autism and how this was experienced by young people, and how they perceived the intersection of experiencing both. The authors interviewed 17 young people aged 13-17 in the UK. The young persons' diagnosis of autism was verified through viewing the diagnostic clinical report. All the young people identified as TGD, but their experience of gender incongruence was not verified via a formal diagnosis, as previously stated there are barriers in accessing formal diagnosis and arguments for self-diagnosis being sufficient. 15 of the young people were White British and two reported their ethnicity as 'Mixed'. For the meta-ethnography where parent accounts were given, these were not included. The authors report the use EBE in the study process and received ethical approval from the NHS HRA. They used IPA qualitative methodology which is an idiographic approach suited to understanding the phenomena of a particular lived experience with the researcher making sense of this through their own interpretations (Smith et al., 2021). The authors note that they are non-autistic cisgender researchers and clinicians and describe how they reflected on their positionality as part of the process of IPA.

A further study by Cooper et al. (2022b) in the UK explored the experience of 21 adults aged 18-51 to explore the phenomenology of gender dysphoria (gender incongruence) in autistic adults. Their diagnosis of autism was verified by viewing their diagnostic clinical report. All the participants identified as TGD and self-reported experience of gender incongruence. 20 of the participants were White British and one reported their ethnicity as ‘Mixed’. The authors report the use EBE in the study process and received ethical approval from the NHS HRA. They used an IPA qualitative methodology and analysis sufficient for understanding individual lived experience (Smith et al., 2021). The authors reflect on their non-autistic identities and how they used reflexivity in the process of IPA to aid their sense-making of the narratives shared by autistic participants.

Another study by Cooper et al (2023) brought the multiple perspectives of the previous studies (Cooper et al., 2022a; Cooper et al., 2022b, Cooper et al., 2023) together to generate a multiperspective qualitative analysis. As this involved further interpretation of the previous two studies included in the review (Cooper et al., 2022a; Cooper et al., 2022b) it was deemed helpful to also include this in the meta-ethnography.

Another recent study by Maroney and Horne (2022) conducted in the USA interviewed 13 adults aged 18-29 about their experience of being ATGD. The authors sought to explore the intersectional experience of being autistic and having a TNG gender identity, including understanding their resistance strategies. 11 of the participants reported having received a clinical diagnosis of autism, one was seeking an autism diagnosis and one self-identified as being autistic. 3 participants reported a clinical diagnosis of gender dysphoria (gender incongruence), and all participants reported their gender identity as TNG. The authors explain that they feel identities should be validated irrespective of diagnosis. 7 participants reported their ethnicity as White, 1 as Asian, 1 as Latina, 2 were Hispanic/White, 1 was Multiracial, and 1 was Latinx. The authors did not report including EBE in the study but had received ethical approval from a University IRB. The authors used a grounded theory qualitative methodology and analysis. The authors provide a reflexivity statement to explain how they managed their own perspectives during the process and analysis; both authors describe themselves as White, neurotypical and cisgender.

A study by Strang et al. (2018b) conducted in the USA interviewed young people about their gender identity trajectory and explored the themes in their lives. There were 22 young people with an age range of 12.9-20.76. The participants met diagnostic criteria for autism and most met clinical criteria, or most of the criteria for gender dysphoria (gender incongruence). Gender incongruence was recorded over the length of the study to monitor stability or changes over time. This was the only shortlisted study to record any changes to participants' experiences of gender incongruence. 18 participants reported their ethnicity as White, two as Asian and two as 'Other'. The study received ethical approval from an IRB In terms of inclusion of EBE they report the study as utilising Stakeholder Research Methodology. The authors report using a framework analysis qualitative methodology to analyse interview data which is rooted in thematic analysis. This is often used to analyse data, particularly when a stakeholder research methodology is utilised (Gale et al., 2013). The authors describe the characteristics of the analysts which include both autistic and non-autistic, TGD, and cisgender people as well as diversity in other areas such as ethnicity and educational attainments. Alongside the interview they utilised a range of questionnaires to measure aspects of participant's presentation, it is beyond the scope of this review to include quantitative data.

The final study included was by Strang et al. (2022) in the USA, and they interviewed and assessed 31 young people aged 12-19 and 46 parents whose ages were not disclosed. All participants had met diagnostic criteria for autism and gender dysphoria (gender incongruence). Of the 31 young people 21 were White non-Hispanic/ Latinx, two were Asian non-Hispanic/Latinx, one was White Hispanic/Latinx, one was Mixed-race non-Hispanic/Latinx, and one was Mixed-race Hispanic/Latinx. The authors used a framework analysis qualitative methodology and analysis. The authors also report Stakeholder Research Methodology to include EBE in the study. The study received ethical approval from a Children's National IRB. The authors again report using a framework analysis.

Assess the Quality of the Chosen Studies

Papers were assessed using a quality appraisal tool by the researcher and their Academic Supervisor to ensure reliability. As all the papers were a qualitative design and the CASP (Critical Appraisal Skills Programme, 2023) checklist for qualitative papers was utilised to assess factors such as validity and utility; this is a frequently used tool and was chosen as it determines the strengths and limitations of the studies, and their overall quality can be categorised. This was adapted slightly to fit the context of the research area and informed also by the 'Quality Appraisal Checklist for Qualitative Studies' developed by The National Institute for Health and Care Excellence (NICE, 2012). The results are displayed in Table 5. A 3-point scoring system developed by (Feder et al., 2006) was used to assess quality based on ratings for questions 6-13. A score of 1 was given in the absence of information, 2 was given if there was information but it was not sufficient, and a score of 3 was given when the issue had been fully addressed. An overall score of <15 was considered low quality, a score of 16-23 was considered mid quality, and a score of >24 was considered high quality. Further explanation for scores is in Appendix 1A-1C. None of the studies were removed during this process. The process was reviewed by the authors Academic Supervisor.

Table 5

Quality Appraisal of the Reviewed Papers (adapted from CASP; 2023)

Study	Year	Clear Aim	Appropriate Methodology	Is Autism Clearly Defined?	Is being TGD/ Experiencing Gender Incongruence Clearly Defined?	Is the Role of the Researcher Clearly Described?	Appropriate Research Design	Appropriate Recruitment Strategy	Data Collection Addressed the Research Issue	Adequate Consideration on R/P* Relationship	Ethical Issues	Sufficient Rigour of Data Analysis	Clear Findings Statement	Valuable Research	Total Score	Total Rating
Bruce et al.	2023	Yes	Yes	?	Yes	Yes	3	1	3	1	3	3	3	3	20	Mid Quality
Coleman-Smith et al.	2020	Yes	Yes	Yes	?	Yes	3	3	3	1	3	1	3	3	20	Mid Quality
Cooper et al.	2022a	Yes	Yes	No	Yes	Yes	3	3	3	3	3	3	3	3	24	High Quality
Cooper et al.	2022b	Yes	Yes	No	Yes	Yes	3	3	3	3	3	3	3	3	24	High Quality
Cooper et	2023	Yes	Yes	Yes	Yes	Yes	3	3	3	3	3	3	3	3	24	High

al.																Quality
Maroney and Horne	2022	Yes	Yes	Yes	No	Yes	3	3	3	1	3	1	3	3	20	Mid Quality
Strang et al.	2018b	Yes	Yes	No	Yes	Yes	3	3	3	3	3	3	3	3	24	High Quality
Strang et al.	2021	Yes	Yes	Yes	Yes	Yes	3	3	3	3	3	3	3	3	24	High Quality

*R/P (Researcher/ Participant)

Most of the studies included in the meta-ethnography were deemed to be of ‘high-quality’ when scored using the CASP (2023) framework and rated 24 using the Feder et al. (2006) system (Cooper et al., 2022a; Cooper et al., 2022b; Cooper et al., 2023; Strang et al., 2018b; Strang et al., 2021). The remaining were deemed ‘mid-quality,’ and all had a score of 20 (Bruce et al., 2023; Coleman-Smith et al., 2020; Maroney & Horne, 2022). None of the studies were deemed ‘low-quality.’

Weaker areas included providing a definition of autism (Bruce et al., 2023; Cooper et al., 2022a; Cooper et al., 2022b; Strang et al., 2018), or of gender incongruence and/ or being TGD (Coleman-Smith et al., 2020; Maroney & Horne, 2022). Most studies had a satisfactory recruitment strategy except Bruce et al. (2023), where they recruited online and there was a lack of control regarding ATGD identities – although people are increasingly self-identifying (Lewis, 2017). Studies (Bruce et al., 2023; Coleman-Smith et al., 2020; Maroney & Horne, 2022) could have been more explicit in explaining how the participant and researcher relationship was considered, for example the use of EBE or an independent researcher. There were mild concerns regarding the rigour data analysis in two studies (Coleman-Smith et al., 2020; Maroney & Horne, 2022), this was generally pertaining to insufficient saturation for the methodology or a lack of transparency on quality control checks.

It may be that there are factors related to some information not being explicit within the articles and that the areas covered by the quality assessment were considered but omitted with good reason such as a journal word count.

In terms of methodology each study utilised a qualitative methodology, whether grounded theory, IPA, thematic analysis or framework analysis to analyse transcripts of interview data.

Grounded theory follows a process of generating a theory based on the themes that emerge in data, and the relationship or process between the themes. This was first developed by (Glaser & Strauss, 1967). This has been adapted in more recent texts to support non-expert qualitative researchers to be able to utilise the approach (Mills & Birks, 2014). IPA seeks to generate themes across data and is useful for studies which have small samples (Smith et al., 2009). Reflexive thematic analysis is a newer approach to thematic analysis, and values the researcher's subjective experience of the data and how this evolves in the analysis to generate meaning from the data (Braun and Clarke, 2019). Framework analysis is a derivative of thematic analysis and is popular for analysing transcripts of interviews (Gale et al., 2013). The framework analysis approach follows a set process and can involve stakeholders in the analysis of data as themes are identified and developed (Strang et al., 2018b). Although there is variation across the studies in the qualitative methodology, they each use a similar approach of extracting themes from the data to look for commonalities across their participants.

The use of interviews to gather data is considered appropriate to the research question and aims posited by the studies. For example, Coleman-Smith et al. (2020) interviewed 10 autistic participants to explore the experience of gender incongruence. This allowed them to generate questions suitable to exploring this experience and develop a theory based on the responses of participants. If they had utilised a quantitative approach such as the development of a questionnaire, they would not have generated data that was as 'rich' and would have had to pre-empt the questions and may have missed relevant nuances of the participant's experience (Smith & Eatough, 2007; Smith et al., 2021). A larger sample would have strengthened their results and provided more validity (Glaser & Strauss, 1967).

Nevertheless, the study samples vary from 10-36 participants which would be considered small in quantitative research (Field, 2009) but appropriate for most qualitative approaches. To recruit the participants the studies had a variety of approaches including opportunity sampling from an NHS setting which included the studies by Coleman-Smith et al. (2022a), Cooper et al. (2022b) and Cooper et al. (2023). Opportunity sampling from online forums was utilised by Bruce et al. (2023) and Maroney and Horne (2022), Strang et al. (2022) sampled from a medical centre, with Strang et al. (2018b) recruiting via consultation with gender specialists.

It is of note that several studies for example, did not mandate participants having a clinical diagnosis pertaining to gender incongruence, and this may have been due to a reluctance for young people to receive diagnoses as has been noted with young people presenting with personality disorders (Laurenssen et al., 2013). Also of note is that for adults the recognition that having a TGD identity does not require a diagnosis to be valid (Bockting, 2019), and therefore self-identification was sufficient for inclusion. Maroney and Horne (2022) included one participant who was seeking a diagnosis of autism, and one who self-identified as autistic demonstrating a wish to include people based on self-reported experience. In relation to a TGD identity only three of their participants had received a clinical diagnosis with others self-identifying as TNG. This is not dissimilar to Strang et al. (2018b) where of their sample of young people some met the diagnostic criteria, whereas other mostly met the criteria. It could be considered problematic in terms of validity of the sample for clinical diagnosis of symptomology of autism and gender incongruence to not be recognised without a formal diagnosis, however it could be argued that it is important to recognise individual experiences and not receiving a diagnosis does not automatically equate to not being affected by an issue.

The data collection across all studies addressed the research issue. Coleman-Smith et al. (2020) describe in detail how the participants were interviewed, including the number of times, which is consistent to the grounded theory approach they interviewed some participants more than once. They also highlight how the interview schedule evolved as data was generated. Cooper et al (2022a; 2022b; 2023) describe the setting in which participants were interviewed, the topic guide and highlighted the modifications made to ensure its accessibility for an autistic person. There were no concerns across the remaining studies about the data collection not being commensurate to their research aims.

Adequate consideration on researcher and participants relationships was a strength across the studies, perhaps due to its importance in qualitative research to address issues of bias (Florczak, 2021). For example, Maroney and Horne (2022) report their own positionality and the reflexive stance of the grounded theory approach although this would have been strengthened by using a third-party EBE. Strang et al. (2018b; 2022) report the stakeholder approach and the utilisation of more than one person in the analysis of data, and the use of a stakeholder as a quality control when analysing the data. Of the approaches this utilised a diverse team of analysts which strengthened the overall interpretations and conclusions of the data.

All the studies included in the review report adequate ethical approval whether it was granted in the UK by a University such as in the case of Bruce et al. (2023), the NHS HRA as in the studies by Coleman-Smith et al. (2020), Cooper et al. (2022a), Cooper et al. (2022b) and Cooper et al., (2023), or in the USA via an IRB as noted in the studies by Strang et al. (2018b), Maroney and Horne (2022) and Strang et al. (2022).

In each of the studies most of the authors demonstrate sufficient rigour of data analysis, this included demonstrating themes and/or sub-themes and providing multiple quotes to substantiate each claim. These were also consistent with the qualitative methodological approach. For example, Cooper et al. (2022b) provides superordinate themes such as ‘Making sense of distress and finding my identities’ but also includes subordinate themes which included “1. *Experiencing and describing my body distress*. 2. *Making sense of who I am*. 3. *Intersecting and competing needs*.” These were then substantiated with supporting quotes. This was further supported by noting that 21 (100% of the sample) were included in theme one, 17 in subordinate theme 2 and 19 in subordinate theme 3. The amount of detail varied across studies, but all were deemed to be sufficient for inclusion in the review.

Each study provided a clear findings statement. Coleman-Smith et al. (2020) were tentative in their conclusions and discussed how the findings fit with the reflective journals kept by researchers’, they also noted how credibility checks were provided and audited by an independent researcher. Cooper et al. (2022a; 2022b; 2023) were also tentative in their conclusions but were explicit in noting that more than one researcher was involved in the process and determining the conclusions based on the study findings, they also noted that supervision procedures consistent with an IPA approach were used. Bruce et al. (2023), Maroney and Horne (2022), and Strang et al. (2018b; 2022) also reported their findings clearly, the conclusions were consistent with the themes generated, and the authors considered the wider implications of the research.

All the studies can be valuable additions to the area of interest. The intersectionality of being ATGD is a new area of study. The earliest study included in the meta-ethnography is Strang et al. (2018b). Other research pertaining to only one characteristic is more common as demonstrated in the initial searches for papers.

Data Extraction

The researcher read and re-read the studies and extracted data such as themes and quotes from the articles. This was then inputted into a Microsoft Excel spreadsheet. The researcher was then able to develop her own understanding of the themes presented in individual articles but also begin to link themes across them. This is displayed in Appendix 1D-E.

Phases 4-6 (Determining how the studies are related, translating the studies, and synthesising the translations)

The analysis process was non-linear and as such phases 4-6 are linked together. Following the process outlined by Noblit and Hare (1988) the researcher determined how the studies were related, translated the studies into each other, and synthesised the translations. However, as themes developed, morphed, and changed, in some cases several times, the spreadsheet was dynamic until it felt that no further themes would be identified (France et al., 2016). Moreover, even in later stages it felt appropriate to revisit initial codes and consider how initial interpretations had changed as new information changed previous ideas.

Figure 6 (Appendix 1F) details how data extracted from the studies were coded. As the researcher became more immersed in the process some themes were coded more than once, and in some cases where themes were not developing the researcher revisited them to determine how they fit. Links between papers were common such as autism being described as a barrier or a facilitator. However, others such as ‘Future can be varied’ a theme initially coded from the sub-theme of “I'm sure my gender will stay the same” within the major theme

‘Gender Exploration and Expansiveness’ were eventually removed due to their lack of support within their respective study and across the studies in the review. Strang et al (2018) explained their sub-theme as mainly supporting: “Gender as a constant throughout life” however the authors noted that few participants considered the possibility of gender changing in the future “I also know it can change over time, just like your sexuality can.” Strang et al (2018). This was removed due to a lack of support across studies.

This is further explained in Figure 7 (Appendix 1G) which outlined the initial themes/ codes which informed Phase 5. At this point quotes from the authors, and quotes supporting each theme were considered alongside the themes which led to some themes no longer being considered relevant or themes being grouped together. Figure 8 (Appendix 1H) shows how weaker themes were revisited with some merging into each other. For example, on refection the theme ‘assumption of autism meaning they are not transgender or experiencing gender dysphoria’ was merged with ‘autism as a barrier.’ Further analysis also led to revisions of key concepts and author quotes led to initial development of reciprocal translations. These are outlined in Table 9 and are also displayed in Figure 9 (Appendix 1I).

Table 9

A Table of Reciprocal Translations

Translation Number	Key Concept	Reciprocal Translation	Researcher's Comment
1	Autism as a barrier	Communication challenges, sensory difficulties, interpersonal difficulties, difficulties coping with change, difficulties making sense of neurotypical societal expectations, misread, diagnostic overshadowing	Factors related to autism are described as a barrier in being authentic to the self and having gender related needs met
2	Autism as a facilitator	Can see more clearly – more in tune with gender, liberated to live authentically (immunity to social norms/ freedom), understanding of autism aiding understanding of gender identity	Factors related to autism are described as a facilitator in understanding the self and being authentic to the self
3	Need for supportive relationships	Need for support and connection with others to aid understanding and exploration of gender, reduce impact abuse/ discrimination, connection and belonging important, fear of rejection may delay sharing identities	Supportive relationships, whether family or friends a key factor in sharing gender identity and wellbeing

4	Impact of environment and people	People as a negative influence – e.g., preventing or restricting gender understanding/ exploration, stressors across areas of life, experience of conflict, worries about abuse/ harassment, need to shield identity (work/ family), trigger of internalised transphobia/ self-blame	The impact of unsafe spaces and people who are not supportive a factor in reduce wellbeing e.g., suicidal ideation, low-self-esteem, trauma etc.
5	Need for support in transition	Transition viewed as a way of reducing feelings of gender incongruence, difficulties in transition such as accessing healthcare, people who are supportive in the process viewed positively	People generally see transition as a positive step but note barriers such as family/ accessing services
6	Adaptations to Autism needed	Meeting others who are ATGD viewed positively, spaces adapted for autism related needs seen as helpful, affirmative healthcare providers who are knowledgeable regarding autism viewed as helpful, need for practical support as well as psychological	Accessing services viewed as challenging, non-affirmative clinicians viewed as unhelpful, and a need for finding services that meet needs are wanted

Initially the above reciprocal translations felt sufficient, although it is noted that some had more support across the respective studies than others. The ideas were alike and could be linked together, a key element of the process of translation. As the analysis moved towards synthesis, and after the papers were re-read in respect of the above translations and after the researcher's discussion with their Academic Supervisor it was decided that based on the data it would be more logical to group some of the themes together. Autism as a barrier and as a facilitator were strong themes, although it is noted that Bruce et al. (2023) did not provide any support for the latter. The researcher reconciled this by noting that their paper explored ATGD identities in respect of accessing healthcare, and across all papers there were salient points regarding the challenge of this. Further discussions in supervision arrived at the consideration of themes 3-6 having commonalities and that this related to 'needing support and adaptations' related to being ATGD and wanting to do something whether it is sharing identity, accessing healthcare, or finding supportive people. To ensure nuances between the studies were not lost the themes 3-6 were included as sub-themes. The final three major themes are displayed in Figure 10 (Appendix 1J).

An example of how one of the themes developed is in displayed in Figure 11 (Appendix 1K), this was done by hand with paper copies however this has been typed to provide an example. Phase 7 – the last step involves sharing the findings which are explored in the results section.

Results

The meta-synthesis drew together data gathered from 167 people and reports three major themes, with four sub-themes also identified for theme three, these are displayed in Table 10 with each theme representing an aspect of the experience of being ATGD. They are also conceptualised within Figure 12 ‘A Tentative Model of the Lived Experience of Being ATGD’.

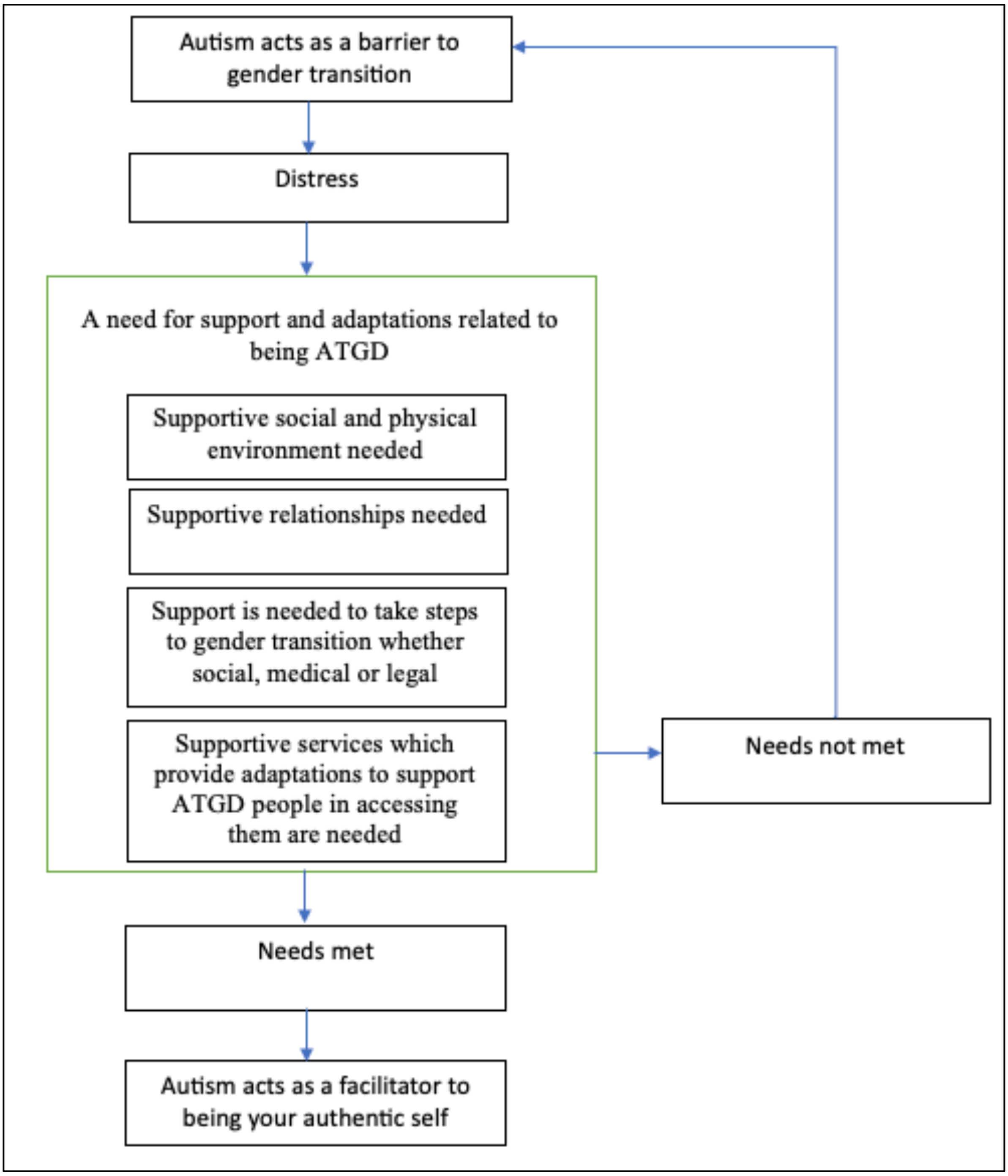
Table 10

Major Themes and Sub-Themes Identified from the Meta-Synthesis

Major Themes and Sub-Themes
1. Autism acts as a barrier to gender transition
2. Autism acts as a facilitator to being your authentic self
3. There is a need for support and adaptations to mitigate external and internal factors
3.a Supportive relationships are necessary
3.b The impact of the environment/other people can hinder wellbeing
3.c There is a need for support in gender transition
3.d Adaptations to services are needed to support ATGD people in accessing them

Figure 12

A Tentative Model of the Lived Experience of Being ATGD



First Major Theme

The first major theme was ‘Autism acts as a barrier to gender transition’ which was supported by all eight studies included in the review as displayed in Table 11.

Table 11

A Table of Quotes Supporting Theme 1: Autism acts as a barrier to gender transition

Study	**Quote supporting 'Autism acts as a barrier to gender transition'**
Bruce et al. (2023)	One participant explained how their doctor described medication and medical procedures in-depth but “after he found out I was autistic, he treated me like a toddler” p. 196.
Coleman-Smith et al. (2020)	‘…[Autism] makes it really difficult to say how I feel… I know lots of trans people who don't have a problem voicing their emotions, and how dysphoria affects them” p. 2648.
Cooper et al. (2022a)	“it’s just getting there, that’s the main thing for me” p. 7 in respect of practical barriers such as busy waiting areas, travelling to clinics, and sensory overload.
Cooper et al. (2022b)	“Being autistic is like everybody else has got the rulebook and you didn’t, so you can understand why gender would come into it because that was the rulebook you do not get” p. 969.

Cooper et al. (2023)	“I was stuck between having really bad gender dysphoria not wearing a binder or feeling really uncomfortable sensory wise” p. 270.
Maroney and Horne (2022)	“In trans spaces, it’s a lot less likely that I’m going to like find people who are going to know what it means that I’m autistic, so then I’m going to have to keep saying, you know sorry I’m so awkward, like, I’m autistic…” p. 8.
Strang et al. (2018b)	“I guess I’m not good at explaining it [gender] much to people and when people ask questions, I’m often over-whelmed by the questions” p. 4048.
Strang et al. (2021)	“I’m not sure how I’m perceived” p. 737.

Across all the studies autism was seen as a barrier although for different people this manifested in different ways. It was seen as a barrier and cause of conflict across more than one domain such as in understanding identity and in expression authentic self, as well as in sharing their experience of gender incongruence: “Kate: [Autism] makes it really difficult to say how I feel… I know lots of trans people who don't have a problem voicing their emotions, and how dysphoria affects them” (Coleman-Smith et al, 2020 p. 2648).

Participants reported barriers they associated with autism caused them to feel excluded: “Being autistic is like everybody else has got the rulebook and you didn’t, so you can understand why gender would come into it because that was in the rulebook you do not get” (Cooper et al., 2022b p. 969). Confusion and distress related to gender identity was common, and autism felt like a component in respect of those feelings.

Sensory difficulties related to autism were identified as an aspect of experiencing gender incongruence. This was also common in transitioning their gender identity with some participants identifying: “Sensory dysphoria” (Cooper et al., 2022b p. 968) as a barrier to reducing their distress. For example, the feel of items of clothing, the fit of clothing, challenges of menstruation and growing facial hair.

The social and communication difficulties typical of a person with autism were noted as a challenge by another participant: “…socializing and relating to others” and “a lack of spaces that are “specifically for people like me” (Maroney & Horne, 2022 p. 7). Participants spoke of wanting to access supportive spaces and people but felt this was either difficult for them due to autism or the space was not available to them.

In social situations there were specific difficulties related to autism that acted as a barrier to communication: “A lot of the social cue stuff is really annoying because you don’t pick up as much gender stuff I guess… It doesn’t help that I don’t know like how I’m seen socially… It’ll broadly be clear if I pick up on what are feminine or female social cues or mannerisms” (Strang et al., 2018b p. 4048). Finding it challenging to read people, or being unsure how they would be read was an important point raised in some studies, as participants were describing being left to make sense of things alone or left in limbo.

For some it was overwhelming to be asked to explain their gender related distress and can be especially challenging for young trans people: “I guess I’m not good at explaining it [gender] much to people and when people ask questions I’m often overwhelmed by the questions” (Strang. et al., 2018b p. 4048). This suggests that even when people take steps to access support they are reliant on clinicians being skilled enough to adapt their practice to meet need, however many described not having their needs met, feeling overwhelmed and not feeling capable of advocating for their autistic and gender-related needs.

Second Major Theme

The second major theme was ‘Autism acts as a facilitator to being your authentic self’ which was supported by seven studies included in the review as displayed in Table 12.

Table 12

A Table of Quotes Supporting Theme 2 Autism acts as a facilitator to being your authentic self

Study	**Quote supporting 'Autism acts as a facilitator to being your authentic self'**
Coleman-Smith et al. (2020)	"counteracts fears of negative perceptions, liberating the individual to live authentically according to their gender identity" p. 2647.
Cooper et al. (2022a)	"… it's not very complicated to me so I'm able to distinguish sex and gender and it's not like I look at it and get confused" p. 8
Cooper et al. (2022b)	"It's been such a relief to accept that there is something different about me and just try to do things in different way that works for me" p. 968.
Cooper et al. (2023)	"after having a diagnosis [of autism] a lot more of my experiences have come to light" p. 270.
Maroney	"… growing up I was always like a tom boy or a more butch girl or whatever… I had just never really internalized gender like

and Horne (2022)	properly because I’m autistic” p. 5.
Strang et al. (2018b)	“Because I interact with people less, there is less of a chance for people to insult me [about gender]” p. 4048.
Strang et al. (2021)	“There were descriptions of feeling less alone after “meeting others with similar ‘journeys’” p. 738.

Across the studies autism was also felt to be a facilitator toward ‘gender authenticity’ and their authentic self. In part due to less influence of others’ perceptions of gender identity but also in supporting a person’s own understanding of their gender identity and taking steps to make connections with others.

For some participants they felt that autism was a protector it: “counteracts fears of negative perceptions, liberating the individual to live authentically according to their gender identity” (Coleman-Smith et al., 2020 p. 2647). It was noted in that same study that: “Most participants felt their autism diagnosis (for most happening prior to their GD diagnosis) was integral to their developing understanding of their gender identity” (Coleman-Smith et al., 2020 p. 2649).

It was noted that autism can aid understanding of gender: “… it’s not very complicated to me so I’m able to distinguish sex and gender and it’s not like I look at it and get confused” (Cooper et al., 2022a p. 8). Some explained discomfort in needing to find explanations and accepting being transgender and autistic was helpful: “It’s been such a relief to accept that there is something different about me and just try to do things in different way that works for me” (Cooper et al., 2022b p. 968). Autism was viewed as playing a role in self-understanding “after having a diagnosis [of autism] a lot more of my experiences have come to light” (Cooper et al, 2023 p. 270).

Autism as “immunity to social norms”, and was felt to: “allow participants to live authentically and present as they wanted (e.g., haircut, clothes)” (Maroney & Horne, 2022 p. 5). With one non-binary participant stating: “… growing up I was always like a tom boy or a more butch girl or whatever… I had just never really internalized gender like properly because I'm autistic" (Maroney & Horne, 2022 p. 5). Labelling identities was also felt to be a "gradual relief".

Some adolescents described having a non-binary gender expression but still wished to be perceived as a binary gender: "I [a transgender young man] don't mind having hips because it makes it easier to dance" (Strang et al., 2018b p. 4049). Mostly participants in Strang et al (2018b) reported autism as being difficult, some reported positive impacts such as: "Because I interact with people less, there is less of a chance for people to insult me [about gender]." (Strang et al., 2018b p. 4048. The authors note that few participants considered that gender could change in the future: "I know that it can change over time, just like your sexuality can" (Strang et al., 2018b p. 4050). It is of note that finding groups where people were both autistic and transgender can be helpful for connecting and interaction: "There were descriptions of feeling less alone after "meeting others with similar 'journeys,." p. 738. This can help counteract feelings of isolation: "[I've learned] there's not just me in the world – I'm not the only one going through it – that is, transgender and autism" (Strang et al., 2021 p. 738).

Third Major Theme

The third major theme was 'There is a need for support and adaptations to mitigate external and internal factors' which was supported across the eight studies included in the review. This major theme combined four minor themes as displayed in Table 13. This was due to the authors interpretation during the analysis that these factors together related more broadly to a need for support and this was due to both internal and external factors identified because of being ATGD.

Table 13

A Table of Quotes Supporting Themes 3a-d: 'There is a need for support and adaptations to mitigate external and internal factors'

Sub-Theme	**Studies Supporting Sub-Theme**	**Quotes**
Supportive relationships are necessary	Coleman-Smith et al. (2020) Cooper et al. (2022a) Maroney and Horne (2022) Strang et al. (2018b) Strang et al. (2021)	"accessing supportive relationships/ environments was instrumental to enabling understanding and exploration of gender identity and providing a wider sense of belonging and so increasing personal congruence. These "precious" and "rare" relationships create the necessary preconditions for undertaking transition" (Coleman-Smith et al., 2020 p. 2647).
The impact of the environment/other people can hinder wellbeing	Bruce et al. (2023) Coleman-Smith et al. (2020) Cooper et al. (2022b)	"this guy attacked me and I was in a very vulnerable place 'cause, again, I had no idea, I just saw myself as male" (Cooper et al., 2022b p. 970).

	Maroney and Horne (2022) Strang et al. (2018b)	
There is a need for support in gender transition	Bruce et al. (2023) Coleman-Smith et al. (2020) Cooper et al. (2022a) Cooper et al. (2022b) Cooper et al. (2023) Maroney and Horne (2022) Strang et al. (2018b) Strang et al. (2021)	"I get that a healthy amount of skepticism is practically a pre-requisite for any scientific occupation but the amount of people I've had tell me that 'I'm not autistic' or that you know 'being transgender is just a phase' is kind of unflattering to the profession" (Maroney & Horne, 2022 p. 9).
Adaptations to	Bruce et al. (2023)	"Some point in the future, hopefully sooner rather than later, I'd like to have HRT [hormone

services are needed to support ATGD people in accessing them	Cooper et al. (2023) Maroney and Horne (2022) Strang et al. (2018b) Strang et al. (2021)	replacement therapy] or at least puberty blockers until I’m at an age where people think I can be trusted to make decisions. But HRT would be very nice” (Strang et al., 2018b p. 4047).

Sub-Theme 3a. Supportive relationships are necessary

Across several studies a need for support and connection with others to aid understanding and exploration of gender was identified, and it was felt that this was necessary. For example: “accessing supportive relationships/environments was instrumental to enabling understanding and exploration of gender identity and providing a wider sense of belonging and so increasing personal congruence. These “precious” and “rare” relationships create the necessary preconditions for undertaking transition" (Coleman-Smith et al., 2020 p. 2647). Coleman-Smith et al (2020) noted this was in part due to some feeling they were: “Reaching a Precipice” and needing to manage a: “sense of conflict with others who restricted their gender expression” (Coleman-Smith et al., 2020 p. 2650). For some this led to a point where they were no longer able to: “tolerate suppression and concealment,” by gender masking and in this instance accessing support such as from a GIC (Coleman-Smith et al., 2020 p. 2650). Supportive relationships were a factor in achieving gender authenticity.

Cooper et al (2022a) reported young people feeling “socially different” although they note young people often centred their narratives around their gender identity rather than autism. Maroney and Horne (2022) in their study reported that finding people who share similar characteristics such as TGD or autistic identities provided comfort, and in particular spaces where people do not feel a need to “mask”, or: “abide by arbitrary social norms” (p. 7), which may act to reduce experiences of isolation following incidences such as bullying.

Meeting others who are similar was felt to be validating: “like actually being able to ground things that you've read or talked to other people one on one who are in similar circumstance”" (Strang et al., 2021 p. 737). The author noted that being in a group was seen as helpful: “as a place to learn about and explore gender identity” (Strang et al., 2021 p. 737). Groups were seen as helpful emotional support: “I… come to get help – if I’m feeling down that day, it helps” (Strang et al., 2021 p. 738). Some young people described: “… the double wombo-combo of ASD and GD”, and the need to find people of shared identity and experiences (Strang et al., 2021 p. 738). In the same study some young people reported wanting to support and help others. It is noted by Strang et al (2018b) that one of their participants found that spending time in a group for people who are ATGD concluded with them no longer identifying as TGD.

Sub-Theme 3b. The impact of the environment/ other people can hinder wellbeing

The environment and the negative effect of interactions with people was also a sub-theme. Some felt the environment including societal and cultural expectations pertaining to gender and social communication was a source of distress, and for some they felt misunderstood, and, in some cases, this had left them vulnerable to abuse.

The effect of the environment was summarised in this response: “social environment is predominantly restrictive – it hinders understanding, exploring and expressing gender identity, amplifying or maintaining feelings of conflict underpinned by a lack of acceptance of neurodiversity and the dominance of cis-normativity in Western society” (Coleman-Smith et al., 2020 p. 2647). This was not helped by challenges in accessing healthcare support due to long-waiting lists at gender clinics and long distances to travel were also felt to be restrictive (Bruce et al, 2023),

The impact of autism was noted due to the impact in navigating the social environment, including social interactions and how they were treated by others: “[transition is] about having the courage to assert yourself, but you reach the point of not being able to not assert yourself anymore… I was already bullied at work, I was struggling due to my Asperger's… and to do anything that would make me more open to bullying… I couldn't afford that… I wouldn't have had the confidence to say 'right guys I'm not a woman" (Coleman-Smith et al., 2020 p. 2650).

Bullying and abuse were commonly experienced, and for some caused confusion as they did not understand why other people would perceive their gender identity differently to how they did: "this guy attacked me and I was in a very vulnerable place 'cause, again, I had no idea, I just saw myself as male" (Cooper et al., 2022b p. 970). Maroney and Horne (2022) noted that participants felt they needed to "shield" their identities due to "fear of discrimination and safety concerns". This was further described by Strang et al (2018b, p 4049): 'I just worry about being a total outcast". Suppression of gender expression felt to be necessary for safety but also a factor in maintaing distress.

Sub-Theme 3c. There is a need for support in gender transition

"[Autism] makes it really difficult to say how I feel… I know lots of trans people who don't have a problem voicing their emotions, and how dysphoria affects them" (Coleman-Smith et al., 2020 p. 2648). Often people preferred to conceal their gender feelings and distress. Participants in one study reported that transitioning was the: "lesser of two evils", with positive benefits associated with transitioning but leaving people feeling "fake" (Coleman-Smith et al., 2020 p. 2653).

The need for external support to physically transition was seen as frustrating: "…feels like I'm covered in like a thick coat of black paint that I can't get out of and when I'm sad like that, I feel trapped that I can’t get out of it and there’s nothing I can do… I have to wait for surgery which takes too long” (Cooper et al., 2022 p. 7).

It was felt that accessing support was a “Battle”, and a wish for the struggle: “to be acknowledged in their identities by people in positions of power”, and the negative impact of their communication difficulties in achieving this (Cooper et al., 2022 p. 970).

In relation to family, some reported acceptance of one identity but not the other: “… it hasn’t been good which is a little amusing given they are okay with me being transgender but not autistic”, and that family could show acceptance by providing emotional or financial support (Maroney & Horne, 2022 p. 8).

Finding support from practitioners who are knowledgeable and affirming of gender identity and autistic identity is challenging: “I get that a healthy amount of skepticism is practically a pre-requisite for any scientific occupation but the amount of people I’ve had tell me that ‘I’m not autistic’ or that you know ‘being transgender is just a phase’ is kind of unflattering to the profession” (Maroney & Horne, 2022 p. 9). Finding supportive spaces is considered difficult and accessing support such as medical intervention can help alleviate distress: “Especially since I’ve started hormones my dysphoria has been so reduced that I don’t really notice it anymore” (Strang et al., 2018b p. 4047).

Younger people reported specific needs such as practical assistance e.g., teaching such as: “advice on name changes and gender identifiers” (Strang et al., 2022 p. 736), was important as was advice on using make-up, passing as their preferred gender identity, voice, and learning how others perceived them.

Sub-Theme 3d. Adaptations to services are needed to support ATGD people in accessing them

Multiple barriers to accessing gender healthcare services were reported across the studies. In some cases, this was specifically due to challenges due to being autistic: “I feel like my autism kind of gets ignored in a way. Like I have the diagnosis. It’s on my file, but no one really bothers. No one’s really acted any kind of differently towards it. With my autism I need kind of things explained and stuff like that. You can’t talk to me very professionally, otherwise I won’t understand and that kind of stuff. They just make no alterations at all” (Cooper et al., 2023 p. 271). Multiple suggestions were given by the authors such as “changes to the structure of appointments, clinic environments and clinician communication style.”

Suggestions for adaptations were also posited: “affirming experiences with providers were those who validate their experiences, were supportive and non-judgemental, and viewed their clients as experts”, and also: “emphasised the importance of affirming language, such as using clients’ pronouns, name, and being “up to date [on] lingo,” (Maroney & Horne, 2022 p. 9). It was also noted that clinicians understanding of diversity across identities, being explicit about processes and being aware of sensory needs was helpful. Fears of gatekeeping by gender clinicians was common: “’Am I personing in a way that will get me gatekept away from this?’ because there’s always that fear too” (Bruce et al., 2023 p. 196). Young people within the Strang et al. (2018b) study reported a wish for HRT: “Some point in the future, hopefully sooner rather than later, I’d like to have HRT [hormone replacement therapy] or at least puberty blockers until I’m at an age where people think I can be trusted to make decisions. But HRT would be very nice” (p. 4047).

Needing support to understand how to express gender identity and to share their TGD identity was common as people felt unskilled to do this: “[I want to learn] how to pass” (Strang et al., 2018b p. 737). Being aware of the specific needs of young TGD people, and providing teaching sessions is seen as helpful, as was recognising medical gender needs: “will someone please just tell me how to get rid of this thing [genitals]” (Strang et al., 2021 p. 737). Specific interventions identified included addressing ‘scripts’ and supporting flexible thinking which can support young people in exploring their gender identity without judgement. Informal aspects of meeting in a group are also seen as helpful such as: “hanging out”; “chatting”, and “the group is basically a rag-tag bunch of misfits, so you’d basically have to be trying not to fit in” (Strang et al., 2021 p. 739).

The meeting of needs related to having a supportive social and physical environment and relationships during transition. Adaptations by services also felt important in meeting needs. All of these were factors in autistic traits being a facilitator towards their authentic selves. When needs were not met, due to a lack of support, or a perceived lack of support, this seemed to result in distress and affected wellbeing. Autism was felt to act as a barrier when needs were not sufficiently met.

Discussion

Due to the area being new, all of the research added value by providing data from a first-person perspective as this is currently lacking in peer-review publications.

This review of data using the meta-ethnographic method of Noblit and Hare (1988) has followed the systematic process of synthesising the qualitative findings across eight studies relevant to the experience being an ATGD person.

Across the studies the themes that emerged are interrelated, with shared challenges relating to being ATGD. It has been previously noted that being autistic can have a negative impact on wellbeing (DePape & Lindsay, 2015). In this review it emerged throughout the studies that traits related to autism such as communication difficulties were perceived as making it harder to express gender related distress, whether with people close to them, or with professionals and subsequently having their needs met. Difficulties in accessing healthcare due to autism have been identified in previous studies (Lewis, 2016), and adaptations in gender identity clinics may be helpful in reducing distress (Nicolaidis et al., 2015).

Autism could also be perceived as a facilitator to being an ‘authentic self’ and in achieving ‘gender authenticity’. This was also related to autistic traits such as being less attuned to, or interested in other people’s perceptions, thus reducing concerns about achieving gender related stereotypes and cultural norms. This is consistent with Jack (2012) who reported that being autistic could act as a protector as people felt able to conceptualise gender away from cisnormative stereotypes.

Of note is the need for support and adaptations to mitigate external and internal factors. This was multifaceted and, in some cases, these are likely barriers in autism being a facilitator in living authentically. For example, needing supportive relationships as a way of obtaining a safe space to explore gender identity and to mitigate against abuse and discrimination. The external environment and people acted as a source of potential distress due to worries about abuse and harassment (as noted in a report by GALOP, 2020), and oftentimes leading to the concealing of gender identity. One way of making sense of this could be the minority stress model (Meyer, 2015) which proposes that being in a minority can have negative implications, in this instance not being able to live authentically and wishing to conceal identity to prevent or limit distressing experiences, such as by 'gender masking'. Due to the reasons explained above this often meant a need for support during gender transition, which was viewed as a positive step to reducing gender related distress.

Adaptations due to being autistic were highlighted as important due to the challenges in accessing services. This was linked to needing clinicians to not make assumptions, particularly in relation to unhelpful discourses such as their gender related distress being a component of autism, which is consistent with research recently published (Moore et al., 2022). Participants reported feeling invalidated by assumptions and highlighted the need for adaptations to be made to help them to verbalise their distress and access interventions (Coleman-Smith et al., 2020). Adaptions could include support with communication as this has been noted in other studies as a barrier to accessing healthcare (Nicolaidis et al., 2015), as well as developing clinicians to have specialist knowledge to meet the needs of people with autism (Adams & Young, 2021).

Clinical Implications

The findings of this meta-synthesis suggest that healthcare providers should recognise the impact of autism in the context of client's also experiencing gender incongruence, recognise this both as a barrier and as a facilitator and the importance of contextual factors such as the presence of supportive relationships. Identifying a persons' current experience of, and/or worries about their environment and contact with people may also be a useful way of developing a holistic care plan and in establishing whether they feel they need to 'gender mask'. For example, if they are concealing their gender identity due to concerns about their ability to understand how they will be perceived by others or concerns due to transphobia this should be considered in respect of psychological interventions aimed at improving wellbeing, and how physical changes and interventions can be managed safely. Support may be requested to meet goals around 'gender authenticity', however the environmental context should be considered, and discussed particularly if this hasn't been previously considered by the person.

Social connection was important across the studies; it was highlighted that accessing spaces with similar people, and with appropriate adaptations to address barriers such as quieter venues were seen as supportive in providing a space for people to explore identity (Strang et al., 2018b; 2022). This was particularly present in the adolescent participants across the studies, and therefore the provision of safe spaces may be a helpful addition to clinical provision in healthcare, or in the community sector. Specific adaptations for autistic people should be made to improve access to services such as considering the sensory impact of the environment, spreading appointments to avoid over-loading a person with questions, and 'chunking' information, though the healthcare needs of autistic people has been on the NHS agenda for some time (NHS England, 2022). This is important in reducing discrimination and disadvantage that may be experienced by an autistic person accessing a service, and under The Equality ACT (2010) is also a legal requirement (Legistlation.gov.uk, n.d.). Healthcare providers could also provide tailored groups to address difficulties such as practical barriers to transition, and psychological interventions directed towards addressing cognitive difficulties such as ‘scripts’ and concrete thinking in relation to gender identity. The studies also highlighted a need for an affirmative approach such as the use of preferred pronouns.

Strengths and Limitations of the Meta-Ethnography

Although only eight studies were utilised, this is an emerging area of research and as such this review can be seen to be comprehensive, although as the field matures, further reviews will be necessary to assimilate new data. The review does not include grey literature which could provide a new insight into the population, particularly if there is a publication bias in this field, although the impact on the results of the meta-ethnography can only be speculative (Hopewell et al., 2007). The current review included both adolescents and adults, and although there are multiple crossovers in experience, it would be preferable to separate these formally to extrapolate age-related needs. This review should also be viewed in the cultural context in which the data was collected, this was mostly within Western societies and future research would benefit from exploring other cultures. Even within Western societies there can be differing approaches to transgender healthcare. For example, the studies highlighted a need for an affirmative approach such as the use of preferred pronouns. Though there is a lack of follow up data to establish whether or not this approach is supported. Affirmative approaches are not currently supported by the literature, and there is variance between countries in what this means in practice which will have influenced this review as studies from the UK and USA were included (Coyne et al., 2023; Levine & Abbruzzese, 2023). However, conversion therapies are not supported either (GOV.UK, 2021). There may be nuances and implications in other demographics including but not limited to religious beliefs, ethnicity, and disability. In wider cultural contexts, theories around neurotypical and heteronormative narratives may also be useful considerations in the application of this review into clinical practice (Jack, 2012; Oswald et al., 2021; Pyne, 2021).

Conclusions

The experience of being ATGD has numerous challenges, including in accessing healthcare, and the co-morbidity of both identities can be a factor in poorer mental health. However, adaptations to healthcare and a focus on finding appropriate support networks were viewed as useful across the studies. Future studies exploring this topic would be of benefit to clinical practice.

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The Empirical Paper: What is the experience of adults with a diagnosis of Gender Incongruence at an NHS GIC (Gender Identity Clinic) in England who have sought treatment, but decided to detransition, or retransition during the treatment pathway?

Abstract

Introduction

Some people who experience gender incongruence, comprised typically of feelings of gender dysphoria, will refer to a GIC to access medical interventions to align their body with their gender identity (NHS England, 2013). Recent research has noted the phenomenon of people pausing or stopping (detransitioning) their gender identity following a period of transitioning, with studies in the UK suggesting this is prevalent in around 1-6.9% of cases (Hall et al., 2021; Richards & Doyle, 2019). Although some studies have noted detransition, or pausing and/or stopping, may not be wholly attributable to the cessation of feelings of gender incongruence but rather difficulties external to them (Turban et al., 2021), this area is still largely under researched.

Methods

Participants were recruited from an NHS GIC and were interviewed about their experience of pausing or stopping transition, and in some cases transitioning again. Interviews were transcribed and analysed utilising IPA methodology (Smith et al., 2021).

Results

Five participants took part in the research study, all had been assigned male at birth. Two participants had stopped gender transition and did not have any intention to transition again, one had paused and wishes to transition again, and two had already begun to transition again. There were four main themes: 1. A *sense of difference from childhood*; 2. *Gender transition is challenging in multiple ways;* 3. *Conflicts are experienced*, and 4. *Stopping transition has challenges and benefits*.

Discussion

Gender transition is a varied experience and people experiencing this have multiple needs. Psychological support is viewed as beneficial and helpful in navigating the challenges of transition, and in pausing and stopping transition. GIC’s should consider the dynamic nature of transition in clinical decision making and offer adequate medical and psychological support.

Introduction

Around 262,000 people in England and Wales have a TGD identity (Office for National Statistics, 2023). TGD is an umbrella term which encompasses a broad spectrum of gender identities where a person feels their gender identity is not congruent with their sex-assigned at birth (Stonewall, n.d.; WPATH, 2022). Often TGD people report experiencing unease that there is a mismatch between their assigned sex at birth and their gender identity and they may decide to medically transition their gender identity via the NHS to reduce their distress (NHS England, 2013).

Gender transition whether medical or otherwise, is not restricted to a binary experience of gender. Some people may identify their gender in a non-binary way; they may identify with both male and female genders, or neither. For some, gender may be experienced more dynamically and fluidly with gender identity and expression changing depending on their experience at the time. There are many ways in which gender can be expressed, without rules, and without limitations (Richards et al., 2016).

Gender transition can be a non-medical process such as a ‘social’ transition whereby a person makes changes to their gender expression; they may change their name or use different pronouns. They may choose to do this all the time, or only with specific people or situations. However, the personal impact of social transition is poorly understood at present but an emerging area of interest (Morandini et al., 2023).

Some people may wish to access support via the NHS for distress caused by gender incongruence, and of these some may wish to pursue a medical transition to align their body with their gender identity. Current NHS guidelines (NHS England, 2013) require a person to have received two independent diagnoses of Gender Incongruence – the official diagnostic term given to someone who has experienced a persistent incongruence between their experience of gender and assigned-sex (ICD-11, 2017), before they can access medical interventions. Recommendations for medical interventions must follow national guidelines (NHS England, 2013; RCPSYCH, 2013).

Some supporters of trans rights disagree with the current ‘gatekeeping’ model in relation to medical transition and instead support an informed consent model of care that would effectively remove this process, in part due to long waits to access support (Pearce et al., 2020). Also, negative experiences accessing gender-related care have been reported (Ellis et al., 2015). Fundamentally though current waiting lists are long and viewed by patients as unsatisfactory (Wylie et al., 2007).

There are long-waiting lists even to access psychological support via an NHS GIC which may be a factor in why some choose to access psychological support locally. Within the ‘Minority Stress Model,’ it could be speculated that in the current culture trans people may be experiencing higher levels of mental health difficulties (Meyer, 1995). Research suggests that accessing psychological and medical interventions via a GIC can be beneficial for improving co-morbid difficulties common in the patient population such as anxiety and depression, however people report anxiety in accessing services (Coleman et al., 2012; White Hughto & Reisner, 2016). This is further augmented by a study reporting many TGD people have endured negative experiences accessing healthcare services (McNeil et al., 2012), although those who receive affirmative approaches view this as more helpful (Hunt, 2013). Research demonstrates that TCC (Trans Community Connectedness) could be a factor in wellbeing and being more connected to the trans community may mean better overall psychological health (Pflum et al., 2015).

The long waiting lists alongside negative healthcare experiences within the NHS may be a factor why some people may access medical interventions such as HRT or surgery privately, or via the internet (Rotondi et al., 2013). Not everyone who experiences gender incongruence will access any support, with some choosing to keep their TGD identity and/or gender incongruence hidden, or tentatively 'coming out' and navigating the social and cultural difficulties that they may experience (Brumbaugh-Johnson & Hull, 2018).

For those who wish to access support from the NHS they are referred to a GIC. GIC's can offer psychological support, speech and language support, and support people to make more permanent changes through a 'medical' transition such as gamete storage, having facial hair removal, hormonal interventions and gender affirming surgeries (RCPSYCH, 2013).

Aside from social and medical transition, some TGD people will also follow a 'legal' transition to have their gender legally recognised under the Gender Recognition Act (Legislation.gov.uk, 2004). Gender specialists, clinicians who specialise in working with people with gender incongruence can also support patients in applying for a Gender Recognition Certificate (HM Courts and Tribunals Service, 2021). This legal process has also been criticised as a gatekeeping and dehumanising approach to self-expression and self-identification by TGD people (Florence, 2019).

There has been considerable interest in gender transition in the media with concerns raised about the process of gender transition, however there are also concerns that 'anti-trans' narratives are becoming more dominant within a polarised and politicised climate (Slothouber, 2020). Some people have advocated for a different, or broader approach to the current process of transitioning due to concerns that people will regret their transition (Entwistle, 2021; Withers, 2020), and for further research and services to support those who detransition (Butler & Hutchinson, 2020). Although at present there is an absence of empirical evidence to support this view or provide an alternative narrative or explanation for why there is variation in how gender identity is experienced and what this means for healthcare providers.

Detransition

Most TGD people who transition their gender via NHS pathways are discharged from GIC's and do not need further support (Dhejne et al., 2016). Some TGD people may decide they wish to detransition. Gender detransition is the process of re-identifying with one's assigned sex at birth following a gender transition, although within the literature there is variance in what constitutes detransition (Expósito-Campos, 2021). Some of the studies report this as being a process that can occur following medical interventions e.g., taking HRT or having gender-affirming surgeries, whereas others use the term more broadly to include anyone who has ever identified with a TGD identity and then re-identified with their assigned sex at birth. Detransition and/ or regret are suggested as being unavoidable phenomena as people are unable to find spaces to explore their gender identity and access support to fulfil gender related goals (MacKinnon et al., 2021). Nevertheless, a recent review of regret after gender affirmative surgeries reports the regret rate as being <1% (Bustos, et al., 2021).

Expósito-Campos (2021) make a distinction between the phenomena of detransition and desisters. They report detransition as a process that can occur after a social or medical transition. Whereas desisters are those who may have experienced symptoms of gender incongruence and/ or identified with a TGD identity but have reverted to their assigned sex prior to having any social or medical interventions. The probability of multiple narratives that cross-over between both phenomena cannot be discounted, and Expósito-Campos (2021) raise the possibility of 'transitional periods' as part of someone's identity development. This raises the question of what can be 'reversed' and whether desistance is something that happens prior to undertaking any steps which result in permanent physical changes, with detransition pertaining to acts which do.

There are few data at present regarding detransition. There have been some case studies including one by Levine (2018) who reported the case of a person who had spent 31-years living full time as a transgender woman before making the decision to return to their assigned male sex. They had taken HRT but had not had surgery due to concerns about taking time away from work. Korpaisarn and Modzelewski (2019) published a case study of a 29-year-old female who lived as a transgender male for 10 years. They began to transition at age 16 and at age 17 had HRT, and at age 19 had a mastectomy and then at age 20 had a hysterectomy-oophorectomy. At age 25 following hospitalisation due to schizophrenia, they then detransitioned. Further case studies have been published, one providing an outline of a young woman who transitioned to a transgender male identity and then detransitioned following two-years taking HRT (Marchiano, 2021), a reflective report following therapeutic intervention with a trans man who detransitioned (D'Angelo, 2020), two case study outlines (Expósito-Campos et al., 2022), and a case study of a woman who transitioned to a transgender male identity and then detransitioned and experienced regret following surgery due to the impact on their ability to breastfeed (Gribble et al., 2023). Although case-studies can be a useful way of sharing clinical practice, they are not generalisable and therefore the clinical applications are limited. However, they are thoughtful accounts which can inform future research endeavours.

An audit of TGD people in a UK medical practice reported four instances of detransition out of sixty-eight TGD people (practice prevalence of 337/100,000). Of these four transgender males, one wanted to gradually detransition (although unclear how this affected their gender identity), one no longer wished to live as a male – again it is unclear if they re-identified with their assigned-sex or not. One did decide to re-identify with their birth sex, however another felt transition was a mistake and was identifying their gender as non-binary. Four other people had stopped HRT but had continued to identify with a TGD identity (Boyd et al., 2022).

A clinical audit conducted by Richards & Doyle (2019) at a GIC in England found that out of 303 active case files, there was one instance of detransition. They report that this person went on to re-transition three-years later and had cited a lack of support from their spouse as the reason for detransitioning. In two other case files there were retrospective data of two other people detransitioning prior to attending the GIC. One of these people had transitioned three times and had also cited a lack of support from family. The other had detransitioned and then transitioned again for the same reason. In total this equated to a detransition rate of less than one percent (Richards & Doyle, 2019).

It is important to consider the above audit with caution, only a proportion of active case files were reviewed, it has also been suggested that those wishing to detransition may not directly contact GIC to share this information (Littman, 2021). It could also be suggested that detransitioning may not happen whilst someone is under the care of the clinic but rather following discharge. Regardless, this audit provides a provisional insight into the likely complexity that is detransition and highlights the difficulties some patients have in accessing interventions due to a lack of social support. A subsequent retrospective case notes review of people discharged across a yearlong period conducted in the UK reported a higher detransition rate of 6.9% (Hall et al., 2021).

A recent mixed-methods study in the United States found that from a survey of 27,515 TGD people, 17,151 (61.9%) had pursued gender affirmation. 2242 (13.1%) reported a history of detransition, and of those 82.5% reported at least one external factor as a main reason e.g., lack of support from spouse or family. 15.9% of respondents reported at least one internal factor as a main reason for example fluctuations and/ or uncertainty regarding gender identity. The study also found a history of detransition was associated with a having an unsupportive family, a male sex assigned at birth, a non-binary gender identity and bisexual sexual orientation (Turban et al., 2021).

The above study reports detransition as being prevalent for 13.1% of the sample, much higher than reported in Richards and Doyle (2019). One reason for this may be due to people no longer being under the care of a GIC, although this is not reported, and pursuit of gender affirmation is broadly defined and therefore is not exclusive to medical and psychological interventions traditionally offered in GIC's. The study also does not report how many of those who had detransitioned, then decided to retransition. As had previously been reported those who detransitioned due to external factors may be more likely to retransition but this is not differentiated between or from those who detransitioned due to internal factors.

Guerra et al. (2020) from research conducted in Spain report 8 cases of detransition out of a cohort of 796 people. They note variance in narratives reported, and demonstrated the non-linear journey that people may have and highlighted the focus on medical interventions (both by clinicians and the people studied), which for some people may not be the most beneficial intervention. The data presented in case-study form helps provide more context to the research area, however, it would be useful for a formal methodological approach to be used to improve standardisation and reduce potential researcher bias.

Expósito-Campos (2021) to consolidate the existing research suggests detransitioners can be split into core and non-core groups. In core gender detransitions the decision to detransition is due to the cessation of a TGD identity. Whereas in non-core gender detransitions the decision to detransition is motivated by external factors not related to the cessation of a TGD identity e.g., health concerns, lack of social support etc. This differentiation is supported in part by early research into reasons for detransition, although this is a binary approach to detransition and may be more complex than this model currently allows.

More recently Vandenbussche (2021) conducted a survey of 237 people who had detransitioned, they report that there were complex psychological needs related to gender dysphoria, comorbid conditions, feelings of regret, internalised homophobia, and sexist prejudices. It was noted that there is a need for support for stopping/ changing HRT as well as with accessing reversal interventions such as surgery. Their results also suggest that social support was a crucial factor in recovery. One of the limitations of this study is that it does not indicate overall prevalence of these difficulties but is able to highlight some of the difficulties faced by those detransitioning and offers insight into the support that could be offered.

An online survey of 101 people who reported they had detransitioned reported assorted reasons for their decision including 65.2% (*n* = 45) of assigned female at birth respondents reporting that they became more comfortable identifying as their natal sex, compared to 48.4% (*n* = 15) assigned males (Littman, 2021). The methodology of this study is of concern, partly due to there being no control in ensuring people, or the information being given was genuine especially at a time when this is a divisive issue.

Currently few qualitative studies exist and the experience of people detransitioning is poorly understood making it challenging for clinicians to offer appropriate interventions. A qualitative study utilising constructivist grounded theory methodology sampled 28 people who reported multiple reasons for detransition including: health concerns, and a change in their understanding of gender identity. However, not all people reported feeling regret, but the challenges of medical transition were noted as problematic (MacKinnon et al., 2022). The study included people who reported a social, legal, or medical transition, and thus used a broad definition of detransition which they explain is consistent with the current body of research. In respect of the people studied all were self-identifying as stopping transition which reduces the reliability of the data as there was no control for individual definitions of detransition or ensuring that the experiences they were describing had in fact happened.

More recently a qualitative study utilising reflective thematic analysis methodology conducted interviews with 20 young people aged 16-25 and report the process of detransition can be non-linear and varied. For example, some reported feelings of anger and mistakes, some reported nothing would have prevented them from transitioning (Pullen Sansfaçon et al., 2023). People were recruited using snowball sampling and the study coordinator verified that they had detransitioned from a social, legal, or medical transition however it is unclear how this was done. Another limitation of the sample is that 19 out of 20 people included were assigned female at birth, and only one person assigned male at birth is represented. However, they used people from multiple countries and therefore likely capture a range of perspectives across cultures.

Retransition

Further research into detransition is necessary to understand this experience, but also to understand factors related to people who retransition. Retransition being the process followed by a small number of people who have transitioned their gender identity, detransitioned and then made the decision to transition again. A recent study found 23 out of 317 reported having detransitioned, with some reporting a retransition to a new gender identity e.g., non-binary (Durwood et al., 2022). They interviewed 15 young people and used thematic analysis to analyse interview transcripts and noted that none of the people studied spontaneously shared any regret regarding their initial transition. In a similar study utilising the same people which examined the rates of detransition and current gender identities it was reported that out of 317 young people 7.3% had detransitioned at least once (Olson et al., 2022). They concluded that detransition is infrequent.

Further research to understand how best to understand the needs of people experiencing these unique phenomena are also needed (Turban & Keuroghlian, 2018), as currently protocols do not exist to support those wishing to detransition or retransition (Butler & Hutchinson, 2020). Some have suggested that current healthcare simply focuses on medical transition (Shepherd & Hanckel, 2021) and although psychological support is provided in GIC’s, some feel this should be more embedded. As detransition is a relatively new phenomenon Hildebrand-Chupp (2020) suggest research on this topic should involve people who have detransitioned to better understand the experience, and the most reliable ways of capturing valid data.

Aims

The aims of the current study are:

- To understand the experience of transitioning gender identity when a patient has then decided to pause, stop, or reverse their transition (detransition).
- To understand the experience of then re-continuing gender transition and/or reversing the process of detransition (retransitioning).

Research Question

What is the experience of adults with a diagnosis of Gender Incongruence at an NHS GIC in England who have sought treatment, but decided to detransition, or retransition during the treatment pathway?

Method

This is a qualitative study utilising IPA methodology (Smith et al., 2021). IPA was identified as the most appropriate method due to the aim of the study being to learn about the experience of pausing or stopping transition, and how people made sense of this. IPA being committed to phenomenology and sense making meant this was an appropriate approach. IPA has theoretical underpinnings rooted in idiography, phenomenology, and hermeneutics. The idiographic focus pertains to the study and understanding of unique and subjective phenomena. Phenomenology relates to the study of an experience. Hermeneutics relates to how the researcher interprets and subsequently develops meaning. Double-hermeneutics is a feature of IPA and relates to the situation whereby the researcher interprets and tries to make sense of the experience that is shared by the participant (Smith et al., 2021). Further information was gathered about participants such as their demographics and GIC pathway, as a relatively new area of research, it was felt this was necessary to more fully understand the context of the participants.

Ethical Approval

Guidance and ethical considerations relating to conducting research with TGD populations were consulted prior to conducting the research (Adams et al., 2017). Vincent (2018) proposes that research with TGD populations should be transparent, take into consideration the history of TGD people, understand the significance of nuanced language use, and be respecting of TGD persons' spaces.

To meet these standards two EBE with experience of being patients under a GIC supported the research from the development of the research question, until the end of the study

(Hildebrand-Chupp, 2020). This was to ensure that the rationale for the research was acceptable to the TGD community. The EBE also provided accountability to the research, and in the management of the research to ensure it was inclusive.

It is noted here that our EBE preferred the terms ‘paused’ or ‘stopped’ in relation to detransition, with ‘paused’ referring to those who intended to transition again, and ‘stopped’ for those who did not intend to pursue a transition.

Ethical Approval was sought and granted from The University of Birmingham (Appendix 2A) and from the Health Research Authority, 307378 (Appendix 2B). Local approval was sought from a Healthcare Foundation Trust’s Research and Innovation Department (Appendix 2C).

Reflexivity Statement

The author is a cisgender woman who has worked as a Senior Assistant Psychologist in an NHS GIC and takes a critical realist position. Critical realism takes the stance that there is something that can be known, and those experiencing this are able to share their interpretation of it, which in turns helps the researcher to make sense of new and novel phenomenon. Critical realism is concerned with people’s reality, and the verbal interactions between the researcher and participant helps the researcher to connect to the participants’ reality which makes the use of IPA appropriate (Danermark et al., 2002; Lyons & Coyle, 2021).

Drawing on the authors’ clinical experience working within a GIC, and based on the current research evidence base they are inclined to think that 'detransitioning' is a highly personal process. For some the process of transitioning may not feel possible due to external factors and they may detransition. For others this may be an internal change, and can lead to reverting to their assigned sex at birth, or toward another gender identity, and this experience may be a source of regret and distress or conceptualised as part of their journey in making sense of their gender identity.

To ensure quality within the study the researcher, the Academic and Field Supervisor's discussed their own positionality and their views regarding gender identity, and explored the possible impact of these, and the potential implications during data interpretation (Mason-Bish, 2019). The researcher also attended specialist IPA workshops including discussions and reflections with peers, kept a reflective diary, and had regular supervision to limit bias and ensure the IPA process was being followed. Alongside this the author followed the four quality indicators as identified by Nizza et al (2021). This included ensuring that a compelling narrative was constructed, a vigorous experiential account was developed to give meaning to the participants' experiences, there was a close and analytical reading of the participants' words to give meaning to the data, and the author attended to convergence and divergence to interweave similarities and differences.

Participants

It was important to the design of the study, in particular the homogeneity necessary for IPA (Smith et al., 2021), that participants had followed a similar trajectory within an NHS GIC, and that this could be verified by the GIC. This was to ensure that the people who took part in the study had experience of pausing or stopping following the commencement of a medical transition. Participants were convenience sampled by the GIC from a database of all known patients who had paused or stopped.

To be eligible to take part in the study participants had to be aged 18 or over. Participants were only accepted to take part in the research if they had received two independent diagnostic appointments and received a diagnosis of Gender Incongruence or its historical equivalent (ICD-11, 2017). Participants must have had the capacity to be able to provide informed consent and be fluent in English or were able to be supported by a translator (none of the participants needed this). Having a mental health difficulty or taking any related medications did not exclude a participant if they were deemed able to provide informed consent. Participants must have paused or stopped following the commencement of hormonal interventions. Due to recent research highlighting the dynamic nature of some people's experience of transitioning their gender identity, this study includes those who may have, or wish to retransition (Richards & Doyle, 2019).

Participants were recruited via the NHS GIC via a Participant Contact Form (Appendix 2D) and provided with a Participant Information Sheet (Appendix 2E). All eligible participants were convenience sampled via an NHS GIC and contacted by the GIC to ask if they would like to take part in the study. If they decided to take part in the study, they completed an Informed Consent Form (Appendix 2F). Following participation, a letter was sent to the participants GP with a summary of their involvement (Appendix 2G), this was a recommendation made by the ethics committee from the NHS HRA and participants could opt out during the informed consent process.

Procedure

Due to GIC's being national providers, and their patients living across England it was decided that the study should be conducted via the online platform Microsoft Teams. This was to reduce barriers to participation.

Once prospective participants contacted the researcher, a time was arranged to meet online to conduct the study. The researcher ensured the participant understood the study procedure and then asked for their informed consent, which was returned via email.

Initially The Participant Questionnaire was completed, this covered various details including the participants' demographics and experience whilst a patient at the GIC (Appendix 2H). Following this an interview was conducted which was recorded on an NHS approved encrypted Dictaphone. The Interview Guide was developed to explore the experience of transitioning gender identity, pausing, or stopping transition of gender identity and, if relevant, retransitioning gender identity (Appendix 2I). As each participant was unique, and the questionnaire raised points of interest to their experience, prompts were used.

After the interview was completed, participants were debriefed and asked if they wanted to receive a summary of the research findings after the completion of the study. Participants were sent a £20 voucher; however two did not want to receive this. At this point all information was stored securely for seven-days to allow participants time to withdraw from the study if they wished to do so.

When seven-days had passed the researcher, with the consent of participants contacted the GIC to request they complete a questionnaire about the participant (Appendix 2J). This included information about their trajectory on the NHS pathway for assessment and interventions relating to gender transition. The researcher also transcribed the audio file, pseudonymised it by removing any identifiable information, stored it securely on an encrypted University server, and then deleted the audio recording.

Analysis

Data were analysed using IPA (Smith et al., 2021). Initially each transcript was read and re-read, and notes were made by hand. This happened sequentially so each participant's transcript was initially analysed in isolation to maintain individual voices. These were then checked by a member of the research team and during specialist workshops. Following this the researcher began noting the transcript, and initial experiential Statements were assigned (See Table 14 for an exert of participant 4's transcript with initial notes and experiential statements: Appendix 2K). Experiential statements displayed with supporting quotes are displayed in: Table 15. Table of Participant 4's experiential statements with Supporting Quotes (Appendix 2L). Then PETs (Personal Experiential Themes) were developed (Table 16. Table of the Development of Participant 4's PETs, Appendix 2M). After this they were discussed and agreed with the Academic Supervisor. Finally, these were developed into GETs (Group Experiential Themes); Table 17 The Development of GET 'Gender transition is challenging' (Summary), Appendix 2N). The researcher discussed the conclusions with reference to the information recorded in their reflective diary to further ensure quality assurance (Elliott et al., 1999). Once completed the data were archived and will be kept for ten-years in line with procedures outlined by The University of Birmingham.

Results

Participant Characteristics

Participant characteristics are outlined in Table 18. Five people took part in the research study and were all assigned male at birth. They had an age range of 28-73 (*M* = 52; *SD* = 18.79) at the time of the study, and a range of 21-70 (*M* = 45.6, *SD* = 19.53) at the time of their respective referrals. Two participants had stopped transition with no plan to retransition. Two had already begun to transition again following a period of pausing. One had paused but intended to transition again in the future.

Table 18

Participant Characteristics

Participant Number	Current Situation	Pronouns	Gender Identity	Sexuality	Age When Referred to GIC	Current Age
1	Stopped	He/Him	Gender non-conforming man	Gay	21	28
2	Stopped	He/Him	Male	Asexual	54	63
3	Paused	‘I don’t know’	Non-binary	Attracted to Women	52	59
4	Started transition again	They/ Them	Non-Binary	Bisexual	31	37
5	Started transition again	She/ Her/ ‘Don’t Bother’	Both as transitioning/ Female	Asexual	70	73

Participant 1 reported stopping transitioning from a transgender woman gender identity to a ‘gender non-conforming man’ identity and were using he/him pronouns. He reported his sexuality as ‘gay.’ Participant 2 reported stopping transitioning from a transgender woman gender identity to their assigned-male sex, utilising he/him pronouns. He reported his sexuality as ‘asexual.’ Participant 3 who had paused transition reported their current gender identity as ‘non-binary’ but reported a wish to transition to a transgender woman gender identity. Pausing their transition, they reported ‘I don’t know’ when asked what pronouns they used, and when asked about their sexuality they reported they are attracted to women but were unsure how to conceptualise that in relation to their ‘paused’ gender identity. Participant 4 who had begun to transition again reported a non-binary gender identity, and the use of they/them pronouns, they described their sexuality as ‘bisexual’. Participant 5 reported her gender identity as ‘both’ – referring to binary gender identities as she is transitioning to a transgender woman identity and felt this was a process towards her identity which she felt she had not yet reached. She reported her pronouns as ‘she/her’ but reported they ‘don’t bother’ with pronouns. She reported her sexuality as ‘asexual.’

Further information of participants’ history and experience is provided in: Table 19 Participant Questionnaire Demographics, Table 20 Characteristics of gender transition and history, Table 21 Participant history relating to discrimination, abuse, bullying, being away from family of origin and forensic history, Table 22 Experience of accessing interventions related to symptoms of gender incongruence, Table 23 Participant history of mental health difficulties, autism diagnosis status, psychological intervention and risk, and Table 24 Participant history of learning disabilities, physical health, dependency to substances and eating disorders (See Appendix 2O-T).

The GIC completed a questionnaire regarding the participants. There was a range of between 35-1075 days between referral and initial assessment (*M* = 495; *SD* = 447.34). There was a range of between 62-294 days between 1st and 2nd diagnostic assessment (*M* =153.2; *SD* =

86.83). The approximate number of days between 2nd diagnostic assessment and pausing or stopping was *M* = 652.2 (*SD* = 492.62). The number of days between pausing or stopping and retransition ranged between 30-670 with a mean of 350 days (*SD* = 452.55).

The GIC recorded reasons for pausing or stopping transition which included: concerns regarding whether they had feminised ‘too much,’ concerns about how hormonal treatment may affect their body (*n* = 2), difficulties with their wife and one participant stopped hormonal interventions but did not give a reason. Reasons for retransition were not recorded.

Further information was gathered from the GIC, this is outlined in Table 25 Information regarding pathway and process (see Appendix 2U).

Qualitative Analysis

Each of the GETs were supported by all participants. These are outlined in Table 26.

Table 26

Themes Developed from Interview Transcripts

GETs	Supporting Quote
1. A sense of difference since childhood	"Well, I felt there was something not quite right, but I couldn't put my finger on it, when I was very young erm, I mean if I'd know there was such a thing as gender, gender transition" (Participant 5 on her childhood experience).
2. Gender transition is challenging in multiple ways	"I'm still friends with these people which makes me really angry with myself, because you know I have fairly small family and they've actually all been fairly horrible to me, and they are also the reason that sometimes fairly horrible to myself" (Participant 4 discussing their family)
3. Conflicts are experienced	"Those that are hostile are vehemently hostile and that is you would, you would know almost immediately if you were transitioned, but if your sort of standing there in the shadows like I am you don't know whose who yet and that's quite intimidating" (Participant 3 describing their concerns in sharing their TGD identity).
4. Stopping transition has challenges and benefits	"Relief to not have to focus on passing anymore, especially to be able to go okay you know what I want to wear nice baggy jumpers and you know I want to be able to present in a way that makes me…. Happy and not just performancing for other people" (Participant 1 on stopping transition).

1. Sense of difference since childhood

The first theme pertained to all the participants reporting a sense of their gender identity being different from an early age and noticing that their experience and interests did not fit into conventional expectations of their assigned gender during their developmental years.

Participants reported that their assigned gender had been uncomfortable for them, but they had not had the knowledge of, or space to explore their feelings. For example, a lack of role models had been a factor in why they did not seek support earlier on: “As a child, used to erm be confused and so on. I didn’t really start transitioning until my 40’s. There were no role models, no, there was no-one, so you just didn’t understand it you you muddled along as you did, you didn’t know what was going on, why things were not quite right” (Participant 3). This was also encapsulated as: “not feeling the same as people around me” (Participant 2), with participants noticing that their experience was atypical to their peers.

Participants frequently reported not being able to make sense of their difficulties: “Well, I felt there was something not quite right, but I couldn’t put my finger on it, when I was very young erm, I mean if I’d know there was such a thing as gender, gender transition” (Participant 5). In some instance participants reflected a wish to have known more in childhood to make sense of their experience at the time.

Finding out about medical gender transition’s was viewed as a factor in decision making to transition: “I never realised you could transition just using hormones, so I thought ah I could change the way I look and make me feel better, whatever, you know a nice silhouette and being able to sort of bring different clothes over and think that looks good, whatever, so that was where it kind of took off to being like wanting to transition” (Participant 2). In some instances, it led to a wish to relive their childhood and experience a ‘second puberty,’ although this did not always meet expectations.

The sense of feeling different led to some looking for answers to make sense of their experience with some participants reporting exploration of gender identity when they had the resources to do so. One participant who stopped transitioning to a transgender woman identity and instead now reported his identity as a gender non-conforming man, reflected of his experience that in childhood he experienced feeling different:

“Waking up in the night and coming downstairs crying to mum saying that I don’t fit in with the other boys at school and that I feel like I should have been born a girl which … in hindsight…. Is number one because I’m autistic and number two because I’m gay you know I’m not going to fit in with the masses in particular” (Participant 1).

He felt that coming to terms with his autistic identity and being gay had been a factor in ceasing to pursue a transgender woman identity and move towards a label that was more unique to his experience, rather than something that he found challenging to meet.

It was not unusual for some participants to have enjoyed wearing feminine clothing and have kept it hidden during childhood and even into adulthood:

“For years I lived, I had girlfriends and lived with a woman for a number of years, and I kept everything secret and kept clothes and wigs, shoes and things, vast collection in the loft and only accessed when she wasn’t around… I wasn’t the slightest bit interested in male clothes it was always fashion and female looks…I’m thinking was it kind of sexual thing, I don’t know, I know that some trans women, see they look and dress like mothers, very old fashioned and I was the opposite” (Participant 2).

Some participants felt that their experience of gender incongruence in childhood had caused them distress that was not supported by their family. For example, one participant reported:

“Growing up there was some things that would suggest to anybody on the outside looking in that something wasn’t quite right with me. I think it would have been a problem, something I think it would have been a problem and a problem to sort but not in a way that was, I think it, to sort and resolve in a way that’s comfortable for them” (Participant 4).

Conflict and difficulties with families were common in childhood across most participants, however, participants 2-5 had experienced difficulties or restrictions from those close to them, or in the case of participant 1 he had concerns and worries about how he would be perceived when stopping transition had meant he was in a gay relationship, and he was unsure if his family would be supportive.

Most participants felt their needs were not met in childhood, in part due to not sharing their distress, or feeling safe to share it, and in some cases, they felt this affected their development, and their current mental health:

“…it caused a lot of problems that I’m only working through now because my social developed was always lacking, retarded me, because of that, my father was, very masculine, very bullying, sadistic, person” (Participant 5).

Participants frequently reported that the experience of their childhood had an impact on their experience today with one reporting that the invalidation of their experience led to a negative view of the self, and internalised transphobia:

“I think you know in my case as well it’s my own perception of me and it’s my own sort of my upbringing and my inherent transphobia about myself and you know, because it’s much easier to be white middle class male hetero and fairly successful” (Participant 4).

Overall, the sense of being different, and the confusion this created had a lasting impact on mental health and wellbeing. Finding out about gender transition had been a reason to pursue finding support, whether it satisfied their needs in adulthood, or if they had found alternative explanations for their distress.

2. Gender transition is challenging in multiple ways

The second theme was gender transition is challenging in multiple ways. This pertained to participants varied experiences of transition, the barriers they had experienced in pursuing this, and the disappointment when expectations were not met.

Many participants reported difficulties pertaining to their social and familial connections, which had led to the end of relationships, and with one participant who had remained with their wife reported how they had controlled their transition:

"Well, the rules were always that this was private erm. The kids knew and my wife, but she was adamant that it was not something to be released to our social circle or our family…it feels like my gender thing is a little bit of… a luxury rather than a necessity and we're down to our bare bones of necessity to survive… I think my wife sees the social stigma of it erm and she's not now in a in a strong enough position to be able to erm to deal with it" (Participant 3).

The negative reactions from family were cited as a cause of distress during transition: "I'm still friends with these people which makes me really angry with myself, because you know I have fairly small family and they've actually all been fairly horrible to me, and they are also the reason that sometimes fairly horrible to myself" (Participant 4). It was common for experiences with family members to have had a lasting impact on their mental health and wellbeing, and specifically towards experiences of internalised transphobia.

Family reaction could be a factor in stopping transition due to distress caused by conflict: “Stopping transition was a realisation that actually nothing was better because I was still on my own, I was still drunk for most of the time, I was still having a shit time with family, and friends and ultimately erm something had to give, and the only thing left to give was transition” (Participant 4).

However, pausing transition to appease family and romantic partners was cited as a source of distress: “I hate looking at myself, and with the HRT you are in sort of half, half body you’ve got male bits and female bits and that’s kind of weird” (Participant 3). It felt that steps taken to reduce gender incongruence could come at a cost whether it was loss of familial, romantic, and work relationships, but also stopping to try to improve personal situations did not necessarily create an acceptable outcome either. For example, participant 5 reported a wish to pursue transition again following the end of her relationship and the impact of pausing transition had left her feeling distressed: “having more of a proper transition, rather than being a no man’s land” (Participant 5).

For some, pausing could be a place of reflection to consider what they wanted for the future, although feasibility was a barrier: “In the family circumstances, it’ll be erm two, two sort of identities, it would be easier and less confusing to live as one … but some things are not possible so I will take the, I will, the part time if that was possible. I would prefer full time” (Participant 3).

Another barrier to transitioning pertained to concerns about risk: “you’re going to get clocked, and in the current hysteria, erm, I think you need a pretty thick skin. Erm but to be honest as long as people don’t offer me violence, I don’t give a monkey[s]” (Participant 3). Some participants described being more resilient than others when considering the impact of current political and cultural views towards TGD people.

Barriers to transition were also prevalent in the workplace, with one participant leaving a job, and another reporting being a victim of a hate crime which they did not feel was adequately addressed, and they subsequently adopted a non-binary gender identity to present as male in their workplace:

“it wasn’t dealt with we just went back to normal and then I said erm ‘Has this been reported as a hate incident because it is?’ and they said [laughs] ‘well because it’s staff there’s nothing in our policy that says we need to report this, record this, as a hate incident’, and I said ‘well okay then, so if I go and shout at a, if I go and call a pregnant lady fat or I’m going overtly racist to a colleague what will you do about that?’, ‘oh we’d have to deal with that’, right okay then, ‘Can you see my point then?” (Participant 4).

In this case of participant 4 they had dealt with several difficult and distressing events related to being a victim of a crime; ultimately pausing transition did not feel sufficient as gender incongruence was still prevalent; however as a way of rectifying this conflict they had decided to pursue a non-binary gender identity. Although this to an extent fit with their experience of their gender, they did suggest that they ‘fit’ more within feminine expressions of gender, but a non-binary gender identity allowed them to present in conventional ways for the purpose of work, but ultimately people they cared about knew how they felt and that was the overriding factor that mattered to them.

Other barriers to transitioning included societal and cultural factors and these were often cited as a factor in decision making: “The main thing would be without these strident harpies and Christian bible bashing people who keep on trying to associate a trans woman with a pervert, and that really is, I think that is less medical and [more the?] the social environment” (Participant 3). Participant 5 reported her partner’s concerns with them not following cultural norms regarding gender roles, they reported they said: “Don’t come round here in your women’s clothes” when informed of her transgender identity and her wish to transition. I interpreted these sorts of comments to suggest that participants generally felt that a kinder more compassionate and accepting society would have a positive impact on the wellbeing of TGD people in general.

Transition could be disappointing for some, in part due to changes not meeting expectations. For example, participant 2 made the decision to stop transition, in part due to being disappointed by the outcome of his medical transition and he was left feeling disappointed by the permanent changes that had been left:

“I dunno, I never quite could, was quite able to carry this off I don’t think. Always waiting for the moment, the preparation you know buying the clothes, oh well, I’ll you know post covid I’ll be able to go out and do this and do that, and you know, when I get a bit more, when all my hairs gone [laughs] then that’ll look better and for years just waiting for more hair, and then when it finally has sort of has more or less gone, erm this I don’t like it wish I was… put it back” (Participant 2). There was a sense of disappointment that it had not been what he had hoped, and perhaps longed for, having felt restricted for so long and then finally ‘taking the plunge’ later in life.

Some participants found that taking HRT was challenging due to side effects such as the lowering of their libido leading to some wanting to pause or stop taking them, so this returned: “Well, I wanted to be a cis-hetero male and go and have some intimacy with somebody” (Participant 4). The impact of the side effects could be a factor in developing and maintaining relationships which for some was problematic when they sought intimate connections with people.

Others reported noticing their libido had lowered but they had been more amenable to this change: “I thought it would make relationships with women, if I had any in the future, probably on a nicer footing in that there wouldn’t be any sexual, I didn’t have any sexual attraction any more or any sexual feelings” (Participant 2). Amongst older participants sex was less of a priority, with companionship and connection being more important to them.

The health implications of medical transition were noted by some participants as a factor in pausing or stopping transition. With another participant reporting potentially serious side-effects that had caused concern:

“I felt peculiar, yeah, and I thought I’d got phlebitis in this leg, pain in that leg was terrible, now it’s subsided, I saw the doctor about it, and they did some blood tests and there was something happening, but after a week or so it had gone” (Participant 5).

For two participants (2 and 5), the side effects of HRT had been a factor in ceasing to take hormones, although participant 5 had intended to take them again. Participant 2 had noticed physical changes as a result of taking HRT that left him feeling embarrassed: “I was just becoming an old woman instead of an old man, so that’s when I started to have doubts and you know I thought I had a decent male body and what am I doing trying to make these changes, risk my health cos I had all these pains and I would strain where I used to probably open a jar or something like that, you'd automatically undo it and all of a sudden it hurts" (Participant 2). In part not meeting the image of themselves that they had envisaged, sometimes for decades, was disappointing and likely had an impact on self-esteem.

3. Conflicts are experienced

The third theme was that conflicts were experienced. Participants frequently reported keeping their identity hidden, or only sharing with a 'safe' group of people due to fears of how they would be perceived and/or treated. For some this led to a splitting of their gender identity – presenting in a way that felt authentic around some people, and in an inauthentic way to others. In part due to experiences of abuse some had moved to a 'non-binary' gender identity and expressions of gender identity, not because they necessarily felt this was an authentic representation of their gender identity, but because it felt safer and left them more able to maintain relationships with family and continue in their job role.

Some participants made a conscious choice to not tell their family about their TGD identity: "You bottle things up in life. So, something like that, I don't talk about that, you don't talk about things like that so no" (Participant 5).

Others reported trying to maintain two gender identities during their transition:

"I think I convinced myself that actually I'm more comfortable as a non-binary person… I was trying to balance and present one way to family or whatever and then have this other person, … I'd even sort of separated out my clothes and possessions and things in two different bedrooms. One was [male name] room and one was [female name] room. Why can't you in the modern age erm present differently to different people? It's a, if you don't want to identify as female to your family that should be okay, but then if you just want to identify as female in another setting that should be fine, if I feel like going out err dressed female or dressed as a male it shouldn't make any difference overall" (Participant 2).

They also felt strongly that GIC's should accept that this is the case for many TGD people and not pressure people into making changes they are not ready for. In part this could be telling family, friends, and workplaces where they were concerned about the reaction and subsequent impact on their quality of life.

Others reported also keeping it hidden for safety reasons: "…identifying as non-binary for me as a recovering alcoholic is a fairly safe thing for me to do, because I can assess a situation I am in and then I can identify however I want" (Participant 4). Adapting gender identity, and essentially masking their true feelings and gender expression felt a safer way to exist in what was sometimes perceived as a less tolerant society.

Participants reported negative experiences during gender transition, although periods of pausing transition were also felt to have been negative experiences. One participant reported distressing events happening when they had transitioned toward a female identity: "Having problems like having a bottle thrown at me, as I was walking past a pub after finishing work late. Because that happened, and things like when I was queueing up in [coffee shop] in [city] and someone pulled their penis out and started masturbating in front of me, it's funny how I've never been a victim of hate crime since I have overtly sort of paused, although you know I don't identify as a trans female anymore, or at the moment" (Participant 4). They noted how since identifying as non-binary, and only sharing this with a select few people, they have not had any further negative experiences.

Two participants did think that the experience of abuse should be expected by people with a TGD identity: “it’s just if you draw attention to yourself you’ve got to accept criticism really” (Participant 5), and another felt that he stopped transition to move away from narratives of ‘victimhood’ (Participant 1).

Pausing transition could also lead to a unique situation where they were not overtly TGD and therefore not explicitly knowing the views of people they meet regarding their identity: “Those that are hostile are vehemently hostile and that is you would, you would know almost immediately if you were transitioned, but if your sort of standing there in the shadows like I am you don’t know whose who yet and that’s quite intimidating” (Participant 3).

Having a supportive network helped in managing safety concerns; one participant who had stopped transition reported a supportive family and friend network had been a relief, and another who had stopped transition reflected that more support during transition, and through stopping transition, would have helped normalise their experience. Generally, participants did not have a support network that included TGD people.

Participant 4 noted that even those in their own small support network people who have a TGD identity could be experiencing significant difficulties themselves:

“I’m really pally with a [colleague] who’s transitioned, and for erm, she’s a trans girl or trans lady, and she gets about 20,000 social media posts a week from Evangelical Christians, far right nob-heads, and there’s a trigger plan in place in case people turn up at her house” (Participant 4).

And when pausing transition, they noted that some support received from people may on reflection have been disingenuous: “…trans person but is also a TERF (Trans Exclusionary

Radical Feminist) … I think she befriended me for sort of quite insidious reasons and actually when I started, addressed some things, and when things became more stable, they disappeared."

Others that felt more support would have been helpful and would have potentially validated their experience whether they were transitioning or stopping transition: "Could have had little groups to practice speech and everything, talk about things. I've never had that group support, and I don't know anybody else that has transitioned." I asked what support might have been helpful and they noted: "Only probably the erm exposure to people like myself maybe. Cos then I'd realise that I'm not the only one going through these feelings" (Participant 2).

Conflicts experienced had an impact on participants, in multiple ways and was a factor at least in part when making decisions to stop or pause transition. It was not necessarily the case that difficulties ceased and then retransition was pursued but participants often found ways to reconcile with their situation to find a path that was a better 'fit' for them.

4. <u>Stopping transition has challenges and benefits</u>

The fourth theme was that stopping transition has challenges and benefits, this included participants' reports that although there could be benefits in pausing or stopping, particularly when this meant less pressure such as to pass, to maintain relationships, or to continue medical interventions, it could also be challenging. This also included a recognition of the need for some support during transitional states.

There are challenges and benefits when stopping transition – although this can mean different things to different people. Participant's 1 and 2 both reported that they had stopped transition.

Pressure to pass and meet female stereotypes was noted as demanding and therefore during pausing or stopping transition, not having to pass, or expressing their gender identity in a different way was a benefit: “I was so overwhelmingly trying to pass that I was dressing and presenting in a way that didn’t really make me happy it was just purely to push the erm the illusion if you like that I was female” (Participant 1). For participant 1 he noted that it caused him increased social anxiety and at times was a factor in not leaving the house. They reported relief at finding a path that normalised their gender expression without needing to pass as female: “Relief to not have to focus on passing anymore, especially to be able to go okay you know what I want to wear nice baggy jumpers and you know I want to be able to present in a way that makes me…. Happy and not just performancing for other people” (Participant 1).

Asked whether he thought it was ever likely that he would retransition he reported:
“The magical question of: ‘If you could press a button and wake up a biological woman, would you?’… err I would be tempted to consider that as an option, but would I be realistically…. you know… the realistic reality-based option of taking hormones... and being transgender would I do that… no I wouldn’t” (Participant 1). I got the impression from Participant 1 that he had not reconciled with his assigned male sex but had created a gender non-conforming man identity to relieve some of the pressure he had experienced, and in the process had found a way of connecting with and being authentic to his feelings.

Participant 1 reported that he experienced concerns when stopping his transition, for example the impact on his relationship, and whether his partner would continue to find him attractive, and how his now same-sex relationship would be perceived by his family: “Previously I was presenting as a female and my partner is male, so obviously going from that to now presenting as a same sex couple err… that has added [laughs] some more social anxiety to me" (Participant 1). His use of humour in managing his worries such as anticipated homophobia felt telling of his anxieties with the transition process and an insight into the challenges and difficulties he had faced both externally and internally.

Participant 2 reported a factor in his stopping transition was wanting to distance himself from current media narratives regarding transgender women:

"I don't want to be part of some of the things that are happening. Like the stuff in Scotland and the prisons, and you know when they say things like err you know trans women, they are they going to women's prisons to rape them and I'm thinking that can't be right because you don't have feelings like that you know" (Participant 2).

He felt strongly that current narratives in the media could not be representative of transgender women due to the side-effects caused by HRT, predominantly the lowering of libido. He also reported feeling guilty at the potential impact on the healthcare of cisgender women: "there was a worldwide shortage, and I knew that women were wanting HRT now that erm, and I thought: Is it right that I am sort of taking some of these when there's women who really, really, benefit and really need it?" (Participant 2).

Part of their decision making may have been informed by his concern of being judged to be involved in something which he felt was the opposite of his intention.

Participant 2 also noted that although the transition had not left him feeling mentally changed, he did feel physically changed: "… it just didn't look right… I knew it was never going to be perfect but just thought this wasn't what I wanted and you know facially, I was just becoming an old woman instead of an old man, so that's when I started to have doubts…"

They went on to say: "I don't think it's really worth the risk and do I gain anything, I don't think it's made me any different, it's just changed my body a bit, I don't think mentally changed hugely, I'm still the same person but erm I don't know, but, just, I wanted to feel a better person and erm it hasn’t, maybe changing sex is not the way to do that” (Participant 2). I interpreted this as part of his disappointment in the changes that occurred to his body, and the conflict this created for him which ultimately led to his decision to no longer pursue a gender transition.

The process of having physical changes reversed via the NHS was noted by Participant 1: “I personally feel like but erm you know I’ve been left with a lot of breast tissue... I’m currently waiting to… erm what seems like limbo at the moment erm to be referred,…”

His frustration at the lack of a formal process for reversing changes (which meant this was still unresolved) may have led to conflicting feelings towards those that had supported his gender transition:

“I think from my experience no there was no one particular thing where they said should have gone... we need to we need to look into this more but like I said I personally feel like the therapy… therapy should be mandatory before starting medically transitioning because then I feel like you know if I had a competent therapist who was happy to … push me and challenge me on … thoughts and viewpoints that they could have started going actually some of the reasons that your thinking about detransitioning is because… you think it would be easier being a woman than being a gay man and because you were attributing you know wearing feminine clothes and having long hair and wearing make-up with being a woman that’s not at all what being a woman is actually you can do that as a man and I feel like if that had been done with me you know it could have saved me six years of hormones [laughs]” (Participant 1).

Participant 2 also raised concerns about the physical changes to their body “I felt a bit embarrassed I think, my breasts were slightly sort of visible…”

He went on to say: "… back to what the clinic did… I'm obviously not going to be like trying to put you off but I mean I looked back at the original papers and the consent form and how it can… increase risk of things like diabetes and stuff and heart conditions and I thought I can't believe I signed up to that because I'm really health conscious…" (Participant 2).

Participant 3 who had paused transition felt that the process of stopping transition, or pausing had a negative impact on them which has been challenging: "Living a fake identity now, of someone who I had grown away from err, and, and become and now I've retreated back is quite uncomfortable… It's just been lonely, that's all. Yeah. I think that sums it up quite, erm, because by not transitioning further or remaining in I'm, I'm not part of that community that we had found and err our situation is quite isolated so yeah" (Participant 3). They were hopeful that in the future they could continue to transition their gender identity.

Participant 4 noted that they wished they had addressed some of their difficulties prior to initially transitioning as it had felt challenging to pause transition: "I'm never going to know sort of why I'm trans, why I'm trans I guess but I think there was a lot of trauma to deal with, a lot of other things that I needed to deal with before I could consider something as erm evasive as a new identity" (Participant 4).

Participants generally reported that they felt they needed more support throughout transition regardless of the direct of gender transition. Participants referred to feeling isolated, wanting to meet like-minded people and to access more formal psychological support as part of transition process, although they note that they would have been unlikely to access support if it was offered.

Participants generally felt that during pausing or stopping transition people should receive adequate support and intervention, in part to ensure safety regarding medical interventions but also psychological support to explore the challenges that people are likely to be experiencing:

"I would be very concerned… obviously I have no experience as a doctor or even as the like but I would be very concerned if somebody who has gone through that transition process has then just said actually I am thinking of detransitioning and no longer need the need the services of the gender clinic thanks for all the help and never contact you again I'd be like [laughs] ring 999 like my god this is like you can't you can't just drop off like that when it's such a massive… part of your life" (Participant 1).

Participant 2 also felt some support would have been useful: "I don't think now it would have made any difference to my, the course I am taking now, but it might have made it easier if someone said, oh yeah I felt like that for a while but then, then you know, don't give it all up because you might you might change your mind again" (Participant 2).

Participant 4 who had begun to transition again reported finding discussing their transition journey during this research study was helpful: "The reason, and as I said I wanted to do this, maybe my experiences erm just hearing you, you know listening to me, sort of try to put these things into context and to explain and rationalise why I did what I did is quite helpful I think" (Participant 4).

Some participants reported 'mandatory therapy' as something they thought would be helpful: "I think that talking helps, but then there isn't an infinite number of psych appointments, but I do wonder if talk, having talking therapy should be mandatory before you make some quite big decisions around transition, or pausing transition….I think some people would have, I think a lot of trans people will already have made their mind up, but that's really difficult but I think, I don't, it's really hard isn't it because everyone's pathway is different" (Participant 4). The way participants talked about 'mandatory therapy' was their way of saying that they would have benefitted from having more readily available specialist support from a suitably qualified practitioner. Participant 1 described being offered therapy but turning it down due to feeling 'firm' regarding his identity:

"…now I feel like some therapy should be mandatory, you know when I, when I went to the gender clinic and they did offer me therapy, but at the time I was very firm in you know who I believed I was,… you think it would be easier being a woman than being a gay man, and because you were attributing you know wearing feminine clothes and having long hair and wearing make-up with being a woman, that's not at all what being a woman is actually you can do that as a man, and I feel like if that had been done with me you know it could have saved me six years of hormones" (Participant 1).

It may be that on reflection, or having been through an experience such as gender transition that people feel able to consider the factors that led to transition in the first place and be more critical towards their motivation. Certainly, they are advocating for support and feel on reflection that this could have made a difference in their experience.

Following on to considerations of support following initial gender transitions Participant 3 felt there should be a follow-up or similar intervention when someone is pausing or stopping transition: "I would hope there was some sort of follow up because it's quite specialised care, and if someone's been on HRT and they were to stop, and they need surgical intervention or something there's gonna be some confusion" (Participant 3).

Participant 5 noted she tried to do things herself instead of trying to access support: “I’ve been a bit backward with support I suppose I’ve just tried to do it on my own, that’s probably counterproductive. I don’t want to be burden on anyone, least of all the NHS, just the pressure they are under at the moment you know” (Participant 5).

She also noted that support can be from others who have experienced a similar thing: “Someone with the same sort of background to myself, age kind of thing, erm, but be someone yeah. It gives you a whole new perspective doesn’t it, the people you meet, new perspective on things” (Participant 5).

This theme highlights a need for support along the care pathway, with space to explore and reflect a priority. Particularly in the context of processing past difficulties and dealing with conflicts occurring across stages of transition.

Discussion

The authors position in relation to the topic of pausing/ stopping and restarting transition will have had an impact on the results, and the final themes were a co-construct between the participant's and the researcher. Over time the authors understanding of detransition has evolved, and will continue to do so as more peer-reviewed articles exploring this topic are published.

It was important to the integrity of this research study, and due to variance in previous definitions in the current body of research that participants could be verified as having met clinical criteria for Gender Incongruence (ICD-11, 2017), and made a decision to stop or pause following the commencement of HRT interventions as per the clinical guidance (NHS England, 2013). This did mean that only nineteen people met the criteria to be invited to take part, and of those five did. Small numbers of prospective participants were consistent with data reported from GIC's in England (Hall et al., 2021; Richards & Doyle, 2019). It was a challenge for the study to recruit, in part due to the small participant pool, and the wish of participants not wanting to be involved in clinical research as noted by Littman (2021). Anecdotally through discussions with the NHS GIC some potential participants declined as although they were pausing, they did not want to be considered a 'detransitioner.' Language in this area is in its infancy and therefore unlikely to encapsulate all experiences leading to some potential jarring. The current cultural and political context within the area of gender identity and a propensity towards anti-trans rhetoric in the media may have been a factor (Pearce et al., 2020), perhaps leaving 'detransition' as a loaded term, and one that doesn't encapsulate all experiences of pausing and/or stopping sufficiently.

Interestingly all the participants who agreed to take part were assigned-male at birth, there were fewer people assigned-female at birth who were invited, but all declined to take part. As such the results of this study could not be generalised to include people assigned female at birth as their experience may have unique aspects not captured in this study. None of the participants had come via the GID's, and all had transitioned after the age of eighteen, with some medically transitioning much later in life. It is difficult to speculate on the reasons for this although I note those who declined due to pausing to have a baby and then not wishing to be considered a 'detransitioner' may be a factor in why some younger people declined to take part.

Most people who took part in the study had waited a long time to be seen, and many had sought and accessed HRT interventions either through private clinics or via the internet prior to attending an NHS GIC. The time between assessments ranged between 62-294 days with a pause or stop ranging from 201-1242 days at the time of the study. Some began to transition again between 30-670 days, with the participant reporting 30 days noting in that time they had made the decision to end their relationship so they could proceed with gender transition. The long waiting lists, and time spent within clinical pathways suggests decisions are not made quickly and flippantly.

Participants reported different and unique experiences with two stopping without intention to ever transition their gender identity again, one was pausing and wished to proceed but felt unable to in their current circumstances, and two who had begun to transition again, although one of those transitioning again had reported a shift to a non-binary identity which felt for them a coping mechanism rather than a true expression of their gender identity. As this is a newer area of research multiple narratives are likely to be captured in studies over time. At present we are beginning to understand some of the reasons why people leave the GIC pathway.

A major limitation of qualitative research approaches is a lack of generalisability, and thus findings should be considered with this in mind. However, a strength of IPA is the transferability of the findings in specific circumstances such as in an NHS GIC. Through identifying commonalities within the data and also points of individuality, this provides insights into their experience, a starting point for any clinician or academic wanting to deepen their understanding in this area. Through the consideration of the sense making of participants' and the researchers own interpretation of this a narrative has been developed providing a deeper understanding than previously known (Smith & Eatough, 2007; Nizza et al., 2021; Smith et al., 2021).

The overall themes suggest some similarities and some differences in people's respective experience of transitioning, and in pausing, stopping and for some transitioning again. Participants spoke of their sense of difference from childhood, in part confusion in their experience of gender compared to peers, and a lack of answers, which is consistent the findings of a review conducted exploring the experience of gender incongruence (Cooper et al., 2020). There are also nuances in the experience of autism and gender incongruence which may account for participant 1 relating their distress initially to gender identity, and then deciding to stop transition when they related this to other aspects of their identity (Strang et al., 2018). Many participants reported unmet needs in childhood and not feeling safe consistent with research reviews exploring risk of abuse in childhood for young TGD people (Tobin & Delaney, 2019). Of note also is a review reporting older TGD adults may also be vulnerable to abuse and poorer health outcomes (Velasco et al., 2023), which may account for some of the experiences captures in this study.

Gender transition is generally viewed as challenging. Participants noted a myriad of barriers when transitioning gender identity, which is also consistent with previous research findings (Cooper et al., 2020). In the current study participants reported disappointment when their expectations of transition were not met, consistent with previous findings (MacKinnon et al., 2022). We note that participants frequently reported clinicians were supportive of their pausing or stopping transition. Although accessing surgery to reverse the effects of gender transition e.g., mastectomy, was challenging for one participant. This was due to a lack of a treatment pathway and despite support from their local NHS GIC, they were reliant on approval from a separate funding body.

Participants reported conflict between their need for safety and a need for support. Participants reported keeping their identity hidden or identifying their gender identity in another way such as a non-binary gender identity. It was felt that this provided the opportunity to keep their TGD identity hidden in places such as the workplace where it did not feel safe to share this. The experience of the workplace for TGD people is poorly understood, but a recent review suggests it can be a difficult environment and inclusivity practices can be helpful (Huffman et al., 2021). Participants reported either negative experiences of harassment, discrimination or abuse consistent with a report published by Stonewall (Bachman & Gooch, 2018). Also noted was anxiety that a negative experience could happen to them due to having a TGD identity, and the stress being TGD caused (Meyer, 1995); including for participants to conceal or hide their TGD identity or refrain from leaving the house. In some cases, stopping transition was a relief as they no longer felt stress related to their gender identity.

Participants spoke of a need for a support network, in part to validate their experience whether it is to transition, pause, stop, or transition again, and to be connected. Only participant 1 reported a supportive family. Participant 2 had never shared his TGD identity with family and was now stopping transition. Participant 3 had only shared with their wife and children and were asked not to share it further due to their wife's concern about social stigma. Participant 4 had shared their gender identity with family but had found this was not a positive or supportive experience: "*I told my uncle about sort of transitioning, and he sent me a Nivea, a men's Nivea skincare set for Christmas. Because that's the kind of person he is, and my mum was really*" (Participant 4).

Since pausing transition and starting transition again, participant 4 noted using a non-binary gender identity as a coping mechanism whereby they did not need to share their TGD identity with family or at work, instead keeping it to their friends' network. Participant 5 had shared her gender identity with her partner, but she had not been supportive, and she had stopped transition, but within a month they ended the relationship and began to transition again, she had not made her family aware. Having contact with the TGD community was seen as beneficial, participants reported being isolated and lonely when not connected, consistent with the suggestion that TCC is helpful for overall wellbeing (Pflum et al., 2015).

Finally, participants reported that stopping or pausing transition had both challenges and benefits. For example, one participant who stopped transition reported not needing to '*pass*' was a relief however other anxieties were raised such as now presenting as a same-sex couple. Changes to the body also presented challenges such as being left with the appearance of breasts, or the loss of body hair, with a wish to reverse these changes. Participants spoke about the need for support across all stages of transition. Participants felt that during a period of stopping or pausing there should be support provided, and that during transition psychological support would have been beneficial – although did not necessarily agree they would have accepted it or that on reflection it would have made a difference. Therapy being described by participants as mandatory is likely meant to mean the provision of support as opposed to conversion therapies which have been demonstrated to be damaging (Government Equalities Office, 2020). Participants generally reported thinking that psychological support, support groups etc. would be beneficial. Lack of support has been cited as a factor in stopping transition (Turban et al., 2021).

Clinical Implications

It may be helpful for GIC's to embed in their treatment pathways details of the challenges and barriers of transitioning, comprehensively address personal safety and risk concerns, consider the limitations of medical transition and the realistic benefits, and be more proactive in dispelling myths and normalise the range of gender identities (e.g., non-binary).

GIC's should also consider gender transition as being non-linear, and dynamic rather than static. Care plans should be developed with this in mind given the experiences shared by participants in this study and both the internal changes they experienced, as well as external factors which mitigated their gender transition experiences. GIC's should recognise that for some patients there is a need to live a 'dual' life, and that this may be a cause of distress, although this may be less distressing than holding a TGD identity.

The development of a specific pathway for when people pause or stop would also be beneficial in ensuring medical and psychological needs are identified and supported, including accessing reversal surgeries. Further research is needed to address how evidence-based practice should be delivered in this area.

Psychological therapy underpinned by principles of person-centred care (Rogers, 1951) could usefully be offered to patients, and the provision of groups for patients who wish to meet others who are experiencing similar difficulties may also be clinically useful.

GIC treatment plans could be informed by current data pertaining to pausing and stopping, which should be shared with patients,' and consideration should be given to potential situations/ circumstances that could transpire whereby they may wish to pause or stop, and an agreed plan developed for this instance.

Strengths and Limitations

The current study is a small sample and reliant on the sense making of participants when reflecting on their situation and the interpretations of the author. The authors' interpretations of the participant's narrative have informed the co-construction of a narrative. The author acknowledges their own position in how these develop and found keeping a reflective diary useful. They had initially expected to meet with people who had stopped transition who might be experiencing regret and other associated negative feelings however this was not the case. It may be due to sampling methods that those who may feel this way would not wish to remain in contact with clinics or access further support such as psychological therapy and would therefore not be included in this study. Although the sample is homogenous - they all had the same experience of stopping their medical transition and coming off the treatment pathway - they were continuing their journey in different ways. Some were stopping completely, one had paused and two had begun to take steps to continue again. It is my opinion that GIC's and healthcare providers offer people a ‘golden bridge’ when developing care plans, so that those who do wish to pause/ stop or even start again feel able to assert their needs and have them supported without prejudice or judgement. As such any conclusions from this study should be considered with the above in mind. Nevertheless, this is a new and novel study which provides further insight into the experience of pausing, stopping, and restarting a gender transition and can be utilised by clinicians working in the field to aid their understanding. Further research utilising a larger sample would be beneficial to aid understanding of this phenomenon, including specifically sampling participants who have received medical intervention and have decided to stop transition and do not wish to continue. Quantitative studies could provide more generalisable data, although this can be more open to interpretation as we note gender transition may be more dynamic for some people, despite this further research regarding prevalence and common trajectories relating to gender transition would be clinically useful.

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Press Release: The Literature Review

University of Birmingham Press Release

Date: 15/12/2023

GIC's are challenging for autistic transgender, and gender diverse people to access

Accessing gender-related healthcare is challenging for autistic people according to a new meta-ethnography from The University of Birmingham.

A review of eight qualitative research papers resulted in three major themes. This included perceiving that autism acts as a barrier to gender identity. For example understanding social rules related to gender identity: *"Being autistic is like everybody else has got the rulebook and you didn't, so you can understand why gender would come into it because that was in the rulebook you do not get"* (Cooper et al., 2022b p. 969). Having autism was felt to be a limitation across various aspects of life, including in exploring and sharing their gender identity. For example, in one study it was noted by a participant: *"I hate trying to be a girl but I have to try and force myself to be a man because there's only two options"* (Cooper et al., 2022b p. 969). This leaves some people feeling unsure about their gender identity and needing support to explore this.

Autism was also considered to act as a facilitator in some instances, as a way of being authentic and to improve their resilience. For some participants they felt that autism was a protector it: *"counteracts fears of negative perceptions, liberating the individual to live authentically according to their gender identity"* (Coleman-Smith et al., 2020 p. 2647).

The third theme noted that there is a need for support and adaptations to mitigate external and internal factors. This included a need for supportive relationships to counteract difficulties encountered as an autistic transgender and gender diverse person. These supportive relationships likely act a buffer against the negative impact of the environment and people, particularly those who are less accommodating of autistic transgender and gender diverse people. Transitioning gender identity can be arduous and support is needed, particularly when people feel autism has left them lacking an awareness of the skills necessary to safely 'pass.' Finally in this theme it is noted that people wish for adaptations and for their needs to be recognised, for example communication and sensory needs when attending GIC's. One participant reported: *"[Autism] makes it really difficult to say how I feel… I know lots of trans people who don't have a problem voicing their emotions, and how dysphoria affects them"* (Coleman-Smith et al., 2020 p. 2648).

Eileen Wood, a Trainee Clinical Psychologist at The University of Birmingham who conducted the review of the data explained: *"What we are seeing across the studies is a unique narrative of the experience and needs of people who are autistic transgender and gender diverse, and understanding and listening to this is a helpful and necessary step in providing gender-related healthcare that meets their needs"*.

The review suggests several recommendations to improving gender-related healthcare for people with autism, this includes further training for clinicians to develop specialist knowledge of autism, and adaptations in clinics such as shorter appointments with information provided in 'chunks' rather than longer appointments which could be overwhelming. It is also concluded that the provision of social support, such as groups could be helpful for people to meet like-minded people and develop a supportive network.

It is hoped that the publication of this review will have positive implications for gender-related healthcare provided in NHS GIC’s.

For media enquiries please contact: email address.

Notes to the editor:

The University of Birmingham is the original ‘redbrick’ University, part of the prestigious Russell Group; our thriving population enjoys a wide range of courses, and exceptional campus and research facilities. Among their staff and alumni are 10 Nobel Laureates, and their research community have contributed to some of science’s greatest discoveries.

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Press Release: The Empirical Paper

University of Birmingham Press Release

Date: 15/12/2023

Pausing or stopping gender transition has challenges and benefits

People assigned male at birth who pause or stop gender transition report challenges and benefits during this process and could benefit from support during all stages of stages gender transition, according to a new research study at The University of Birmingham.

Those that stop transition report benefits such as feeling: "*Relief to not having to focus on passing anymore*," although they also report challenges in social situations: "*I felt a bit embarrassed I think, my breasts were slightly sort of visible…."* Participants who stopped transition reported difficulties in reversing the effects of HRT and in accessing reversal surgeries.

Participants reported needing more support across all stages of gender transition, they reported feelings of isolation, and a wish to seek like-minded people and to access psychological support as part of the transition process. Some participants felt psychological therapy should be a mandatory part of the transition process, however they did not think it would have changed their transition trajectories. The authors note that they were advocating for further support, as opposed to conversion therapies which have been deemed a harmful practice (Government Equalities Office, 2020).

Stopping or pausing gender transition is thought to occur infrequently, with data from studies in the UK demonstrating a prevalence of between 1 and 6.9% (Hall et al., 2021; Richards & Doyle, 2019). Of the five people interviewed, two had stopped transition and did not wish to transition again, one had paused due to caring responsibilities, and two had begun to transition again following a period of pausing. Some noted a shift in gender identity, for example a change from pursuing a trans woman gender identity to a non-binary identity: *"…identifying as non-binary for me as a recovering alcoholic is a fairly safe thing for me to do, because I can access a situation I am in, and I can identify however I want".*

Eileen Wood, a Clinical Psychology Doctorate Student, and lead author reported wanting to find an authentic group of participants and collaborated with a Gender Identity Clinic (GIC) in England to gain approval from the NHS Health Research Authority to conduct a research project. Eileen was inspired by other projects exploring 'detransition,' and noted the dynamic nature of gender transition reported and wanted to capture the phenomenon. Eileen noted: *"The two EBE who supported our project, and who had been patients with a GIC felt the terms 'paused' and 'stopped' were less politically loaded than detransition, and therefore we utilise these terms as much as possible."*

The project highlights some key factors related to gender transition, including the conflict people might feel between needing safety and needing support. Some participants reported needing to keep their gender identity hidden from family, work colleagues and the wider public, and reports of utilising a non-binary gender identity as a safety mechanism or a 'stop gap' was not unusual. Negative experiences, or anxiety about keeping safe were common. Having a support network, whether made up of family, friends, colleagues, or the wider transgender and gender diverse community was viewed as beneficial as a way of validating feelings.

Childhood was viewed as a challenging time, whether it was a sense of difference, confusion about gender identity or a lack of role models to normalise their experience. Some felt feeling different left them looking for answers, one participant who stopped transition reported that: *"crying to mum saying that I don't fit in with the other boys at school and that I feel like I should have been born a girl, which… in hindsight… is number one because I'm autistic and number two because I'm gay, you know I'm not going to fit in with the masses".* Participants who were pausing or had begun to transition again reported feeling their gender related needs in childhood were not met, and none had shared these with family as a child.

Finally of note is that all participants reported gender transition was challenging, they reported numerous barriers, for example not being supported by friends, family and/or their work, and this was often the contributing factor to deciding to pause transition. For others it can be disappointment when expectations of transitioning are not met. Eileen stated: *"Assuming pausing or stopping gender transition is the end of the line for everyone is probably doing a disservice to patients, dynamic presentation of gender identity may have underlying factors which warrant exploration in a safe non-judgemental space, and for those who pause or stop a continuation of care to meet medical and psychological needs is viewed as helpful".*

It is hoped that this will lead to other, larger scale projects exploring pausing and stopping gender transition to better understand the process, and in the development of an NHS pathway and interventions.

For media enquiries please contact: email address.

Notes to the editor:

The University of Birmingham is the original ‘redbrick’ University, part of the prestigious Russell Group; our thriving population enjoys a wide range of courses, and exceptional campus and research facilities. Among their staff and alumni are 10 Nobel Laureates, and their research community have contributed to some of science’s greatest discoveries.

References

Government Equalities Office. (2020). Conversion Therapy: An evidence assessment and qualitative study. Retrieved from https://pure.coventry.ac.uk/ws/portalfiles/portal/44880617/2020_12_15_Conversion_Therapy_Reserach_Report_AJ_edited_clean_4_.pdf

Hall, R., Mitchell, L., & Sachdeva, J. (2021). Access to care and frequency of detransition among a cohort discharged by a UK national adult gender identity clinic: retrospective case-note review. *British Journal of Psychiatry Open, 7*(e184), 1-8. https://doi.org/10.1192/bjo.2021.1022

Richards, C., & Doyle, J. (2019). Detransition rates in a large national gender identity clinic in the UK. *Counselling Psychology Review, 34*(1), 60-66. https://doi.org/10.53841/bpscpr.2019.34.1.60

Appendix 1

Table 6

CASP (2023) Questions 1-5 Comments Relating to the Reviewed Studies

Study	Clear Aim		Appropriate Methodology		Is autism clearly defined?		Is being TGD/ experiencing gender incongruence clearly defined?		Is the role of the researcher clearly described?	
1	3	Clear aims.	3	The researchers seek to understand the experiences and use interviews and thematic analysis to address this.	1	Autism is not clearly defined, although research is cited pertaining to areas such as health disparities.	3	Gender related terms are clearly defined.	3	This is discussed at length with particular attention to the demographics and experience of the researchers and how this impacted the analysis.

2	3	Clear aims.	3	The research seeks to understand the unique experience of the phenomenon and gathers rich data to address the research question, quantitative approaches would be limited in the information they could obtain.	3	Autism is clearly described.	2	Some gender related terms are clearly defined, however there could be more elaboration regarding TGD identities.	3	The role of the researcher in grounded theory is adequately described and included the use of an independent researcher for quality control.
3	3	Clear aims.	3	The research seeks to understand the unique experience of the phenomenon and gathers rich data to address the research question, quantitative approaches	1	Autism is not clearly defined, although research pertaining to this is cited.	3	Gender related terms are clearly defined, including use of broad definitions to describe participants.	3	The role of the researcher is clearly defined, and how this was considered in the process is explicitly described.

				would be limited in the information they could obtain.						
4	3	Clear aims.	3	The research seeks to understand the unique experience of the phenomenon and gathers rich data to address the research question, quantitative approaches would be limited in the information they could obtain.	1	Autism is not clearly defined, although research pertaining to this is cited.	1	Gender related terms are clearly defined, including use of broad definitions to describe participants.	3	The role of the researcher is clearly defined, and how this was considered in the process is explicitly described.

5	3	Clear aims.	3	The research takes multiple perspectives and aims to synthesise these using IPA methodology.	3	Autism is clearly defined.	3	Gender related terms are clearly defined.	3	A detailed account is provided on the role of the researcher.
6	3	Clear aims.	3	The research utilises a critical-constructivist version of grounded theory to analyse the data.	3	Autism is clearly defined.	1	Gender incongruence and being TGD are not clearly defined although relevant research is cited.	3	A detailed account is provided on the role of the researcher.
7	3	Clear aims.	3	Use of stakeholder design utilising framework analysis, obtains relevant data to answer research question	1	Autism is not clearly defined, although research pertaining to this is cited.	3	Gender related terms are clearly defined.	3	A detailed account is provided on the role of the researcher(s).

8	3	Clear aims	3	Use of stakeholder design utilising framework analysis, obtains relevant data to answer research question	3	Autism and neurodiversity are clearly defined.	3	Gender related terms are clearly defined.	3	A detailed account is provided on the role of the researcher(s).

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Table 7

CASP (2023) Questions 6-10 Comments Relating to the Reviewed Studies

Study	Appropriate Research Design	Appropriate Recruitment Strategy	Data collection addressed the research issue	Adequate consideration on R/P relationship

1	3	The researchers explain their use of interviews and thematic analysis and justify their appropriateness and usage.	1	The researchers recruit via online sampling - this does have its limitations however, as they are not seeking to explore those with diagnoses it is appropriate to utilise community sampling methods.	3	The data gathered was relevant to the aims.	1	The researchers reflect on their processes aimed at ensuring a fair equitable analysis but did not use a formal EBE who was not involved in the research which may have added another element.
2	3	The researcher explains their justification for the use of grounded theory as a way of gathering data to saturate themes.	3	The recruitment strategy utilised opportunity sampling included recruiting participants from relevant NHS settings and from the community and included screening to ensure they met the criteria to be able to answer the research question.	3	Data gathered was relevant to the research question, some participants were interviewed twice due to the use of grounded theory, interviews were utilised and how the schedule evolved was described.	1	The researcher discloses the reflexive nature of grounded theory and how they followed guidelines to ensure credibility to the study however they did not use EBE in this process.

3	3	The researcher explains why IPA was utilised and why is it is important in understanding the lived experiences of the young people and their parents.	3	The recruitment strategy included recruiting participants from relevant NHS settings and included screening to ensure they met the criteria to be able to answer the research question.	3	The researcher is explicit regarding the setting in which they interviewed the participants, the topic guide, the modifications made for autistic participants.	3	The researcher is explicit in how they considered their own positionality and the reflexive stance of the approach.
4	Yes	The researcher explains why IPA was utilised and why is it is important in understanding the lived experiences of the participants.	3	The recruitment strategy included recruiting participants from relevant NHS settings and included screening to ensure they met the criteria to be able to answer the research question.	3	The researcher is explicit regarding the setting in which they interviewed the participants, the topic guide, the modifications made for autistic participants.	3	The researcher is explicit in how they considered their own positionality and the reflexive stance of the approach.

5	3	The researcher explains why IPA was utilised and why is it is important in understanding the lived experiences of the participants.	3	The recruitment strategy recruited from multiple locations to seek to understand perspectives, at various stages of life and transition.	3	The researcher is explicit regarding the setting in which they interviewed the participants, the topic guide, the modifications made for autistic participants.	3	The researcher explains their use of EBE and how they used supervision and reflexivity during the IPA process to mitigate potential biases.
6	3	The researcher explains their justification for utilising a critical-constructivist version of grounded theory.	3	The recruitment strategy involved recruiting participants from online forums, and utilised credibility checks to ensure trustworthiness of the data.	3	The data gathered was commensurate to the questions asked.	1	The researcher is explicit in how they considered their own positionality and the reflexive stance of the approach.
7	3	The researcher gives a strong rationale for the use of framework analysis and its importance to the design of the research.	3	Rigorous inclusion and exclusion criteria, multiple controls including proof of diagnosis to ensure participants are appropriate.	3	Data obtained was relevant to aims.	3	The stakeholder approach utilised more than one person in the analysis of the data and provided a quality control.

8	3	The researcher gives a strong rationale for the use of framework analysis and its importance to the design of the research.	3	Rigorous inclusion and exclusion criteria, multiple controls including proof of diagnosis to ensure participants are appropriate.	3	Data obtained was relevant to aims.	3	The stakeholder approach utilised more than one person in the analysis of the data and provided a quality control.

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Table 8

CASP (2023) Questions 11-14 Comments Relating to the Reviewed Studies

Study	Ethical Issues	Sufficient rigour of data analysis	Clear findings statement	Valuable Research

1	3	Approval was sought via a university and informed consent was clearly detailed and participants were able to withdraw consent.	3	The authors report their findings and give sufficient explanation and quotes for the themes that emerged from the data.	3	Findings are presented clearly, and the conclusion is commensurate to this.	3	This is a useful study was applications to better understanding ATGD people's experiences.
2	3	Approval was sought from a university and the NHS and participants were subject to informed consent procedures.	1	The authors report their findings and give sufficient explanation and quotes for the themes that emerged from the data. However, they advise some themes are richer than others.	3	Conclusions are tentative and the researchers utilised reflective journals and data was discussed by the authors and credibility checks were provided which were audited by an independent researcher.	3	The research area is emerging, and the study is relevant to add to this, the conclusions are discussed within this context.

3	3	Approval was sought from NHS and participants were subject to informed consent procedures. Adaptations were made for the inclusion of participants who needed this.	3	The authors report their findings and give sufficient quotes and examples for the IPA method.	3	Conclusions are tentative and there was more than one researcher involved and supervision procedures around IPA were utilised.	3	The researchers provided sufficient literature review at the beginning of their paper and consider the context in which the results are relevant and their clinical implications.
4	3	Approval was sought from the NHS HRA and participants were subject to informed consent procedures. Adaptations were made for the inclusion of participants who needed this.	3	The authors report their findings and give sufficient quotes and examples for the IPA method.	3	Conclusions are tentative and there was more than one researcher involved and supervision procedures around IPA were utilised.	3	The researchers provided sufficient literature review at the beginning of their paper and consider the context in which the results are relevant and their clinical implications.

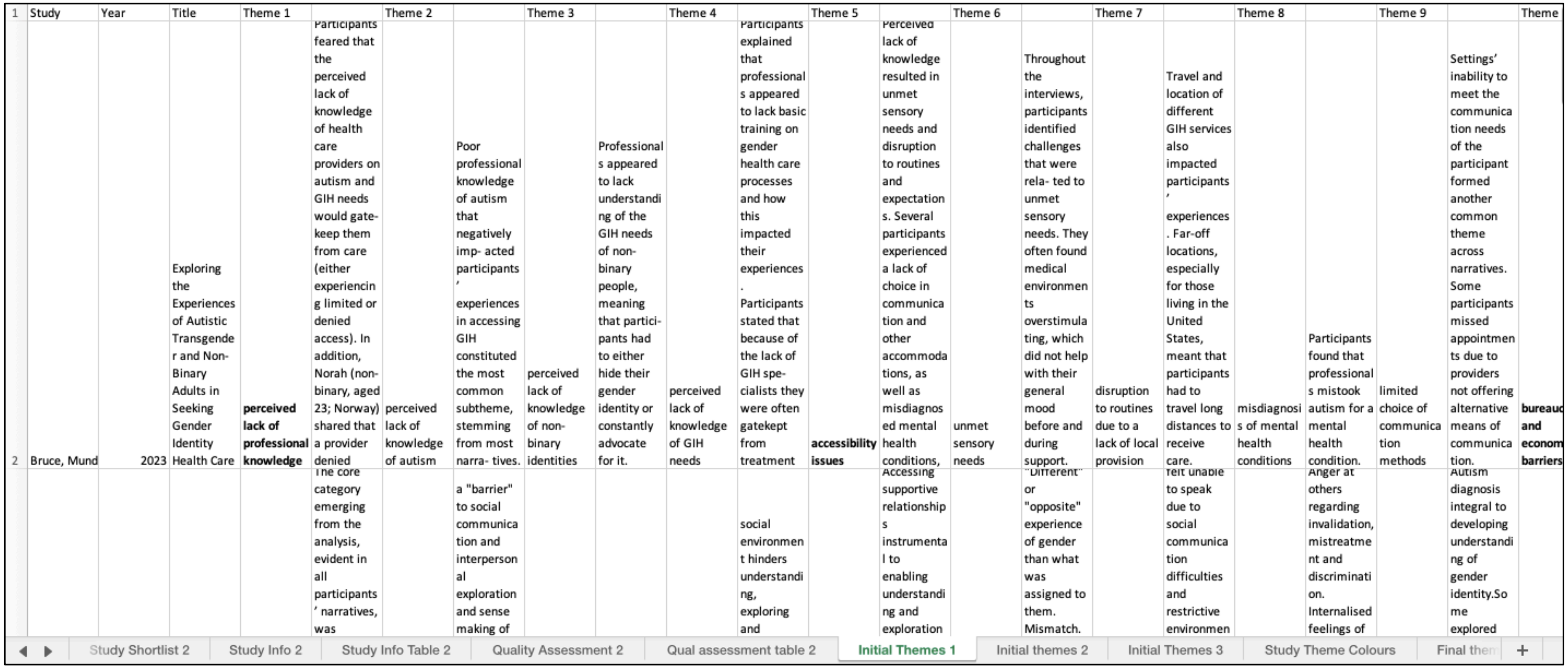
5	3	Approval was sought from the NHS HRA and participants were subject to informed consent procedures. Adaptations were made for the inclusion of participants who needed this.	3	The authors report their findings and due to high number of participants involved can substantiate the themes with a high degree of support.	3	Conclusions are appropriate based on the data presented and the current findings in existing studies.	3	The researchers provided sufficient literature review at the beginning of their paper and consider the context in which the results are relevant and their clinical implications.
6	3	Approval was sought from a university institutional review board; consideration was also given to participants capacity to take part and give consent.	1	The authors report their findings and give sufficient quotes and examples for the grounded theory method. It may have been helpful to have an independent EBE to provide insight into this.	3	The authors report their findings clearly and consider clinical and wider applications.	3	The authors report numerous research papers related to the topic studied and consider the impact of the current study, limitations, and future areas for research.
7	3	Ethical approval obtained; informed consent process explained.	3	Data analysis adequately explained, and themes generated and discussed.	3	Conclusions commensurate with themes generated from the data and the importance of the study results considered.	3	New emerging area of research with multiple clinical implications.

8	3	Ethical approval obtained; informed consent process explained.	3	Data analysis adequately explained, and themes generated and discussed.	3	Conclusions commensurate with themes generated from the data and the importance of the study results considered.	3	New emerging area of research with multiple clinical implications.

Appendix 1D

Figure 4

The Initial Extraction Grid Example 1

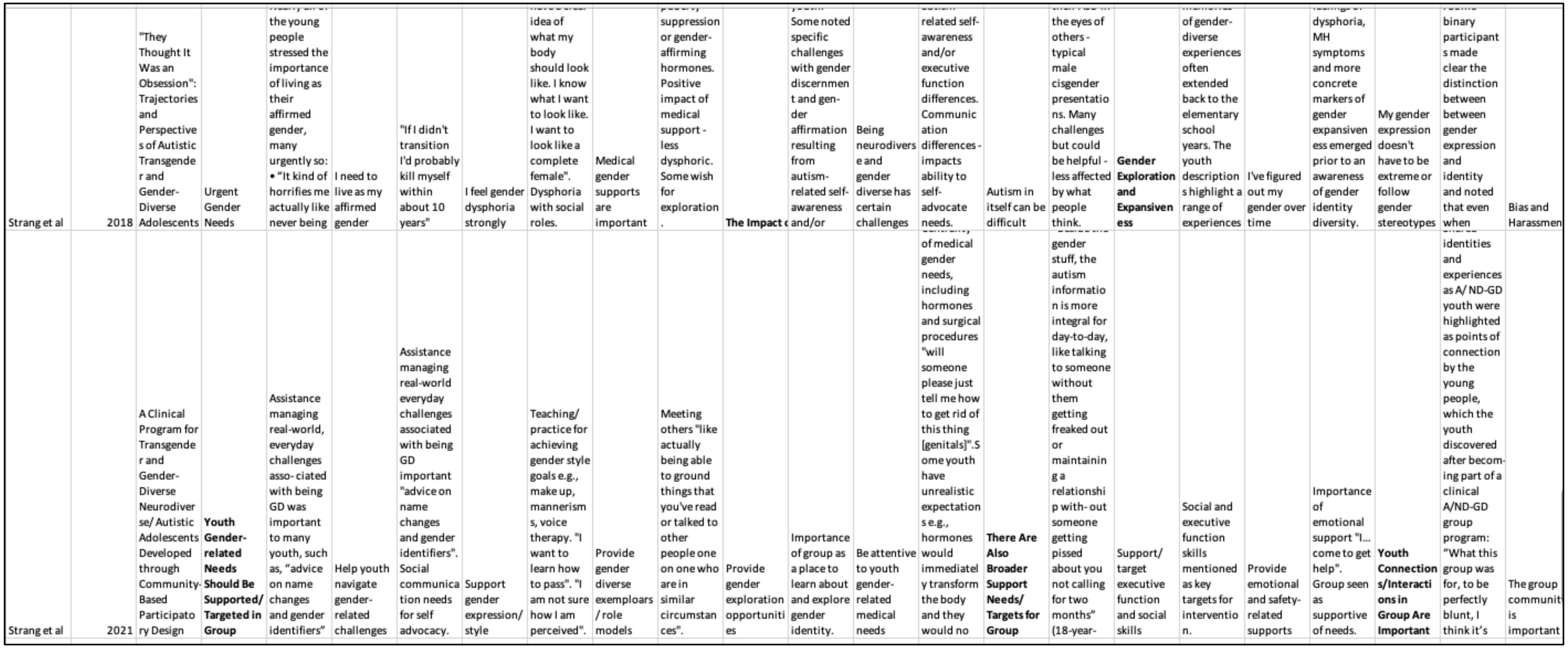


1	Study	Year	Title	Theme 1		Theme 2		Theme 3		Theme 4		Theme 5		Theme 6		Theme 7		Theme 8		Theme 9		Theme
2	Bruce, Mund	2023	Exploring the Experiences of Autistic Transgender and Non-Binary Adults in Seeking Gender Identity Health Care	**perceived lack of professional knowledge**	Participants feared that the perceived lack of knowledge of health care providers on autism and GIH needs would gate-keep them from care (either experiencing limited or denied access). In addition, Norah (non-binary, aged 23; Norway) shared that a provider denied	perceived lack of knowledge of autism	Poor professional knowledge of autism that negatively impacted participants’ experiences in accessing GIH constituted the most common subtheme, stemming from most narra- tives.	perceived lack of knowledge of non-binary identities	Professionals appeared to lack understanding of the GIH needs of non-binary people, meaning that participants had to either hide their gender identity or constantly advocate for it.	perceived lack of knowledge of GIH needs	Participants explained that professionals appeared to lack basic training on gender health care processes and how this impacted their experiences. Participants stated that because of the lack of GIH specialists they were often gatekept from treatment	**accessibility issues**	Perceived lack of knowledge resulted in unmet sensory needs and disruption to routines and expectations. Several participants experienced a lack of choice in communication and other accommodations, as well as misdiagnosed mental health conditions,	unmet sensory needs	Throughout the interviews, participants identified challenges that were related to unmet sensory needs. They often found medical environments overstimulating, which did not help with their general mood before and during support.	disruption to routines due to a lack of local provision	Travel and location of different GIH services also impacted participants’ experiences. Far-off locations, especially for those living in the United States, meant that participants had to travel long distances to receive care.	misdiagnosis of mental health conditions	Participants found that professionals mistook autism for a mental health condition.	limited choice of communication methods	Settings’ inability to meet the communication needs of the participant formed another common theme across narratives. Some participants missed appointments due to providers not offering alternative means of communication.	**bureau and econom barriers**
					The core category emerging from the analysis, evident in all participants’ narratives, was		a "barrier" to social communication and interpersonal exploration and sense making of				social environment hinders understanding, exploring and		Accessing supportive relationships instrumental to enabling understanding and exploration		"Different" or "opposite" experience of gender than what was assigned to them. Mismatch.		felt unable to speak due to social communication difficulties and restrictive environmen		Anger at others regarding invalidation, mistreatment and discrimination. Internalised feelings of		Autism diagnosis integral to developing understanding of gender identity.Some explored	

Appendix 1E

Figure 5

The Initial Extraction Grid Example 2



Strang et al	2018	"They Thought It Was an Obsession": Trajectories and Perspectives of Autistic Transgender and Gender-Diverse Adolescents	Urgent Gender Needs	the young people stressed the importance of living as their affirmed gender, many urgently so: • "It kind of horrifies me actually like never being	I need to live as my affirmed gender	"If I didn't transition I'd probably kill myself within about 10 years"	I feel gender dysphoria strongly	idea of what my body should look like. I know what I want to look like. I want to look like a complete female". Dysphoria with social roles.	Medical gender supports are important	suppression or gender-affirming hormones. Positive impact of medical support - less dysphoric. Some wish for exploration .	**The Impact**	Some noted specific challenges with gender discernment and gender affirmation resulting from autism-related self-awareness and/or	Being neurodiverse and gender diverse has certain challenges	related self-awareness and/or executive function differences. Communication differences - impacts ability to self-advocate needs.	Autism in itself can be difficult	the eyes of others - typical male cisgender presentations. Many challenges but could be helpful - less affected by what people think.	**Gender Exploration and Expansiveness**	of gender-diverse experiences often extended back to the elementary school years. The youth descriptions highlight a range of experiences	I've figured out my gender over time	dysphoria, MH symptoms and more concrete markers of gender expansiveness emerged prior to an awareness of gender identity diversity.	My gender expression doesn't have to be extreme or follow gender stereotypes	binary participants made clear the distinction between between gender expression and identity and noted that even when	Bias and Harassmen
Strang et al	2021	A Clinical Program for Transgender and Gender-Diverse Neurodiverse/ Autistic Adolescents Developed through Community-Based Participatory Design	**Youth Gender-related Needs Should Be Supported/ Targeted in Group**	Assistance managing real-world, everyday challenges asso- ciated with being GD was important to many youth, such as, "advice on name changes and gender identifiers"	Help youth navigate gender-related challenges	Assistance managing real-world everyday challenges associated with being GD important "advice on name changes and gender identifiers". Social communication needs for self advocacy.	Support gender expression/ style	Teaching/ practice for achieving gender style goals e.g., make up, mannerisms, voice therapy. "I want to learn how to pass". "I am not sure how I am perceived".	Provide gender diverse exemploars / role models	Meeting others "like actually being able to ground things that you've read or talked to other people one on one who are in similar circumstances".	Provide gender exploration opportunities	Importance of group as a place to learn about and explore gender identity.	Be attentive to youth gender-related medical needs	of medical gender needs, including hormones and surgical procedures "will someone please just tell me how to get rid of this thing [genitals]".Some youth have unrealistic expectations e.g., hormones would immediately transform the body and they would no	**There Are Also Broader Support Needs/ Targets for Group**	gender stuff, the autism information is more integral for day-to-day, like talking to someone without them getting freaked out or maintaining a relationship with- out someone getting pissed about you not calling for two months" (18-year-	Support/ target executive function and social skills	Social and executive function skills mentioned as key targets for intervention.	Provide emotional and safety-related supports	Importance of emotional support "I… come to get help". Group seen as supportive of needs.	**Youth Connections/Interactions in Group Are Important**	identities and experiences as A/ ND-GD youth were highlighted as points of connection by the young people, which the youth discovered after becom- ing part of a clinical A/ND-GD group program: "What this group was for, to be perfectly blunt, I think it's	The group communit is important

Appendix 1F

Figure 6

Phase 4 Determine How the Studies are Related

				Autism as a barrier	Distress	Autism as a facilitator	Need for supportive relationships	Impact of environment and people	Need for support in transition	Incongruence of sex and GI	Isolation	Adaptation for Autism	Assumption of Autism meaning they are not Trans/GD	Emergence of identity over time	Future can be varied	Autism as a barrier	Distress	Autism as a facilitator	Need for supportive relationships	Impact of environment and people	Need for support in transition	Incongruence of sex and GI	Isolation	Adaptation for Autism	Assumption of ASD meaning they are not GD	Emergence of identity over time	Fu be
Maroney, Horne	2022	"Tuned into a different channel": Autistic transgender adults' experiences of intersectional stigma.	**Labeling Myself as Both Trans and Autistic Has Been "Freeing," but I Sometimes "Shield My Identities" to Avoid Stigma**	described a freeing sense of relief as they began to understand and claim their autistic-TNG identities. Despite this increasing that ease autistic-TNG participants reported they experi-enced once they found language that fit, they also	Being autistic doesn't jive with gender norms, freeing autistic-TNG people to be empathetic and open	"doesn't stick" or resonate with them, it's interrelated to being autistic. Autism as immunity to social norms, could live authentically and present as they wanted. Not holding self to gendered expectation and felt relative freedom.	I have to "shield my identities from others" or avoid disclosing due to stigma and seeking safety	hide parts of self from society that does not accept them. Difficulty of being self in social settings. Vigilant due to safety concerns. Coming out online easier. Worries re stigma and marginalisation for both identities. Misunderstood due to	Labelling my identities was intuitive and a "gradual relief", helping to name something "I've always known"	labels that fit "freeing". Initially painful to accept ASD but began to help them make sense and was a relief. Other identities e.g., ethnicity interrelated with ASD, influenced and impacted it. ASD can clash with identities e.g., don't	**Identifying as TNG-Autistic Means My "Circle Has Gotten Smaller" as I Prioritize the "Handful" of People Who "Get Me," Including Other TNG-Autistic People and Online Communities**	Participants described sources of social support as well as unique challenges to finding a support system that was validating and understanding of participants as both autistic and TNG.	I feel most comfortable with others who share my trans or autistic identities, and I prioritise connection in online spaces with other TNG-Autistic folks	support for ASD and GD onlinr. Could have conversations where the expectation of normativity is gone. Prefer spaces where don't have to mask .Make connections and support others. Easy to communicate with other ASD and GD	"Normative" expectations rooted in cissexism and ableism have made it difficult to navigate interpersonal relationships, but I have a handful of people who support me	fitting in with others expectations. Challenges in socialising and relating to others. Conflict of needing solitude and support.felt like "outcast". Challenge fitting in, some support which provided validation of identity. Importance	Intersectional discrimination creates within and between group tensions in the TNG and autistic communities	discrimination or challenges fitting in with communities they felt they should feel part of TNG, ASD, due to cissexism, heterosexism, ableism, racism and intersectional stigma. Easier to fit in one community e.g., neurodivergent or LGBTQ. some found	Supportive family members view my identities as valid, but it is complex, and few members support both.	unwilling to acknowledge or acceptance and understanding. Famuly support influenced by cultural or societal norms. Some families had greater difficulty accepting autism. Acceptance included being "open minded", encouragement to	**Seeking Care While Trans and Autistic Is a Perilous Journey to Find a Provider Who Knows Enough About Even One of My Experiences**	highlighted the lack of health and mental health services and providers that were knowledgeable about autistic or transgender individuals, particularly those living at the intersection of both. Participants spoke with anger when detailing experiences	There are a number of barriers to accessing services as a TGN-autistic person due to limited affirming providers or services	impossible" to find providers who understand both autism and their gender identity, or providers who will not use them against them - frequently invalidated. Limited support and resources. Worry about being discriminated against - avoided seeking	Sometimes it's a means to an end: I've experienced providers who use autism to undermine gender identity, fail to affirm my identities, or overexplain unrelated challenges	services for support. Seeking diagnosis for access to services for interventions. Negative experiences from providers who didn't prioritse needs or provide tgn affirmative care. Providers making assumptions about them. providers not	TG au sh inc pro wh the kn of int n s aff ide an my ex as
		"They Thought It Was an		gender needs was the most prominent theme both in terms of emotional emphasis and quantity of statements . Nearly all of the				"I don't like my body at all. It feels wrong and I have a clear idea of what my		Importance of medical support, some hopeful to start puberty suppression		arising from the co-occurrence of neurodiversity and gender diversity were described by many youth. Some		Challenges with gender discernment and gender affirmation resulting from autism related self-awareness		Gender and gender diversity obfuscated their ASD in the eyes of others - typical		youth described their gender identity as developing and coming into focus over time, and as previously noted, memories		Vague feelings of dysphoria, MH symptoms		binary identities described comfort with, and in some cases preference for, nonbinary gender expressions . Some binary		gender exploration over time was a central aspect of many of the participants' gender discernment (Table 4, Theme 3a),		Discomfort exploring	

Appendix 1G

Figure 7

Phase 5 Translating Studies Part 1

1			Distress	Incongruence of sex and GI	Need for support in gender transition	Autism as a barrier	Emergence of identity over time	Assumption of Autism meaning they are not Transgender of experiencing GD	Future can be varied	Need for supportive relationships	Impact of environment and people	Autism as a facilitator	Adaptations wanted due to autism
2	Study	Year											
3	Bruce, Munda	2023			x	x					x		x
4	Coleman-Smith, Smith, Milne, Thompson	2020	x	x	x	x		x		x	x	x	
5	Cooper, Butler, Russell, Mandy	2022	x		x	x				x		x	
6	Cooper, Mandy, Butler, Russell	2022	x		x	x		x			x	x	
7	Cooper, Mandy, Butler, Russell	2023			x	x	x					x	x
8	Maroney, Horne	2022	x		x	x		x		x	x	x	x
9	Strang et al	2018	x	x	x	x	x	x	x	x	x	x	x
10	Strang et al	2021			x	x				x		x	x
11													

Appendix 1H

Figure 8

Phase 5 Translating Studies Part 2

Appendix 1I

Figure 9

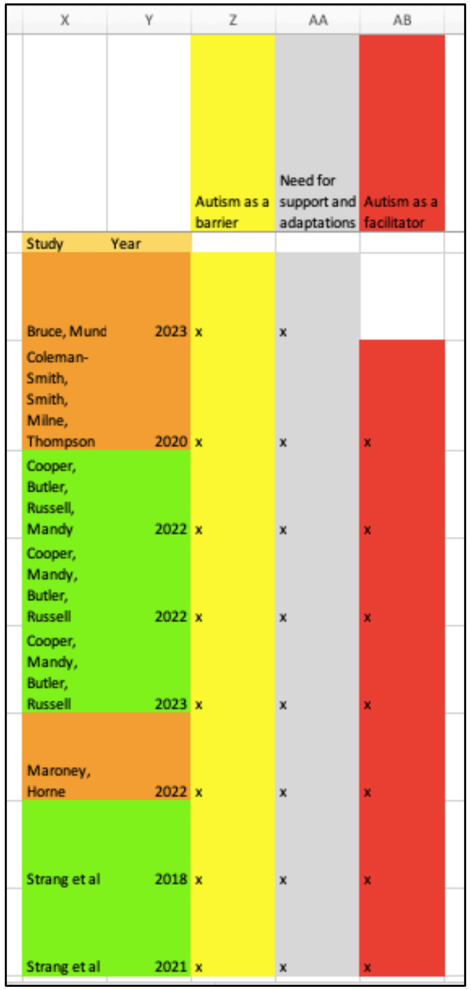
Phase 5 Translating Studies Part 3

O	P	Q	R	S	T	U	V
		Autism as a barrier	Autism as a facilitator	Need for supportive relationships	Impact of environment and people	Need for support in transition	Adaptation for Autism
Study	Year						
Bruce, Mund	2023	x			x	x	x
Coleman-Smith, Smith, Milne, Thompson	2020	x	x	x	x	x	
Cooper, Butler, Russell, Mandy	2022	x	x	x		x	
Cooper, Mandy, Butler, Russell	2022	x	x		x	x	
Cooper, Mandy, Butler, Russell	2023	x	x			x	x
Maroney, Horne	2022	x	x	x	x	x	x
Strang et al	2018	x	x	x	x	x	x
Strang et al	2021	x	x	x		x	x

Appendix 1J

Figure 10

Phase 5 Translating Studies Part 4



X	Y	Z	AA	AB
		Autism as a barrier	Need for support and adaptations	Autism as a facilitator
Study	Year			
Bruce, Mund	2023	x	x	
Coleman-Smith, Smith, Milne, Thompson	2020	x	x	x
Cooper, Butler, Russell, Mandy	2022	x	x	x
Cooper, Mandy, Butler, Russell	2022	x	x	x
Cooper, Mandy, Butler, Russell	2023	x	x	x
Maroney, Horne	2022	x	x	x
Strang et al	2018	x	x	x
Strang et al	2021	x	x	x

Appendix 1K

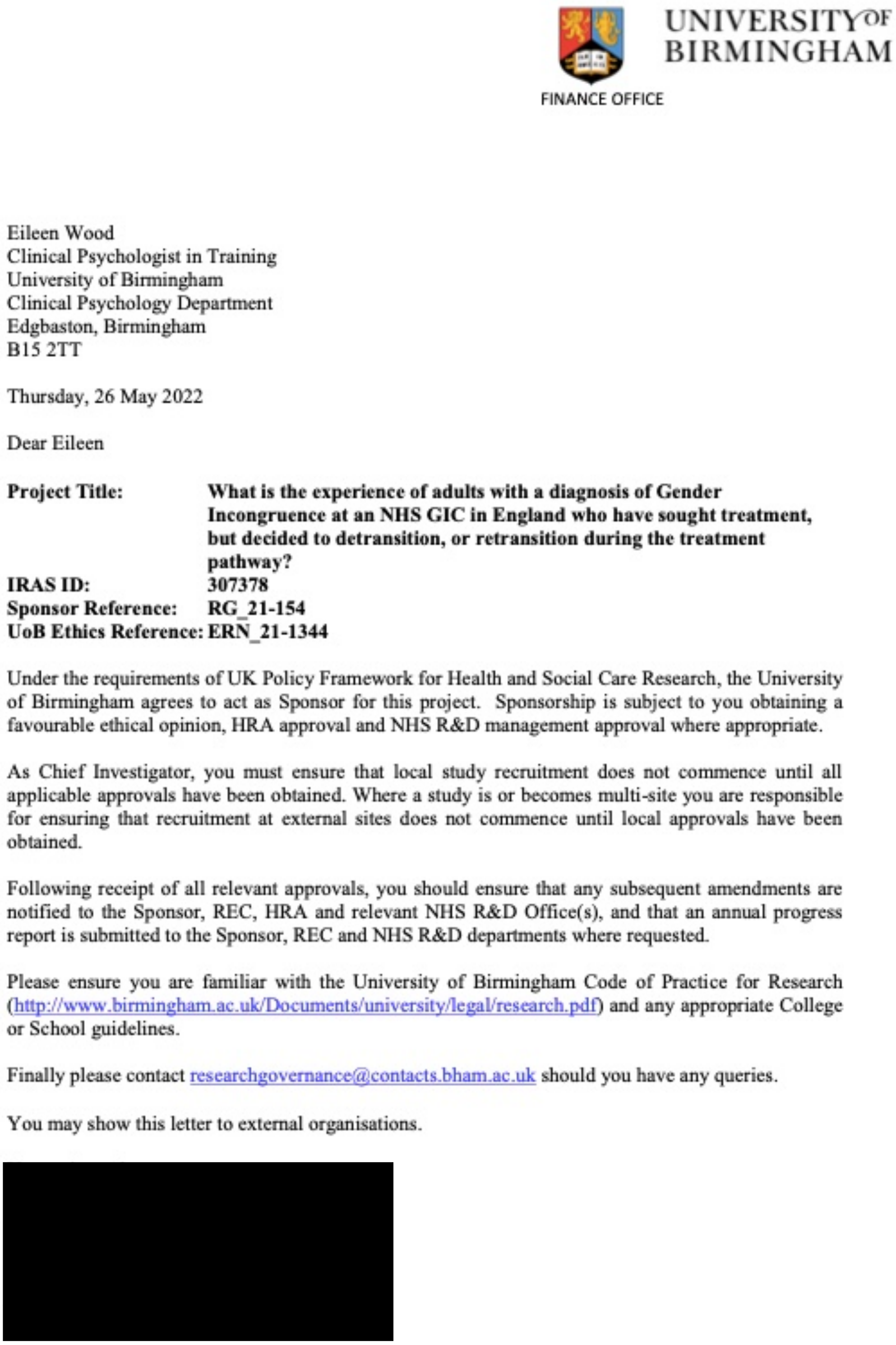
Figure 11

Synthesising the Translations Part 1

Study	Year	Theme	Info										Quote	Author	Further Info	Thoughts	
Bruce, Munc	2023	**perceived lack of professional knowledge**	access). In addition, Norah (non-binary, aged 23; Norway) shared that a provider	perceived lack of knowledge of autism	GIH constituted the most common subtheme, stemming from most narra- tives.	perceived lack of knowledge of GIH needs	that because of the lack of GIH specialists they were often gatekept from						r; aged 24; Teeside, United Kingdon) stated that even if a professionl's	Negative experiences, talked down to, ignored in favour of a person perceived	difficulties with clinics an issue, participants feeling frustrated and invalidated	from professionals who are perceived as not accomodating of difficulties	
Coleman-Smith, Smith, Milne, Thompson	2020	**Conflcit vs C**	category emerging from the analysis, evident in all participants' narratives, was '*conflict versus congruence*'. This lies at the heart of the experience of GD in adults with autism who have sought to undertake social and physical transition.	Autism as a barrier	a "barrier" to social communication and interpersonal exploration and sense making of gender identity. Marginalisation and invalidation of gender experiences as a result of autism. Impact on capacity to access services and having needs met by services.	Concealing, and suppressing gender feelings	to speak due to social communication difficulties and restrictive environments. Concealing gender identify and suppressing helped to escape some associated conflict and distress. Concealing experiences fearing wider societal disapproval	Percolation of gender feelings	diagnosis integral to developing understanding of gender identity.Some explored mandated sex to better understand it, unintended consequence of confirming their lack of it.Pieces coming intro place. Learning about transgenderism a key	Provision of clinical care	diagnosis may increase anxiety when attending a GIC.need for guidance from services.Felt denied treatment due to ASD. Distress at lack of transparency and predictability.fear of not being given treatment. Communication difficulties.		[Autism] makes it really difficult to say how I feel… I know lot's of trans people who don't have a problem voicing their emotions, and how dysphoria affects them. P 2648Kate: Autism complicates things…it's always more complicate	A key theme emerging from this research is that autism was fundamental to the sense of conflict in compounding the challenges associated with GD. Autism as a barrier, as a restrictor	Impacts - coming to understand identity, express authentic self, exacerbates the impact of the social environment, communication as a barrier, affects social communication, interpersonal sense-making	Autism perceived as a barrier affecting access to appropriate healthcare, autism related difficulties such as challenges with communications cited as a major factor as is ignorance from professionals who are perceived as not accomodating of difficulties	
			at the need of support to										…feels like I'm covered	Autistic participant	styles seen as helping or		

Appendix 2

Appendix 2A: The University of Birmingham Ethical Approval Letter



UNIVERSITY OF
BIRMINGHAM
FINANCE OFFICE

Eileen Wood
Clinical Psychologist in Training
University of Birmingham
Clinical Psychology Department
Edgbaston, Birmingham
B15 2TT

Thursday, 26 May 2022

Dear Eileen

Project Title: **What is the experience of adults with a diagnosis of Gender Incongruence at an NHS GIC in England who have sought treatment, but decided to detransition, or retransition during the treatment pathway?**
IRAS ID: **307378**
Sponsor Reference: **RG_21-154**
UoB Ethics Reference: **ERN_21-1344**

Under the requirements of UK Policy Framework for Health and Social Care Research, the University of Birmingham agrees to act as Sponsor for this project. Sponsorship is subject to you obtaining a favourable ethical opinion, HRA approval and NHS R&D management approval where appropriate.

As Chief Investigator, you must ensure that local study recruitment does not commence until all applicable approvals have been obtained. Where a study is or becomes multi-site you are responsible for ensuring that recruitment at external sites does not commence until local approvals have been obtained.

Following receipt of all relevant approvals, you should ensure that any subsequent amendments are notified to the Sponsor, REC, HRA and relevant NHS R&D Office(s), and that an annual progress report is submitted to the Sponsor, REC and NHS R&D departments where requested.

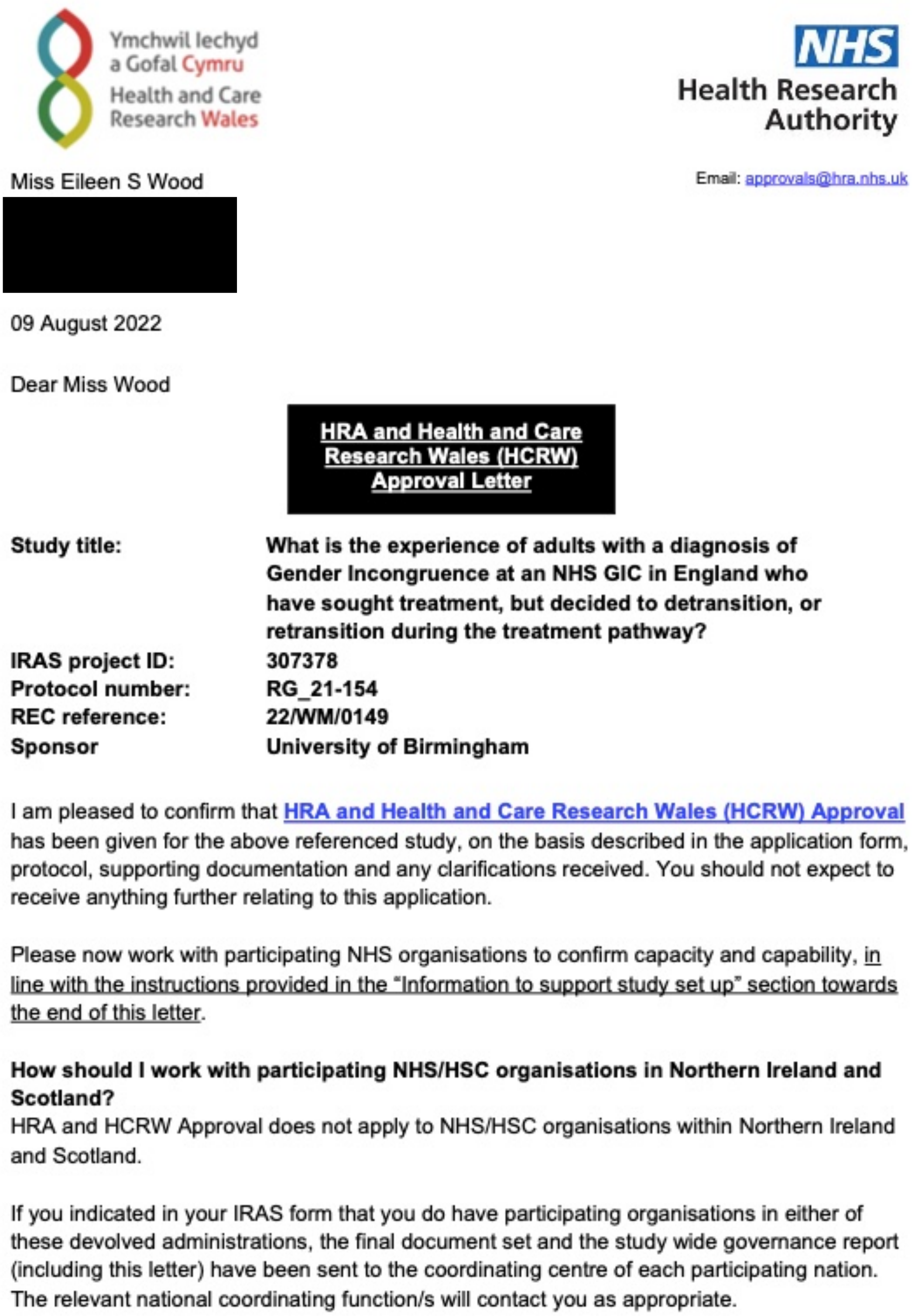
Please ensure you are familiar with the University of Birmingham Code of Practice for Research (http://www.birmingham.ac.uk/Documents/university/legal/research.pdf) and any appropriate College or School guidelines.

Finally please contact researchgovernance@contacts.bham.ac.uk should you have any queries.

You may show this letter to external organisations.

[redacted]

Appendix 2B: The NHS HRA Ethical Approval Letter Page 1 of 2



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Email: approvals@hra.nhs.uk

Miss Eileen S Wood
[redacted]

09 August 2022

Dear Miss Wood

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**What is the experience of adults with a diagnosis of Gender Incongruence at an NHS GIC in England who have sought treatment, but decided to detransition, or retransition during the treatment pathway?**
IRAS project ID:	**307378**
Protocol number:	**RG_21-154**
REC reference:	**22/WM/0149**
Sponsor	**University of Birmingham**

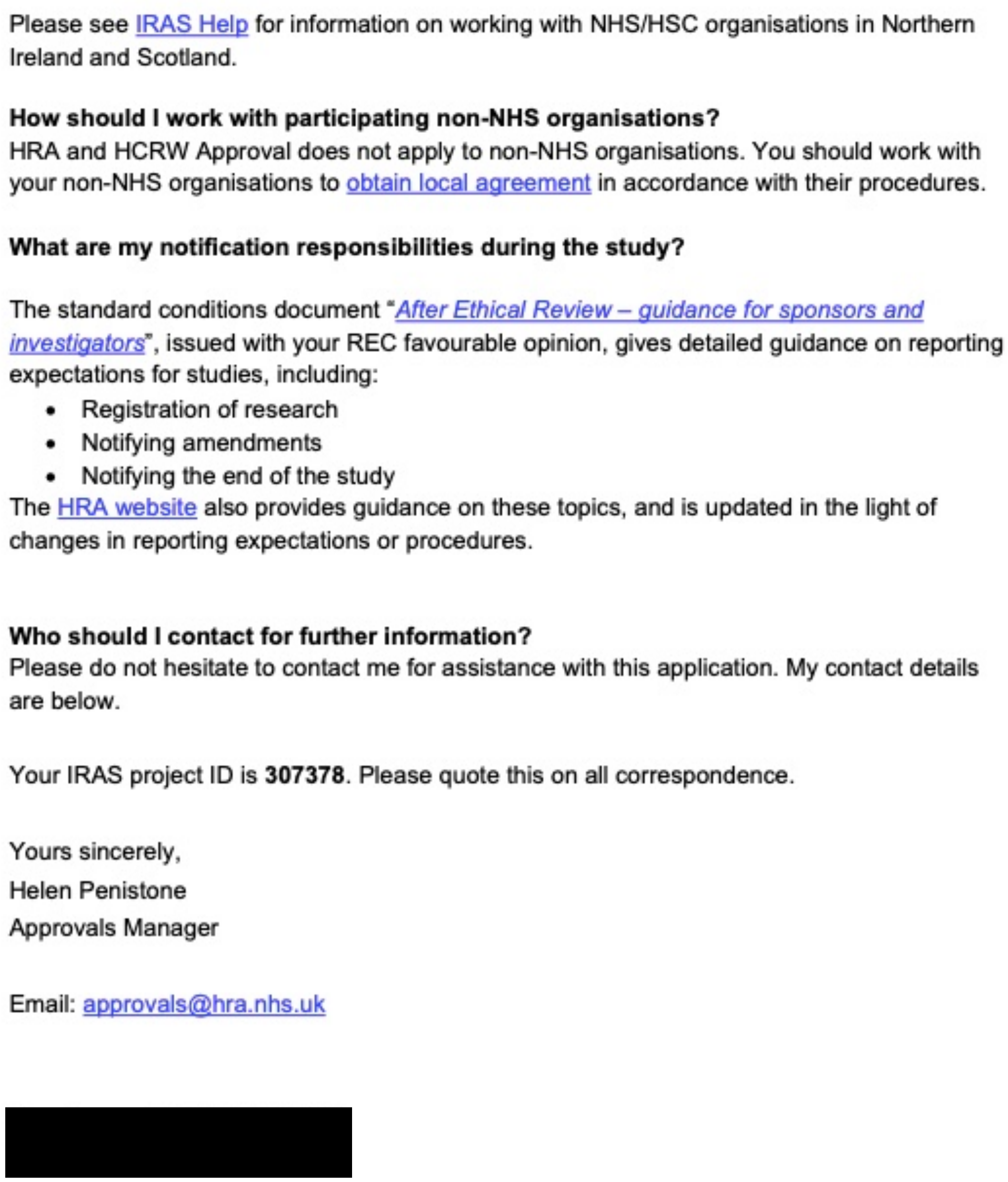
I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

The NHS HRA Ethical Approval Letter Page 2 of 2



Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

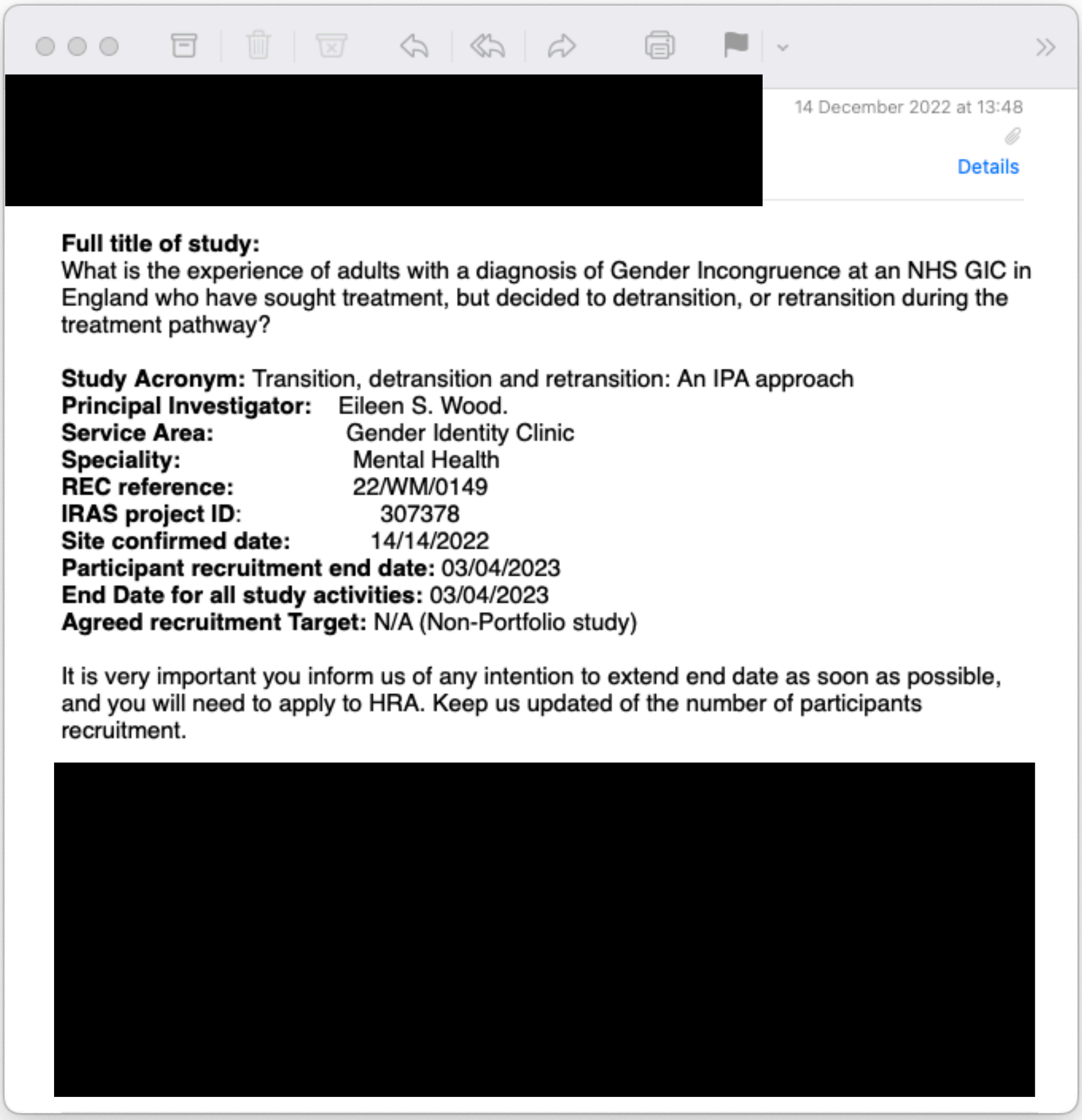
Your IRAS project ID is **307378**. Please quote this on all correspondence.

Yours sincerely,
Helen Penistone
Approvals Manager

Email: approvals@hra.nhs.uk

[redacted]

Appendix 2C: The Local Research and Innovation Department Email of Ethical Approval



[redacted]

14 December 2022 at 13:48

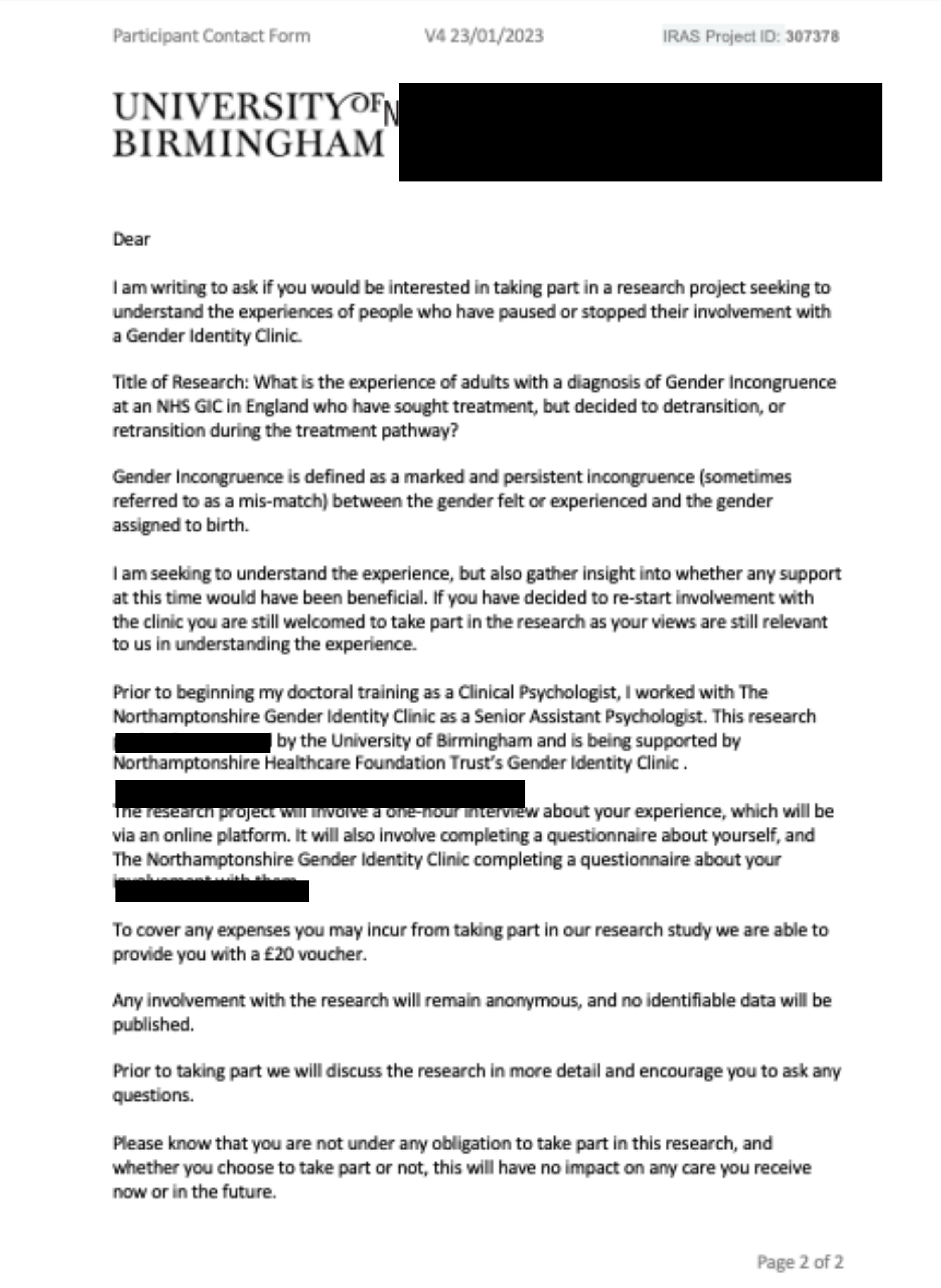
Full title of study:
What is the experience of adults with a diagnosis of Gender Incongruence at an NHS GIC in England who have sought treatment, but decided to detransition, or retransition during the treatment pathway?

Study Acronym: Transition, detransition and retransition: An IPA approach
Principal Investigator: Eileen S. Wood.
Service Area: Gender Identity Clinic
Speciality: Mental Health
REC reference: 22/WM/0149
IRAS project ID: 307378
Site confirmed date: 14/14/2022
Participant recruitment end date: 03/04/2023
End Date for all study activities: 03/04/2023
Agreed recruitment Target: N/A (Non-Portfolio study)

It is very important you inform us of any intention to extend end date as soon as possible, and you will need to apply to HRA. Keep us updated of the number of participants recruitment.

[redacted]

Appendix 2D: The Participant Contact Form Page 1 of 2



Participant Contact Form V4 23/01/2023 IRAS Project ID: 307378

UNIVERSITY OF
BIRMINGHAM [redacted]

Dear

I am writing to ask if you would be interested in taking part in a research project seeking to understand the experiences of people who have paused or stopped their involvement with a Gender Identity Clinic.

Title of Research: What is the experience of adults with a diagnosis of Gender Incongruence at an NHS GIC in England who have sought treatment, but decided to detransition, or retransition during the treatment pathway?

Gender Incongruence is defined as a marked and persistent incongruence (sometimes referred to as a mis-match) between the gender felt or experienced and the gender assigned to birth.

I am seeking to understand the experience, but also gather insight into whether any support at this time would have been beneficial. If you have decided to re-start involvement with the clinic you are still welcomed to take part in the research as your views are still relevant to us in understanding the experience.

Prior to beginning my doctoral training as a Clinical Psychologist, I worked with The Northamptonshire Gender Identity Clinic as a Senior Assistant Psychologist. This research [redacted] by the University of Birmingham and is being supported by Northamptonshire Healthcare Foundation Trust's Gender Identity Clinic .

[redacted] about your experience, which will be via an online platform. It will also involve completing a questionnaire about yourself, and The Northamptonshire Gender Identity Clinic completing a questionnaire about your [redacted]

To cover any expenses you may incur from taking part in our research study we are able to provide you with a £20 voucher.

Any involvement with the research will remain anonymous, and no identifiable data will be published.

Prior to taking part we will discuss the research in more detail and encourage you to ask any questions.

Please know that you are not under any obligation to take part in this research, and whether you choose to take part or not, this will have no impact on any care you receive now or in the future.

Page 2 of 2

The Participant Contact Form page 2 of 2

Participant Contact Form V4 23/01/2023 IRAS Project ID: 307378

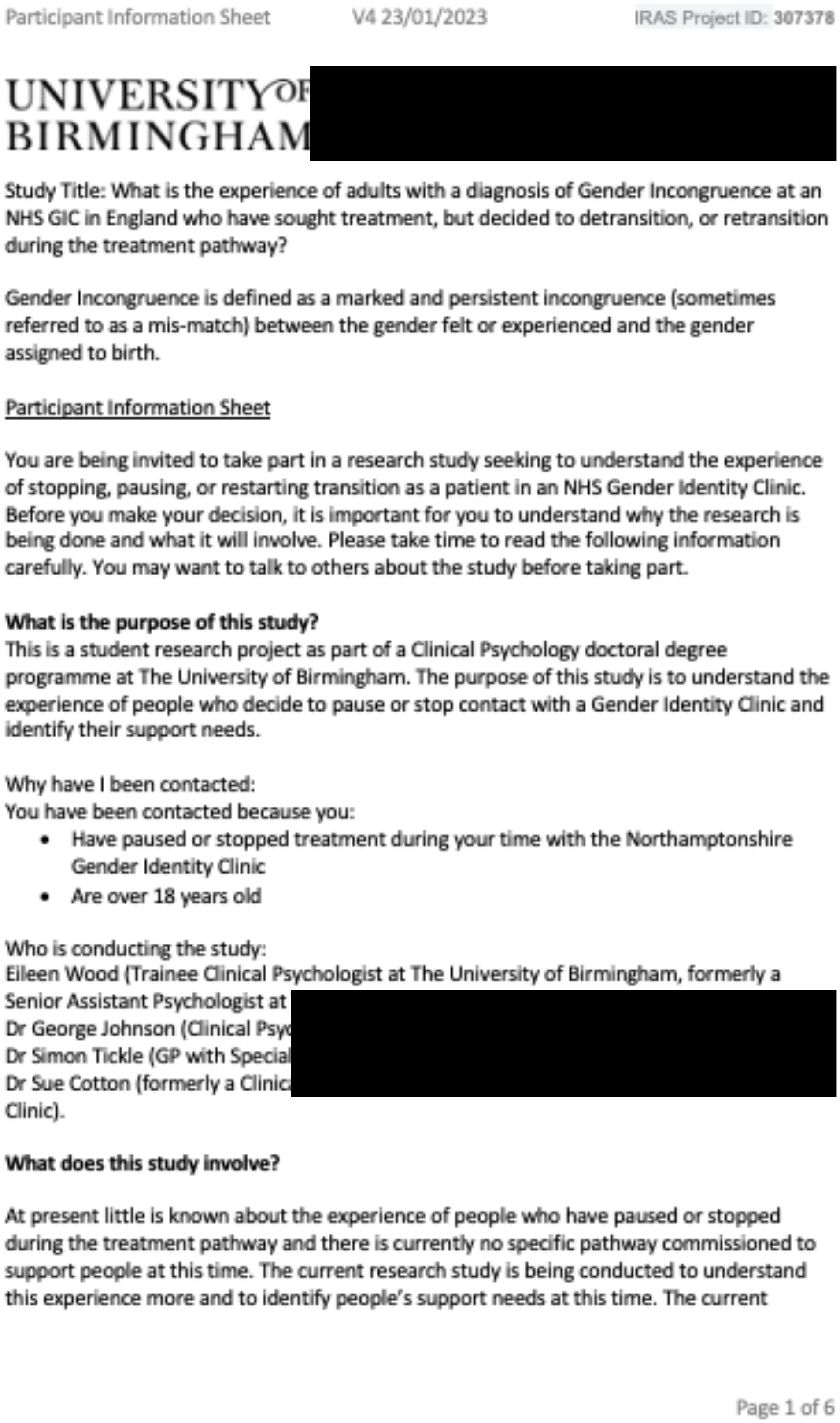
If you would like to ask any further questions, or take part in the study please contact Eileen Wood [redacted] and they will arrange to meet with you,

Yours sincerely,

Eileen Wood
Trainee Clinical Psychologist
University of Birmingham

Page 2 of 2

Appendix 2E: The Participant Information Sheet Page 1 of 6



Participant Information Sheet V4 23/01/2023 IRAS Project ID: 307378

UNIVERSITY OF
BIRMINGHAM [redacted]

Study Title: What is the experience of adults with a diagnosis of Gender Incongruence at an NHS GIC in England who have sought treatment, but decided to detransition, or retransition during the treatment pathway?

Gender Incongruence is defined as a marked and persistent incongruence (sometimes referred to as a mis-match) between the gender felt or experienced and the gender assigned to birth.

Participant Information Sheet

You are being invited to take part in a research study seeking to understand the experience of stopping, pausing, or restarting transition as a patient in an NHS Gender Identity Clinic. Before you make your decision, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. You may want to talk to others about the study before taking part.

What is the purpose of this study?
This is a student research project as part of a Clinical Psychology doctoral degree programme at The University of Birmingham. The purpose of this study is to understand the experience of people who decide to pause or stop contact with a Gender Identity Clinic and identify their support needs.

Why have I been contacted:
You have been contacted because you:

- Have paused or stopped treatment during your time with the Northamptonshire Gender Identity Clinic
- Are over 18 years old

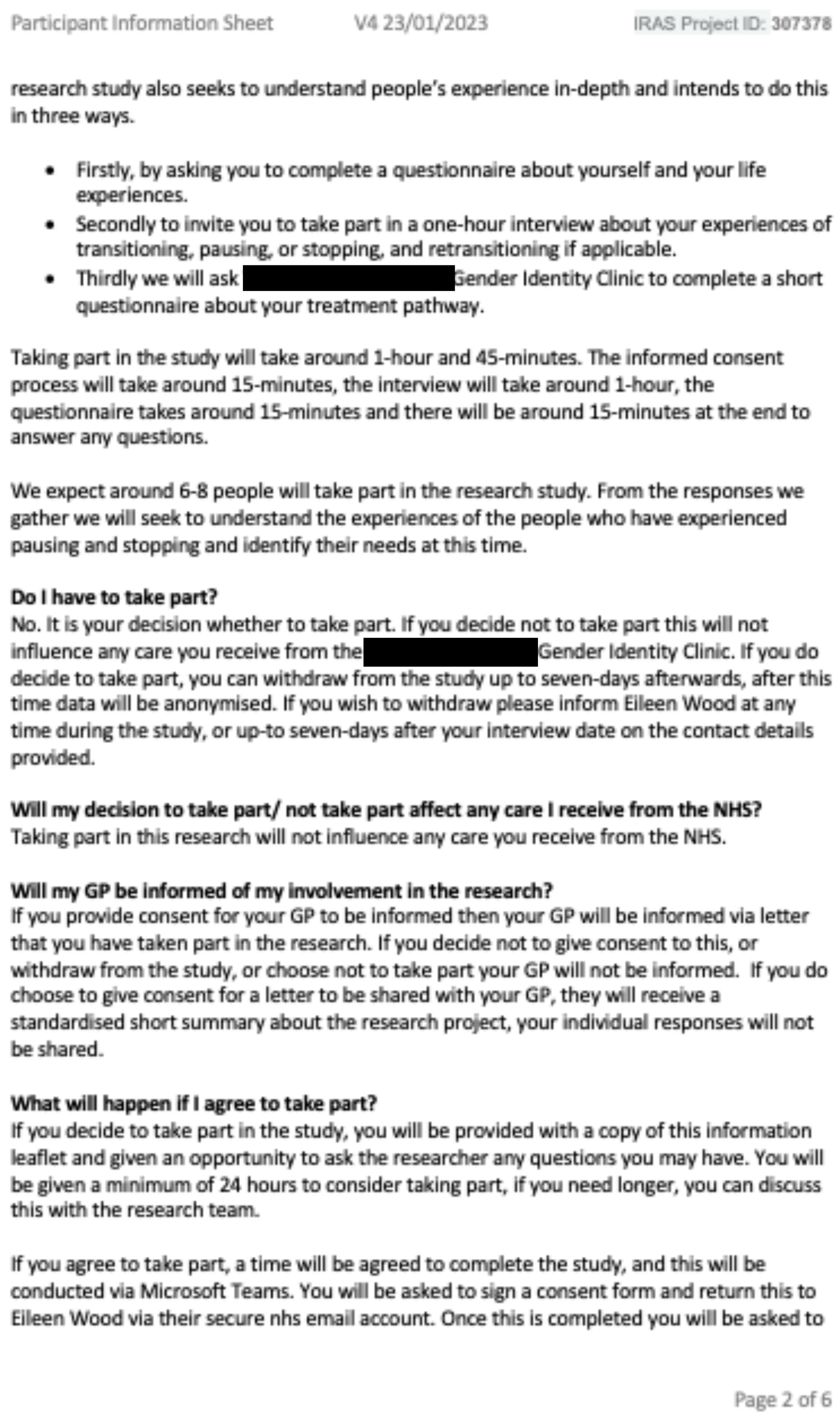
Who is conducting the study:
Eileen Wood (Trainee Clinical Psychologist at The University of Birmingham, formerly a
Senior Assistant Psychologist at [redacted]
Dr George Johnson (Clinical Psy
Dr Simon Tickle (GP with Special
Dr Sue Cotton (formerly a Clinic
Clinic).

What does this study involve?

At present little is known about the experience of people who have paused or stopped during the treatment pathway and there is currently no specific pathway commissioned to support people at this time. The current research study is being conducted to understand this experience more and to identify people's support needs at this time. The current

Page 1 of 6

The Participant Information Sheet Page 2 of 6



research study also seeks to understand people's experience in-depth and intends to do this in three ways.

- Firstly, by asking you to complete a questionnaire about yourself and your life experiences.
- Secondly to invite you to take part in a one-hour interview about your experiences of transitioning, pausing, or stopping, and retransitioning if applicable.
- Thirdly we will ask [redacted] Gender Identity Clinic to complete a short questionnaire about your treatment pathway.

Taking part in the study will take around 1-hour and 45-minutes. The informed consent process will take around 15-minutes, the interview will take around 1-hour, the questionnaire takes around 15-minutes and there will be around 15-minutes at the end to answer any questions.

We expect around 6-8 people will take part in the research study. From the responses we gather we will seek to understand the experiences of the people who have experienced pausing and stopping and identify their needs at this time.

Do I have to take part?
No. It is your decision whether to take part. If you decide not to take part this will not influence any care you receive from the [redacted] Gender Identity Clinic. If you do decide to take part, you can withdraw from the study up to seven-days afterwards, after this time data will be anonymised. If you wish to withdraw please inform Eileen Wood at any time during the study, or up-to seven-days after your interview date on the contact details provided.

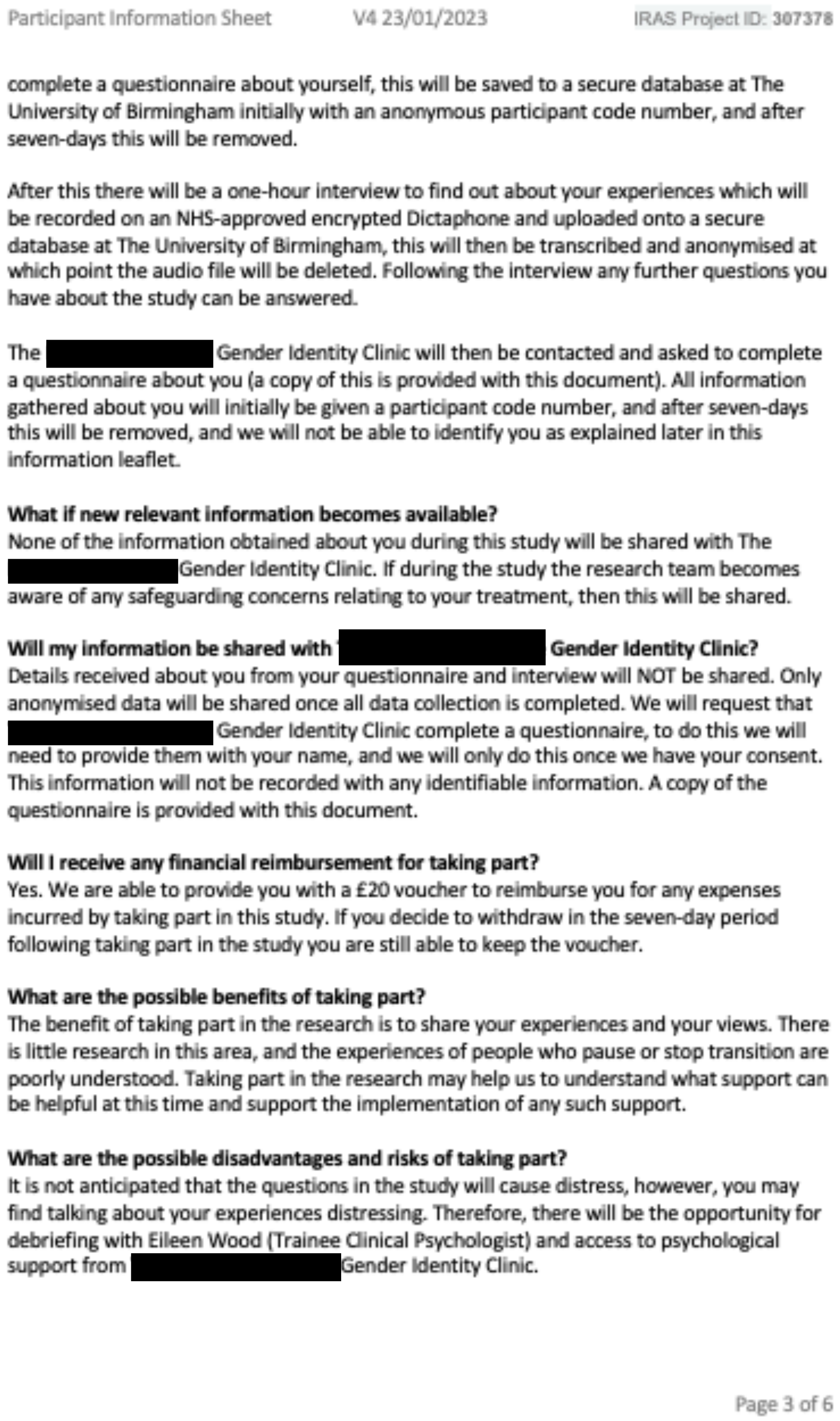
Will my decision to take part/ not take part affect any care I receive from the NHS?
Taking part in this research will not influence any care you receive from the NHS.

Will my GP be informed of my involvement in the research?
If you provide consent for your GP to be informed then your GP will be informed via letter that you have taken part in the research. If you decide not to give consent to this, or withdraw from the study, or choose not to take part your GP will not be informed. If you do choose to give consent for a letter to be shared with your GP, they will receive a standardised short summary about the research project, your individual responses will not be shared.

What will happen if I agree to take part?
If you decide to take part in the study, you will be provided with a copy of this information leaflet and given an opportunity to ask the researcher any questions you may have. You will be given a minimum of 24 hours to consider taking part, if you need longer, you can discuss this with the research team.

If you agree to take part, a time will be agreed to complete the study, and this will be conducted via Microsoft Teams. You will be asked to sign a consent form and return this to Eileen Wood via their secure nhs email account. Once this is completed you will be asked to

The Participant Information Sheet Page 3 of 6



complete a questionnaire about yourself, this will be saved to a secure database at The University of Birmingham initially with an anonymous participant code number, and after seven-days this will be removed.

After this there will be a one-hour interview to find out about your experiences which will be recorded on an NHS-approved encrypted Dictaphone and uploaded onto a secure database at The University of Birmingham, this will then be transcribed and anonymised at which point the audio file will be deleted. Following the interview any further questions you have about the study can be answered.

The [redacted] Gender Identity Clinic will then be contacted and asked to complete a questionnaire about you (a copy of this is provided with this document). All information gathered about you will initially be given a participant code number, and after seven-days this will be removed, and we will not be able to identify you as explained later in this information leaflet.

What if new relevant information becomes available?
None of the information obtained about you during this study will be shared with The [redacted] Gender Identity Clinic. If during the study the research team becomes aware of any safeguarding concerns relating to your treatment, then this will be shared.

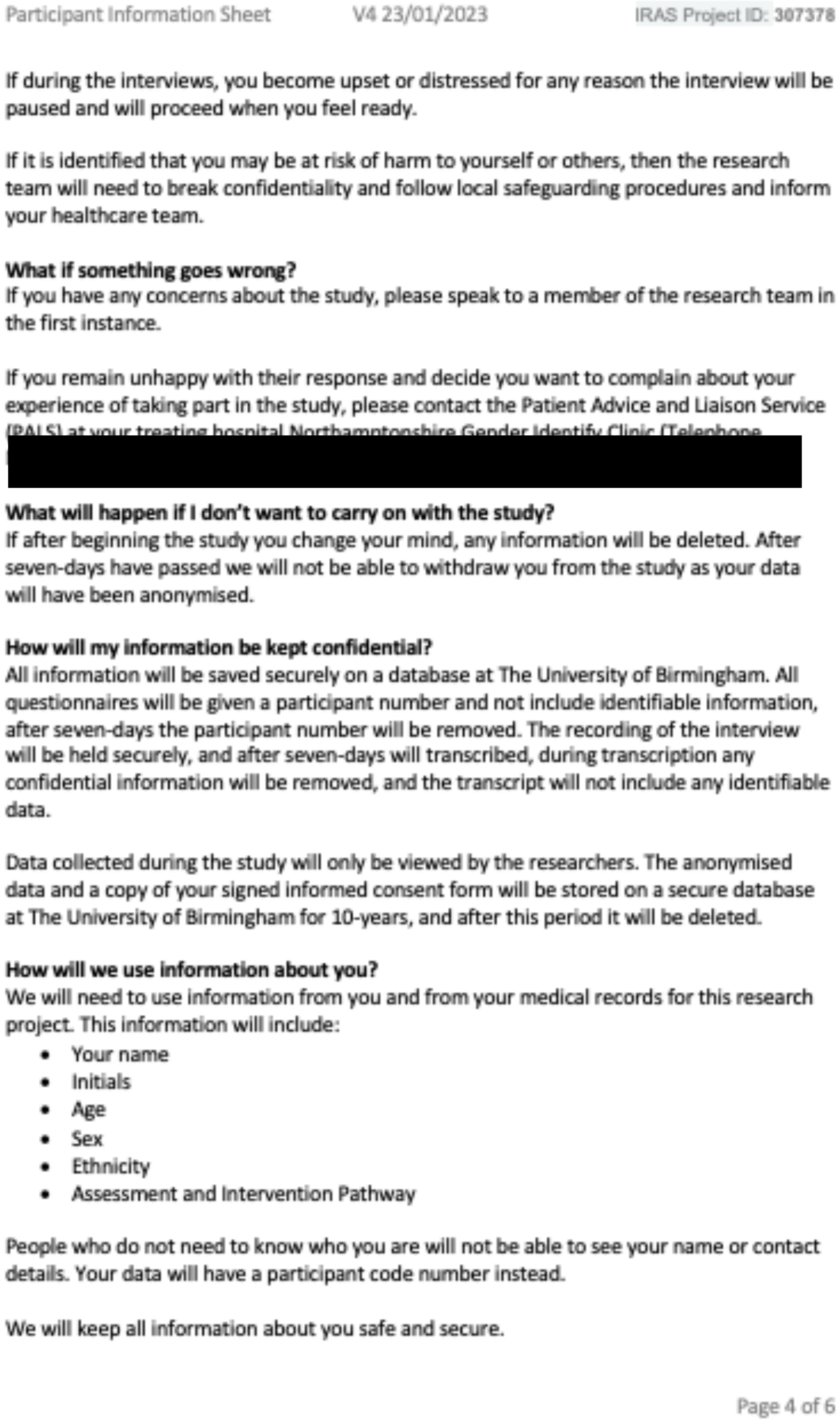
Will my information be shared with [redacted] Gender Identity Clinic?
Details received about you from your questionnaire and interview will NOT be shared. Only anonymised data will be shared once all data collection is completed. We will request that [redacted] Gender Identity Clinic complete a questionnaire, to do this we will need to provide them with your name, and we will only do this once we have your consent. This information will not be recorded with any identifiable information. A copy of the questionnaire is provided with this document.

Will I receive any financial reimbursement for taking part?
Yes. We are able to provide you with a £20 voucher to reimburse you for any expenses incurred by taking part in this study. If you decide to withdraw in the seven-day period following taking part in the study you are still able to keep the voucher.

What are the possible benefits of taking part?
The benefit of taking part in the research is to share your experiences and your views. There is little research in this area, and the experiences of people who pause or stop transition are poorly understood. Taking part in the research may help us to understand what support can be helpful at this time and support the implementation of any such support.

What are the possible disadvantages and risks of taking part?
It is not anticipated that the questions in the study will cause distress, however, you may find talking about your experiences distressing. Therefore, there will be the opportunity for debriefing with Eileen Wood (Trainee Clinical Psychologist) and access to psychological support from [redacted] Gender Identity Clinic.

The Participant Information Sheet Page 4 of 6



If during the interviews, you become upset or distressed for any reason the interview will be paused and will proceed when you feel ready.

If it is identified that you may be at risk of harm to yourself or others, then the research team will need to break confidentiality and follow local safeguarding procedures and inform your healthcare team.

What if something goes wrong?
If you have any concerns about the study, please speak to a member of the research team in the first instance.

If you remain unhappy with their response and decide you want to complain about your experience of taking part in the study, please contact the Patient Advice and Liaison Service [redacted]

What will happen if I don't want to carry on with the study?
If after beginning the study you change your mind, any information will be deleted. After seven-days have passed we will not be able to withdraw you from the study as your data will have been anonymised.

How will my information be kept confidential?
All information will be saved securely on a database at The University of Birmingham. All questionnaires will be given a participant number and not include identifiable information, after seven-days the participant number will be removed. The recording of the interview will be held securely, and after seven-days will transcribed, during transcription any confidential information will be removed, and the transcript will not include any identifiable data.

Data collected during the study will only be viewed by the researchers. The anonymised data and a copy of your signed informed consent form will be stored on a secure database at The University of Birmingham for 10-years, and after this period it will be deleted.

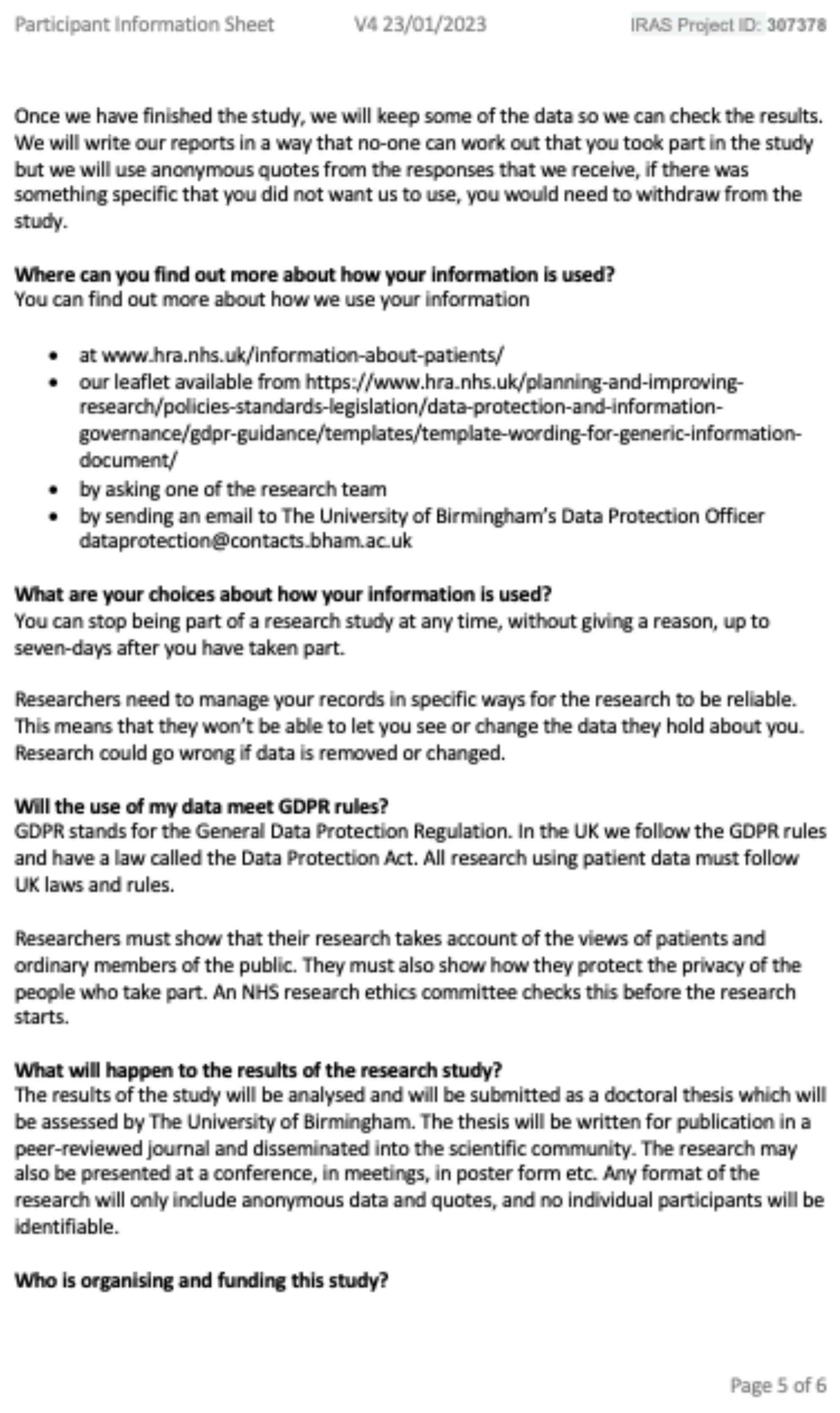
How will we use information about you?
We will need to use information from you and from your medical records for this research project. This information will include:

- Your name
- Initials
- Age
- Sex
- Ethnicity
- Assessment and Intervention Pathway

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a participant code number instead.

We will keep all information about you safe and secure.

The Participant Information Sheet Page 5 of 6



Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study but we will use anonymous quotes from the responses that we receive, if there was something specific that you did not want us to use, you would need to withdraw from the study.

Where can you find out more about how your information is used?
You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- our leaflet available from https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/data-protection-and-information-governance/gdpr-guidance/templates/template-wording-for-generic-information-document/
- by asking one of the research team
- by sending an email to The University of Birmingham's Data Protection Officer dataprotection@contacts.bham.ac.uk

What are your choices about how your information is used?
You can stop being part of a research study at any time, without giving a reason, up to seven-days after you have taken part.

Researchers need to manage your records in specific ways for the research to be reliable. This means that they won't be able to let you see or change the data they hold about you. Research could go wrong if data is removed or changed.

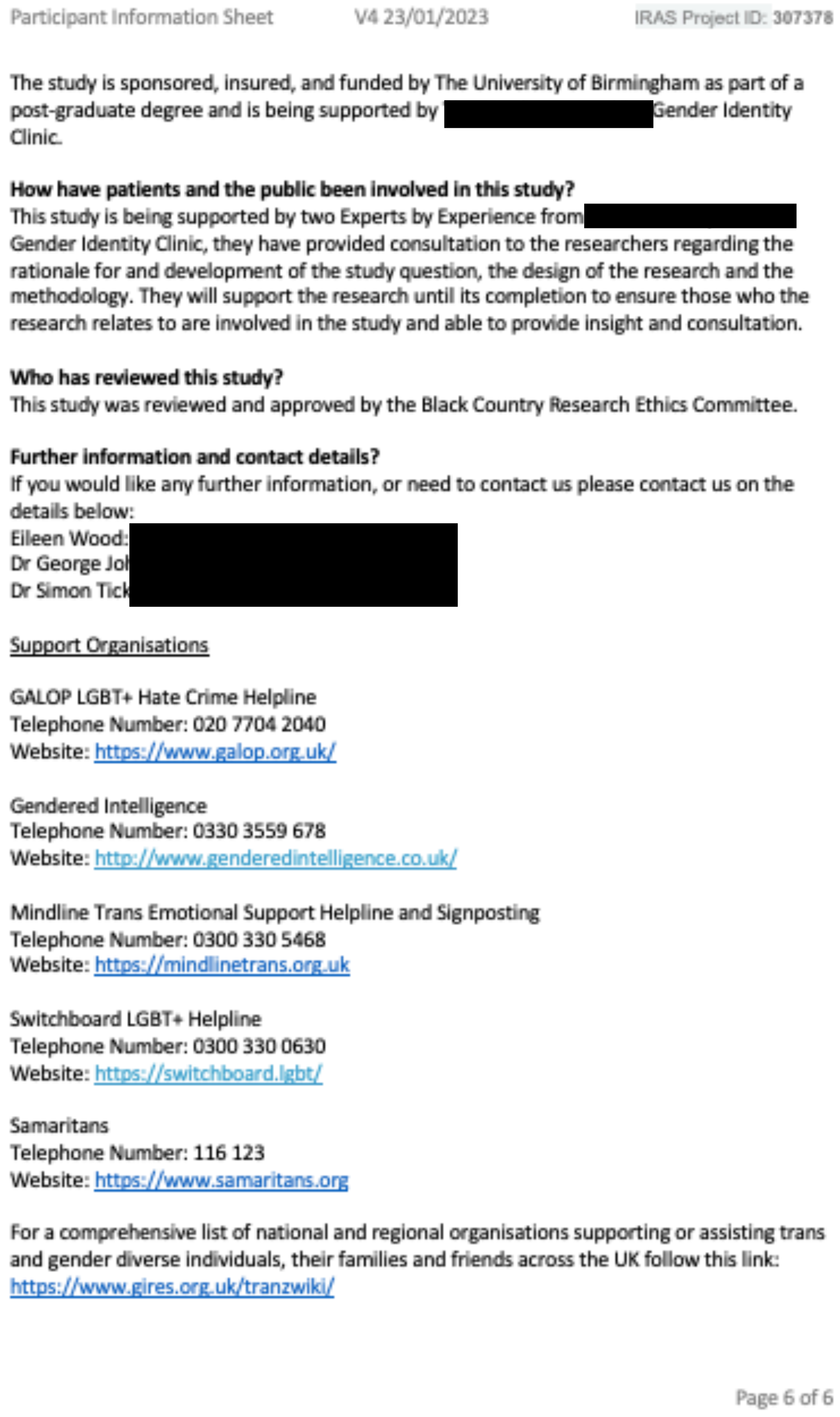
Will the use of my data meet GDPR rules?
GDPR stands for the General Data Protection Regulation. In the UK we follow the GDPR rules and have a law called the Data Protection Act. All research using patient data must follow UK laws and rules.

Researchers must show that their research takes account of the views of patients and ordinary members of the public. They must also show how they protect the privacy of the people who take part. An NHS research ethics committee checks this before the research starts.

What will happen to the results of the research study?
The results of the study will be analysed and will be submitted as a doctoral thesis which will be assessed by The University of Birmingham. The thesis will be written for publication in a peer-reviewed journal and disseminated into the scientific community. The research may also be presented at a conference, in meetings, in poster form etc. Any format of the research will only include anonymous data and quotes, and no individual participants will be identifiable.

Who is organising and funding this study?

The Participant Information Sheet Page 6 of 6



The study is sponsored, insured, and funded by The University of Birmingham as part of a post-graduate degree and is being supported by [redacted] Gender Identity Clinic.

How have patients and the public been involved in this study?
This study is being supported by two Experts by Experience from [redacted] Gender Identity Clinic, they have provided consultation to the researchers regarding the rationale for and development of the study question, the design of the research and the methodology. They will support the research until its completion to ensure those who the research relates to are involved in the study and able to provide insight and consultation.

Who has reviewed this study?
This study was reviewed and approved by the Black Country Research Ethics Committee.

Further information and contact details?
If you would like any further information, or need to contact us please contact us on the details below:
Eileen Wood: [redacted]
Dr George Jo
Dr Simon Tic

Support Organisations

GALOP LGBT+ Hate Crime Helpline
Telephone Number: 020 7704 2040
Website: https://www.galop.org.uk/

Gendered Intelligence
Telephone Number: 0330 3559 678
Website: http://www.genderedintelligence.co.uk/

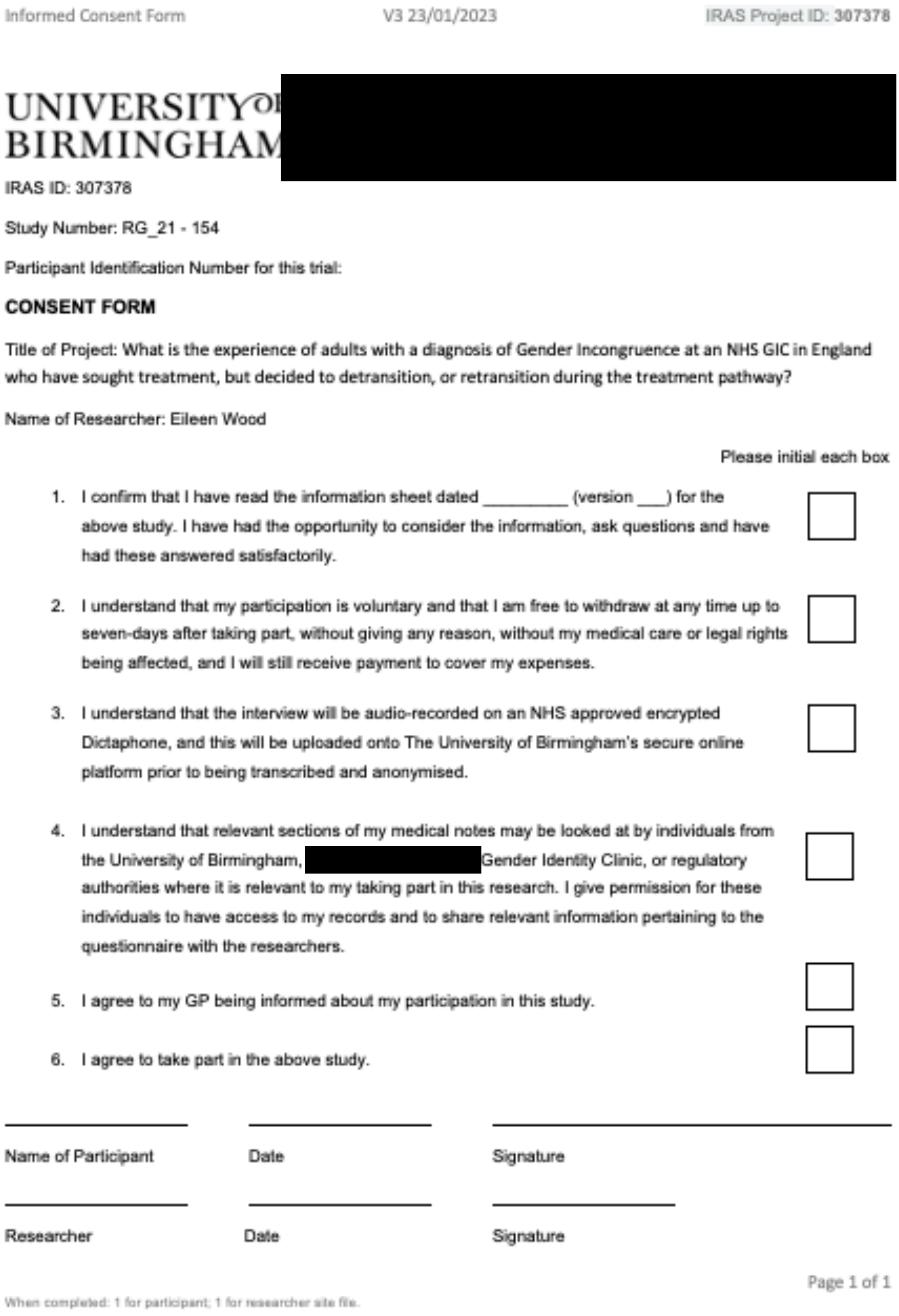
Mindline Trans Emotional Support Helpline and Signposting
Telephone Number: 0300 330 5468
Website: https://mindlinetrans.org.uk

Switchboard LGBT+ Helpline
Telephone Number: 0300 330 0630
Website: https://switchboard.lgbt/

Samaritans
Telephone Number: 116 123
Website: https://www.samaritans.org

For a comprehensive list of national and regional organisations supporting or assisting trans and gender diverse individuals, their families and friends across the UK follow this link: https://www.gires.org.uk/tranzwiki/

Appendix 2F: The Informed Consent Form



Informed Consent Form V3 23/01/2023 IRAS Project ID: 307378

UNIVERSITY OF BIRMINGHAM [redacted]

IRAS ID: 307378

Study Number: RG_21 - 154

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: What is the experience of adults with a diagnosis of Gender Incongruence at an NHS GIC in England who have sought treatment, but decided to detransition, or retransition during the treatment pathway?

Name of Researcher: Eileen Wood

Please initial each box

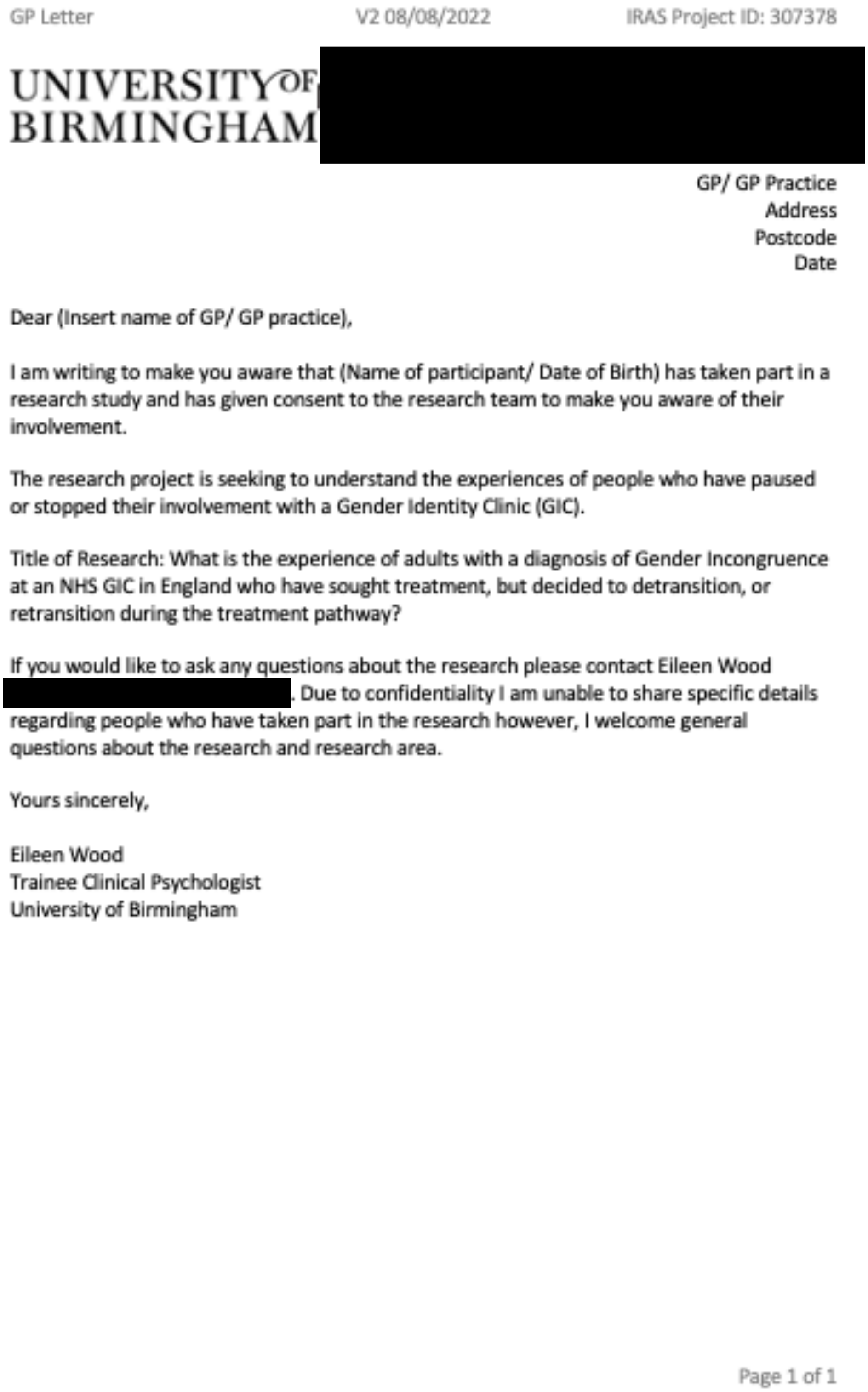
1. I confirm that I have read the information sheet dated _________ (version ___) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time up to seven-days after taking part, without giving any reason, without my medical care or legal rights being affected, and I will still receive payment to cover my expenses. ☐
3. I understand that the interview will be audio-recorded on an NHS approved encrypted Dictaphone, and this will be uploaded onto The University of Birmingham's secure online platform prior to being transcribed and anonymised. ☐
4. I understand that relevant sections of my medical notes may be looked at by individuals from the University of Birmingham, [redacted] Gender Identity Clinic, or regulatory authorities where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records and to share relevant information pertaining to the questionnaire with the researchers. ☐
5. I agree to my GP being informed about my participation in this study. ☐
6. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Researcher	Date	Signature

Page 1 of 1

When completed: 1 for participant; 1 for researcher site file.

Appendix 2G: The GP Summary Letter



GP Letter V2 08/08/2022 IRAS Project ID: 307378

UNIVERSITY OF
BIRMINGHAM [redacted]

GP/ GP Practice
Address
Postcode
Date

Dear (Insert name of GP/ GP practice),

I am writing to make you aware that (Name of participant/ Date of Birth) has taken part in a research study and has given consent to the research team to make you aware of their involvement.

The research project is seeking to understand the experiences of people who have paused or stopped their involvement with a Gender Identity Clinic (GIC).

Title of Research: What is the experience of adults with a diagnosis of Gender Incongruence at an NHS GIC in England who have sought treatment, but decided to detransition, or retransition during the treatment pathway?

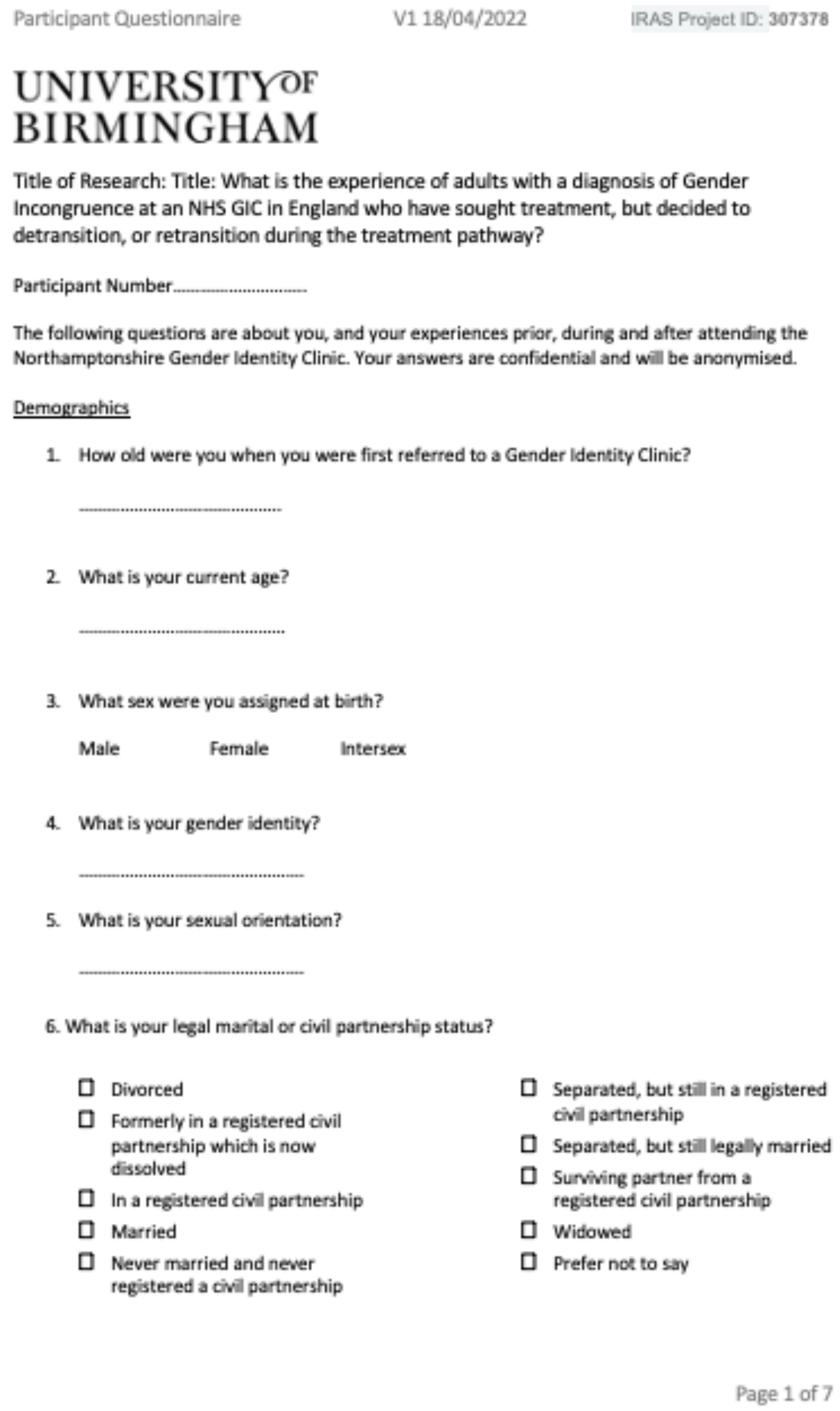
If you would like to ask any questions about the research please contact Eileen Wood [redacted]. Due to confidentiality I am unable to share specific details regarding people who have taken part in the research however, I welcome general questions about the research and research area.

Yours sincerely,

Eileen Wood
Trainee Clinical Psychologist
University of Birmingham

Page 1 of 1

Appendix 2H: The Participant Questionnaire Page 1 of 7



Participant Questionnaire V1 18/04/2022 IRAS Project ID: 307378

UNIVERSITY OF BIRMINGHAM

Title of Research: Title: What is the experience of adults with a diagnosis of Gender Incongruence at an NHS GIC in England who have sought treatment, but decided to detransition, or retransition during the treatment pathway?

Participant Number…………………………

The following questions are about you, and your experiences prior, during and after attending the Northamptonshire Gender Identity Clinic. Your answers are confidential and will be anonymised.

Demographics

1. How old were you when you were first referred to a Gender Identity Clinic?

   ……………………………………………

2. What is your current age?

   ……………………………………………

3. What sex were you assigned at birth?

   Male Female Intersex

4. What is your gender identity?

   ……………………………………………

5. What is your sexual orientation?

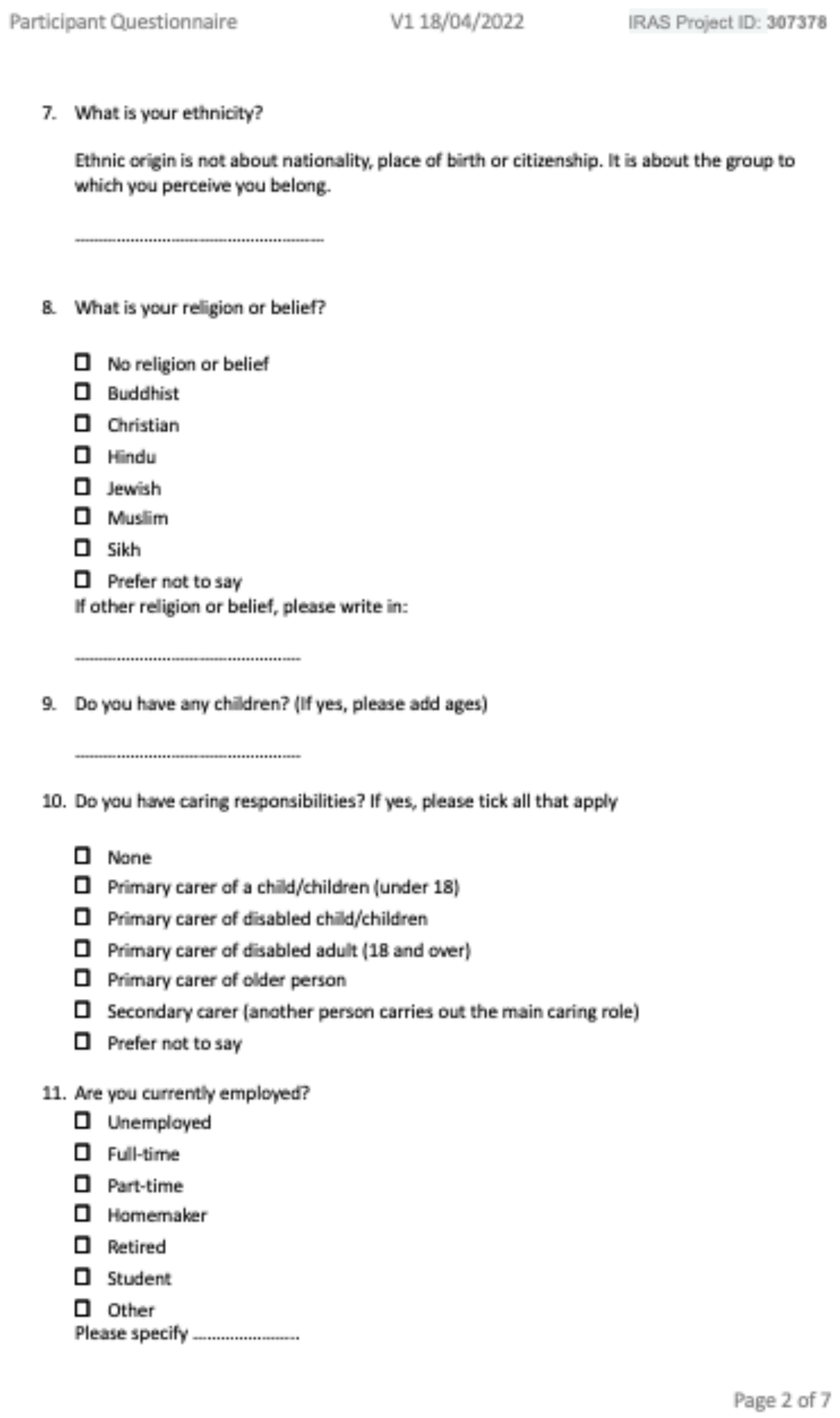
   ……………………………………………

6. What is your legal marital or civil partnership status?

- ☐ Divorced
- ☐ Formerly in a registered civil partnership which is now dissolved
- ☐ In a registered civil partnership
- ☐ Married
- ☐ Never married and never registered a civil partnership
- ☐ Separated, but still in a registered civil partnership
- ☐ Separated, but still legally married
- ☐ Surviving partner from a registered civil partnership
- ☐ Widowed
- ☐ Prefer not to say

Page 1 of 7

The Participant Questionnaire Page 2 of 7



Participant Questionnaire V1 18/04/2022 IRAS Project ID: 307378

7. What is your ethnicity?

   Ethnic origin is not about nationality, place of birth or citizenship. It is about the group to which you perceive you belong.

   ……………………………………………

8. What is your religion or belief?

   ☐ No religion or belief
   ☐ Buddhist
   ☐ Christian
   ☐ Hindu
   ☐ Jewish
   ☐ Muslim
   ☐ Sikh
   ☐ Prefer not to say
   If other religion or belief, please write in:

   ……………………………………………

9. Do you have any children? (If yes, please add ages)

   ……………………………………………

10. Do you have caring responsibilities? If yes, please tick all that apply

    ☐ None
    ☐ Primary carer of a child/children (under 18)
    ☐ Primary carer of disabled child/children
    ☐ Primary carer of disabled adult (18 and over)
    ☐ Primary carer of older person
    ☐ Secondary carer (another person carries out the main caring role)
    ☐ Prefer not to say

11. Are you currently employed?
    ☐ Unemployed
    ☐ Full-time
    ☐ Part-time
    ☐ Homemaker
    ☐ Retired
    ☐ Student
    ☐ Other
    Please specify ……………………

Page 2 of 7

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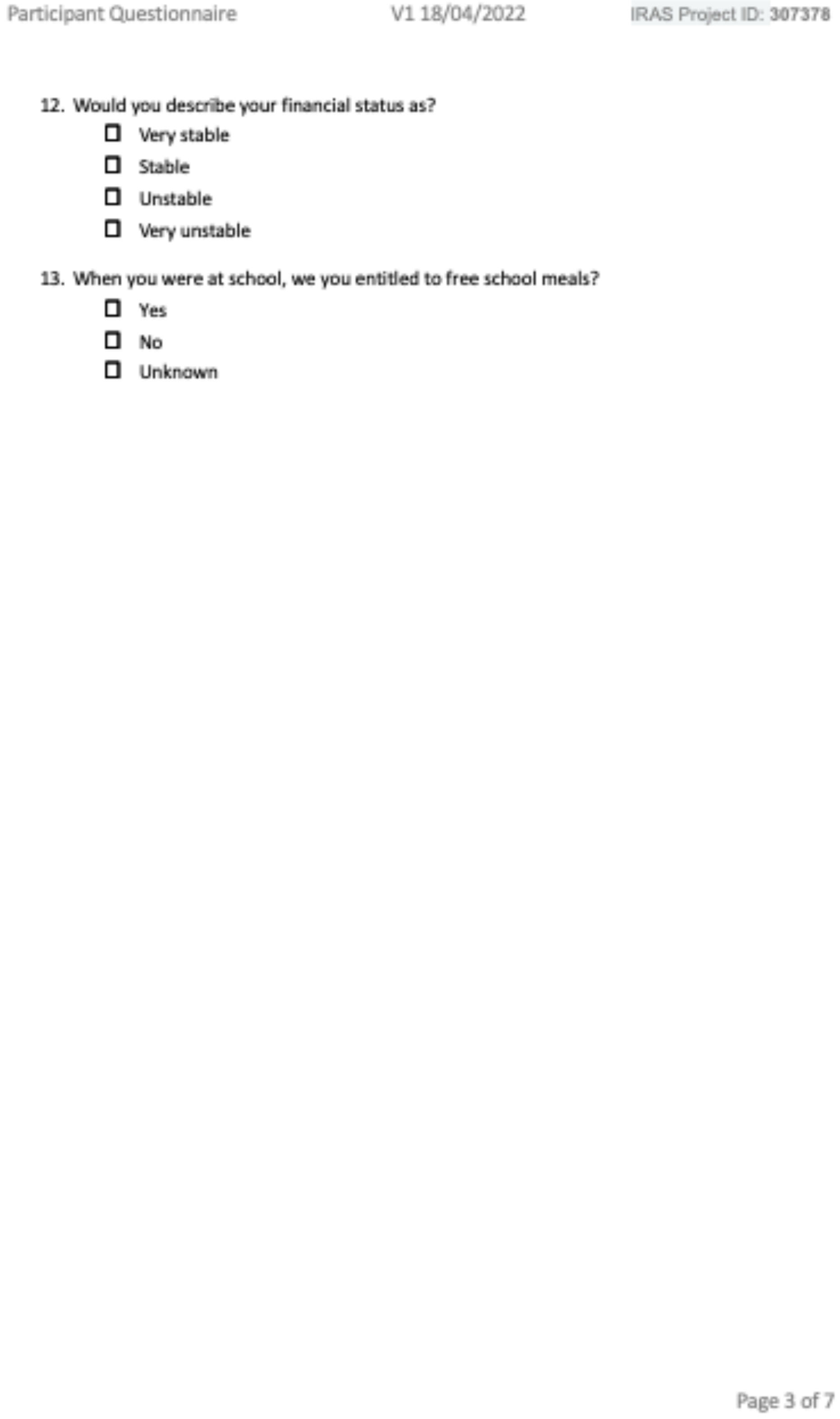

Participant Questionnaire V1 18/04/2022 IRAS Project ID: 307378

12. Would you describe your financial status as?
    - ☐ Very stable
    - ☐ Stable
    - ☐ Unstable
    - ☐ Very unstable
13. When you were at school, we you entitled to free school meals?
    - ☐ Yes
    - ☐ No
    - ☐ Unknown

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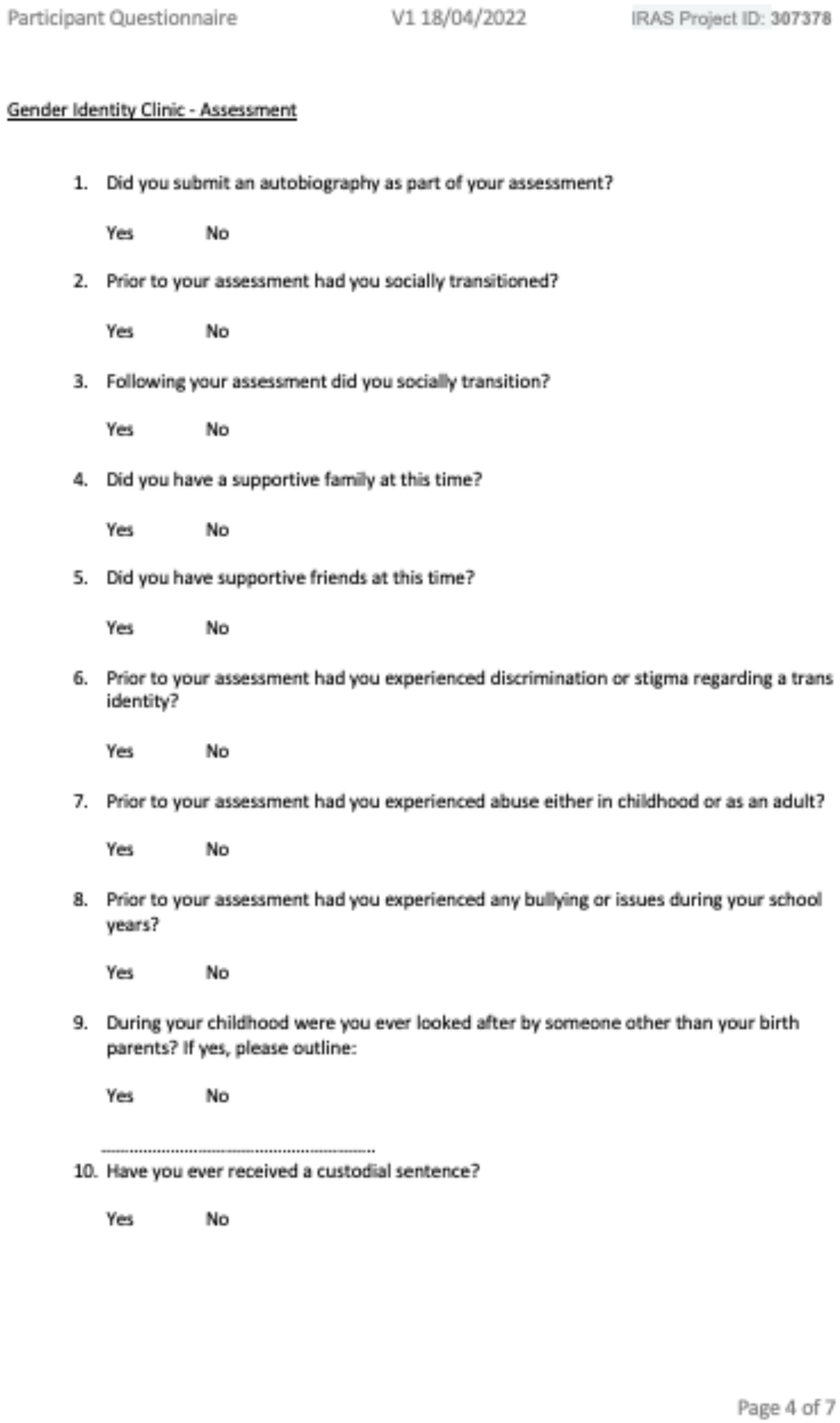


Gender Identity Clinic - Assessment

1. Did you submit an autobiography as part of your assessment?

   Yes No

2. Prior to your assessment had you socially transitioned?

   Yes No

3. Following your assessment did you socially transition?

   Yes No

4. Did you have a supportive family at this time?

   Yes No

5. Did you have supportive friends at this time?

   Yes No

6. Prior to your assessment had you experienced discrimination or stigma regarding a trans identity?

   Yes No

7. Prior to your assessment had you experienced abuse either in childhood or as an adult?

   Yes No

8. Prior to your assessment had you experienced any bullying or issues during your school years?

   Yes No

9. During your childhood were you ever looked after by someone other than your birth parents? If yes, please outline:

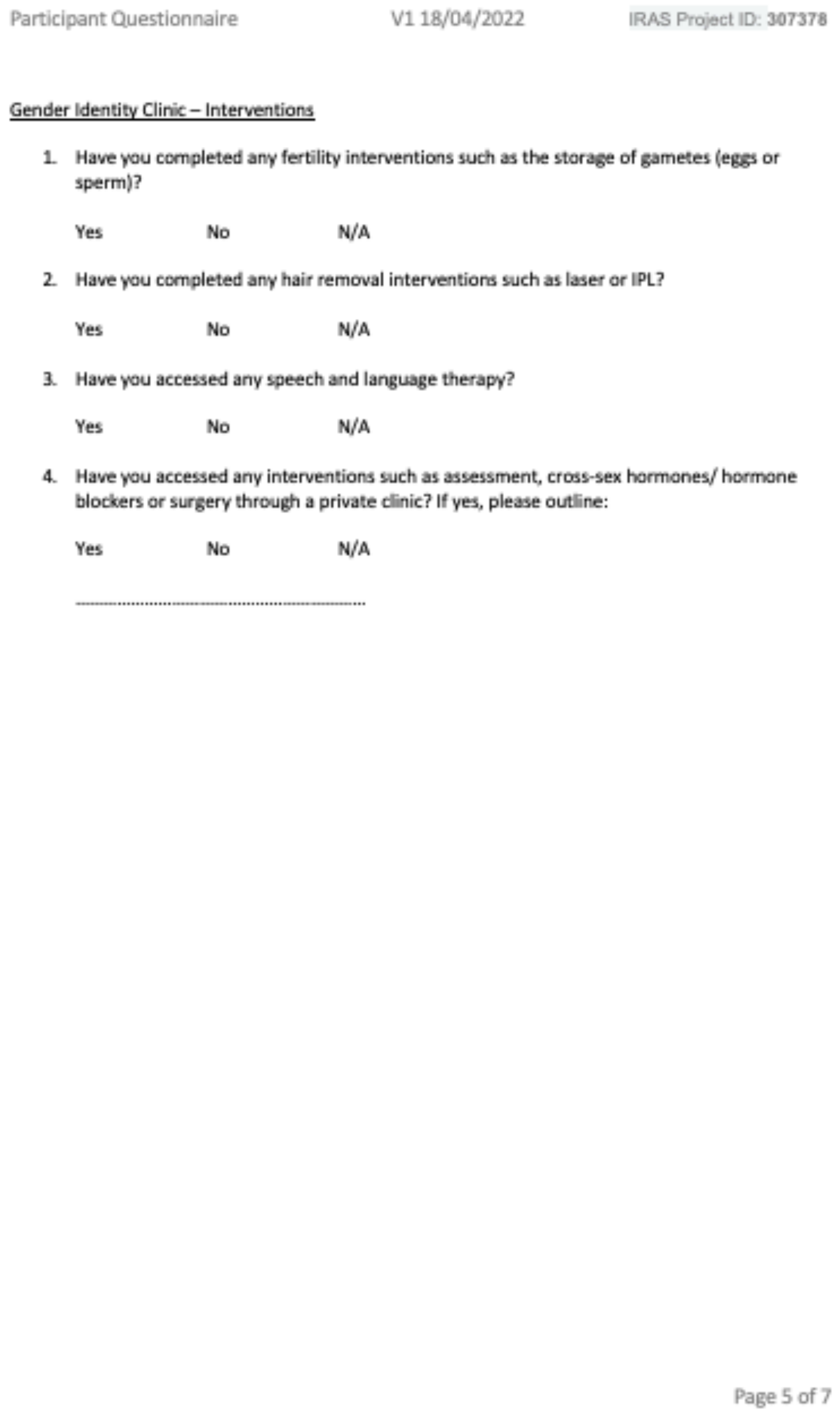
   Yes No

   ……………………………………………………

10. Have you ever received a custodial sentence?

    Yes No

The Participant Questionnaire Page 5 of 7



Participant Questionnaire V1 18/04/2022 IRAS Project ID: 307378

Gender Identity Clinic – Interventions

1. Have you completed any fertility interventions such as the storage of gametes (eggs or sperm)?

   Yes No N/A

2. Have you completed any hair removal interventions such as laser or IPL?

   Yes No N/A

3. Have you accessed any speech and language therapy?

   Yes No N/A

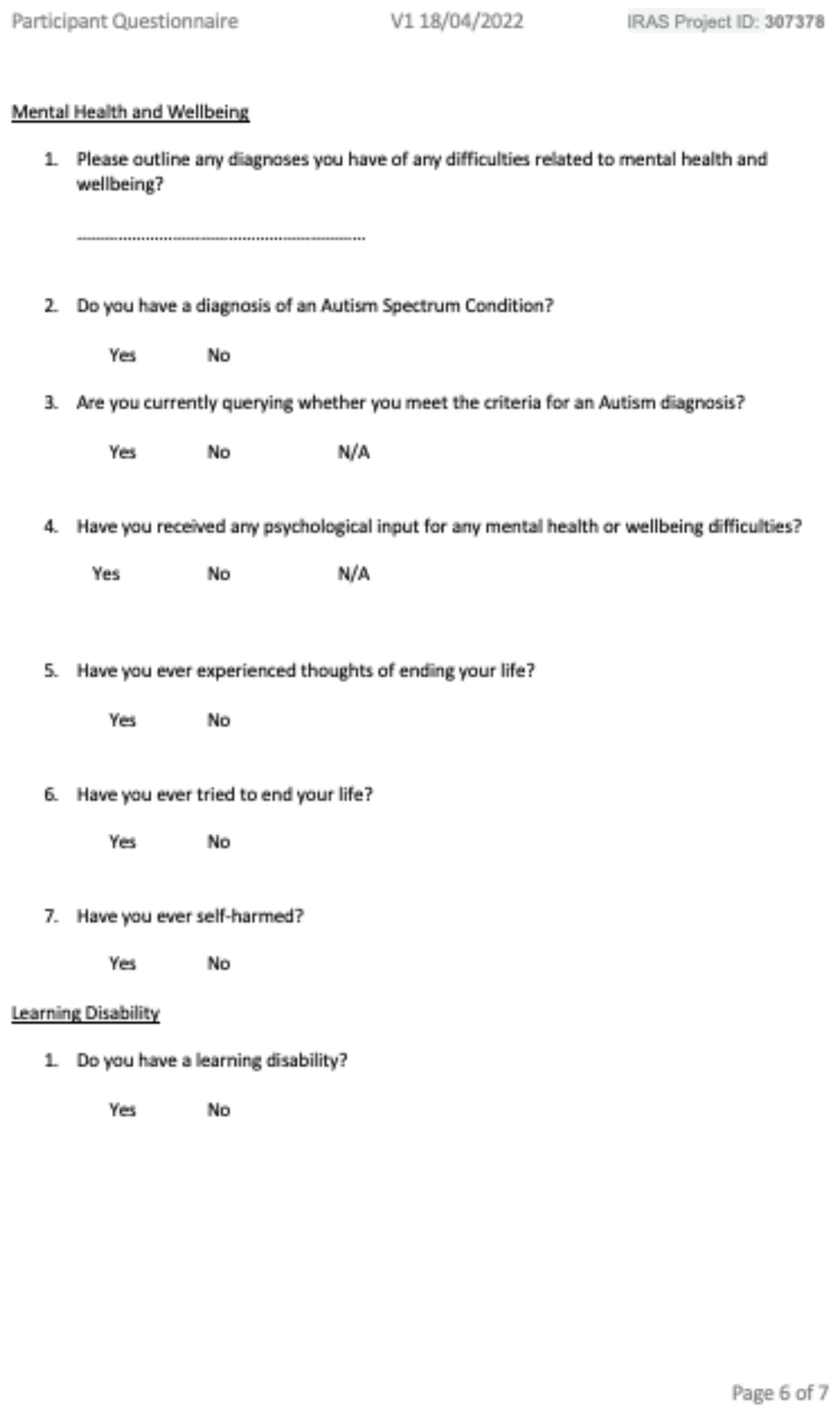
4. Have you accessed any interventions such as assessment, cross-sex hormones/ hormone blockers or surgery through a private clinic? If yes, please outline:

   Yes No N/A

   ……………………………………………………

Page 5 of 7

The Participant Questionnaire Page 6 of 7



Participant Questionnaire V1 18/04/2022 IRAS Project ID: 307378

Mental Health and Wellbeing

1. Please outline any diagnoses you have of any difficulties related to mental health and wellbeing?

   ………………………………………………………

2. Do you have a diagnosis of an Autism Spectrum Condition?

   Yes No

3. Are you currently querying whether you meet the criteria for an Autism diagnosis?

   Yes No N/A

4. Have you received any psychological input for any mental health or wellbeing difficulties?

   Yes No N/A

5. Have you ever experienced thoughts of ending your life?

   Yes No

6. Have you ever tried to end your life?

   Yes No

7. Have you ever self-harmed?

   Yes No

Learning Disability

1. Do you have a learning disability?

   Yes No

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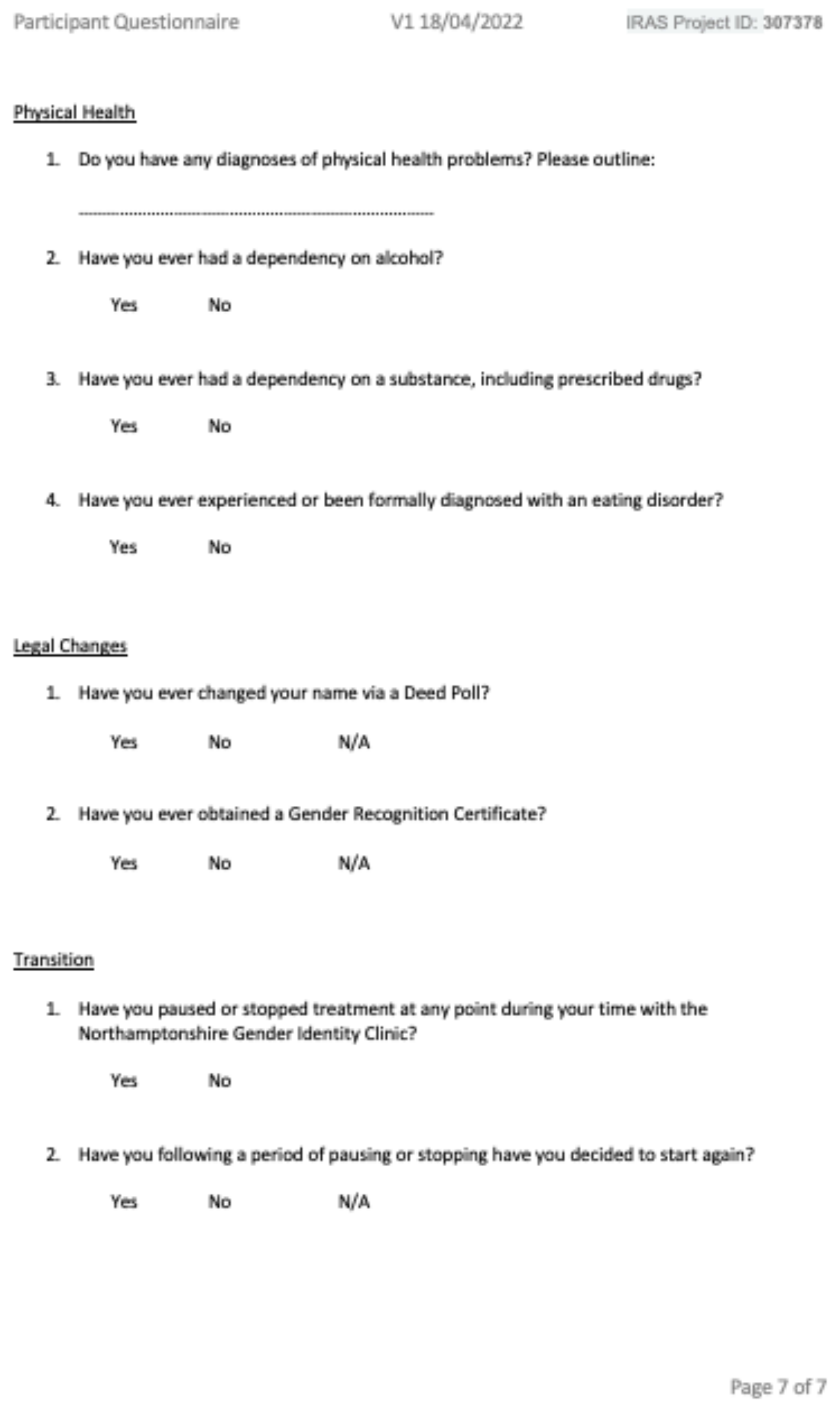
The Participant Questionnaire Page 7 of 7



Physical Health

1. Do you have any diagnoses of physical health problems? Please outline:

   ....

2. Have you ever had a dependency on alcohol?

   Yes No

3. Have you ever had a dependency on a substance, including prescribed drugs?

   Yes No

4. Have you ever experienced or been formally diagnosed with an eating disorder?

   Yes No

Legal Changes

1. Have you ever changed your name via a Deed Poll?

   Yes No N/A

2. Have you ever obtained a Gender Recognition Certificate?

   Yes No N/A

Transition

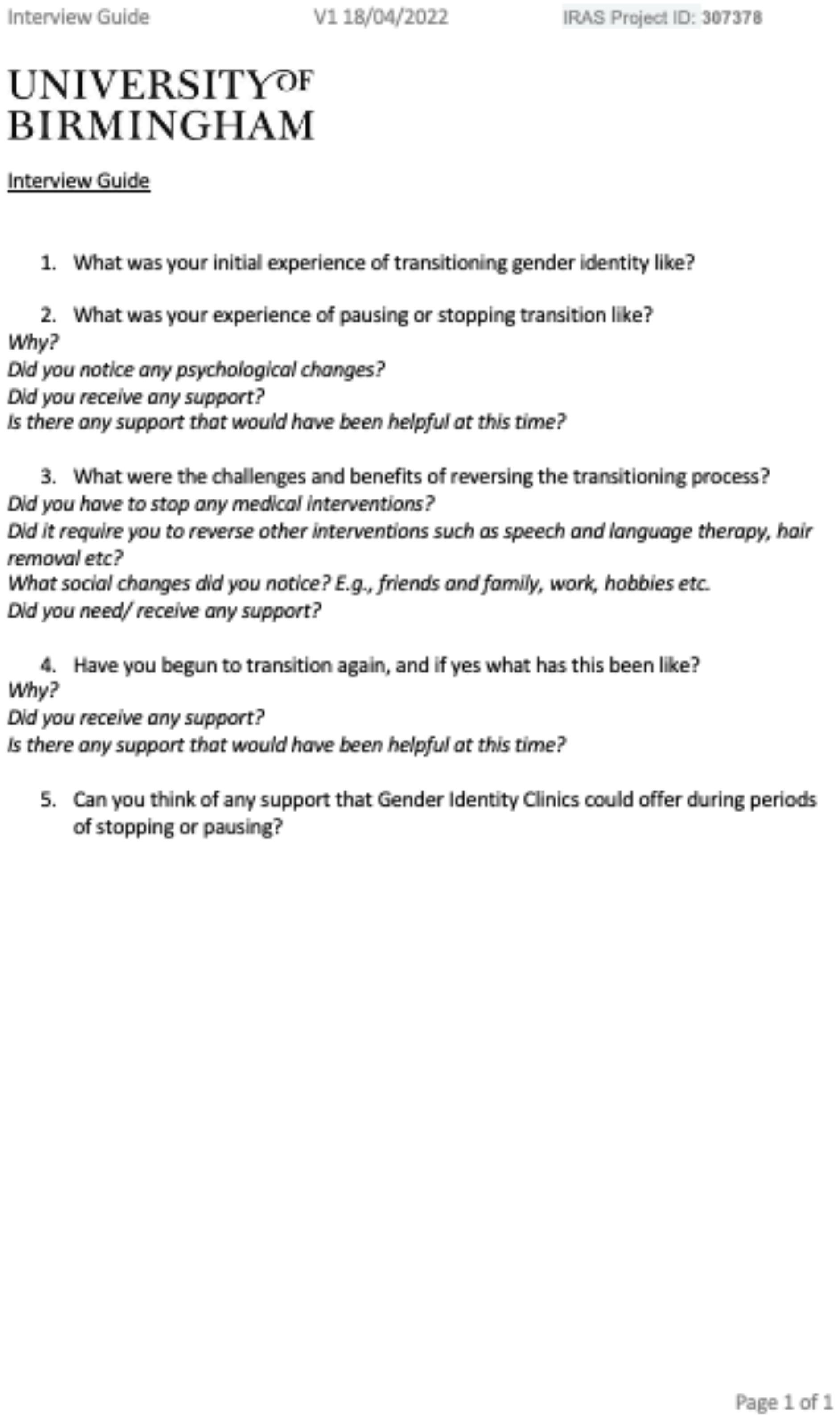
1. Have you paused or stopped treatment at any point during your time with the Northamptonshire Gender Identity Clinic?

   Yes No

2. Have you following a period of pausing or stopping have you decided to start again?

   Yes No N/A

Appendix 2I: The Interview Guide



Interview Guide V1 18/04/2022 IRAS Project ID: 307378

UNIVERSITY OF BIRMINGHAM

Interview Guide

1. What was your initial experience of transitioning gender identity like?

2. What was your experience of pausing or stopping transition like?

Why?
Did you notice any psychological changes?
Did you receive any support?
Is there any support that would have been helpful at this time?

3. What were the challenges and benefits of reversing the transitioning process?

Did you have to stop any medical interventions?
Did it require you to reverse other interventions such as speech and language therapy, hair removal etc?
What social changes did you notice? E.g., friends and family, work, hobbies etc.
Did you need/ receive any support?

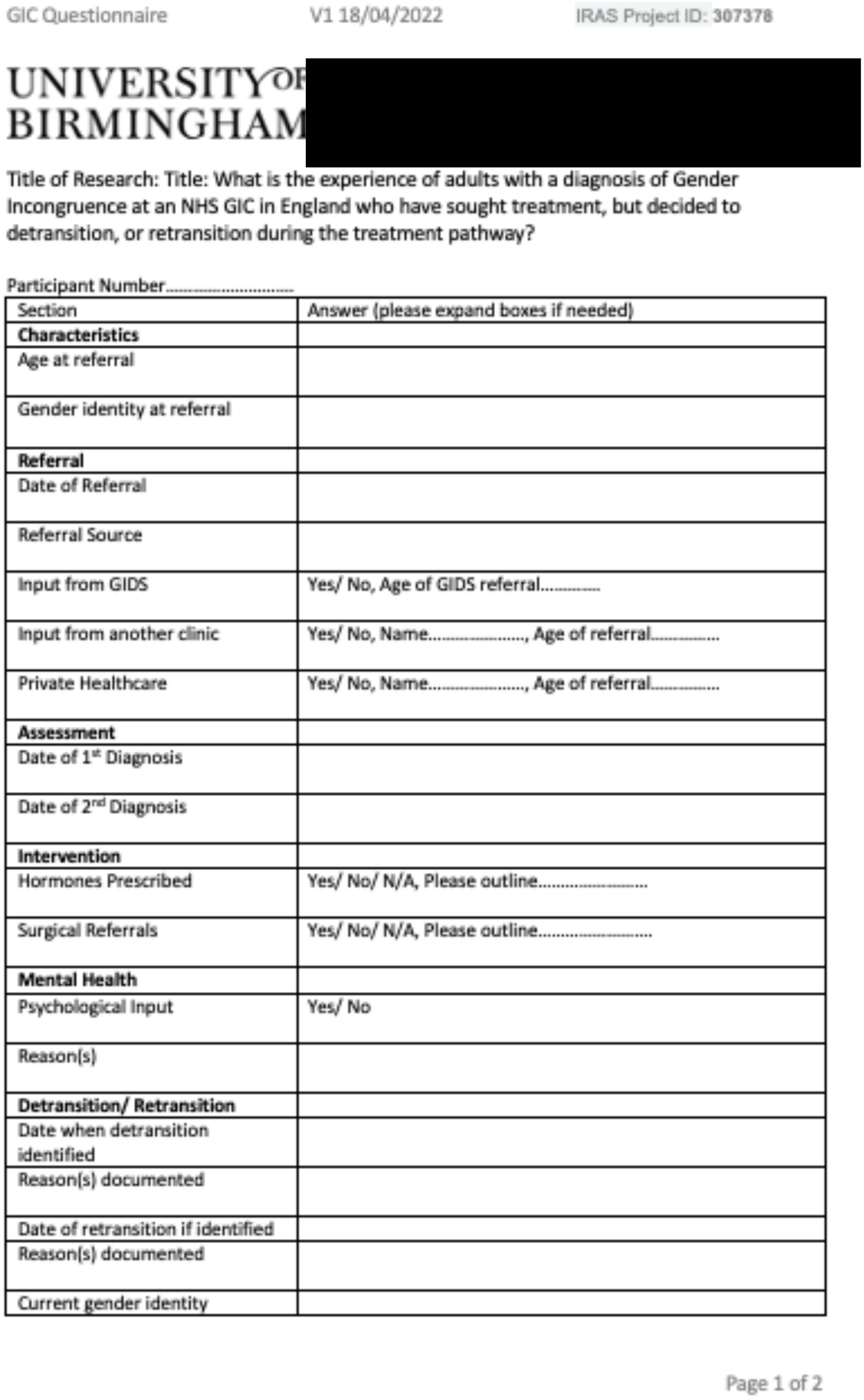
4. Have you begun to transition again, and if yes what has this been like?

Why?
Did you receive any support?
Is there any support that would have been helpful at this time?

5. Can you think of any support that Gender Identity Clinics could offer during periods of stopping or pausing?

Page 1 of 1

Appendix 2J: The GIC Questionnaire Page 1 of 2



GIC Questionnaire V1 18/04/2022 IRAS Project ID: 307378

UNIVERSITY OF
BIRMINGHAM

[redacted]

Title of Research: Title: What is the experience of adults with a diagnosis of Gender Incongruence at an NHS GIC in England who have sought treatment, but decided to detransition, or retransition during the treatment pathway?

Participant Number……………………….

Section	Answer (please expand boxes if needed)
Characteristics	
Age at referral	
Gender identity at referral	
Referral	
Date of Referral	
Referral Source	
Input from GIDS	Yes/ No, Age of GIDS referral………….
Input from another clinic	Yes/ No, Name…………………., Age of referral……………
Private Healthcare	Yes/ No, Name…………………., Age of referral……………
Assessment	
Date of 1st Diagnosis	
Date of 2nd Diagnosis	
Intervention	
Hormones Prescribed	Yes/ No/ N/A, Please outline…………………….
Surgical Referrals	Yes/ No/ N/A, Please outline…………………….
Mental Health	
Psychological Input	Yes/ No
Reason(s)	
Detransition/ Retransition	
Date when detransition identified	
Reason(s) documented	
Date of retransition if identified	
Reason(s) documented	
Current gender identity	

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The GIC Questionnaire Page 2 of 2

GIC Questionnaire V1 18/04/2022 IRAS Project ID: 307378

Current age	

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Table 14

Exert of Participant 4's Transcript with Initial Notes and Experiential Statements

Experiential Statements	**Text**	**Notes**
Transition was trying to fulfil a need in the context of life events	R: What your initial experience of transitioning gender identity like? P: Erm it was chaotic, alcohol fuelled, erm and in its simplest terms it was a need to do something positive in my life because everything else was going massively wrong. I've always known that I've been fairly uncertain about my gender identity, I didn't always know it was gender identity, but I think yeah. I approached [clinic] not long after getting married, and alcohol abuse going through the roof, and I needed to find some answers and erm managed to erm sort of keep fairly, well not level headed but fairly kind of stable to actually erm get a diagnosis and erm err start working through some things but at the same time going through divorce and barely being at work and being a massive alcoholic but kind of trying to keep a lid on it and making fairly ropey decisions due to an alcohol poisoned brain potentially erm so it was a transition that was erm not the best it wasn't as it was a transition that was more of erm a misguided necessity potentially. And… I don't regret it, I just think that someone could of said is that the right thing to do at the time, because actually you need to look at some of these things first [laughs].	Chaotic Needed to do something positive Always felt uncertain about gender identity Went to GIC to find answers Co-morbidity – alcohol addiction Alcohol had a negative impact on decision making Felt someone should have intervened, prevented transition due to alcohol use Transition not regretted Use of humour to mask pain
Gender exploration began in childhood but kept hidden	R: Can you remember back to when you, you touched on it, can you remember back to when you first started to kind of think about gender and maybe feeling like that was different to what other people… P: So yeah so, I think there's there are erm so growing up there was some things that would suggest to anybody on the outside looking in that something wasn't quite right with me. That might be just a feeling my mother's clothes and hiding it, as I wanted to wear it, going to bed early so I could sort of dress up in my bedroom and hope no-one came in. I think I was about nine or ten and my dad found that I had been researching gender reassignment surgery, and I still remember really clearly, he asked me, erm why I did it and he actually explicitly said is it because you want the surgery and I lied and said no. And part of me thinks what would have happened if I said yes, but I think I know that actually they probably would have not, we wouldn't have explored it, or we wouldn't have explored it in a positive manner potentially. Erm	Growing up – felt something was not right In childhood enjoyed wearing female clothes In childhood – lied about trans identity In childhood – kept trans identity hidden from family In childhood – felt family would not have been supportive of trans identity

	always kind of erm cross dressed privately erm but it was always more of a hap-hazard and more of like a necessity, and erm a release I guess but instead of having an alter-ego like some trans people do or erm you know or sort of socialising as kind of you know your preferred gender and things like that I think that might be sort of circumstances but also my inherent transphobia about my own identity as well so. Erm, you know I think I've always known really but I just didn't know what to do about it. And then I think my mistake the biggest mistake I made I was self-medicating through alcohol and trying to live this cis-hetero life which everyone expected me to because of how I looked and sounded.	Cross-dressed privately Internalised transphobia Didn't know what to do about feelings regarding gender identity Used alcohol as a coping strategy Trying to live a cis-hetero life – as expected by others
Family environment did not feel conducive for sharing gender related difficulties in childhood	R: Kind of going back to you know you kind of saying about dad, sort of asking about the research you had been doing, I wonder what do you think would have happened if you had said you were thinking about that? P: I'm kind of quite conflicted about it because he [father] was quite an unpleasant person and made it fairly well known to me that he didn't like me and thought I would amount to nothing and… he left my mother a number of times and was having affairs, and he was an alcoholic and also I think had significant mental health problems, with what I know about my alcohol problems now, or my mental health now should I say, erm I think that if I said yes I think my mother would have made it about her, because she would have been 'what have I done wrong', or 'why had this happened to me', and for various reasons I think my dad would have used it as a… I don't know what he would have done actually… I don't think I'd allow myself, we wouldn't have been a family where they would have sort of said 'okay you know okay tell me about how you are feeling' and 'what can you do', it wouldn't have been a positive environment it would have been very much a erm I think it would have been something, I think it would have been a problem, something I think it would have been a problem and a problem to sort but not in a way that was, I think it, to sort and resolve in a way that's comfortable for them. Not necessarily me, however I'll never know that though because ultimately I said no, [laughs] I don't I'm just looking at it, and my dad went and told my mother that he found pornography magazines, so and not the research because I told her about this sort of when I first came out as trans and erm she said 'oh I remember that but he said it was porn'. So, I should actually answer there what would have happened, because actually I think even if I said no, I'd have said no, I think any compassionate human being would have thought that's quite a specific thing for a nine-year-old sort of assigned male at birth individual to be looking at. Then there's the as a parent you tell the other parent, 'Oh I just found some naughty magazines,' I think that tells you all you need to know potentially.	Difficult relationship with family growing up If had spoken about trans identity feels mother would have made it about her Unable to think about father's reaction Does not think they would have been supported in childhood if they had shared trans identity Felt family should have picked up on the difficulties they were having
	R: I'm wondering about, sort of describing at age nine these things are going on in your mind, and going	Long time from age 9-30's

	on and you were thirty-one when you first went to the clinic. P: Yep.	when they were referred to a clinic
Suppressed gender identity over a lengthy period – developed coping mechanisms to manage the distress	R: I suppose during those years, which would have been what, twenty plus years what was kind of going on for you at that time? P: I think that I had after that period, I think I had kind of suppressed that and erm I went to school and tried to fit in and tried to sort of I've always been fairly erm sort of on the outside, fairly, gregarious and loud sometimes quite funny, but I think stereotypically I think there's was probably a bit of a front and I think that and then erm I was I spent quite a lot of my teenage years in my bedroom festering because it was so crap at home. When we lived in like a small village and we moved there and I didn't really have a social network so I spent quite a lot of time in my bedroom just sort of not doing a great deal, sometimes wearing my mums underwear, erm and and then sort of mum and dads divorce kind of was drawn out over a couple of years and then I went to university, and started drinking and that was you know, and then I started drinking like an alcoholic straight away, because it was the an easy thing to, I think I've got a fairly addictive personality anyway but err so I was always going to sort of always going to be an alcoholic because it runs in the family, I'd obviously had some kind of trauma, I was dealing with my gender identity somehow erm and I had no life, I went to university with no life skills [laughs] so you know I went to university erm sort of just yeah sort of spent most of that time drunk, err spent about six-months sort of thinking erm that I was gay and I met a gay lad at university which was the first gay that I had ever met erm and that really didn't do anything to help me because I thought my only way to sort of kind of explore this, was 'oh so he must be gay so he must want to have sex with me', but of course he didn't because he was in a loving and committed relationship erm and then I just kind of went, I had no idea what I was doing, and literally just spent my three years at university trying to do some work and getting drunk all the time and then I ended up in a long term relationship with a girl so erm yeah and then alcoholism being a [occupation] just started taking over.	Suppressed feelings of gender dysphoria Tried to live a 'normal life' Developed an extrovert persona Spent considerable time as a teenager isolated Alcohol used as a coping mechanisms when started university References trauma in childhood Felt had no life skills at university Explored same-sex attraction and relationships Felt they lacked the skills for relationships Experience of rejection Began a relationship with a woman Job stress began following university
	R: I remember you said before about feeling like you were conforming to this 'hetero life.' P: Massively so yes.	Conforming to 'societal expectations'
Tried to 'play' a cis-hetero male but	R: An Internalised transphobia going on, grappling with autism as well, I suppose I'm thinking of you coming to the point of transitioning and letting people know about that, did you get much support from wife at the time, friends and family, colleagues.	Tried to 'play' a role Felt they became unpleasant person due to the stressors

caused emotional harm to self and others so decided to seek support with gender identity	[sound difficulties, paused to correct] P: So erm, I think so I had a long term relationship started from university until I was about twenty four, we split up however, and I'm not proud of this, before we split we were on the rocks because she moved down south, and I knew it was going to go pear shaped so I met somebody else, and then kind of moved into that relationship and slowly kind of erm tried to play this cis-hetero male, erm with that girl and we moved in together and then I slowly started to lose it to alcoholism, although I didn't know it at the time or I didn't we you know I was becoming a fairly belligerent and unpleasant person really being horrible and erm then that girl left me, [female name] left me at the age of twenty seven no twenty eight and then I met and again knowing that knowing that relationship was off, sort of immediately, instead of sort of focusing on myself which is what I should have done in the previous relationship, five three four years before, I went straight into another relationship and erm sort of the heavy drinking became heavy drinking again and that masks the problem of addiction doesn't it and then I turned thirty no twenty nine and after sort of eighteen months I proposed to this girl but I could feel myself becoming sort of really really stifled and really really you know there was something in me saying you've got to do everything else but address kind of the alcoholism and also address the gender identity stuff. So my brother got married in [Country] and we went over there, and I got married in, I proposed in [city] because I thought it was the right things to do, not because I think I loved her but because it was the right thing to do, and it was really nice and it was really lovely and she was happy but then in the twelve months from that time to actually getting married I became real unpleasant, drinking, horrendous, erm something going on, a couple of she found out a couple of things, that I'd been struggling with my gender identity, err however she was very unpleasant about it, and erm I just said it was one of those I think about now and again and just tried to brush it under the carpet, erm we got married and we should never have got married, and within a month she'd left and within a month after that I'd referred to [clinic] because I needed to do something. Because I wasn't addressing the alcohol, and I wasn't addressing that fact that I was not really performing at work, and I wasn't addressing my relationship, so I thought right I'm going to have to try and address something well let's refer let's refer to [clinic] and see what happens. But unfortunately, quite a lot of my first transition and quite a lot of my experience with [clinic] and sort of up until my pausing of transition it was massively sort of poisoned by alcohol. Because actually transition for people should have been quite a life affirming thing but for me it wasn't because I was you know I was using transition as an excuse to not work on stuff that was really harming me. Erm but I'm still alive and that blows my mind.	placed on them Avoided dealing with own problems – felt this impacted on their relationships – as did alcohol Made big life decisions e.g., proposal to partner, as a way of avoiding alcoholism and gender identity difficulties Feelings relating to gender identity found out by partner – unpleasant reaction – difficulty 'brushed under the carpet' Referred to GIC shortly after marriage ended Avoided dealing with other difficulties and referred to a GI Gender transition affected by alcohol use Did not find experience of transition affirming Amazed that they are still alive
Need to address	R: I guess were you around that time then, of being referred to [clinic] were you coming out to people you knew?	Transition a weird and chaotic time

gender identity and wider difficulties and gender transition felt like a way to do that initially	P: It was difficult because people were asking questions at work like why are you having like a week off work and then going off sick again. I couldn't say it was because I was so stressed from, everyone knew I was getting divorced, no one really understood why erm and no one really knew I had a drink problem. I think work knew I was drinking quite heavily but I think they just put that down to the divorce and it just turned into a really weird and chaotic and erm time. The thing is I told some people I was trans but I just looked like a fat oafish sweaty bloke because I was in the actual you know the height of severe you know alcoholism you know erm and you know [clinic] said you know start sort of changing your name and things like that and like my alcohol addled brain was like I must do all these things because if I don't do that I won't get any support from [clinic] but of course what I should have done first I mean had two or three years off booze you know and actually you know learn who I was. Because I think the biggest issue for me is that I'm only learning now who I am potentially because I'm not drinking and actually, I'm in recovery. I hope that makes sense.	Work not aware of gender transition Kept alcoholism hidden Felt that how they looked did not look congruent to the identity they were sharing Felt had to make changes such as name changes, or they would not receive support Felt they needed to stop alcohol use to have time for self-reflection

Appendix 2L, Page 1 of 3

Table 15

Table of Participant 4's Experiential Statements with Supporting Quotes

Experiential Statements	**Page Number**	**Quote**
Transition was trying to fulfil a need in the context of life events	1	Erm it was chaotic, alcohol fuelled, erm and in its simplest terms it was a need to do something positive in my life because everything else was going massively wrong.
Gender exploration began in childhood but kept hidden	1	So yeah so, I think there's there are erm so growing up there was some things that would suggest to anybody on the outside looking in that something wasn't quite right with me.
Family environment did not feel conducive for sharing gender related difficulties in childhood	2	I think it would have been a problem, something I think it would have been a problem and a problem to sort but not in a way that was, I think it, to sort and resolve in a way that's comfortable for them.
Suppressed gender identity over a lengthy period – developed coping mechanisms to manage the distress	3	I'd obviously had some kind of trauma, I was dealing with my gender identity somehow erm and I had no life, I went to university with no life skills [laughs] so you know I went to university erm sort of just yeah sort of spent most of that time drunk
Tried to 'play' a cis-hetero male but caused emotional harm to self and others so decided to seek support with gender identity	4	tried to play this cis-hetero male, erm with that girl and we moved in together and then I slowly started to lose it to alcoholism, although I didn't know it at the time, or I didn't we you know I was becoming a fairly belligerent and unpleasant person really being horrible
Need to address gender identity and wider difficulties	5	my alcohol addled brain was like I must do all these things because if I don't do that, I won't get any support from [clinic] but of course what I should have done first I mean had two or three years off booze you know and actually you know learn who I was.
Tried hard to follow	6	it's really difficult not to feel kind of as though people should have helped me more because I

process regardless of wider difficulties and gender transition felt like a way to do that initially		know at the time that actually, people's perception of me as a rambling idiot because I was either really hungover or you know not very well
Wanted to hold onto relationships but also wanted to get support for gender incongruence/ dysphoria	7	I knew at that point, I've know you know, at the point, something needed to give somewhere.
Felt signs of gender related distress were present in childhood but were unsupported	7	either they didn't have any idea which is the most simple and logical explanation or they kind of knew but were horrified
A wish to be a girl when younger but confusion as also attracted to them	8	I really remember as a teenagers seeing girls swimming and thinking Christ, I want to be like them, but then also thinking Christ I really fancy them.
Being unsupported in childhood has had a lasting impact on emotional wellbeing	8	I try not to think what could have been if there had been some positive intervention with my family growing up but yeah that's completely reductive now really and doesn't do much for my mental health
Did not feel they had the resources to transition so made the decision to stop	8	sort of nothing was going well really so I was fully socially transitioned, and I was very much on my own, I didn't have a trans network around me, erm work didn't really know what to do with me
Trying to maintain a relationship with family despite challenges in them accepting their TGD identity	9	I'm still friends with these people which makes me really angry with myself, because you know I have fairly small family and they've actually all been fairly horrible to me, and they are also the reason that sometimes fairly horrible to myself
Transition to binary female initially as unaware of non-binary identities	9	I transitioned to ostensibly a trans female and yeah that felt like the right thing to do, because I didn't know about non-binary identities. I got the feeling that it was that way it was either transition to a binary erm identity or don't transition at all
Transition didn't address	9	it wasn't like a positive affirming things, it was a 'I need to do this;, it's the only thing that

wider difficulties and make things better		could possibly make this better and of course I stopping transition was a realisation that actually nothing was better because I was still on my own, I was still drunk for most of the time, I was still having a shit time with family, and friends and ultimately erm something had to give, and the only thing left to give was transition
Realisation during transition that wider issues needed to take precedence	10	I knew more about my gender identity then and I realised that I realised that I had a problem with alcohol, and I realised that as much as I really liked this person, you know I didn't like the role I was playing
During detransition there was a realisation that being a cis hetero male did not feel right	10	so, I got into a period where I was giving up for a bit but because I was sober and spending time sober, I was starting to understand that being a cis hetero male is not maybe where my life is.

Appendix 2M, Page 1 of 3

Table 16

Table of the Development of Participant 4's PETs

PETs	**Sub-Themes**	**Experiential Statements**	**Page Number**	**Quote**
Unmet Need's – related to gender transition	Romantic Relationships	Transition was trying to fulfil a need in the context of life events	1	Erm it was chaotic, alcohol fuelled, erm and in its simplest terms it was a need to do something positive in my life because everything else was going massively wrong.
Unmet Need's – related to gender transition	Family	Gender exploration began in childhood but kept hidden	1	So yeah so, I think there's there are erm so growing up there was some things that would suggest to anybody on the outside looking in that something wasn't quite right with me.
Unmet Need's – related to gender transition	Family	Family environment did not feel conducive for sharing gender related difficulties in childhood	2	I think it would have been a problem, something I think it would have been a problem and a problem to sort but not in a way that was, I think it, to sort and resolve in a way that's comfortable for them.
Unmet Need's – related to gender transition	Self	Suppressed gender identity over a lengthy period – developed coping mechanisms to manage the distress	3	I'd obviously had some kind of trauma, I was dealing with my gender identity somehow erm and I had no life, I went to university with no life skills [laughs] so you know I went to university erm sort of just yeah sort of spent most of that time drunk
Unmet Need's – related to gender transition	Self	Tried to 'play' a cis-hetero male but caused emotional harm to self and others so decided to seek support with gender identity	4	tried to play this cis-hetero male, erm with that girl and we moved in together and then I slowly started to lose it to alcoholism, although I didn't know it at the time, or I didn't we you know I was becoming a fairly belligerent and unpleasant person really being horrible
Unmet Need's – related to gender	Self	Need to address gender identity and	5	my alcohol addled brain was like I must do all these things because if I don't do that, I won't get any support from [clinic]

transition		wider difficulties		but of course what I should have done first I mean had two or three years off booze you know and actually you know learn who I was.
Transition is hard and wider issues make it challenging to do	Fear of not being understood/ recognised	Tried hard to follow process regardless of wider difficulties and gender transition felt like a way to do that initially	6	it's really difficult not to feel kind of as though people should have helped me more because I know at the time that actually, people's perception of me as a rambling idiot because I was either really hungover or you know not very well
Unmet Need's – related to gender transition	Romantic relationships	Wanted to hold onto relationships but also wanted to get support for gender dysphoria	7	I knew at that point, I've know you know, at the point, something needed to give somewhere.
Unmet Need's – related to gender transition	Family	Felt signs of gender related distress were present in childhood but were unsupported	7	either they didn't have any idea which is the most simple and logical explanation or they kind of knew but were horrified
Unmet Need's – related to gender transition	Self	A wish to be a girl when younger but confusion as also attracted to them	8	I really remember as a teenagers seeing girls swimming and thinking Christ, I want to be like them, but then also thinking Christ I really fancy them.
Unmet Need's – related to gender transition	Family	Being unsupported in childhood has had a lasting impact on emotional wellbeing	8	I try not to think what could have been if there had been some positive intervention with my family growing up but yeah that's completely reductive now really and doesn't do much for my mental health
Transition is hard and wider issues make it challenging to do	Need for resources to transition	Did not feel they had the resources to transition so made the decision to stop	8	sort of nothing was going well really so I was fully socially transitioned, and I was very much on my own, I didn't have a trans network around me, erm work didn't really know what to do with me
Transition is hard and wider issues make it	Impact on life and relationships – experience of	Trying to maintain a relationship with family despite	9	I'm still friends with these people which makes me really angry with myself, because you know I have fairly small family and they've actually all been fairly horrible to me, and they are also

challenging to do	distress/ transphobia	challenges in them accepting their TGD identity		the reason that sometimes fairly horrible to myself
Need for a safe identity and 'network'	Process of learning about self in context of understand of emerging theories and understandings of gender identity	Transition to binary female initially as unaware of non-binary identities	9	I transitioned to ostensibly a trans female and yeah that felt like the right thing to do, because I didn't know about non-binary identities. I got the feeling that it was that way it was either transition to a binary erm identity or don't transition at all
Transition is hard and wider issues make it challenging to do	Reaching a point of wanting to give up because maintaining actions to reduce gender dysphoria too difficult	Transition didn't address wider difficulties and make things better	9	it wasn't like a positive affirming things, it was a 'I need to do this;, it's the only thing that could possibly make this better and of course I stopping transition was a realisation that actually nothing was better because I was still on my own, I was still drunk for most of the time, I was still having a shit time with family, and friends and ultimately erm something had to give, and the only thing left to give was transition
Transition is hard and wider issues make it challenging to do	Focus on self-care and current needs	Realisation during transition that wider issues needed to take precedence	10	I knew more about my gender identity then and I realised that I realised that I had a problem with alcohol, and I realised that as much as I really liked this person, you know I didn't like the role I was playing
Need for a safe identity and 'network'	Shift of identity a wakeup call	During detransition there was a realisation that being a cis hetero male did not feel right	10	so, I got into a period where I was giving up for a bit but because I was sober and spending time sober, I was starting to understand that being a cis hetero male is not maybe where my life is.

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Table 17

The Development of GET 'Gender transition is challenging' (Summary)

PETs	**Experiential Statements**	**Code**	**P***	**Quotes**
Disappointment as changes did not meet expectations and there were negative side effects	Health issues and side effects related to testosterone a factor in stopping transition Shortage of HRT made them feeling guilty and they did not want to disadvantage cis-women	Concern about the impact on their health, and concerns about the need for testosterone for body health. Feelings of guilt at potentially disadvantaging cis-women	2	I thought that, I'm getting all these health issues because … I've stopped all the testosterone erm in my body and I did a bit of research and I thought yeah you need some testosterone and the friend I mentioned at the clinic she was on HRT, and they were giving her testosterone as part of that and I thought, hang on a minute, if they are giving, why are they giving you a CIS woman err testosterone to put her on HRT but as a trans women you don't have any testosterone….. I felt slightly guilty because there was a worldwide shortage, and I knew that women were wanting HRT now that erm and I thought is it right that I am sort of taking some of these when there's women who really really benefit and really need it.
GIC Experience	Felt disempowered	Felt judged at	3	Well, it was 2018 so it was still a mental health issue and it felt very much like

Mixed	at GIC and treated as though they were mentally ill	GIC, gender identity treated as a MH issue		that, err it wasn't empowering you know, it was sit down, tell us about yourself and we'll judge whether you are err fit and proper to be here.
Barrier to transition are multiple	Trans identity had to be kept private at the request of partner	Rules around keeping TGD identity private Only small circle of people allowed to know Had to keep hidden		Well, the rules were always that this was private erm. The kids knew and my wife, but she was adamant that it was not something to be released to our social circle or our family.
Unmet needs – romantic	Wanted to hold onto relationships	7-month wait felt horrific Negative reaction from wife	4	[Telling wife and the end of the relationship] I knew at that point, I've know you know, at the point, something needed to give somewhere.

relationships	but also wanted to get support for gender incongruence/ dysphoria	Relationship a barrier to transition Asked to be removed from the list to appease wife, quickly asked to be put back on the list Knew they needed to access support		
Unmet needs – work	Being bullied at work following transition, and not being supported by their work organisation was	Experienced bullying at work Work environment unsupportive – disingenuous Work reluctant to view bullying as a hate incident 04D fed up that they were experiencing difficulties		[Bullying incident at work] then I said erm ‘has this been reported as a hate incident because it is’ and they said [laughs] ‘well because it’s staff there’s nothing in our policy that says we need to report this, record this, as a hate incident’, and I said ‘well okay then, so if I go and shout at a, if I go and call a pregnant lady fat or I’m going overly racist to a colleague what will you do about that’, ‘oh we’d have to deal with that’, right okay then, ‘can you see my point then’

Transition is hard and wider issues make it challenging to do	also a factor in detransitioning Impact on life and relationships – experience of distress/ transphobia	relating to their trans identity. Alcohol use caused difficulties. Lack of family felt to make life harder. Trying to maintain a relationship with family despite challenges in them accepting their TGD identity		I’m still friends with these people which makes me really angry with myself, because you know I have fairly small family and they’ve actually all been fairly horrible to me, and they are also the reason that sometimes fairly horrible to myself

Gender transition – a challenge	Social and relationship difficulties a barrier to transition	Frustration transitioning – being misgendered – female name/ male appearance – embarrassed. Change in their relationship when they transitioned – partner not accepting as created barriers such as not allowing them to wear female clothes. Ending the relationship to be true to self.	5	…at that time [beginning transition] I wasn't sure whether to change my relationship with my partner [their name], she's been with me throughout the whole thing, just saying you know, 'I should basically accept it if that's what I wanted to do,' you know 'don't come round here in your women's clothes'

Appendix 2O

Table 19

Participant Questionnaire Demographics

Characteristic	**Response**	**Sample (n = 5) n = (%)**
Marital Status	In relationship	1 (20%)
	Married	1 (20%)
	Divorced	1 (20%)
	Single	2 (40%)
Ethnicity	White British	5 (100%)
Religion	No religion	3 (60%)
	Spiritual	1 (20%)
	Buddhist	1 (20%)
Parent	Yes	1 (20%)
	No	4 (80%)
Carer Responsibilities	Yes – Primary or Secondary	2 (40%)
	No	3 (60%)
Employment	Unemployed – Benefits	1 (20%)
	Retired	2 (40%)
	Employed/ Self-Employed	2 (40%)
Financial Status	Stable	5 (100%)
	Unstable	0 (0%)
Received free school meals	Yes	1 (20%)
	No	4 (80%)

Appendix 2P

Table 20

Characteristics of Gender Transition and History

Characteristic	**Response**	**Sample (n = 5) n = (%)**
Completed an autobiography as part of assessment	Yes	4 (80%)
	Unsure	1 (20%)
Social transitioned prior to assessment	Yes	1 (20%)
	No	3 (60%)
	Occasional	1 (20%)
Social transition following assessment	N/A	1 (20%)
	Occasional	2 (40%)
	Yes	2 (40%)
Supportive Family	Yes	2 (40%)
	No	2 (40%)
	Not informed	1 (20%)
Supportive Friends	Yes	1 (20%)
	No friends	1 (20%)
	No	2 (40%)
	Some	1 (20%)

Appendix 2Q

Table 21

Participant history relating to discrimination, abuse, bullying, being away from family of origin and forensic history

Characteristic	**Response**	**Sample (n = 5) n = (%)**
Experienced discriminations/ stigma in relation to transgender identity	No	3 (60%)
	No but a factor in leaving a job	1 (20%)
	Yes	1 (20%)
Experienced abuse	No	3 (60%)
	Yes	2 (40%)
Experienced bullying	Yes	3 (60%)
	No	2 (40%)
Experienced being fostered or adopted	No	4 (80%)
	Yes	1 (20%)
Received a custodial sentence in their life	No	5 (100%)
	Yes	0 (0%)

Appendix 2R

Table 22

Experience of accessing interventions related to symptoms of gender incongruence

P*	Stored Gametes	Accessed Hair Removal	Accessed speech and language	Accessed Interventions Privately	Interventions Accessed Privately	Completed a deed poll name change	Obtained a GRC
1	No	Yes	No	Yes	Prescribed cross-sex hormones	Yes	No
2	No	Yes	Yes	Yes	Prescribed cross-sex hormones	Yes	No
3	N/A	Yes	No	Yes	Non-prescribed cross-sex hormones	No	No
4	Yes	Yes	Yes	No	N/A	Yes	No
5	No	Yes	Yes	Yes	Non-prescribed cross-sex hormones	No	No

Appendix 2S

Table 23

Participant history of mental health difficulties, autism diagnosis status, psychological intervention, and risk

Characteristic	**Response**	**Sample (n = 5) n = (%)**
History of mental health difficulties	Anxiety and Depressive disorders	3 (60%)
	Addiction* co-morbid	1 (20%)
	No	2 (40%)
Diagnosis of autism	Yes	1 (20%)
	No	4 (80%)
Awaiting assessment for or querying autism	Yes	2 (40%)
	No	2 (40%)
	N/A	1 (20%)
Previously accessed psychological interventions	Yes	4 (80%)
	No	1 (20%)
Experienced thoughts of ending their life	Yes	4 (80%)
	No	1 (20%)
History of suicidal behaviours	Yes	1 (20%)
	No	4 (80%)
History of self-harming behaviours	Yes	1 (20%)
	No	4 (80%)

Appendix 2T

Table 24

Participant history of learning disabilities, physical health, dependency to substances and eating disorders

Characteristic	**Response**	**Sample (n = 5) n = (%)**
Diagnoses of a learning disability	Yes	0 (0%)
	No	5 (100%
Physical health difficulties	Yes	3 (60%)
	No	2 (40%)
History of alcohol dependency	Yes	2 (40%)
	No	3 (60%)
History of dependency to non-prescribed or illegal drugs	Yes	3 (60%)
	No	2 (40%)
History of eating disorder	Yes	0 (0%)
	No	5 (100%)

Appendix 2U

Table 25

Information regarding pathway and process

Characteristic	**Response**	**Sample (n = 5) n = (%)**
Referral Source	GP	4 (80%)
	Mental Health Team	1 (20%)
Previous input from GIDS	Yes	0 (0%)
	No	5 (100%)
Input from another clinic	Yes – Private Provider	1 (20%)
	No	4 (80%)
Medical Interventions Prescribed Following Assessment	Yes	5 (100%)
	No	0 (0%)
Referral for surgical interventions	N/A	3 (60%)
	Yes – referral for sex-reassignment surgery following retransition	1 (20%)
	Yes – referral for double mastectomy following detransition	1 (20%)
Psychological Input	Yes	5 (100%)
	No	0 (0%)