

What Happens to Gender Diverse Young People who are Referred to an Adult
Gender Identity Service from a Child and Adolescent Service?
A Cross-Sectional Look at Intervention Choices and Outcomes

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ABSTRACT

Background

In recent years there has been an explosion of referrals to child and adolescent gender identity services. There is a paucity of research on the experiences and outcomes of young adults referred from child and adolescent services to adult services, and with such large increases in referrals it is vital we understand more about the intervention pathways, satisfaction and longer-term outcomes of these gender diverse young people. The findings will enable better tailoring of gender identity services for young people, and be an important step towards ensuring that the support and intervention provided meets the needs of this diverse and growing population

Aim

The aim was to determine the intervention pathways, satisfaction levels and longer-term outcomes of the young people who attended the Gender Identity Development Service (GIDS), and who were referred on to the Charing Cross Adult Gender Identity Clinic (CCGIC).

Method

All attendees of the GIDS who were referred to the CCGIC between 2011 and 2016 were sent an invite to participate in an online questionnaire, which asked about their emerging gender awareness, prevalence of gender affirming interventions, factors influencing intervention decisions, satisfaction with the intervention process, feelings about gender identity, body image and wellbeing.

Results

Of the 365 ex-GIDS clients who were referred to CCGIC, 72 completed the questionnaire. Overall, 59% were taking/had taken hormone blockers; 67% were/had taken cross-sex hormones and 27% intended to start taking them in the future; and 34% had undergone top or bottom surgery, with 56% intending to have surgical intervention in the future. Factors influential in the decision-making process were identified. Participants were generally satisfied with their intervention decisions and the decision-making process. However, areas of dissatisfaction were identified and are discussed.

Conclusion

The study shows that a higher number of young adults who are referred from child and adolescent services to adult services do pursue (or intend to pursue) medical and surgical interventions. Many who do are largely satisfied with the intervention process, but there are areas that require improvement.

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INTRODUCTION

1.1. Chapter Overview

In recent years the dimensionality and diversity of gender identity and gender identity difficulties has received increasing attention in the research literature, popular media and public policy debates (Beek, Cohen-Kettenis, & Kreukels, 2016; Drescher & Pula, 2014). Heightened public awareness has likely contributed to an increase in self-identified gender diversity in children and young people, and there has been a corresponding explosion of referrals to speciality services for gender diverse youth (de Vries, Kreukels, T'sjoen, Algars, & Mattila, 2015). This chapter clarifies key terminology and provides an overview of the current context surround gender identify. Next it provides a scoping review of follow-up studies in adolescents and young adults, followed by the rationale and research questions for the current study.

1.2. Terminology

Language and terminology in this area is shifting and evolving, and there is currently no consensus on what constitutes the most appropriate terminology (Eliason, 2014; Tebbe & Budge, 2016). In this thesis I have endeavoured to use terminology that I consider the least pathologising, but recognise that the terms I have used may or may not be acceptable to all stakeholders, and may in time become obsolete.

1.2.1. Sex

Sex and gender are terms that are often used interchangeably, but although they are inextricably linked, they are quite different. A person's biological sex is often assigned at birth by a medical professional and parents, usually on the basis of the external genitals the baby is born with. However, biological sex is determined by more than genital appearance alone; it also involves a person's internal genitalia, their chromosomal make-up (XX chromosomes for females and XY for males), and secondary sex characteristics (i.e. chest growth/appearance, facial

and body hair, voice, muscle mass and fat distribution), which are usually regulated by hormones (Barker, 2017). Mounting evidence suggests that, contrary to popular belief, sex is not binary in nature (Ainsworth, 2015). Approximately 1.7% of people are born with reproductive, chromosomal and/or sexual anatomy that do not seem to fit the typical definitions of female or male (Hughes, Houk, Ahmed, & Lee, 2006), and are referred to as disorders (or differences) of sex development (DSD).

1.2.2. Gender

Gender, on the other hand, refers to the socially constructed characteristics of women and men, such as norms, roles, expression, and the relationships of and between groups of women and men (Newman, 2002). These vary from society to society and gender can be changed. The majority of people are assigned male or female at birth, and are then taught the appropriate norms and behaviours for their assigned gender – including how they should interact with others of the same or opposite sex within households, communities and work places. When individuals or groups do not subscribe to established gender norms they often face stigma, discriminatory practices or social exclusion (WHO, 2018).

1.2.3. Identity

Identity, as a concept, is historically and culturally contingent, and not easy to define (Baumeister, 1995). In the west, we tend to frame identity in individual and largely intra-psychic terms; and much of our current (western) understanding of identity comes from the work of developmental psychologists Erikson (1968) and Marcia (1966). A personal identity can be defined as the values, principles and roles a person adopts as their own. Identity is thought of as dynamic, in that it continues to develop throughout the lifespan, but both Erikson and Marcia cited adolescence as a key period for identity formation. As adolescents form their identities, they explore and commit to identity-defining roles and values across different life domains (e.g. politics, religion, occupation, friendships, intimate relationships and gender roles). Adolescents are thought to experience four different stages of identity formation (Marcia, Waterman, Matteson, Archer, & Orlofsky, 1993), including identity diffusion/confusion, identity foreclosure, identity moratorium, and identity achievement. Through these stages adolescents

progress from not thinking about these issues, to prematurely forming an opinion without any exploration, to searching for meaningful adult roles and values, and then achieving their own identity as a result of this process (Kroger, 2008; Marcia et al., 1993).

Narrative and social constructionist theorists (Gergen, 1991; McAdams, 1985; Potter & Wetherell, 1987) argue that language and context play a key role in identity formation. We are thought to develop a sense of who we are through the stories we tell (and are told) about ourselves, and that our socio-cultural and historical contexts frame and constrain our language and behaviour (Cerulo, 1997). Identity consists of many integrated aspects of the self, and each person may have any number of identities – an ethnic identity, a political identity, a religious identity, and a national identity to name a few; all of which are influenced by interpersonal relationships, society, and significant events that occur through the life course (Kroger, 2008). A fundamental identity is a person's gender identity.

1.2.4. Gender Identity

Gender identity can be defined as a person's internal sense of themselves as male, female, a combination of both, neither or another gender (APA, 2015a; Leibowitz & De Vries, 2016). The sense of one's gender largely determines how people view themselves and forms an important basis for interactions with others (Steensma, Kreukels, de Vries, & Cohen-Kettenis, 2013).

1.3. Gender Identity Development: A Biopsychosocial Understanding

The biopsychosocial model was introduced in the late 1970s as an alternative to the purely medical model that predominated at the time (Engel, 1977). Engel saw the medical model as too reductionist, and felt that a biopsychosocial model would provide a more holistic and comprehensive understanding of all the factors that play a role in health and disease (Engel, 1977). In the context of gender identity, it is a particularly useful model as it facilitates thinking about the complex array of biological, psychological and social factors that interact to influence gender identity development.

Traditionally, studies on gender identity development have fallen into two types; those focussed on “normative” or typical development, and those focussed on gender diverse development in people with gender dysphoria (see section 1.4 for full definition) or DSD. More recently, these lines of research have begun to converge, to identify factors associated with variability in gender identity development across the entire spectrum (de Vries, Kreukels, Steensma, & McGuire, 2014).

1.3.1. Typical Gender Identity Development

In most cases, a person’s gender identity will develop in line with the gender they were assigned at birth, on the basis of their external genitalia. The following is a review of the biological, psychological and social factors that are thought to influence normative or typical gender identity development.

1.3.1.1. Biological factors: Prenatal exposure to sex hormones is thought to influence sex differentiation of the brain and behaviour in a male or female direction (de Vries et al., 2014; McCarthy, de Vries, & Forger, 2010). Typically, women have more oestrogens in their bodies and men more androgens; most commonly testosterone (Stainton Rogers & Stainton Rogers, 2001). While it is difficult to study prenatal exposure to sex hormones, evidence suggests that exposure to prenatal androgens facilitates interest and engagement in male gender-role behaviour (e.g. child toy preferences and adult career choices), and spatial ability, but appears to have a lesser influence on gender identity (Berenbaum & Beltz, 2016; Cohen-Kettenis & Pfäfflin, 2003; Hines, 2009; Steensma et al., 2013). The effects of prenatal exposure to oestrogens is much less clear as findings tend to be mixed (Cohen-Kettenis & Pfäfflin, 2003).

1.3.1.2. Psychological factors: Infants as young as 3 months old are capable of distinguishing between male and female faces (Quinn, Yahr, Kuhn, Slater, & Pascalis, 2002). However, whether they can categorise or label gender is still up for debate (de Vries et al., 2014). According to cognitive developmental theory (Kohlberg, 1966), gender identity and gender role development are achieved as

part of an inherent maturation process. Between the ages of two and twelve, children are thought to progress through three stages towards a state of gender constancy (i.e. the understanding that they will always be the same sex and that identification is based on external genitalia). The specific stages include the gender labelling stage (age 2-3 years), where a child is able to recognise their own and others' gender; the gender stability stage (age 3-7 years), where the child accepts that gender does not change over time; and the gender consistency stage (age 7-12 years), where the child recognises that a person's gender is fixed across situations regardless of changes in appearance or behaviour. Kohlberg's theory suggests that children acquire gender-typical behaviours as a result of developing a stable concept of gender. However, this view is contested by some as children show gender-typical behaviours well before reaching a state of gender constancy (Cohen-Kettenis & Pfäfflin, 2003).

Gender schema theorists (Bem, 1981) posit that during development, children learn about their culture's definitions of femaleness and maleness. In doing so they begin to construct cognitive gender schemas (Bem, 1981), which are theories about gender-appropriate behaviour that help guide and organise information processing and behaviour. From a young age children acquire knowledge about gender stereotypical behaviour (i.e. that 'boys have short hair' and are 'more aggressive' and that 'girls have long hair' and are 'more caring'). Children are thought to play an active role in gender schema development by remembering and attending to gender-consistent information better than gender-inconsistent information. Children learn to evaluate their own adequacy as a person by matching their preferences, attitudes and behaviours to the prototypes stored within the schema, and thus begin to conform to cultural definitions of femaleness and maleness (Bem, 1981; de Vries et al., 2014). Contemporary gender schema theory combines elements of social learning theory and cognitive developmental theory (Berk, 2013), and a variety of studies support gender schema theory (Cohen-Kettenis & Pfäfflin, 2003).

1.3.1.3. Social factors: Social roles and expectations vary for boys and girls, and gendered characteristics are even ascribed pre-birth. For example, babies who move around a lot in the womb are often thought to be boys (Montgomery, 2010).

According to social learning theory (Bandura, 1977), children learn gender-appropriate behaviour through a combination of operant conditioning and observational learning. Behaviours can be reinforced directly or indirectly by observing gender stereotypes. Evidence suggests that boys tend to identify with same-gender models more than girls, but this might be related to the fact that gender-diverse behaviour is generally more accepted in girls than it is in boys (Aitken et al., 2015; Bussey & Bandura, 1999). Critics of social learning theory state that it is too simplistic, in that it casts children as too passive, and fails to explain how and why gender changes over time (Bem, 1981).

The main criticism of these perspectives is that they each take a partial view. Children's sense of self and identity (i.e. their self-beliefs, cognitions, perceptions, emotional responses, and expressions) are influenced by a complex interplay of biological, interpersonal, social, cultural and geographic factors, and any coherent theory of gender identity will need to integrate them (Bronfenbrenner, 1979; Hidalgo et al., 2013).

1.3.2. Gender Diverse Development

Some children do not follow a typical pattern of gender development, and will instead show what can be described as gender diverse development (Steensma et al., 2013). Gender diversity refers to the extent to which a person's gender identity, expression, and/or behaviour differs from the cultural norms that are prescribed for people of a particular sex (APA, 2015b). For example, in gender diverse development, boys may show a preference for stereotypically female-typed interests and behaviours, and girls a preference for stereotypically male-typed interests and behaviours (de Vries et al., 2014). The term transgender (short: trans) is an adjective used to describe people whose gender identity, expression and/or behaviour does not conform to what is typically associated with the sex they were assigned at birth (APA, 2015b). Trans people may feel they are the other gender (and are sometimes, though not always, referred to as transwomen and transmen); but reflecting a non-binary concept of gender, they might identify as both male and female, neither, or another gender altogether (Grant et al., 2011; Leibowitz & De Vries, 2016). It is important to note however,

that people with gender identities and/or expressions that differ from societal expectations based on gender assigned at birth are a heterogeneous group, and not all gender diverse people will identify as trans.

Gender diversity is not a new (or western) phenomenon. Transgender and non-binary or third gender identities have been documented throughout history and across cultures: The Native American 'two spirit' people; the Polynesian Mahu; the Hijra, Khushra and Acault of Indian, Pakistani and Myanmar societies; the Kathoeys in Thailand; the Muxes in Mexico; and the Xanith of Oman (Bullough & Bullough, 1997). The concept of a third gender is also found in queer theories and in community based studies in North America, but has been explored less in clinical studies (de Vries et al., 2014)

In the remainder of this thesis I will use the terms *trans*, *trans-identified*, *gender diverse*, and *gender diversity* as umbrella terms to describe people whose gender identity does not align with the gender they were assigned at birth on the basis of their biological sex; and I will use *cis* or *cisgender* to describe people whose gender does align with the gender they were assigned at birth. The following section reviews the biological, psychological and social factors that are thought to influence gender diverse identity development.

1.3.2.1. Biological factors: Biological theories highlight three possible pathways to gender diverse development: prenatal exposure to hormones, anatomic brain differences, and genetic influences. Studies indicate that prenatal exposure to testosterone in people with disorders (or differences) in sex development (DSD) may affect male gender identity (de Vries, Doreleijers, & Cohen-Kettenis, 2007; Dessens, Slijper, & Drop, 2005), but findings are inconsistent. For example, while gender dysphoria occurs more in females with congenital adrenal hyperplasia (CAH; an enzyme deficiency that causes prenatal exposure to high levels of testosterone) than females without CAH, not all foetuses with CAH develop a male gender identity (de Vries et al., 2014). Therefore, from these studies, it is not clear how, and to what extent, prenatal androgens affect gender identity development and the possible influence of later cross-sex hormone treatment cannot be ruled out (de Vries et al., 2014).

Post-mortem studies have found differences in the brains of male-to-female trans people, such that some sex-specific characteristics of the brain are more similar to female brains than male brains (Garcia-Falgueras & Swaab, 2008; Taziaux, Swaab, & Bakker, 2012; Zhou, Hofman, Gooren, & Swaab, 1995). However, the studies were small, conducted by the same research group, and have yet to be replicated. Therefore, the extent to which brain differences may play a role in gender diverse development is still unclear (de Vries et al., 2014).

Heritability studies suggest that genes may play a role in gender diverse development (de Vries, et al., 2014). Heritability estimates for gender dysphoria vary between 0.22 and 0.77; although population studies are more likely to be measuring gender variance than gender dysphoria (de Vries et al., 2014; Veale, Clarke, & Lomax, 2010). However, it is worth noting that the psychosocial environments monozygotic twins are raised in are likely to be more similar than those of dizygotic twins.

Some studies have found polymorphisms (genetic variations) in sex steroid-related genes of people who are transgender; CYP17 in female to male transgender persons (Bentz et al., 2008) and AR in male to female transgender persons (Hare et al., 2009; Henningsson et al., 2005) but others have failed to replicate these findings (Bentz et al., 2007; Ujike et al., 2009). No strong candidate gene has emerged that explains the development of gender variance or dysphoria. While studies of gene-environment interactions have not yet been undertaken in this area (de Vries et al., 2014), due to the complexity of gender identity development, it is likely that individual behavioural differences are the result of a complex interplay between genes and the social and psychological environments (Lenroot & Giedd, 2011).

1.3.2.2. Psychological factors: In early studies of gender-variant development, gender diversity/dysphoria was thought to be part of a more pervasive psychological disturbance (Coates & Person, 1985). It has been hypothesised that attachment problems (Marantz & Coates, 1991) or an anxious temperament interacting with parental factors (Bradley & Zucker, 1990) can lead to gender

dysphoria, but these theories have not been empirically supported. And while some studies show a high prevalence of separation anxiety traits (Zucker, Bradley, & Lowry Sullivan, 1996) and other internalizing symptoms in children with gender dysphoria (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003), the direction of causality cannot be determined (de Vries et al., 2014).

1.3.2.3. Social factors: A variety of social factors have been hypothesised to impact gender diverse development, including maternal depression, or enmeshment with the mother and absence of the father (Stoller, 1968); early childhood loss of an attachment figure (Bleiberg, Jackson, & Ross, 1986); and parental reinforcement patterns (Green, 1987). However, many of these theories have not been empirically tested, and those that have were limited to specific aspects of the theory and produced mixed results (Cohen-Kettenis & Pfäfflin, 2003). It is also worth noting that these theories are all based on binary notions of gender, in which gender identity and expression is classified as either female or male and normal or abnormal. In reality, there is vast overlap in female and male behaviour, and what are considered appropriate attitudes or behaviour for a particular gender will vary within and between families and cultures (Wilson, Griffin, & Wren, 2002).

In early follow-up studies with people with DSD (Money, Hampson, & Hampson, 1955) the importance of biological factors were acknowledged, but researchers believed that gender identity aligned with that of rearing, and nurture was thought to overrule nature. As such, gender reassignment surgery was performed on babies with DSD to create sex-compatible external genitalia, with the idea that children would label themselves a girl or a boy, and develop a corresponding self-image (Blizzard, 2002; Money et al., 1955). However, later research found that children with DSD who were operated on and raised in this way sometimes developed gender identity problems, which suggests that biological factors play a greater part than previously thought. However, a more recent review of gender identity outcomes in people with DSD (de Vries et al., 2007), after a chromosomally opposite gender assignment, gender change only occurred in 42% of people; and the initial gender assignment remained the best predictor of gender identity in adulthood. Taken together these findings suggest that gender

identity is influenced by a combination of gender assignment and concomitant social and psychological factors (de Vries et al., 2007, 2014).

In order to make sense of the different biological, psychological and social factors involved in gender diverse identity development, it is important to keep in mind that there is considerable variability in gender diverse development, in terms of age of onset, sexual orientation, presence/absence of comorbid conditions (e.g. autism), gender expression and behaviour, presence/absence of dysphoria (and intensity of dysphoria), desire (or not) for gender affirming intervention etc. – all of which may reflect different causal pathways (de Vries, Noens, Cohen-Kettenis, Van Berckelaer-Onnes, & Doreleijers, 2010). At present, it is unclear whether these represent distinct groups or are part of a gender diverse continuum. Increasingly, gender diversity is considered part of nature's diversity (Ehrensaft, 2016). However, while many people are content with a gender diverse identity; a minority of people are distressed by it.

1.4. Gender Dysphoria

Gender dysphoria refers to the clinical distress that some people experience as a result of the discrepancy between their experienced gender or gender identity and the gender they were assigned at birth (Steensma et al., 2013). Gender dysphoria replaced the previous diagnostic category (gender identity disorder) to avoid pathologising identity. Nonetheless, gender dysphoria is still considered a diagnosable mental disorder, and although highly controversial, is still listed in the most recent DSM 5 (American Psychiatric Association, 2013).

In children, the DSM 5 (American Psychiatric Association, 2013) describes Gender Dysphoria as a strong desire to be of the other gender/insistence that he/she is the other gender (or another gender). Plus at least five of the following:

1. A (strong) preference for cross-dressing;
2. Cross-gender roles in make-believe play;
3. A preference for toys/games of the other gender;
4. Playmates of the other gender;
5. Rejection of gender typical play;
6. Dislike of sexual anatomy;
7. Desire for primary and/or secondary sex characteristics that match one's experienced gender.

In adolescence/adulthood, Gender Dysphoria is described as a marked incongruence between a person's experienced/expressed gender and their assigned gender (usually assigned at birth) for at least 6 months duration, as manifested by two or more of the following: 1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics. 2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of marked incongruence with one's experienced/expressed gender. 3. A strong desire for the primary and/or secondary sex characteristics of the other gender. 4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender). 5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender). 6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender). Gender dysphoria is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning, or with a significantly increased risk of suffering, such as distress or disability (American Psychiatric Association, 2013). It is important to note that not all gender diverse people experience gender dysphoria, and for those that do it does not necessarily persist throughout the person's life (Coleman et al., 2012).

Studies show that in children assigned male at birth, 73-98% of gender identity difficulties starting in childhood do not continue past adolescence/early adulthood, and in children assigned female at birth, they do not continue in 50-88% of cases (Ristori & Steensma, 2016; Wallien & Cohen-Kettenis, 2008). Childhood gender dysphoria is strongly associated with a lesbian, gay or bisexual identity around or after puberty, and this can account for some of the desistance post puberty (Ristori & Steensma, 2016). However, other explanations for the variability include variation in intensity of the gender dysphoria across studies (i.e. some studies have used clinically referred samples whereas others have not); cultural variation in referrals (e.g. in some countries boys are referred more than girls, and if this is due to gender diverse behaviour been seen as more problematic in boys than girls then this could lead to higher rates of boys with less severe gender dysphoria than in other countries); and time at follow-up (Ristori & Steensma,

2016). Not much is known about the factors associated with persistence. Studies suggest that, on a group level, persistence is closely associated with the intensity of the gender dysphoria and the amount of cross-gendered behaviours shown, but the predictive value of these factors on an individual level are less clear, and thus have little clinical utility (Drummond, Bradley, Peterson-Badali, & Zucker, 2008).

Some children express a desire to socially transition to their experienced gender role in early childhood, long before reaching puberty. Social transitions in early childhood are controversial, with divergent views held by healthcare professionals (Coleman et al., 2012). The current evidence base is limited and insufficient in terms of being able to predict the long-term outcomes of social transitions in early childhood (Coleman et al., 2012). Furthermore, the current literature on social transitions is often based on a binary model of gender (Newman, 2002). Increasingly young people identify in a diversity of ways and many have begun to question and reject more traditional assumptions and roles associated with gender identities (NHS England, 2015).

Conversely, gender dysphoria that starts in or continues through adolescence, is much more likely to continue into adulthood (de Vries, et al., 2014). Over the last decade, the age at which adolescents start socially transitioning has decreased (NHS England, 2015). The evidence base regarding physical interventions is limited and still developing. Not all people with gender dysphoria choose physical intervention, but little is known about those that do (NHS England, 2015). Findings on regret after physical intervention are mixed, with some studies reporting regret rates between 0.3% and 2.2% (Dhejne, Öberg, Arver, & Landén, 2014; Wiepjes et al., 2018) and others finding little or no evidence of regret (Imbimbo et al., 2009).

It is important to note, however, that the notion of desistance and persistence is problematic as it serves to perpetuate an unhelpful binary model of gender (Newman, 2002; Wiseman & Davidson, 2012). In western contexts, gender expression is considered binary and prescriptive, such that females and males are expected to behave in feminine and masculine ways. The conflation of

biological terms and the use of feminine and masculine language positions gender expression as a natural phenomenon, rather than a socially constructed one. This naturalistic discourse perpetuates the unhelpful binary model of gender, in which gender diverse behaviour is seen as pathological (Newman, 2002; Wiseman & Davidson, 2012).

1.5. Prevalence of Gender Diversity

The exact prevalence of people with gender dysphoria or who identify as trans is unknown, but several studies have provided estimates (Achenbach & Rescorla, 2003; Arcelus et al., 2015; Clark et al., 2014; Shields et al., 2013).

1.5.1. Children and Adolescents

To date, no epidemiological studies have been conducted on the prevalence of Gender Dysphoria in children or adolescents (Zucker, 2017). Using the 1999 standardisation sample for the Child Behavior Checklist (CBCL) for children ages 6-18 (n = 1822) who had and had not been referred to gender identity services, Achenbach and Rescorla (2003) found that less than 1% of non-referred boys and 1.2% of non-referred girls endorsed the item 'Wishes to be of opposite sex'. Estimates were higher for referred boys (2.7%) and girls (4.7%). In terms of self-identification, a random sample of 2730 adolescents in the US found that 1.3% identified as transgender (Shields et al., 2013); and similarly, in New Zealand, a nationally representative youth survey on the prevalence of transgenderism in adolescents (n = 8166) found that 1.2% identified as transgender and 2.5% were not sure about their gender (Clark et al., 2014). More recently, in a sample of 81,885 US high school students, 3.6% of birth-assigned females and 1.7% of birth-assigned males responded 'yes' to the question 'Do you consider yourself transgender, genderqueer, genderfluid or unsure about your gender identity?'.

1.5.2. Adults

In a national probability sample study in the US (n = 151,456), the proportion of adults who identified as transgender was estimated at 0.5% (Crissman, Berger, Graham, & Dalton, 2017). In a recent systematic review of 21 prevalence studies

of transsexualism (term used by authors) conducted primarily in adult clinic populations around the world, the prevalence of transsexualism varied from 0.45 to 23.6 per 100,000 people. The meta-analytical prevalence (including 12 prevalence studies) was 4.6 in 100,000 people (1 in every 21,739); 6.8 for trans-women (1 in every 14,705) and 2.6 for trans-men (1 in every 38,461). Time analysis demonstrated that reported prevalence has increased over the last 50 years (Arcelus et al., 2015). It is unclear whether the increase in prevalence reflect an actual increase or whether it simply reflects that people feel more comfortable coming out due to increased social acceptance, decreased pathologisation, and greater awareness of therapeutic options available, such as psychological support and gender-affirming medical intervention (Zucker, 2017). The majority of the studies included in the review were conducted in Western European countries, which may reflect a combination of greater socio-cultural acceptance of trans people, greater availability of trans-related services, an academic interest in trans healthcare, and the presence of legislation relating to trans-rights (Arcelus et al., 2015). However, it is worth noting that the notion of tolerance in this context is potentially misleading, as there is a reported increase in trans people in countries where being gay is unacceptable or illegal.

There are a number of possible reasons for the variability in prevalence estimates, including changes to diagnostic criteria and corresponding language/terminology (e.g. gender identity disorder, transsexualism and gender dysphoria), variability in who/what is being measured (e.g. people with gender dysphoria versus people who identify as trans), variability in the type of prevalence recorded (e.g. point prevalence versus period prevalence), differences in study population (e.g. community versus clinical), and variability in awareness/cultural norms (across cultures and time) that allow trans people to be more or less visible and able to access services (Arcelus et al., 2015). Due to a combination of these factors, prevalence studies often focus on more easily identifiable clinical populations (Zucker & Lawrence, 2009), which has led to an overrepresentation of prevalence studies from western countries – despite the presence and acceptance of gender diverse people and communities in countries such as Thailand, India and Pakistan. Notwithstanding the difficulties associated with obtaining accurate prevalence estimates, the aforementioned studies

demonstrate a global, and increasing presence of people with gender dysphoria or who identify as trans.

1.6. Substantial Increase in Referrals to Gender Identity Services

In recent years, there has been a dramatic increase in the number of referrals to both child/adolescent and adult clinics in Europe and North America (Aitken et al., 2015; Butler, De Graaf, Wren, & Carmichael, 2018; Chen et al., 2016; de Vries & Cohen-Kettenis, 2012; Kaltiala-Heino, Bergman, Työläjäarvi, & Frisén, 2018).

Factors thought to explain this increase include a lowered threshold for helpseeking due increased knowledge and decreased stigmatisation of gender diversity; increased awareness of the medical and surgical interventions available; increased service provision; and sociocultural features relating to what identities are available for whom, as well as sex-related differences in pressure to conform (Aitken et al., 2015; Kaltiala-Heino et al., 2018). The large increases in the number of referrals has put considerable pressure on existing services. Wait times to access services continue to rise, along with the distress levels of those waiting for support and intervention (Davies et al., 2013; Ellis, Bailey, & McNeil, 2015).

Alongside the increase in referrals, have been changes in the profile of young people presenting to services. Over the last decade, adolescent clinics around the world have observed a shift in the sex ratio of the young people who present to the clinics with gender dysphoria – from a previously observed larger proportion of assigned males, to a now seen larger proportion of assigned females (Aitken et al., 2015; Butler et al., 2018; Kaltiala-Heino, Sumia, Työläjäarvi, & Lindberg, 2015). The reason for this inverted sex-ratio remains unclear, but it has been suggested that it might be easier for assigned females to come out as trans than assigned males because although trans identities are becoming more accepted, there is still more stigmatisation of cross-gender behaviour in boys than in girls (Aitken et al., 2015). Another possibility, in a world where the gender equality gap is widening rather than narrowing, it could be that male status is still preferable (Butler et al., 2018).

Other changes in profile include an increase in young people presenting in their mid-teens with no prior history of gender dysphoria, young people (particularly assigned females) with increased clinical risk and complexity, greater prevalence of marked ASD features (particularly in assigned females), and a greater variety of different identities, such as non-binary or gender queer identities (De Vries et al., 2010; Kaltiala-Heino, Bergman, Työlajärvi, & Frisén, 2018; Kaltiala-Heino, Sumia, Työlajärvi, & Lindberg, 2015; Zucker et al., 2016).

1.7. Intervention and Support

The provision of medical intervention to children and adolescents is an area of considerable debate and contention. Adolescence is a period of rapid and dramatic physical, psychological and sexual development, and with regards to gender identity, there can be considerable fluidity and variability in outcomes, particularly in pre-pubertal children (Coleman et al., 2012). The inability to predict people's gender identity trajectories makes intervention decisions complex.

Although it is generally agreed that intervention with children and adolescents should involve a comprehensive multi-disciplinary approach, due to a lack of long-term follow-up studies, there is currently no consensus as to which approach to clinical care constitutes best practice (Chen et al., 2016; Coleman et al., 2012; Hembree, 2011). However, from a psychological perspective, it is agreed that intervention (via individual, group or family therapy) should focus on exploring gender identity, role and expression; reducing the young person's distress regarding the gender dysphoria; addressing any other psychological difficulties; enhancing social and peer support; and optimizing the person's psychological adjustment, resilience and wellbeing (Byne et al., 2012; Coleman et al., 2012).

1.7.1. Medical Intervention

With regards to physical intervention with young people in the UK, the number and type of interventions a person receives, and the order in which they take place will vary from person to person; but broadly, a staged approach is followed whereby reversible interventions precede irreversible interventions, in combination with ongoing psychological support – sometimes referred to as “the

Dutch model” (Coleman et al., 2012; Delemarre-van de Waal & Cohen-Kettenis, 2006; Hembree et al., 2009, 2017). After a comprehensive psychological evaluation, the first stage of physical intervention may involve administering hormone blockers (gonadotropin-releasing hormone antagonists or GnRH) to adolescents who experience profound and persistent gender dysphoria. Hormone blockers suppress puberty, the aim of which is to relieve immediate distress by preventing the development of unwanted secondary sexual characteristics, and to allow more time for the young person to explore their gender identity (GIRES, 2014; Wylie et al., 2014); this intervention is considered fully reversible (Wylie et al., 2014), but the potential long-term effects on brain and cognitive development are unclear (Sadjadi, 2013). The onset of puberty marks a critical diagnostic stage for gender dysphoria. In many pre-pubertal children gender dysphoria does not continue post-puberty, whereas gender dysphoria in adolescence is much more likely to continue into adulthood (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011; Steensma, Biemond, De Boer, & Cohen-Kettenis, 2011). Hormone blockers are generally only started after a person has entered the early stages of puberty (i.e. Tanner stages 2-3) – and only if the person has a history of gender dysphoria, there are no psychosocial problems that would interfere with assessment or intervention, they have adequate social support, and a good understanding of the impact of medical interventions (Cohen-Kettenis, Steensma, & de Vries, 2011). In adolescents with gender dysphoria, both psychological support and puberty suppression have been shown to improve global psychosocial functioning and wellbeing (Costa et al., 2015; de Vries et al., 2011, 2014).

If a young person’s gender dysphoria persists and further criteria are met (i.e. self-harm is not escalating, the person has capacity to consent, fertility preservation has been explored etc.) the next intervention offered would be cross-sex hormones, which masculinise or feminise the body; this intervention is partially-reversible (but does lead to infertility if fertility preservation is not sought beforehand) and typically offered to people aged 16 and over. Research suggests that cross-sex hormone therapy reduces symptoms of anxiety and dissociation, lowers perceived and social distress, and improves quality of life and self-esteem in both assigned females and assigned males (Costa & Colizzi, 2016). The third

interventions offered would be surgeries, which are largely irreversible and typically offered to those aged 18 and over (Coleman et al., 2012). The majority of longitudinal studies investigating people pre- and post-surgery (between 2-13 years post-surgery) show results that point towards the benefits of gender affirming surgery (Dhejne, Van Vlerken, Heylens, & Arcelus, 2016), with levels of psychopathology and gender dysphoria in participants similar to normative data (De Cuypere et al., 2006; Johansson, Sundbom, Hojerback, & Bodlund, 2010; Pimenoff & Pfäfflin, 2011; Ruppin & Pfäfflin, 2015; Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005).

1.7.2. Ethical Dilemmas Surrounding Medical Intervention with Adolescents

Adults are offered similar physical interventions to adolescents, but there are key differences and dilemmas in the approaches to assessment and intervention between adults and adolescents. Adults are seen to be competent to make decisions about physical interventions, and the current challenges in adult care relate to moving gender identity away from psychiatry and an association with mental health, towards a consent based model of care (Bockting, 2009). When considering physical interventions for young people, the concerns are related to age and capacity (Byne et al., 2012; Vrouenraets, Fredriks, Hannema, Cohen-Kettenis, & de Vries, 2015). Physical maturation and psychological maturity associated with age are key determinants of eligibility and readiness for physical interventions, and it is the gap between these that characterises the potential dilemmas associated with assessment and intervention in adolescents.

There has been a gradual trend towards providing physical interventions earlier, but this trend is hotly debated (Cohen-Kettenis, Delemarre-van De Waal, & Gooren, 2008; Delemarre-van de Waal & Cohen-Kettenis, 2006; Ehrensaft, 2016; Hidalgo et al., 2013; Vrouenraets et al., 2015; Wren, 2000). Arguments in favour of earlier intervention point to the profound distress (including depression, suicidality and self-harm) experienced by many adolescents with gender dysphoria; distress that can increase at the onset of puberty due to the development of secondary sex characteristics and the increasing social divisions between genders; distress that can be exacerbated by the delayed wait for physical intervention (Costa, Carmichael, & Colizzi, 2016; Giordano, 2008;

Kreukels & Cohen-Kettenis, 2011; Vrouenraets et al., 2015). Preliminary evidence suggests early transitions can lead to positive outcomes (McNeil, Bailey, Ellis, Morton, & Regan, 2012), including a physical appearance that reportedly makes it easier to be accepted as a member of a particular gender compared with people who began physical intervention in adulthood (Kreukels & Cohen-Kettenis, 2011).

Arguments against earlier intervention include concerns that gender identity is still developing in adolescence and may fluctuate/change in the long-term; that early intervention may inhibit spontaneous formation of a stable gender identity, which can develop through a crisis of gender; potential negative implications for physical, reproductive and CNS development, and psychological and psychosexual functioning; impact on sexuality (i.e. blocking hormones may prevent age-appropriate socio-sexual experiences and exploration of sexual orientation); the importance of social context in the shaping how a person experiences their gender diversity; and the question as to who is able to give informed consent (Hembree et al., 2009; Kaltiala-Heino et al., 2018; Kreukels & Cohen-Kettenis, 2011; Vrouenraets et al., 2015; Wylie et al., 2014)

Adolescence is a time of significant developmental change. It is a process of complex adjustment to major physical and emotional changes, as well as increased responsibility and societal expectations in relation to gender. This developmental period is associated with vulnerability to risk taking, poor impulse control, black and white thinking, and a hyper-responsive reward system (Ausubel, 2002). Research also suggests that decision-making in adolescence may be influenced by emotion and social factors, particularly in peer and 'hot' contexts (Blakemore & Robbins, 2012). In the face of these complexities, the degree to which a minor can consent to medical interventions that will have long-term, potentially irreversible consequences, will vary greatly from person to person.

The narrative about the importance of earlier medical intervention is a powerful one – one that is currently playing a significant role in shaping public opinion, and the direction of the field. Trans people who did not receive medical intervention in adolescence are often portrayed as inherently damaged because of it; this

narrative locates the cause of the suffering within the body/person, as a result of puberty, and what tends to be missing from these debates and narratives are the social conditions (i.e. increasing gender differentiation among friendships groups; institutional and social discrimination, marginalisation, bullying, transphobia, being mis-gendered etc.) in which the suffering (i.e. distress, self-harm, worries about 'passing' or others finding out etc.) has developed (Hendricks & Testa, 2012). As Wren states (2014), 'Is this the medicalising of psychological and social ills or are young trans people the ultimate authority on their gender and their relationship to their body?'. The debate will not be settled anytime soon, but nevertheless, the de-contextualizing of young trans people's experience may lead clinicians to miss key causal factors of distress; it also runs the risk of positioning puberty suppression as a 'magic bullet', and may make potential harms of intervention more difficult to ascertain (Sadjadi, 2013).

Another contextual factor that requires more thought and attention, are the ways in which the binary gender discourse is bound up with medical and surgical intervention (Newman, 2002; Wiseman & Davidson, 2012). As mentioned previously, binary notions of gender underpin the pathologising of gender diversity (Newman, 2002; Wiseman & Davidson, 2012). With the changing profile of young people's gender identities, the predicted trajectories are less clear. Some people who experience difficulties with their gender identity may not necessarily experience a complete cross-gender identity, and with the diverse ways people are now identifying (i.e. non-binary, gender queer, gender fluid etc.) not all will seek intervention. In those that do, some may opt for only part of the 'gender reassignment package'. For example, taking cross-sex hormones but not having any surgery, or electing to have top surgery but not bottom (Steensma et al., 2013).

While a small body of literature exists on the outcomes of gender-affirming interventions in adults, very little is known about the longer-term outcomes in adolescents and young adults who have received intervention. As long as there are limited long-term data in support of current guidelines, the above dilemmas will continue to exist, and consensus on intervention is not likely to be reached (Vrouenraets et al., 2015).

1.8. Scoping Review of Follow-Up Studies of Gender Diverse Adolescents and Young Adults

Scoping reviews are a particularly useful way of determining the range of evidence that informs practice in a field and how the research has been conducted, as well as clarifying key concepts, and identifying gaps in the research literature (Arksey & O'Malley, 2005; Peters et al., 2015).

1.8.1. Objective

The objective of the scoping review was to explore the current literature on longer-term outcomes of adolescents and young adults who had received some form of gender affirming intervention.

1.8.2. Inclusion Criteria

The scope of the review was developed by defining inclusion criteria for participants, interventions, study design and outcomes (Peters et al., 2015). Due to resource limitations papers not written in English were excluded.

1.8.2.1. Participants. Studies that included gender diverse adolescents or young adults who had received some form of gender-affirming intervention.

1.8.2.2. Interventions. Gender-affirming interventions, including hormone blockers, cross-sex hormones, surgery and psychological support.

1.8.2.3. Study Design. All quantitative and qualitative designs.

1.8.2.4. Outcomes. Outcomes of interest included intervention pathways chosen, satisfaction (with chosen interventions, body, gender identity, and services), decision-making processes, psychological functioning and mental health, global functioning, quality of life and wellbeing.

1.8.3. Search Strategy

The overall search strategy was performed in three stages. First, a limited search in several databases was performed to determine the relevant terms and index terms used. Second, using the identified keywords and index terms published work was searched for in 6 electronic databases. Third, reference lists of the identified papers were searched to identify any further relevant work. All databases were searched from their start date to April 2018 with no language restrictions.

The search strategy consisted of two overlapping concepts that were searched together using the Boolean operators 'or' and 'and' (MESH headings were also added in databases that contained them).

1. Gender terms (transgender or transsexual or 'gender varian*' or 'gender incongruen*' or 'gender incongruen*' or 'gender dysphori*' or 'gender divers*')

AND

2. Time/treatment terms (treatment pathway* or 'treatment decision*' or 'treatment choice' or longitudinal or 'long term effect' or 'long term outcome*' or 'long term follow up' or 'long term follow-up' or prospective or retrospective or 'cross section*' or 'follow up' or 'follow-up')

1.8.4. Databases

The 6 databases searched included Academic search complete, CINAHL, PEP archive, PsychINFO, PubMed, and Scopus.

1.8.5. Validation of Search Strategies

The search strategy was validated by choosing five known papers from a previously conducted (unpublished) review in the area, and seeing if the search

strategy picked these known papers up. All five papers were picked up by the search.

1.8.6. Extracting and Charting the Results

All citations identified by the searches were downloaded using Mendeley reference management software, and the duplicates removed. The titles and abstracts were screened for relevance and potential inclusion in the review using the inclusion and exclusion criteria. Full texts were obtained for any potentially relevant papers.

1.8.7. Data Extraction and Management

The data extraction form was developed using scoping review guidelines (Peters et al., 2015). Data extracted included information about participants, the interventions, study design and outcomes relevant to the review.

1.8.8. Results

After importing all citations to Mendeley and removing duplicates, 4858 records had been identified. After inspecting titles and abstracts, 4785 irrelevant papers were removed, and full texts were retrieved for the remaining 73 papers. A further two papers were added through hand searching ($n = 75$). After excluding 70 irrelevant papers using the inclusion/exclusion criteria, five studies remained in the final review (see Appendix A for flow chart, including reasons for exclusion).

The included studies ($N = 5$) were all published between 1997 and 2018. Based on country of lead author, studies were conducted in four countries: UK (1), Netherlands (3), and USA (1). The range of mean ages of the participants in the included studies was 15.0 to 22.0, and all had received one or more of the following interventions: psychological support (1 study), hormone blockers (4 studies), cross-sex hormones (2 studies), and surgeries (2 studies). Outcomes assessed by the studies were gender dysphoria (4 studies), psychological functioning (4 studies), global/psychosocial functioning (3 studies) depression (1), anxiety (1 study), anger (1 study), psychopathology (1 study), wellbeing (1 study), quality of life (1 study), satisfaction with surgery (1 study), regret (2 studies), and

body-satisfaction (3 studies). The study designs were all observational longitudinal cohort studies. Brief summaries of each study (N = 5) are provided below.

Study 1 (Cohen-Kettenis & Goozen, 1997): Cohen-Kettenis and colleagues followed-up 19 young people (mean age = 22.0 years), with a diagnosis of transsexualism, between one and five years after undergoing a gender affirming surgery. Post-surgery, the group were no longer gender-dysphoric, and scored in the normal range on a number of different psychological function measures. Assigned females reported varying levels of satisfaction in their top surgery results (40% satisfied; 50% moderately satisfied; and 10% dissatisfied), and 60% were satisfied with their body image. All of the assigned males were satisfied with their body image, and 60% were satisfied with the results of their vaginoplasty surgery. No-one reported regretting having surgery. Limitations of the study include its small sample size.

Study 2 (deVries, Steensma, Doreleijers & Cohen-Kettenis, 2011): deVries and colleagues followed up 70 young people (mean age = 16.6 years), on average, 2 years after they had received hormone blockers, but before starting cross-sex hormones. At follow-up, general functioning had improved, and behavioural, emotional and depressive symptoms had decreased. No change was observed in participants' gender dysphoria, body satisfaction, levels of anxiety or anger. Limitations of the study include a relatively small sample, and, in terms of generalisability, the use of a highly select dysphoric sample (i.e. well-adjusted, with few comorbidities).

Study 3 (deVries et al., 2014): This study was a longer-term evaluation of study 2 above, in which deVries and colleagues followed up 55 young people at three time points: Before starting hormone blockers (mean age = 13.6 years), when starting cross-sex hormones (mean age = 16.7 years), and at least one year after receiving gender affirming surgery (mean age = 20.7 years). The results indicated that gender dysphoria and body image difficulties persisted during puberty suppression, but remitted after taking cross-sex hormones and undergoing gender affirming surgery. Over time, assigned females showed reduced anger,

anxiety and externalising symptoms, whereas assigned males showed stable or slightly more symptomology on these measures. Through the course of the study, psychological functioning steadily improved, and these improvements correlated with post-surgical subjective wellbeing. No-one reported regretting receiving any of the interventions. Limitations of the study included a relatively small sample from a single clinic, and the highly select dysphoric, but well-adjusted sample who had few comorbidities (i.e. the sample was not representative of the full spectrum of gender diverse individuals).

Study 4 (Costa et al., 2015): Costa and colleagues followed up 201 young people with gender dysphoria at four time points: Baseline (mean age = 15.5 years); 6 months from baseline (mean age = 16.5 years) after 6 months of psychological support; 12 months from baseline, after 12 months of psychological support and 6 months of puberty suppression; 18 months from baseline, after 18 months of psychological support and 12 months of puberty suppression. Psychological support and puberty suppression were both associated with improvements in global functioning. Limitations of the study included only focussing on psychosocial functioning as an outcome and a question as to the clinical significance of the significant findings.

Study 5 (Mathews, Kuper & Lau, 2018): Mathews and colleagues followed up 31 adolescents (mean age = 16.0 years), one year after taking cross-sex hormones (n = 28) or hormone blockers (n = 3). At follow-up, 63% of the sample retained clinically elevated competency issues and 19% reported internalizing difficulties. Mothers of the participants reported significantly fewer externalizing and total problems. No statistically significant improvements were reported by the young people themselves, or by fathers.

Overall, these longitudinal follow-up studies suggest that gender dysphoria and body difficulties tend to remit after intervention involving cross sex hormones or surgery, but not hormone blockers. The majority of people report feeling satisfied with surgical outcomes (although this was only assessed in one study). The impact of different interventions on psychological and global functioning is less

clear, as it appears to vary within and between studies. The observed variation may be partially explained by differing severity of symptoms at baseline, baseline differences in comorbidities, and/or differing levels of support (social and psychological).

1.9. Rationale and Clinical Relevance

The current evidence-base is of limited utility in the contemporary UK context – the number of follow-up studies of adolescents into young adulthood is small, and much of the research that does exist has been conducted with small samples, in primarily non-UK populations, and focussing on a limited number of outcomes. To date, although a few studies have looked at the prevalence of gender affirming intervention in adults (Eyssel, Koehler, Dekker, Sehner, & Nieder, 2017; Kailas, Lu, Rothman, & Safer, 2017), no-one has done so in adolescents or young adults. And although one study has looked at satisfaction with surgical outcomes in young adults (Cohen-Kettenis & Van Goozen, 1997), no studies have looked at satisfaction with the process more broadly (i.e. satisfaction with decisions made about interventions, level of involvement in decision-making, information/advice received, timings and length of process etc.). Shared decision-making is seen as an ethical imperative by health professional regulatory bodies, and the principal mechanism for ensuring patients get the care they want and need (Coulter & Collins, 2011); and there are some key drivers for shared decision-making within the National Health Service (NHS) policy (NHS England, 2014, 2017). Furthermore, satisfaction with the process and involvement in decision-making have been cited as key indicators of quality and success in trans healthcare, and ones that are integral to evolving relationships between service users and clinicians (Eyssel et al., 2017). Measurement of patient experiences of trans-healthcare, provides the opportunity for reflection and improvement of care and patient outcomes, and this has not yet been conducted in young trans people who attended a child and adolescent gender identity clinic and who were referred onwards to an adult clinic.

1.9.1. The Gender Identity Development Service (GIDS)

The Gender Identity Development Service (GIDS) is the site of the current study. The GIDS is one of the largest child and adolescent services in Europe. Based at the Tavistock Centre in London, the service offers assessment and intervention for children and young people (up to the age of 18), who are experiencing difficulties with their gender identity development. The multidisciplinary team consists of clinical psychologists, psychiatrists, social workers, child psychotherapists, and paediatric and adolescent endocrinologists. The GIDS was nationally commissioned by NHS England in 2009; its main bases are in London and Leeds, but outreach clinics are located in other areas of the England and Wales (Butler et al., 2018; Carmichael & Davidson, 2009). The intervention and support provided at GIDS is informed by the World Professional Association for Transgender Health (Coleman et al., 2012) and recent guidelines from the Endocrine Society (Hembree et al., 2009). In line with other services in Europe and North America, the GIDS has experienced a dramatic increase in the number of referrals it receives, and a change in profile of the young people who attend the service (Butler et al., 2018). Little is currently known about the longer-term outcomes of the young people who attended the GIDS (Butler et al., 2018; Costa et al., 2015). These factors, in combination with the GIDS' influence and reach in the UK, places the GIDS as an ideal location for the current study.

1.9.2. Population of Interest within GIDS

GIDS is a *gender identity development* service, and, as such, the young people who attend GIDS are a diverse population. Not all people who attend GIDS experience gender dysphoria, and for those that do, it does not necessarily persist (Coleman et al., 2012). Furthermore, not everyone who attends GIDS will experience a complete cross-gender identification and many will identify as non-binary or gender fluid (or another identity). Only a proportion of those who attend GIDS will go on to pursue medical and surgical intervention, and currently very little is known about those that do (NHS England, 2015). Therefore, the current study focusses on a cohort of ex-GIDS attendees who were referred (at age 18) from GIDS to the Charing Cross adult gender identity clinic (CCGIC) where medical and surgical interventions could be obtained. Consequently, the findings

and implications of the current study are applicable to this population only and not to the broader GIDS population.

To my knowledge, this is the first ever follow-up study of a cohort of gender diverse young adults who previously attended a child and adolescent gender identity clinic (the GIDS) and who were referred, at age 18, to an adult gender identity clinic (CCGIC). It is also the first study to investigate the prevalence of different gender affirming interventions in a UK clinic-based sample of gender diverse young adults; the first to characterise the nature of the interventions by assigned gender; and the first to investigate satisfaction levels with the process and involvement in decision-making. With such large increases in referrals to child and adolescent gender identity clinics, the changing profile of clinic attendees, and increasing pressure to intervene earlier, it is vital that we understand more about the intervention pathways, satisfaction levels, and longer-term outcomes of gender diverse young people who go on to pursue further intervention after leaving the child and adolescent clinic. The findings will enable better tailoring of gender identity services for young people, and be an important step towards ensuring that the support and intervention provided meets the needs of this diverse and growing population

1.10. Research Aim and Research Questions

The aim of the research was to determine the intervention pathways, satisfaction levels with the process, and longer-term outcomes of the young people who attended the GIDS, and who were referred on to the CCGIC.

The research questions are as follows:

1. Which intervention pathways did people follow after being referred to the adult clinic?
2. What factors influenced people's intervention decisions?
3. Were people satisfied with the intervention process?
4. What are the longer-term outcomes for the former GIDS attendees?
5. What impact do gender affirming interventions have on body image and wellbeing?

METHOD

2.1. Chapter Overview

This chapter describes the epistemological position taken in conceptualising, designing and conducting the research; the rationale for the chosen methodology; and the methods used to collect and analyse the data.

2.2. Epistemological Position

Ontology is the branch of philosophy concerned with the nature of reality and how we can understand it (Burr, 2015). Epistemology is the branch of philosophy concerned with what constitutes knowledge (e.g. 'facts', relationships, causality etc.) in addition to how we can make claims of knowing (Burr, 2015).

When thinking about psychiatric diagnoses (e.g. Gender Dysphoria), from a positivist position, the ontological assumption would be that 'mental illness' exists in the world, and awaits verification by expert observers; and the epistemological assumption would be that these naturally occurring phenomena are inherently pathological (Pilgrim, 2007, 2009). From a constructivist position, the ontological assumption would be that reality is socially constructed; and the epistemological assumption would be that we can only know about the world through the ways we represent it, and that knowledge constitutes accounts and discourses that are situated or contingent (Pilgrim, 2007, 2009).

In research, the epistemological position of the researcher states their view on what constitutes acceptable knowledge, and is used to frame the research design (Darlaston-Jones, 2007). In the current study I take a critical realist position (Bhaskar, 2008). Critical realism was developed in response to the limitations of both positivism and constructivism (Bhaskar, 2008). The ontological premise combines the positivist's search for evidence of a reality that is independent of

human consciousness with the idea that the meaning made of this reality is socially constructed (Oliver, 2011); that is to say it is shaped by the cultural, historical, political, and social norms that operate within a particular context and time (Clark, MacIntyre, & Cruickshank, 2007; Darlaston-Jones, 2007). Critical realism accepts our social constructions as the reality of our social worlds (Oliver, 2011). The epistemological consequence is that knowledge must be approached sceptically or critically because our attempts to describe and explain the world around us are imperfect, and the ways we order our world, into categories and relationships between categories, could never be justified absolutely, and so remain open to critique (Scott, 2013).

A critical realist position is particularly relevant to the study of gender identity, as it is not possible to conceptualise and account for the experiences of people who identify as transgender or non-binary, without acknowledging both the material reality of the body (i.e. how it links to gender assignment and expression etc.) and the social processes that frame and constrain a person's gender identity and expression (e.g. gender norms that dictate acceptable/unacceptable behaviour according to gender, and laws that prohibit self-identification; Brickell, 2006; Lorber & Farrell, 1991).

2.3. Methodology

Methodology refers to the tools we use to help us know about the reality we seek to explore (i.e. how we generate and analyse data; Green & Thorogood, 2014). Quantitative methods are arguably the most appropriate methods to determine the frequency of occurrence of particular outcomes and experiences, therefore, a cross-sectional survey design was used to determine the intervention pathways and longer-term outcomes of young adults who had previously attended GIDS and who were referred to the CCGIC. Qualitative methods aim to make sense of phenomena, in terms of exploring the meaning people make of their experiences (Greenhalgh & Taylor, 1997), and therefore participants were provided with comment boxes throughout the questionnaire, and invited to use them to expand on and provide context to their quantitative answers. The qualitative data were

organised into codes and themes by question, and used to provide context or to elucidate specific issues identified by the quantitative data of the question.

2.4. Study Design

The study used a cross-sectional survey design.

2.5. Ethical Considerations

2.5.1. Ethical Approval

Ethical approval was obtained from the London Riverside National Health Service research ethics committee (REC reference number 17/LO/1674; see Appendix B) and sponsorship and indemnity was provided by the University of East London (see Appendix C).

2.5.2. Informed Consent

An information sheet was provided at the start of the questionnaire (Appendix D), and potential participants were encouraged to discuss the study with their friends and family before agreeing to participate. After reading the information sheet, participants were required to sign an online consent form (Appendix E) before proceeding with the questionnaire.

2.5.3. Confidentiality and Anonymity

No personally identifiable data was collected during the course of the study, except for the email addresses of the participants who wished to be entered into the prize draw to win £100 worth of Amazon vouchers and those who wished to be sent the results at the end of the study. Any email addresses provided were held separately from the questionnaire data and not linked in any way. All participant data was treated confidentially and in accordance with the Data Protection Act 1998. All participant data was stored on a password-protected computer. Unique participant identification numbers were used on the databases/programmes used for analysis.

2.5.4. Protecting Vulnerable participants

For multiple reasons gender diverse individuals sometimes change their identity and relocate. To minimise the risk of sending potentially sensitive written material to the wrong person, most recent addresses were obtained from the CCGIC client records. Furthermore, the invitation letter that was sent in the mail did not contain any information or references to gender identity or gender identity clinics.

Reflecting on one's views and experiences in this area has the potential to be an informative and empowering experience. However, it is a potentially sensitive topic, as many people will have experienced significant distress, challenges, victimisation and stigma with regards to their gender identity/expression. At the end of the questionnaire, all participants were provided with a list of support services and encouraged to use them if they felt they needed additional support at any time.

2.6 Population and Sample

The population of interest were the 365 people who were discharged, at age 18, from GIDS and referred to the CCGIC between 2011 and 2016 (mean age = 19.9 years; SD 1.79; 95% CI 19.9 to 20.1%). Of this population, 64.7% were assigned female (AF) at birth (n = 236; mean age 19.7 years; SD 1.79; 95% CI 19.5 to 19.9%) and 34.8% were assigned male (AM) at birth (n = 127; mean age = 20.2 years; SD = 1.79; 95% CI 19.8 to 20.5%). Details of ages and gender assigned at birth were unavailable for two of the 365 referred. Of this group, one person was deceased and one did not have a postal address. Invites to participate in the online questionnaire were sent out via post to the remaining 363 people.

2.7. Procedure

2.7.1. Inclusion/Exclusion Criteria

Clinic attendees referred to the CCGIC before 2011 were not invited to participate in the study, as clinic records prior to 2011 were reportedly unreliable. Clinic attendees referred to the CCGIC after 2016 were also not considered, as, due to waitlist times at the CCGIC, it was unlikely that many of these people would have

had any surgical interventions by the start date of data collection. Due to limited resources, non-English speakers were excluded from the study. People under the age of 18 were also excluded from participating.

2.7.2. Participant Identification Process.

All eligible participants were identified using the GIDS patient database. Names and postal addresses of clinic attendees were obtained from the GIDS and CCGIC databases.

2.7.3. Recruitment Process

Letters inviting people to participate (Appendix F) were sent via mail to all eligible participants (N = 363). To minimise the risk of disclosing the person's identity, should any of the letters have been opened by someone other than the intended recipient, the invitation letters contained very basic information about the study, on university letterhead, and without mention of gender identity. The letter included instructions on how to access more detailed information on the study, where to direct questions, how to access the online questionnaire and information about entering a prize draw to win a £100 Amazon voucher.

When participants accessed the online questionnaire they were first directed to an information sheet (Appendix D), then an online consent form (Appendix E), and then to the questionnaire (Appendix G). At the end of the questionnaire participants were provided with a list of resources (Appendix H). Participant IP addresses were checked to prevent repeated participation.

To maximise the participant response rate, leaflets advertising the study (Appendix I) were placed in the CCGIC waiting room, and given to clinic staff to distribute to ex-GIDS clients. CCGIC clinicians were also emailed on a bi-weekly basis reminders of which ex-GIDS clients they were due to see that week. Data collection for the current study took place during the spring of 2018, but the survey will remain open and online until the end of 2018.

2.8. Materials

The questionnaire was developed in accordance with good practice guidelines on the conducting and reporting of survey research (Kelley, Clark, Brown, & Sitzia, 2003), and used a participatory approach by involving young trans people in the questionnaire development and piloting (N = 2). Information and outcomes of interest gathered via the questionnaire are outlined below. All questions were in a forced-response format, such that participants could not proceed without providing an answer to a question, but an 'I prefer not to answer' option was provided for each question. Comment boxes were also provided after each question. Skip patterns/logic was used to ensure that participants only viewed, and could answer, questions that were relevant to them.

2.8.1. Sociodemographic Information

Age, gender identity, gender assigned at birth, ethnicity, relationship status, and employment status.

2.8.2. Emerging Gender Awareness

This included the age the person first became aware of a difference between the gender they were assigned at birth and their expressed/experienced gender; the age they were first referred to GIDS; and the age they started socially transitioning. Responses were given in text and then re-coded into numbers. Answers such as 'since I was very little' or 'as long as I can remember' were recoded into a 5 years and younger category.

2.8.3. Intervention Pathways Chosen

Interventions of interest included hormone blockers, cross-sex hormones, top surgery (a common umbrella term in the literature to define breast and/or chest surgery) and bottom surgery (a common umbrella term in the literature to define genital surgery), psychological support (individual therapy, group session and/or family work), and speech and language therapy. Other information gathered included age person received the intervention, and plans (if any) for future intervention (same options as above).

2.8.4. Factors Influencing Decisions about Interventions

Participants were asked 'To what extent did the following factors influence the decisions you made regarding your treatment choices?' Answer options included 1. Information provided by staff at GIDS, 2. Information provided by staff at an adult gender identity clinic, 3. Information provided by staff at another NHS service, 4. Information from charity/third sector organisations, 4. Opinions/advice from family members, 5. Opinions/advice from friends, 6. Opinions/advice from partner, 7. Information on the internet (participants were invited to expand on this answer in a comments box), 8. Weighing up the risks and benefits of interventions, and 9. Other (participants were invited to expand on this answer in a comments box). Participants rated the extent to which each factor had influenced their decisions on a scale of 0 (not at all) to 10 (greatly).

2.8.5. Satisfaction with the Intervention Process

Satisfaction refers to the person's subjective evaluation of their experience (Brockington, Robinson, Benner, & Scheltema, 2004). Participant satisfaction with the intervention process was operationalised using the different measures described below.

2.8.5.1. Decision-making around interventions. To assess satisfaction with the process, participants were asked to rate their levels of agreement with the following statements for each intervention type (i.e. hormone blockers, cross-sex hormones, top surgery, bottom surgery, and speech and language therapy): 1. I am satisfied with my decision to take/have (intervention), 2. I felt involved in the decision-making process about whether or not to take/have (intervention), 3. The information/advice I received about (intervention) from the clinic(s) I attended helped me make a decision about (intervention). Response options were on a 5-level Likert scale (strongly agree, agree, neither agree or disagree, disagree, strongly disagree, and not applicable).

The question format for psychological support, differed from the above format, in that participants were asked to rate their level of agreement with a single statement about each type of psychological support (e.g. individual therapy, group sessions and family work), in each type of service (e.g.

GIDS/adult/private/another service). For example, Attending (individual/group/family) counselling and therapy at (GIDS/adultGIC/private/another service) helped me to make decisions about my transition process. Response options were on a 5-level Likert scale (strongly agree, agree, neither agree or disagree, disagree, strongly disagree, and not applicable).

2.8.5.2. Previous decisions about interventions. Participants were asked 'If you were making decisions about interventions today, would any of your past decisions about interventions be different?' Answer options (for each intervention type) included yes, no, not sure and not applicable. Two new variables were created to obtain percentages and counts of those who answered 'yes' or 'not sure' to decisions about one or more interventions.

2.8.5.3. Intervention timings and length of process. Satisfaction with intervention timings and length of the process (for each of the intervention types) was assessed by asking participants 1. 'What did you think about the length of the process (from the point you were referred to the point when you received the intervention)?' Answer options included too short, about right, too long, not sure, and not applicable; and 2. 'What did you think about the timings of when you had the interventions?' Answer options included too soon, about right, too long, not sure, and not applicable.

2.8.6. Satisfaction with Gender Identity and Body Image

Satisfaction with gender identity and body image were assessed by asking participants 'In general, how do you feel about the following aspects of yourself? 1. Your gender identity, and 2. Your body in relation to your gender identity. Response options were on a 5-level Likert-type scale (very satisfied, satisfied, neither satisfied nor dissatisfied, dissatisfied, very dissatisfied, and I prefer not to say). Participants were invited to provide more detail in a comment box.

2.8.7. Psychological Wellbeing

Psychological wellbeing was measured using the Warwick-Edinburgh Mental Well-being Scale (WEMWBS; Tennant et al., 2007), which is a 14 item scale

designed to monitor mental wellbeing in the general population. The items are worded positively (e.g. 'I've been feeling optimistic about the future') and cover both the emotional and functioning aspects of mental wellbeing. There are 5 response categories (none of the time – 1 point; rarely – 2 points; some of the time – 3 points; often – 4 points; all of the time – 5 points), which are summed to provide a single score ranging from 14-70. Scores of 0-32 points indicate very low wellbeing; 32-40 below average; 40-59 average; 59-70 above average. The internal consistency in the validation sample was high ($\alpha = .91$).

2.9. Analysis

Data were analysed using SPSS version 23. The quantitative responses were primarily analysed using descriptive statistics (frequency tables and t-tests). ANOVAs were used to establish associations between different intervention types and continuous outcomes of interest. A priori sample size calculations were generated for the t-tests and ANOVAs. Data were analysed by assigned gender as previous research suggests they are different populations and thus need to be thought as separately (Costa et al., 2015). To increase the cell sizes and/or ease interpretation of the results some categorical variables were transformed into new variables (e.g. different forms of psychological support, types of hormone treatments, and types of surgeries); some categorical variables were transformed into fewer categories (e.g. by grouping strongly agree and agree, and strongly disagree and agree on Likert scale responses); and some categorical variables were dichotomised (e.g. to create yes/no variables).

The qualitative responses to each question (i.e. the comment box data at the end of a question) were collated and analysed inductively by reading through the responses to a particular question and coding them to identify recurrent themes. The codes and themes relating to a particular question were then used to provide context or to elucidate specific issues identified by the quantitative data for that question.

RESULTS

3.1. Chapter Overview

This chapter first describes the sociodemographic characteristics of the sample and explores key ages in emerging gender awareness. Next, the prevalence of gender affirming interventions and factors influencing intervention decisions are outlined. Satisfaction with the transition process and outcomes are presented, before ending the chapter with a look at how different interventions impact body image and wellbeing.

3.2. Sociodemographic Characteristics

Of the 365 people who were referred from the GIDS to the CCGIC from 2011 to 2016, one person was deceased and one had no postal address. Of the 363 invitation letters sent out, 12 were returned to sender, leaving 351 people who were sent an invite to participate in the study. Of these, 82 people responded, giving an overall response rate of 24.0% (82/351). Of the 82 responders, 9 dropped out after signing the consent form and one person was under 18, thus all 10 were excluded from the analyses. The following analyses are based on the remaining 72 participants.

The mean age of the sample ($N = 72$) was 20.0 years old ($SD\ 1.70$; $CI\ 19.6$ to 20.4), with a range of 18 to 24 years (see Tables 1 and 3). Of the sample, 79.2% ($n = 57$) were AF, and 19.4% ($n = 14$) were AM. An independent samples t-test revealed a statistically significant difference between the mean ages of AFs and AMs, with AFs being significantly younger ($M = 19.6$ years; $SD\ 1.53$; 95% $CI\ 19.2$ to 20.1) than AMs ($M\ 21.2$ years; $SD\ 1.85$; 95% $CI\ 20.2$ to 22.3), $t(67) = 3.30$, $p = .002$; $d = 0.81$. According to Cohen's conventions (Cohen, 1988) this constitutes a large effect size. An apriori sample size calculation, on the basis of a 2-tailed test, with a medium effect size, and an alpha of .05, indicated a sample size of 88 was need to detect a significant effect, but due to the exploratory nature of the study, the t-test was run despite this. However, a post-hoc sample size calculation, on the basis of a 2-tailed test, with a large effect size, and an alpha of .05, indicated a sample size of 50 was need to detect a significant effect. The majority of the

sample self-identified as a men or transmen (72.2%; n = 52); as White British/Irish (80.6%; n = 58). Half of sample were in a relationship (50%; n = 36).

Table 1: Sociodemographic characteristics of participants

Sociodemographic characteristics		N	%
Age	18	17	23.5%
	19	16	22.2%
	20	15	20.8%
	21	4	5.6%
	22	13	18.1%
	23	3	4.2%
	24	2	2.8%
	Preferred not to answer	2	2.8%
Gender identity	Man	32	44.4%
	Trans-man	20	27.8%
	Woman	8	11.1%
	Trans-woman	4	5.6%
	Partly as a man, partly as a woman	1	1.4%
	Neither as a man or a woman	0	0.0%
	Non-binary/gender fluid or similar	2	2.8%
	Don't know yet and/or questioning	0	0.0%
Gender assigned at birth	Other*	5	6.9%
	Assigned female at birth (AF)	57	79.2%
	Assigned male at birth (AM)	14	19.4%
	Not known	1	1.4%
Ethnicity	White British/Irish	58	80.5%
	White Other	5	6.9%
	Black/African/Caribbean/Black British	1	1.4%
	Asian/Asian British	2	2.8%
	Mixed/multiple ethnic group	4	5.6%
	Preferred not to answer	2	2.8%
Relationship status	Married/civil partnership	1	1.4%
	Living with a partner	10	13.9%
	In a relationship(s)	25	34.7%
	Single	35	48.6%
	Preferred not to answer	1	1.4%
Employment status**	Working (full or part time)	25	34.7%
	At College or University	39	54.2%

Sociodemographic characteristics	N	%
Unemployed	10	13.9%
Volunteering	2	2.8%
Disabled	1	1.4%
Preferred not to answer	1	1.4%

*See Appendix J for participants' explanations of 'other'

** Counts will not sum to 72 as participants could tick more than one category

3.3. Emerging Gender Awareness

On average, people first became aware of a difference between the gender they were assigned at birth and their expressed/experienced gender at 10.4 years old (SD 3.96; 95% CI 9.5 to 11.4; range 5-17 years; see Table 2). An independent samples t-test revealed that there was no statistically significant difference in the age people first became aware between those AF (M = 10.6; SD = 3.90) and those AM (M = 9.79; SD 4.17), $t(69) = -.69$, $p = .494$; $d = 0.17$. On average, people were first referred to GIDS at 14.9 years old (SD 1.69; 95% CI 14.5 to 15.3; range 9-18 years). An independent samples t-test revealed no significant difference in referral age between those AF (M = 14.9; SD = 1.50) and those AM (M = 14.8; SD = 2.42), $t(69) = -.28$, $p = .779$; $d = 0.07$. On average, people started socially transitioning at 15.1 years old (SD 1.94; 95% CI 14.6 to 15.5; range 7-19). An independent samples t-test revealed a statistically significant difference in the age people started socially transitioning, with those AF starting earlier (M = 14.7; SD 1.86) than those AM (M = 16.4; SD 1.74), $t(67) = 3.12$, $p = .003$; $d = 0.76$. According to Cohen's conventions (Cohen, 1988) this constitutes a large effect size. An apriori sample size calculation, on the basis of a 2-tailed test, with a medium effect size, and an alpha of .05, indicated a sample size of 88 was need to detect a significant effect in each of these examples, but due to the exploratory nature of the study, the t-tests were run despite this. However, a post-hoc sample size calculation, on the basis of a 2-tailed test, with a large effect size, and an alpha of .05, indicated a sample size of 50 was need to detect a significant effect.

Table 2: Mean ages at different time points during emerging gender awareness by gender assigned at birth

		All participants (N = 71)	Assigned female (AF) (n = 57)	Assigned male (AM) (n = 14)	p-value
Age (Yrs.) first became aware of difference between GAB* + EG*	Mean (SD)	10.50 (3.94)	10.60 (3.90)	9.79 (4.17)	.494
	Range	5-17yrs**	5-17yrs	5-15yrs	
Age (Yrs.) first referred to GIDS	Mean (SD)	14.92 (1.69)	14.93 (1.50)	14.79 (2.42)	.779
	Range	9-18yrs	11-17yrs	9-18yrs	
Age (Yrs.) started socially transitioning	Mean (SD)	15.07 (1.94)	14.71 (1.86)	16.43 (1.74)	.003
	Range	7-19yrs	7-18yrs	13-19yrs	

*GAB – Gender assignment at birth; EG – Expressed/experienced gender

** All ages 5 and below were collapsed into one category 'Age 5 and under'

3.4. Prevalence of Gender-Affirming Interventions

3.4.1. Hormone Blockers Prevalence

Overall, 59.2% (N = 42; AF = 31; AM = 10) of the sample had taken or were currently taking hormone blockers; 1.4% (n = 1; AM = 1) intended to start taking them in the future; and 11.1% (n = 8; AF = 5; AM = 3) were undecided as to whether or not they would start taking hormone blockers in the future (see Table 3). Reasons cited for being undecided were provided by seven of the eight people who were undecided, and included not knowing whether blockers provided any additional benefit if taken alongside cross-sex hormones (3); only intending to take them if distress levels relating to periods worsened (1); unsure whether it was 'too late' to take them (1); and not knowing whether blockers were offered at the adult clinic (2). See Appendix K for full quotes. The average age people started taking hormone blockers was 16.4 years old (SD 1.27; range 14-20 years).

Table 3: Prevalence of gender affirming interventions, age at start of interventions, and intentions to start/have interventions in the future by gender assigned at birth

	All people	Assigned Female (AF)	Assigned Male (AM)
Total*	100.0% (72)	78.2% (57)	19.4% (14)
Age, years			
Mean (SD)	20.0yrs (1.70)	19.6yrs (1.53)	21.2yrs (1.85)
Range	18-24yrs	18-24yrs	18-24yrs
Ever taken hormone blockers (HB)			
Yes	59.2% (42)	55.4% (31)	71.4% (10)
Currently taking	23.9% (17)	21.4% (12)	35.7% (5)
No longer taking	35.3% (25)	33.9% (19)	35.7% (5)
No	40.8% (29)	44.6% (25)	28.6% (4)
Mean age first started taking HB (SD)	16.5yrs (1.27)	16.4yrs (1.17)	16.8yrs (1.62)
Intention to start HB in the future	1.4% (1)	0.0% (0)	7.7% (1)
Undecided about starting HB in the future	11.1% (8)	8.9% (5)	23.1% (3)
Ever taken cross-sex hormones (CSH)			
Yes	67.1% (47)	63.6% (35)	78.6% (11)
Currently taking	64.3% (45)	60.0% (33)	78.6% (11)
No longer taking	2.8% (2)	3.6% (2)	0.0% (0)
No	31.9% (23)	36.4% (20)	21.4% (3)
Mean age first started taking CSH (SD)	18.0yrs (1.17)	18.1yrs (1.03)	17.7yrs (1.62)
Intention to start CSH in the future	27.1% (19)	30.4% (17)	15.4% (2)
Undecided about starting CSH in the future	5.7% (4)	7.1% (4)	0.0% (0)
Ever had top surgery (TS)**			
Yes	21.1% (15)	26.8% (15)	0.0% (0)
No	78.9% (56)	73.2% (41)	100.0% (14)
Mean age first had TS	19.9yrs (1.34)	19.9yrs (1.35)	-
Intention to have TS in the future	55.7% (39)	60.7% (34)	30.8% (4)
Undecided about having TS in the future	11.4% (8)	8.9% (5)	23.1% (3)

Ever had bottom surgery (BS)			
Yes	12.7% (9)	7.1% (4)	35.7% (5)
No	87.3% (62)	92.9% (52)	64.3% (9)
Mean age first had BS	21.1yrs (1.05)	21.3yrs (1.50)	21.0yrs (0.71)
Intention to have BS in the future	25.7% (18)	25.0% (14)	30.8% (4)
Undecided about having BS in the future	37.1% (26)	39.3% (22)	30.8% (4)
Ever attended individual therapy (IT)			
Yes	73.6% (53)	71.9% (41)	78.6% (11)
No	26.4% (19)	28.1% (16)	21.4% (3)
Ever attended group sessions (GS)			
Yes	23.9% (17)	21.4% (12)	28.6% (4)
No	76.1% (54)	78.6 (44)	71.4% (10)
Ever attended family therapy (FT)			
Yes	40.0% (28)	42.9% (24)	30.8% (4)
No	60.0% (42)	57.1% (32)	69.2% (9)
Ever had speech & language therapy (SLT)			
Yes	0.0% (0)	0.0% (0)	0.0% (0)
No	100.0% (69)	100.0% (55)	100.0% (13)
Intention to have SLT in the future	12.9% (9)	10.7% (6)	23.1% (3)
Undecided about having SLT in the future	8.6% (6)	8.9% (5)	7.7% (1)

*Some row counts will not sum because gender assigned at birth was missing for one participant

**Note: Top surgery is only available on the NHS to those assigned female at birth

3.4.2. Cross-Sex Hormones Prevalence

Overall, 67.1% (n = 47; AF = 35; AM = 11) of the sample had taken or were currently taking cross-sex hormones, 27.1% (n = 19; AF = 17; AM = 2) intended to start taking them in the future, and 5.7% (n = 4; AF = 4) were undecided as to whether or not they would start taking cross-sex hormones in the future. The average age people started taking cross-sex hormones was 18.0 years old (SD 1.17; range 16-20 years).

3.4.3. Surgery Prevalence

Overall, 33.8% (n = 24; AF = 19; AM = 5) of the sample had had either chest or genital surgery. 21.1% (n = 15; AF = 15) had undergone chest surgery and 12.7% (n = 9; AF = 4; AM = 5) had undergone surgical intervention in the genital area. The average age people had chest surgery was 19.9 years old (SD 1.34; range 17-21) and genital surgery 21.1 years old (SD 1.05; range 19-22).

With regards to plans for surgical intervention in the future, 55.7% (n = 39; AF = 34; AM = 4) intended to have chest surgery, and 11.4% (n = 8; AF = 5; AM = 3) were still undecided. Of the eight people that were undecided, three people cited the reason for being undecided was that they were going to wait and see how they felt after starting/observing the effects of taking cross-sex hormones. Overall, 25.7% of the sample (n = 18; AF = 14; AM = 4) intended to have genital surgery, and 37.1% (n = 26; AF = 22; AM = 4) were undecided. Of the 26 people who were undecided about genital surgery, 18 people cited a reason for this, which included not feeling satisfied with current surgical methods and results, and hoping for future advances in this area (6); still in the process of weighing up the risks and benefits of genital surgery (5); too soon to make a decision (3); not feeling dysphoric about their genitals or currently not feeling the need for genital surgery but not ruling it out in the future (2); not knowing enough about genital surgeries (2); concerns about the pain involved (1); and wanting to wait and see how they felt after the effects of cross-sex hormones and/or chest surgery (1; see Appendix L for full quotes). We do not know the specific types of chest or genital surgeries the participants desired.

3.4.4. Psychological Support Prevalence

Overall, 73.6% (n = 53; AF = 41; AM = 11) of the sample had attended individual counselling or therapy in relation to their gender identity; 23.9% (n = 17; AF = 12; AM = 4) had attended group sessions; and 40.0% (n = 28; AF = 24; AM = 4) had attended family therapy.

3.4.5. Speech and Language Therapy Prevalence

None of the sample had attended speech and language therapy (SLT), and only 17.4% (n = 12) had been offered it. Of the sample, 12.9% (n = 9; AF = 6; AM = 3) intended to start SLT in the future, and 8.6% (n = 6; AF = 5; AM = 1) were undecided. Reasons for being undecided were provided by all six participants, and included not being aware SLT was an option (2); unsure if it will be needed/waiting to see the effect of hormones first (2); not been offered it yet (1); and considering obtaining it privately (1). It is worth noting here that SLT is not offered at GIDS, but is offered at adult services.

3.5. Factors Influencing Decisions about Interventions

Overall, the three factors cited as being most influential on people's intervention decisions were 1. Weighing up the risks and benefits of the different interventions (M = 6.58; SD 3.42; 95%CI 5.77 to 7.39; range 0-10), 2. Information found online (M = 5.87; SD 3.24; 95%CI 5.11 to 6.64; range 0-10), and 3. Information provided by staff at the GIDS (M = 5.34; SD 3.49; 95%CI 4.51 to 6.16; range; 1-10). See Figure 1. Participants who rated information found online as being influential, were invited to provide more detail in a comments box, where the following sources were cited: websites (e.g. www.reddit.com, www.transbucket.com), bulletin boards (e.g. www.4chan.org), blogs (e.g. www.tumblr.com), videos (www.youtube.com), talking to others on forums/group chats (e.g. www.susans.org), NHS websites, and websites of surgeons and patient reviews.

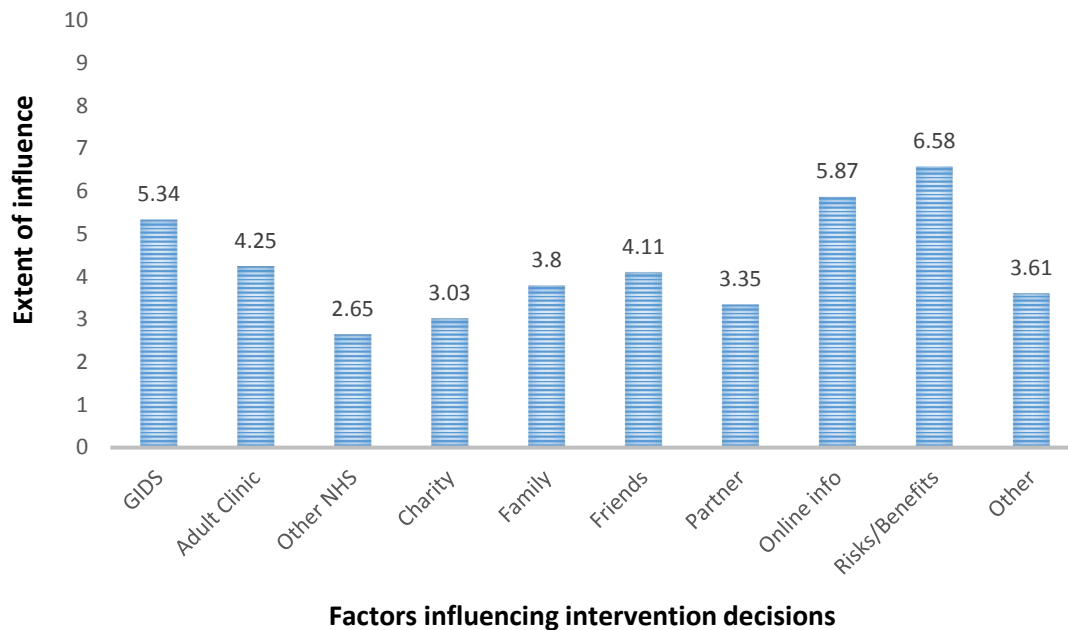


Figure 1: Factors influencing participants' decisions about intervention, as measured by mean influence ratings (N = 72)

When analysed separately by gender assigned at birth, the above patterns remained for AFs, such that the factors cited as most influential on people's intervention decisions were weighing up the risks and benefits of the different interventions (M = 6.66; SD 3.29), followed by information found online (M = 6.00; SD 3.01), and then information provided by staff at the GIDS (M = 5.07; SD 3.45). However, a different pattern emerged for AMs, whereby the most influential factor cited was information provided by staff at the GIDS (M = 6.29; SD 3.71), followed by weighing up the risks and benefits of the different interventions (M = 6.00; SD 3.98), and then opinions/advice from friends (M = 6.07; SD 4.20).

3.6. Satisfaction with the Intervention Process

3.6.1. Hormone Blockers

Of the people who had taken or were taking hormone blockers (N = 42), 83.3% (n = 35; AF = 25; AM = 9) either 'agreed' or 'strongly agreed' that they were satisfied with their decision to take hormone blockers (see Figure 2); 83.3% (n = 35; AF = 26; AM = 8) also 'agreed' or 'strongly agreed' that they felt involved in the decision-making process about whether or not to take hormone blockers; and

71.4% (n = 30; AF = 23; AM = 6) 'agreed' or 'strongly agreed' that the information/advice they received from the clinic(s) they attended helped them to make a decision about hormone blockers.

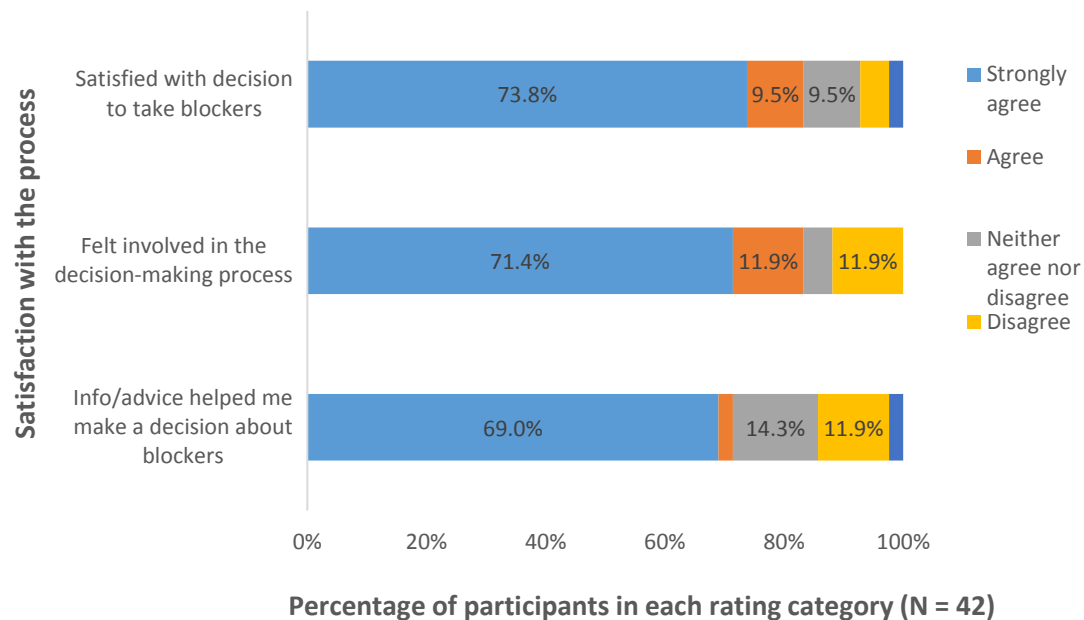


Figure 2: Satisfaction and involvement with the process in people who had taken or were taking hormone blockers (N = 42)

Of the people who had never taken hormone blockers (N = 29), 27.5% (n = 8; AF = 7; AM = 1) either 'agreed' or 'strongly agreed' that they were satisfied with their decision not to take hormone blockers; 24.1% (n = 7; AF = 7; AM = 0) 'agreed' or 'strongly agreed' that they felt involved in the decision-making process about whether or not to take hormone blockers; and 31.0% (n = 9; AF = 8; AM = 1) 'agreed' or 'strongly agreed' that the information/advice they received from the clinic(s) they attended helped them to make a decision about hormone blockers (see Figure 3).

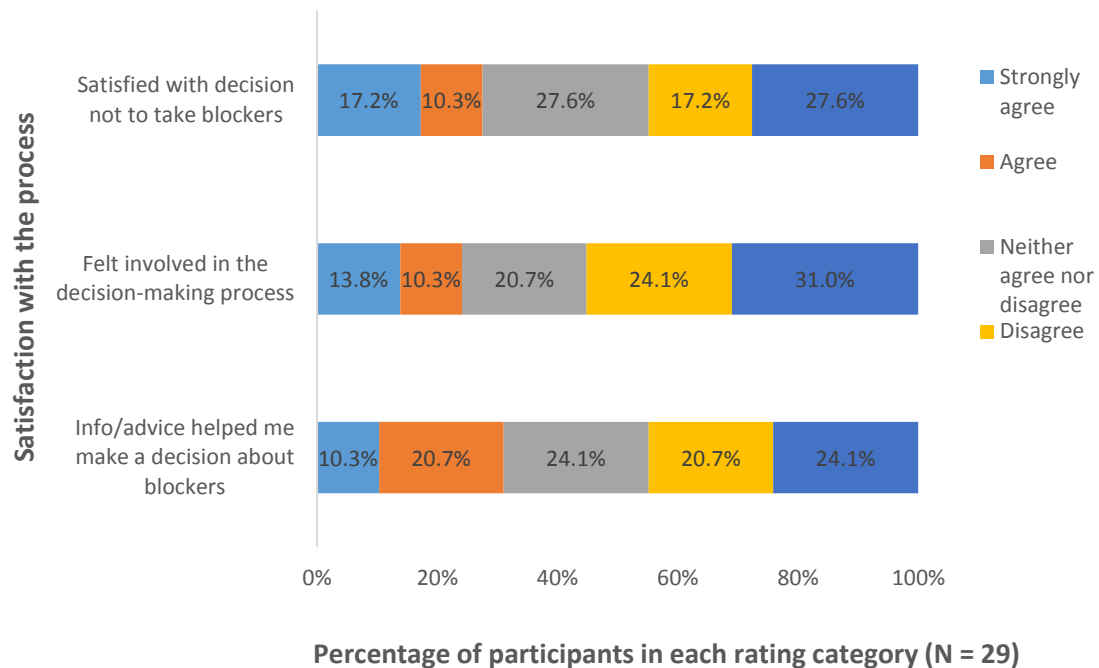


Figure 3: Satisfaction with the process in people who had never taken hormone blockers (N = 29)

Of the 29 people who had never taken hormone blockers, 20 provided context to their answers in a comment box. By the time they reached services, over half thought (or were told) that it was too late to take hormone blockers (12), and one third of people felt the decision was made for them by clinicians/services (7). A minority of people pointed to unhelpful information/advice from clinicians or GP as the reason they had not taken hormone blockers (2), and a minority had felt pressured by clinicians to take blockers but had not (2). One person reported being dissuaded by their family from taking blockers, and one person had obtained testosterone privately, so did not need/want to take blockers (see Appendix M for full quotes).

3.6.2. Cross-Sex Hormones

Of the people who had taken or were taking cross-sex hormones (N = 47), 97.9% (n = 46; AF = 35; AM = 10) either 'agreed' or 'strongly agreed' that they were satisfied with their decision to take cross-sex hormones (see Figure 4); 93.7% (n = 44; AF = 34; AM = 9) 'agreed' or 'strongly agreed' that they felt involved in the decision-making process about whether or not to take cross-sex hormones; and

82.9% (n = 39; AF = 31; AM = 7) 'agreed' or 'strongly agreed' that the information/advice they received from the clinic(s) they attended helped them to make a decision about cross-sex hormones.

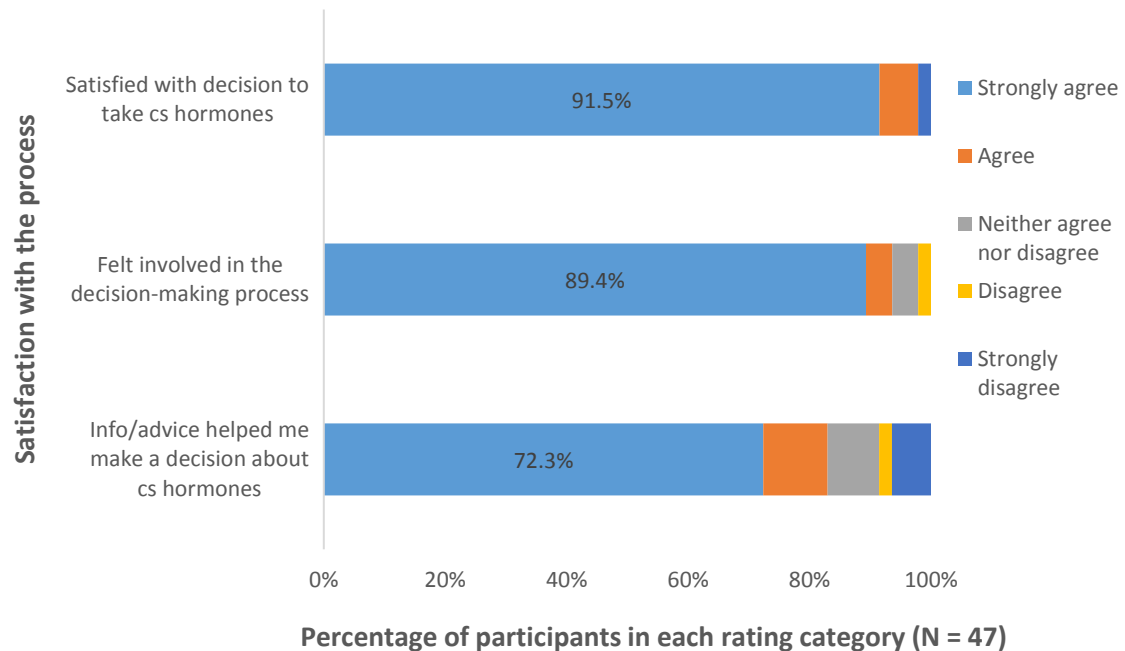


Figure 4: Satisfaction with the process in people who had taken or were taking cross-sex hormones (N = 47)

3.6.3. Surgeries

3.6.3.1 Top surgery. Of the people who had undergone top surgery (N = 15), 100% (n = 15; all AF) had either 'agreed' or 'strongly agreed' that they were satisfied with their decision to have the surgery (see Figure 5); 100% (n = 15; all AF) 'agreed' or 'strongly agreed' that they felt involved in the decision-making process about whether or not to have top surgery; and 80.0% (n = 12; all AF) 'agreed' or 'strongly agreed' that the information/advice they received from the clinic(s) they attended had helped them to make a decision about top surgery. Just under half (46.7%; n = 7; all AF) 'agreed' or 'strongly agreed' that they were satisfied with the post-operative hormone advice they had received.

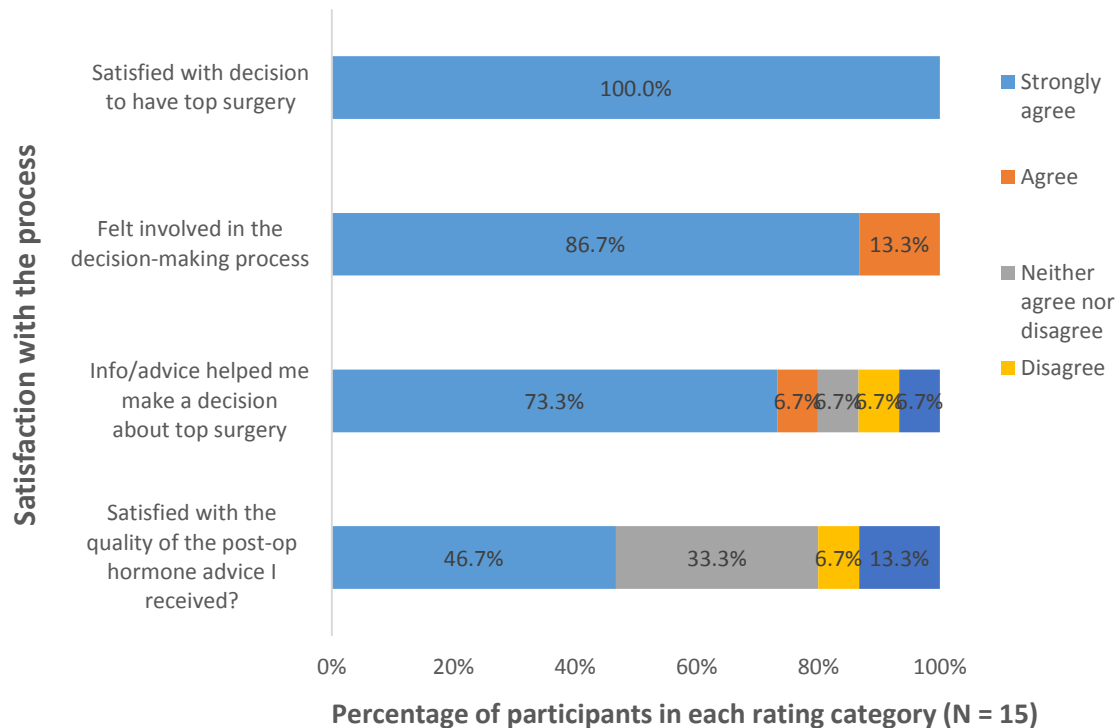


Figure 5: Satisfaction with the process in people who had undergone top surgery (N = 15)

3.6.3.1 Bottom surgery. Of the people who had undergone bottom surgery (N = 9), 100% (n = 9; AF = 4; AM = 5) either 'agreed' or 'strongly agreed' that they were satisfied with their decision to have the surgery (see Figure 6); 88.9% (n = 8; AF = 4; AM = 4) 'agreed' or 'strongly agreed' that they felt involved in the decision-making process about whether or not to have the surgery; 77.8% (n = 7; AF = 4; AM = 3) 'agreed' or 'strongly agreed' that the information/advice they received from the clinic(s) they attended had helped them to make a decision about bottom surgery; and 88.8% (n = 8; AF = 3; AM = 5) 'agreed' or 'strongly agreed' that they were satisfied with the post-operative hormone advice they had received.

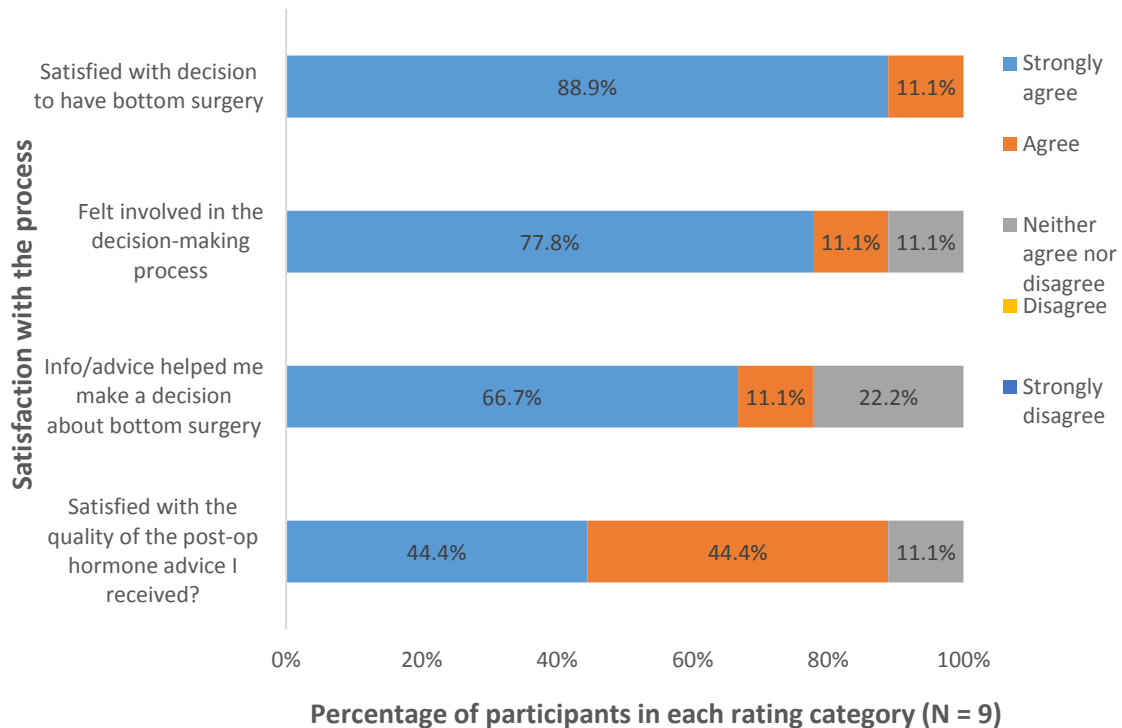


Figure 6: Satisfaction with process in people who had undergone bottom surgery (N = 9)

3.6.4. Psychological Support

3.6.4.1. Psychological support at GIDS. Participants who had attended individual therapy, group sessions and/or family therapy at GIDS were asked to rate the extent to which each psychological support (individual therapy/group sessions/family therapy) had helped them to make decisions about their transition process. Of those who attended individual therapy (N = 38), 57.8% (n = 22; AF = 19; AM = 2) strongly agreed or agreed that it helped them to make decisions about their transition process. Of those who attended group sessions (N = 14), 50.0% (n = 7; AF = 6; AM = 1) strongly agreed or agreed that it helped them to make decisions about their transition process. Of those who attended family therapy (N = 20), 40.0% (n = 8; all AF) strongly agreed or agreed that it helped them to make decisions about their transition process (see Figure 7).

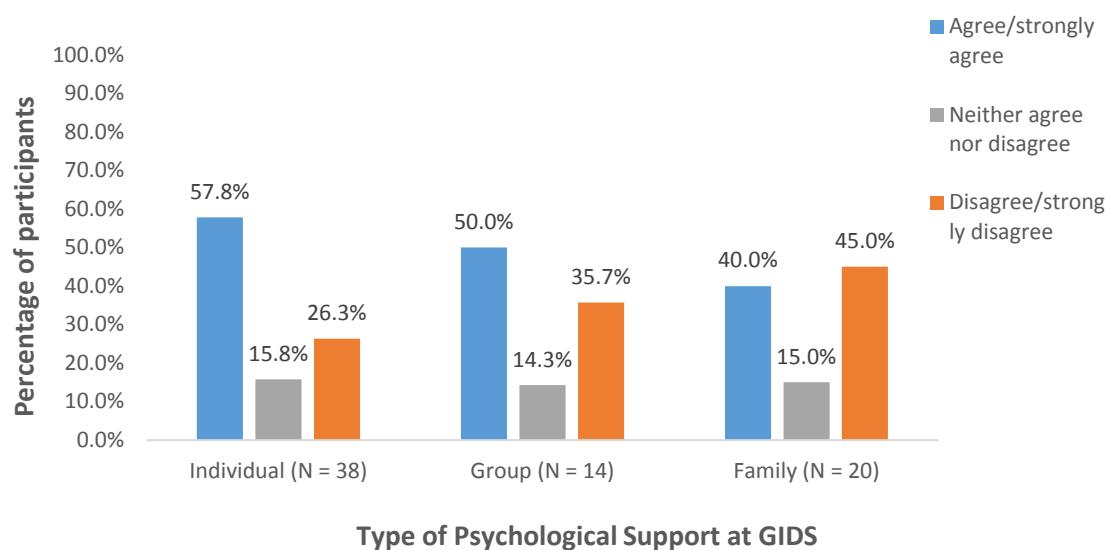


Figure 7: Participant perceptions on whether the psychological support at GIDS helped them make decisions about their transition process, by type of support

3.6.4.2. Psychological support at CCGIC. Participants who had attended individual therapy at CCGIC were asked to rate the extent to which attending individual therapy had helped them to make decisions about their transition process. Of those who attended (N = 19), 63.2% (n = 12; AF = 10; AM = 2) strongly agreed or agreed that it helped them to make decisions about their transition process (see Figure 8).

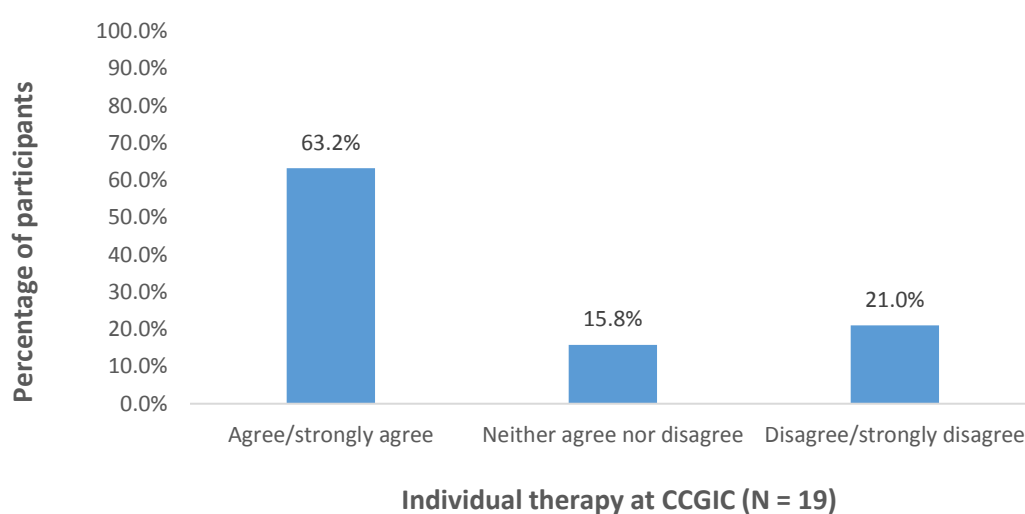


Figure 8: Participant perceptions on whether the individual therapy at CCGIC helped them make decisions about their transition process

3.6.4.3. Private psychological support. Participants who had attended private individual therapy were asked to rate the extent to which attending individual therapy had helped them to make decisions about their transition process. Of those who attended (N = 17), 64.7% (n = 11; AF = 8; AM = 3) strongly agreed or agreed that it helped them to make decisions about their transition process (see Figure 9).

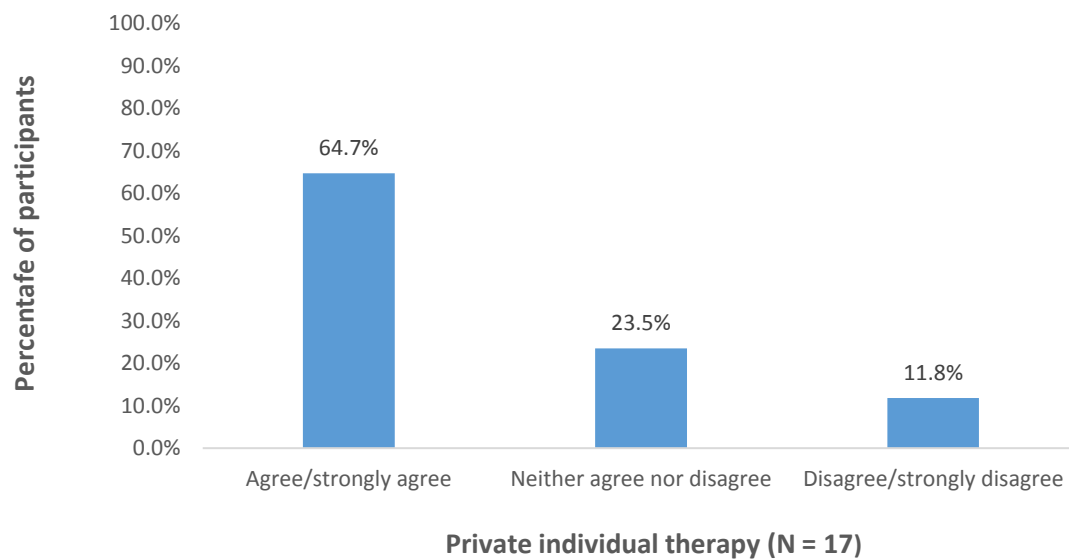


Figure 9: Participant perceptions on whether the private individual therapy they attended helped them make decisions about their transition process

3.6.4.4. Psychological support across services. Participant ratings of the extent to which attending individual therapy had helped them to make decisions about their transition process were compared across services. Broadly the same pattern emerged across services, in that a majority of participants agreed or strongly agreed (GIDS 57.5%; n = 22; CCGIC 63.2%; n = 12; Private 64.7%; n = 11) that therapy had helped them to make decisions about their transition process (see Figure 10).

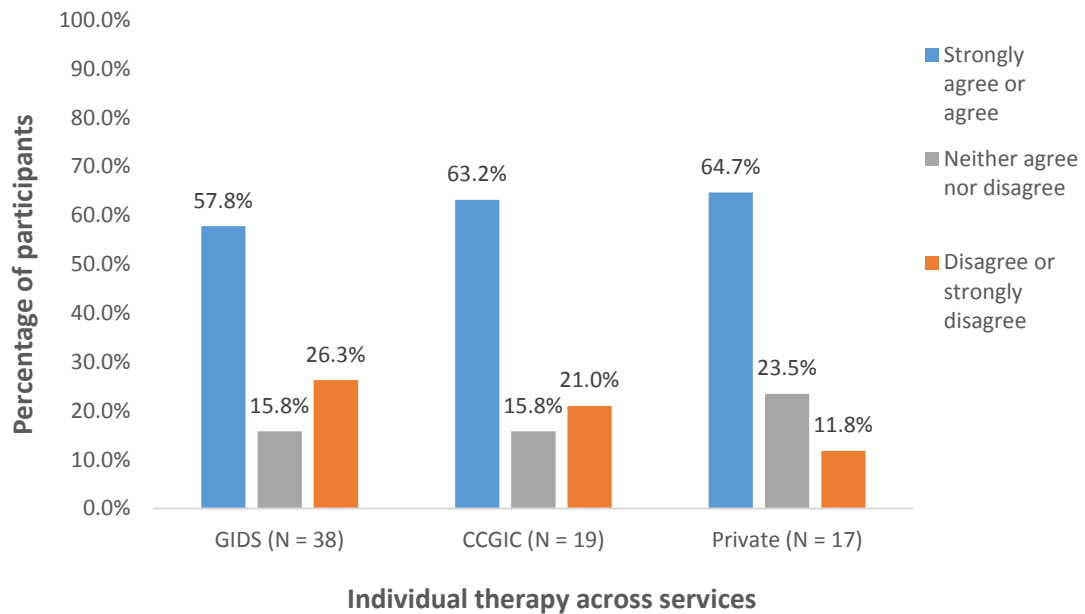


Figure 10: Participant perceptions on whether the individual therapy they attended helped them make decisions about their transition process, by service

3.6.5. Current Reflections on Previous Decisions about Interventions

When asked the question ‘If you were making decisions about interventions today, would any of your past decisions about [counselling/therapy, blockers, cross-sex hormones, top surgery, bottom surgery, speech and language therapy] be different?’ Overall, 40.0% (n = 28; AF = 24; AM = 3) answered ‘yes’ to at least one intervention, and 15.7% (n = 11; AF = 10; AM = 1) answered ‘not sure’ to at least one intervention. When broken down by intervention, the majority of participants responded no (see Figure 11). The two interventions with the highest number of ‘yes’ responses, were hormone blockers and top surgery.

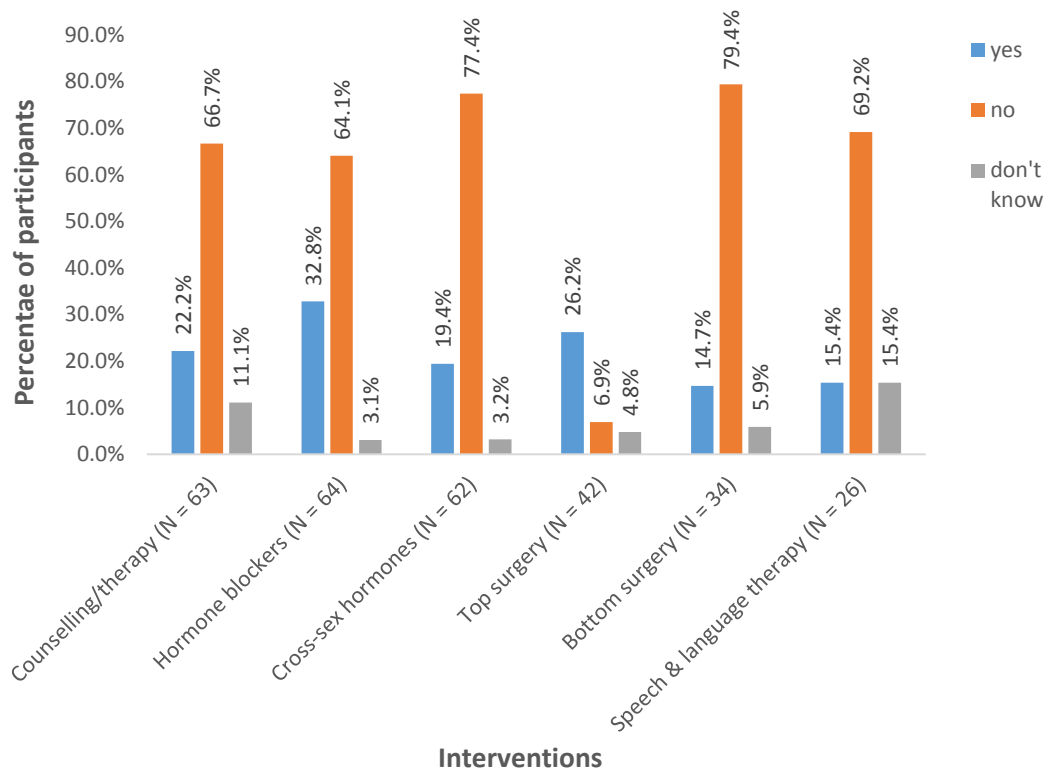


Figure 11: Percentages of participants who would/would not have made different decisions about interventions if they were making them today

Of the 28 people who answered yes in reference to at least one previous decision being different, 24 people expanded on their responses in a text box (see Appendix N for full quotes). Over half of the people who expanded on their responses (n= 16) described a wish to have started interventions sooner; particularly hormone blockers, but also cross-sex hormones, surgery and counselling/therapy.

‘Would seek counselling sooner. Would want blockers & T [testosterone] much sooner to help prevent the last stages of puberty that I had to go through while waiting. Would have had chest surgery 2 years ago’.

Participant self-identified as a man (20 years old)

People had varying opinions on hormone blockers: Several people felt the requirement to take hormone blockers before cross-sex hormones was unnecessary (n = 2). One person would now consider hormone blockers as a long-term treatment, rather than a precursor to hormones, and one reported

negative side effects of hormone blockers, and stated that they would have taken birth control instead.

'I would have taken birth control instead of hormone blockers to stop my menses. Some aspects of hormone blockers are wonderful - there's no fluctuations in my masculinity and femininity like I used to have due to my cycle, and it feels great to feel simply neutral, but the cost has been quite high. I know depression is a common side effect and it's difficult to tell whether I've experienced it as a result or whether my mental health has struggled because I've been so tired that I've felt like I have no future'.

Participant self-identified as a transman (18 years old)

One person would have liked to have accessed speech and language therapy had it been available in their area. Two people felt that counselling/therapy was a 'waste of time' or 'detrimental', but others would have liked to have accessed it earlier (n = 4) and had it continue during the transition between services (n = 1). One person said they no longer want bottom surgery, and two people spoke about their understanding of gender becoming more nuanced and less binary over time, and cited this being the reason why some of their decisions would be different.

'I saw transitioning as going from one extreme to the other. Like I knew I was never gonna be a 'manly man' but I never thought about potentially being gender queer or trans masc...I didn't have sex until I was 20, and I think that helped me come to realise I'm more transmasculine than just a man. Now I'm here, I think I could reconsider chest surgery, but I don't regret it. I can't wait to have my first summer where I can take my top off, and where a binder won't rub me and suffocate me'.

Participant self-identified as a transman (22 years old)

'I've somewhat de-transitioned now, medically speaking (not socially). I would now put more emphasis on the emotional support I could get from therapy. I would consider hormone blockers as a long-term treatment, rather than a precursor to hormones. I would not be on cross-sex hormones. But I would still have wanted top-surgery'.

Participant self-identified as partly a man, partly a woman (age unknown)

3.6.6. Timing and length of process

3.6.6.1. Timing of interventions. With regards to medical interventions, almost two thirds of those who took or were taking hormone blockers (n = 30) and just over half of those taking cross-sex hormones (n = 28) felt the timing of these interventions was too late (see Figure 12). With regards to surgeries, almost half of those who had undergone top surgery felt the timing was too late (n = 12), and the majority of those who had undergone genital surgery felt the timing was either too late (n = 7) or were not sure about the timing (n = 3). A majority of participants (n = 33) felt the timing of psychological support was about right.

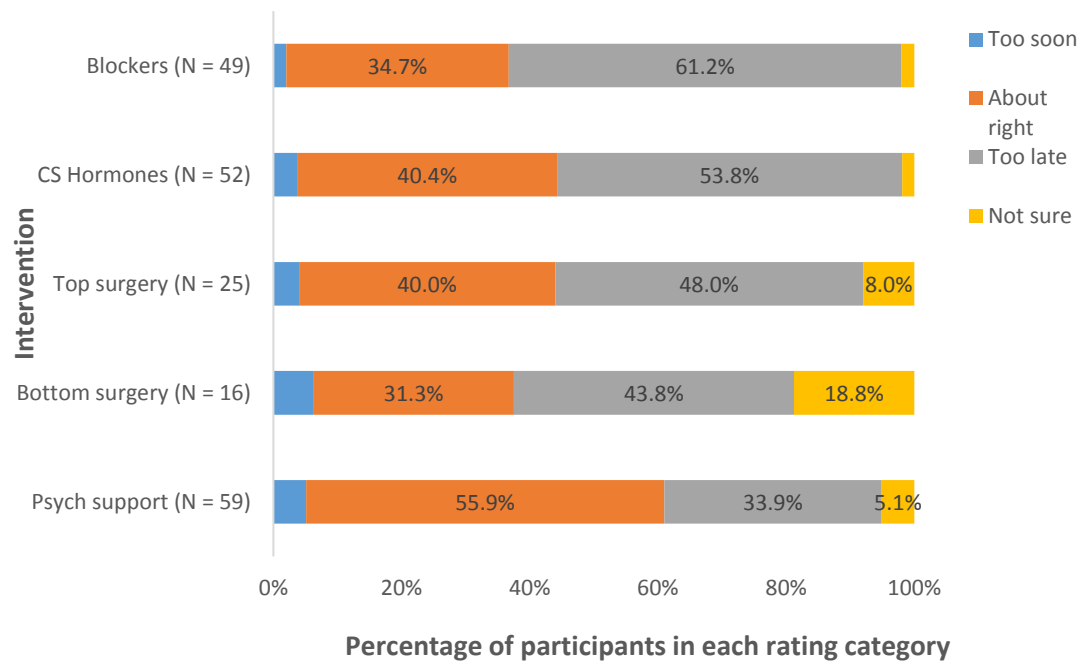


Figure 12: Participants' perceptions of the timings of each intervention

3.6.6.2. *Length of process.* Across all interventions, the majority of people (55.9% to 76.8%; n = 33 to 43) felt that the length of the process was too long (see Figure 13).

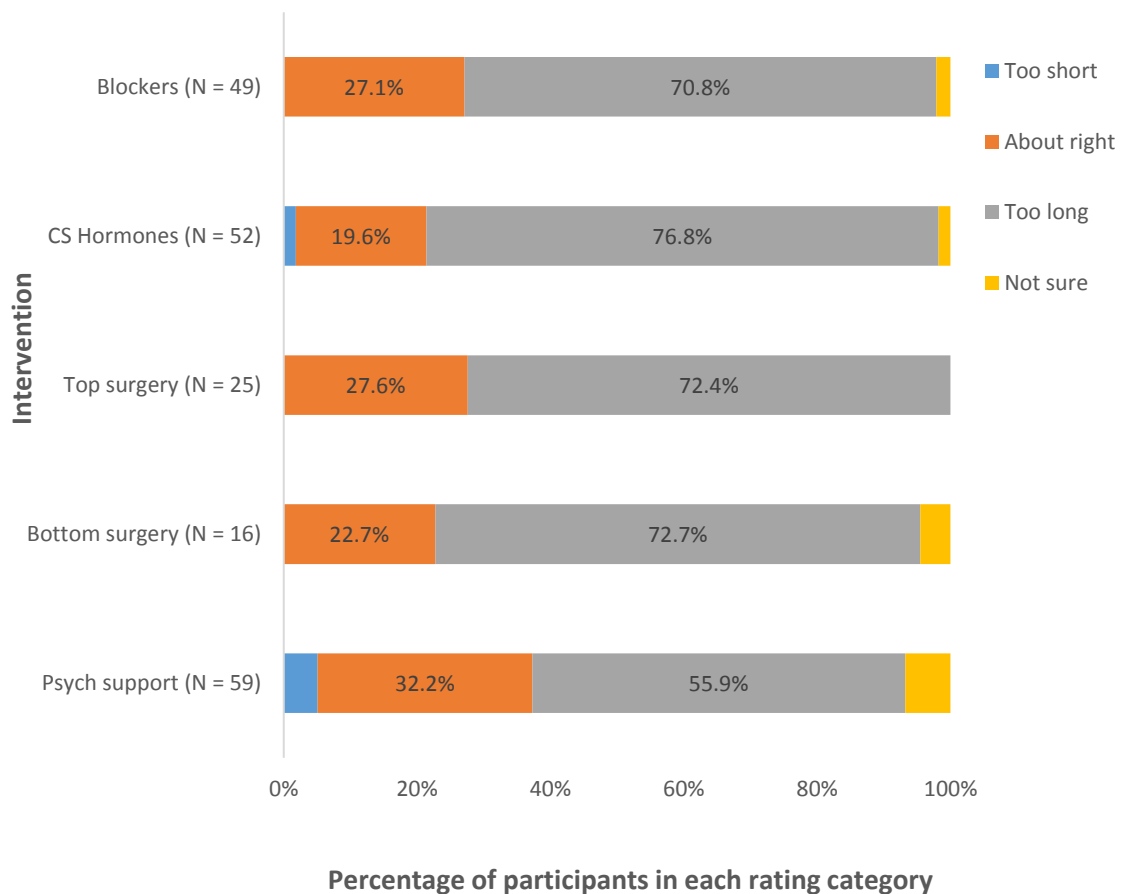


Figure 13: Participants' perceptions of the length of process of each interventions

People elaborated on their responses to the question of timings (N = 25) and length of process (N = 27) in comment boxes (see Appendix O for full quotes). Almost all of the people who left comments felt that the wait for services and interventions was too long (n = 26), and this included the initial wait to be seen at the GIDS, the transition from GIDS to CCGIC, and the wait for interventions once seen by a clinician at a service.

'I waited around two years to get into the children's clinic. I was there for around a year before being kicked out because I was over 18. I'll now have to wait another year and a half to get my first adult clinic appointment and

my second appointment will likely be 6 months after the first. Once I'm on hormones, I'll likely have to wait another year before I can get top surgery'.

Participant self-identified as a transman (18 years old)

People cited various barriers to accessing services or receiving interventions, including a general lack of services (n = 2); appointments being rescheduled or referrals being delayed due to staff leaving or administrative errors (n = 10); mental health difficulties that required attention first (n = 1); not being offered certain interventions (n = 1); and waiting for clinician's signatures (n = 1).

'I am still yet to receive top surgery, I was on a waiting list from nearly a year but have been taken off it due to the surgeon being unable to now do the surgery as he has moved. I'm now unaware of when I will be getting surgery'.

Participant self-identified as a man (20 years old)

With regards to the impact of long waiting times, some people felt that certain steps in the process were unnecessary and delayed intervention (n = 6).

'I would have liked to have received hormones earlier rather than having to attend appointments at adult services to assess whether I was "ready" to take them, and being required to change my legal name before I could even get a recommendation'.

Participant self-identified mostly as a transman, but sometimes genderless (20 years old)

'A potentially more troubling issue is the barriers one faces when trying to get treatment, it is categorically insufficient to truthfully explain your struggles. My experience was being interrogated about the way I present, being told I have to 'be a woman all of the time, not just some of the time'. The criteria for being judged as correctly transgender seem very specific, and god help me if I didn't figure out the rough criteria and start lying'.

Participant self-identified as a woman (19 years old)

'I can't speak for trans feminine people, but the fact that trans masculine people are denied referrals for top surgery until they've been on HRT for a certain amount of time is cruel and ridiculous. Binding is painful, unpleasant, and can be traumatising. Many people can't pass as masculine because of their chest, meaning that physical changes they may experience from HRT (esp. facial hair) make it even more dangerous to exist as a trans person due to how visible discrepancies from gender norms are received'.

Participant self-identified as a man (20 years old)

The long wait and delays to intervention were experienced as particularly distressing by some of the participants (n = 14).

'I was due to start testosterone treatment mid-2015, however due to my GP repeatedly refusing the first injection due to supposed complications despite telling him I wasn't allergic to anything, I wasn't able to start the treatment until June 2016. The injection was done by a local hospital and only then was I allowed to have the continuing injections done at the surgery. The year wait before I was able to start testosterone caused me to become suicidal and depressed'.

Participant self-identified as a man (21 years old)

'My waiting for hormones was very long, and resulted in multiple suicide attempts'.

Participant self-identified as a man (20 years old)

'I'll reiterate how imperative, I believe it is for the service to be understanding and caring toward transgender individuals in relation to their body or their identity. It comes across as very disrespectful when doctors, psychiatrists or other staff are referring to body-parts or other such things with the incorrect terms, or just not taking their time to use gender neutral one. By doing so they're impacting mental health of the individual. I know I dread going to the GICs, I always have and always will. However, if I

thought I wouldn't have to encounter words that make me want to cut myself up I could deal with the process that bit easier'.

Participant self-identified as a man (22 years old)

Due to wait times, some participants turned to private services to obtain intervention (n = 4), and one person felt that the delays to intervention (specifically hormone blockers) meant that top surgery became necessary.

'If I had had hormone blockers before I hit puberty, I would not have needed top surgery. However, specifically for me, this would not have been possible, as I hit puberty around age 8-9, before I had words to describe my gender identity'.

Participant self-identified as a man and a transman (20 years old)

3.7. Feelings about Gender Identity and Body Image

The mean satisfaction rating for gender identity was 4.1 (SD 1.1; 95% CI 3.8 to 4.4; n = 70), which indicates an average rating of 'satisfied'; and the mean satisfaction rating with body (in relation to gender identity) was 2.5 (SD 1.5; 95% CI 2.2 to 2.9; n = 70), which indicates an average rating at the mid-point between 'dissatisfied' and 'neither satisfied nor dissatisfied' (see Figure 14).

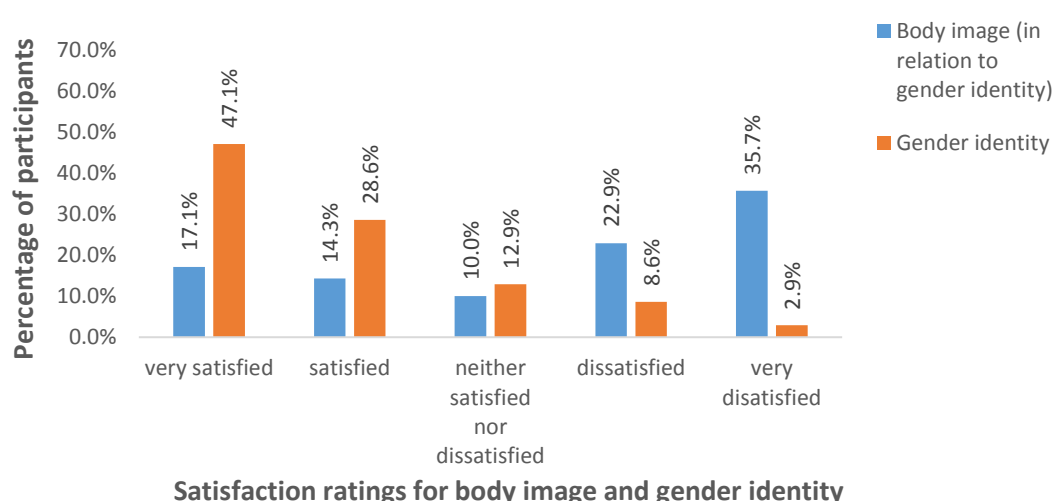


Figure 14: Satisfaction ratings for body image (in relation to gender identity) and gender identity

The body image and gender identity satisfaction ratings were analysed by gender assigned at birth. An independent samples t-test revealed that there was a statistically significant difference in the mean body satisfaction ratings with AMs ($M = 2.77$; $SD = 1.88$; $n = 13$) reporting greater satisfaction with their body (in relation to their gender) than AFs ($M = 2.48$; $SD = 1.45$; $n = 56$), $t(67) = .61$, $p = .033$; $d = 0.15$. According to Cohen's conventions this constitutes a small effect size. An independent samples t-test revealed that there was no statistically significant difference in the mean gender identity satisfaction ratings between those AM ($M = 4.00$; $SD = 1.23$; $n = 13$) and those AF ($M = 4.11$; $SD = 1.09$; $n = 56$), $t(67) = -.31$, $p = .767$; $d = 0.08$. An a priori sample size calculation, on the basis of a 2-tailed test, with a medium effect size, and an alpha of .05, indicated a sample size of 88 was need to detect a significant effect in both these tests, but due to the exploratory nature of the study the t-tests were run despite this. Caution should be taken in interpreting these results.

3.8. Psychological Wellbeing

The mean wellbeing score Warwick-Edinburgh Mental Well-being Scale (WEMWBS) was 46.5 ($SD = 12.55$; $CI = 43.5-49.5$; range 14-68), which falls in the average range of the measure. Of the sample, 17.1% ($n = 12$) were classified as having above average wellbeing, 50.0% ($n = 35$) as average, 17.1% ($n = 12$) as below average, and 15.7% ($n = 11$) as having very low wellbeing (see Figure 15). The internal consistency for the current sample was high ($\alpha = .95$).

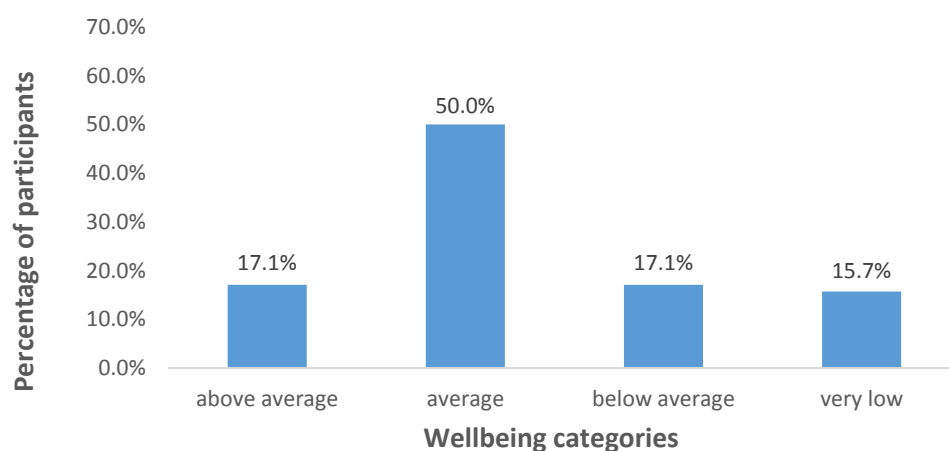


Figure 15: Psychological wellbeing scores

3.9. The Impact of Interventions on Wellbeing and Body Satisfaction

3.9.1. Body Image

A two-way between-groups analysis of variance (ANOVA) was conducted to compare the main effects of medical interventions (2 levels: yes/no) and surgical interventions (2 levels: yes/no), and interaction effects between interventions on body image. There was a statistically significant difference at the $p < .05$ for the intervention groups: $F(2, 67) = 15.17$, $\eta = .312$, $p = .000$, which indicated a statistically significant difference in body image scores between the medical intervention group ($M = 2.85$; $SD = 1.50$), and surgical intervention group ($M = 3.84$; $SD = 1.30$). According to Cohen's conventions (Cohen, 1988), this constitutes a small to medium effect size. The main effect of medical intervention $F(1, 67) = 3.45$, $\eta = .049$, $p = .068$, was not statistically significant, but the main effect of surgical intervention $F(1, 67) = 17.84$, $\eta = .210$, $p = .000$ was statistically significant, which suggested that people who had received surgical intervention had significantly higher body image scores than those who had not received surgical intervention. However, the effect size was small (Cohen, 1988). An a priori sample size calculation, using fixed effects for main effects and interactions, with a medium effect size, and an alpha of .05, indicated a sample size of 400 was needed to detect a significant effect, but due to the exploratory nature of the study, the ANOVA was run despite this. Furthermore, it was not possible to determine whether there were any interaction effects because there were no people in the sample who had received surgery, but not taken cross-sex hormones. Therefore, caution should be taken in interpreting these results.

3.9.2. Psychological Wellbeing

A two-way between-groups analysis of variance (ANOVA) was conducted to compare the main effects of medical interventions (2 levels: yes/no) and surgical interventions (2 levels: yes/no), and interaction effects between interventions on wellbeing. There was a statistically significant difference at the $p < .05$ for intervention on wellbeing: $F(2, 67) = 4.32$, $\eta = .114$, $p = .017$, which indicated a statistically significant difference in wellbeing scores between medical intervention group ($M = 47.22$; $SD = 12.62$), and surgical intervention group ($M = 53.37$; $SD = 9.70$). According to Cohen's conventions (Cohen, 1988), this constitutes a small

effect size. The main effect of medical intervention $F(1, 67) = 0.01$, $\eta = .000$, $p = .926$, was not statistically significant, but the main effect for surgical intervention $F(1, 67) = 7.78$, $\eta = .104$, $p = .007$ was statistically significant, which suggests that people who had received surgical intervention had significantly higher wellbeing scores than those who had not received surgical intervention. However, the effect size was small (Cohen, 1988). An apriori sample size calculation, using fixed effects for main effects and interactions, with a medium effect size, and an alpha of .05, indicated a sample size of 400 was needed to detect a significant effect, but due to the exploratory nature of the study, the ANOVA was run despite this. Furthermore, it was not possible to determine whether there were any interaction effects because there were no people in the sample who had received surgery, but not taken cross-sex hormones. Therefore, caution should be taken in interpreting these results.

DISCUSSION

4.1. Chapter Overview

This chapter will restate the background and aims of the thesis, provide a brief summary of the key study findings, and discuss the findings in relation to the research questions and existing literature. Next, methodological strengths and limitations of the research will be discussed, followed by some personal reflections on the process. The implications of the findings for clinical practice and research will be discussed, before ending the chapter with conclusions.

4.2. Background to the Thesis

In recent years there has been an explosion of referrals to speciality services for gender diverse youth. There is a paucity of research on the experiences and outcomes of young adults referred from child and adolescent gender identity services to adult services, and with such large increases in referrals it is vital we understand more about the intervention pathways, satisfaction, and longer-term outcomes of these gender diverse young people. The findings will enable better tailoring of gender identity services for young people, and be an important step towards ensuring that the support and intervention provided meets the needs of this diverse and growing population

4.3 Aims and Objectives of the Thesis

To my knowledge, this was the first ever cross-sectional follow-up study of a cohort of gender diverse young adults who previously attended a child and adolescent gender identity clinic and who were referred, at age 18, to an adult gender identity clinic. The overall aim of the study was to address current gaps in the literature by determining the intervention pathways, satisfaction levels and longer-term outcomes of the young people who attended the GIDS, and who were referred on to the CCGIC.

4.4 Summary of Main Findings

In this sample of gender diverse young adults, a high proportion were taking cross-sex hormones, and the majority were largely satisfied with their decision to take cross-sex hormones, and with the decision-making processes/support involved. A much smaller proportion of the sample had undergone surgical intervention, but all were satisfied with their decisions and the decision-making processes/support involved. This finding may reflect the cross-sectional nature of the study, the age of the sample, and the fact that many people were in the middle of their intervention journeys. Supporting this idea, a substantial number of the sample intended to have top surgery, and to a lesser extent bottom surgery, in the future. Despite relatively high satisfaction ratings with intervention processes, areas of dissatisfaction were identified and these represent targets for improvement; they include the timings and length of process of interventions, access to hormone blockers, psychological support and post-op hormone advice after top surgery. The factors cited as most influential in people's intervention decisions varied by gender assigned at birth, and included weighing up the risks and benefits of different interventions, information found online, information provided by staff at the GIDS, and opinions/advice from friends. The majority of the sample reported average levels of wellbeing, which are comparable people of a similar age in the general population. While the majority were satisfied with their gender identity, the majority were dissatisfied or neutral about their body image.

4.4.1. Sample Recruited

The study sample was comparable to the population sample with regards to age (i.e. the average age in the study sample was 20.0 years, compared to 19.9 years in the population of young people who were referred from GIDS to CCGIC). Although the sample had a greater proportion of assigned females to males, than in the population (i.e. 78.2% vs 64.7%), it was broadly comparable. The higher proportion of assigned females seen in this sample of young adults (referred to an adult service between 2011 and 2016), supports the temporal shift in sex ratio found in previous studies of adolescent clinic populations (Aitken et al., 2015).

The assigned females in the study were significantly younger than the assigned males, which is in line previous findings (Olson, Schrager, Belzer, Simons, & Clark, 2015). As Aitken and colleagues suggested (2015), it might be easier for AFs to come out as trans than AMs, because although trans identities are becoming more accepted, there is still more stigmatisation of cross-gender behaviour in boys/men than in girls/women – potentially explaining the observed age differences.

The average age at which the sample were referred to the GIDS (14.9 years old) supports the recent observed increase in young people in their mid-teens presenting to services for the first time (de Vries et al., 2010; Kaltiala-Heino et al., 2018; Zucker et al., 2016). Four participants identified as non-binary, genderqueer or genderless, which reflects the diversity of ways in which young people are now identifying. Addressing the medical and mental health needs of these young people will present additional challenges to health professional in trans-related healthcare (Olson et al., 2015; Steensma et al., 2013). With increased diversity comes increased fluidity, and services will need to develop more nuanced and tailored ways of intervening than more traditional binary-focussed pathways.

4.4.2. Research Question 1: Which Intervention Pathways Did People Follow After Being Referred to the Adult Clinic?

Almost two thirds of the sample had taken or were taking hormone blockers. There are no previous studies with which to compare these findings, but one might expect the number to be higher, given that hormone blockers are available in the UK to people once they have entered the early stages of puberty (i.e. Tanner stages 2-3), and that the average age of the sample was 20.0 years old. However, the average age at which people were first referred to services (i.e. post-puberty), long wait times to be seen at the clinics, and possible presence of comorbidities (that can delay access to medical intervention) may help to explain these findings.

The vast majority of the sample were either taking cross-sex hormones or intended to take them in the future (91.4%), and only a minority of the sample had undergone top/chest surgery (21.1%) or bottom/genital surgery (12.7%). While there are no previous studies in adolescents/young adults with which to compare these findings, the figures do align with similar research conducted in adult samples (Kailas et al., 2017). In this adult sample (N = 99), 97.0% were taking cross-sex hormones, 25.0% had undergone top/chest surgery, and 13.0% had undergone bottom/genital surgery. At first glance, these findings are perhaps surprising, considering the how much younger the current sample was (20.0 years old) compared to the sample in the adult study (42.3 years old). One might conclude that those who present to adult services want physical interventions (and those who do not do not); and that prevalence of medical and surgical interventions in clinic populations is fairly stable, regardless of the age people start medical transitions. However, caution should be taken when drawing conclusions on the basis of these comparisons. The study that looked at the prevalence of gender affirming interventions in a clinic-sample was a US study that did so prior to state expansion of insurance cover for gender affirming surgery (Kailas et al., 2017). Thus, the relatively low prevalence of surgical intervention in this adult study could be partially explained by the lack of insurance coverage/funds to cover the surgeries at the time. A study conducted in a non-clinical sample of trans-identified individuals (N = 415) in Germany, where gender affirming intervention is government funded, found similar prevalence (to the current study) of taking cross-sex hormones (AF = 81.4%; AM = 88.5%), but a higher prevalence of surgical interventions (top surgery AF = 62.4%; AM = 21.2%; and hysterectomy/ovary removal (AF) = 36.0%; genital reconstruction surgery (AM) = 44.9% (Eyssel et al., 2017). These differences may, to some extent, reflect differing cultures within the medical professionals in different countries, regarding what constitutes support and their willingness to perform surgeries.

If one compares desire for (more) surgery then a slightly different picture emerges. In the current sample, 55.7% intended to have top/chest surgery (11.4% were undecided) and 25.7% intended to have bottom/genital surgery (37.1% were undecided). These figures are much higher than in the US adult sample (Kailas et al., 2017), in which 22.0% desired top/chest surgery and 4.0%

desired bottom/genital surgery. These differences may reflect generational and cultural differences, differences in approach to intervention, or issues relating to funding.

On average, the current sample started interventions 1.5 to 2 years later than adolescents and young adults in previous studies (de Vries, McGuire, et al., 2014). The current sample started puberty suppression at 16.4 years (compared to 14.8 years in the Dutch sample); cross-sex hormones at 18.0 years (compared to 16.7 years); and gender affirming surgery at 21.2 years (compared to 19.2 years). The age of starting interventions in the Dutch sample are more closely aligned with current age-related guidelines (Coleman et al., 2012; Delemarre-van de Waal & Cohen-Kettenis, 2006; Hembree et al., 2009, 2017). However, drawing comparisons with the Dutch study is problematic, because the Dutch study was an evaluation of an early intervention sample, whereas the current sample was a cross-sectional look at an older (non-early intervention) sample, and therefore we would expect the Dutch sample to have accessed interventions earlier.

Furthermore, there are multiple reasons why the current sample might have started interventions at the ages they did, including presenting to services later and the possible presence of comorbidities that might have required attention first.

When thinking about prevalence of interventions, and comparing findings to previous research, it's important to remember that the current study is not an outcome study. Rather, it is a cross-sectional snap shot in time, where some participants had completed their intervention journey, and others were still in the middle of it. Thus, making direct comparisons with outcome studies, in which participants had completed their intervention journey, is potentially problematic.

4.4.3. Research Question 2: What Factors Influenced People's Intervention Decisions?

The factors cited as being most influential on people's intervention decisions varied by gender assigned at birth. The top three factors cited as most influential for AFs were 1. Weighing up the risks and benefits of different interventions, 2. Information found online, and 3. Information provided by staff at the GIDS. The

top three factors cited at being most influential for AMs were 1. Information provided by staff at the GIDS, 2. Weighing up the risks and benefits of different interventions, and 3. Opinions/advice from friends. There are no previous studies with which to compare these findings.

Effectively communicating risk to clients/patients is a key part of insuring that consent is informed (Paling, 2003). Unfortunately, we do not know how the participants assessed the risks and benefits of gender affirming interventions, or what sources they used to make these evaluations. Studies indicate that when making decisions about surgery, people tend to extract the gist of any information, rather than the details (Lloyd, Hayes, Bell, & Naylor, 2001), and risk assessments are often driven by emotions rather than facts (Ropeik & Clay, 2002). Almost every doctor involved in gender affirming healthcare has to communicate information on risk, yet many doctors do not have adequate training in risk communication (Paling, 2003). Furthermore, the nature and understanding of risk, in this area, is something that is rapidly changing. Future qualitative research is needed to thoroughly explore the ways in which gender diverse people evaluate the risks associated with medical and surgical intervention, and the role that others play in the evaluation process, so that this information can be considered and incorporated into any written materials, online information sources, and risk communication training for doctors.

Increasingly, we are exposed to a huge amount of health information online, and therefore it is important that this information is accurate and trustworthy (Morahan-Martin, 2004). However, people often report finding it difficult to know which internet sources to trust (Morahan-Martin, 2004). The current study showed that websites are an important source of information (regarding decision-making) for gender diverse young people. Although some participants cited NHS websites as being influential sources of information when making decisions about interventions, the other online sources of information cited were websites that are largely unregulated (i.e. blogs, photo and video sharing websites, social networking sites, bulletins boards etc.). While these sites are ideal places to obtain information about people's experiences of transitioning, due to their lack of regulation, they are not necessarily the best places to obtain accurate and reliable

health information (e.g. side effects or long-term impact of hormone treatments, or risks associated with surgery). Future qualitative research exploring the content, design and usage patterns of these websites would provide useful information for those involved in developing and managing websites containing health information for gender diverse people (in terms of maximising their utility as information sources).

The fact that the information provided by staff at the GIDS was cited as being highly influential in people's intervention decisions is interesting, as it appears to contravene the narrative in the media about trans people having poor relationships with gender identity services. These findings put individual complaints in perspective, and demonstrate, that despite the challenges inherent in providing trans-related healthcare, it appears that many are satisfied. Future qualitative research exploring what people found helpful and why would be useful in terms of achieving and maintaining high levels of client satisfaction in this area.

4.4.4. Research Question 3: Were People Satisfied with the Intervention Process?

4.4.4.1. Levels of satisfaction/dissatisfaction with interventions. The majority of participants were satisfied with the intervention process regarding hormone blockers, cross-sex hormones, and surgeries (i.e. satisfied with their decisions, felt involved in the decision-making process, and perceived the information/advice they received from the clinics as helpful). Previous studies with adolescents or young adults after receiving gender affirming interventions have tended to look at satisfaction with outcomes, such as body/appearance and surgery (Cohen-Kettenis & Van Goozen, 1997; de Vries, McGuire, et al., 2014; de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011), rather than satisfaction with the process, so there are no previous findings with which to compare these findings.

The majority of satisfaction studies conducted in adult populations also tend to privilege outcomes over process, but some have looked at satisfaction with gender identity services (Bockting et al., 2004; Davies et al., 2013; Ellis, Bailey, & McNeil, 2015; Eyssel et al., 2017; Wylie, Fitter, & Bragg, 2009). Unfortunately, the process questions in most of the studies did not map onto those asked in the

current study, and so are not directly comparable. An exception to this was Davies and colleagues, who reported overall satisfaction rates of 60% (Davies et al., 2013). The lack of attention in the literature to satisfaction with the intervention process and decision-making is surprising. Particularly in the UK, where NHS commissioning bodies increasingly expect patient satisfaction to be considered as a service performance indicator, and the fact that shared decision-making is a principal mechanism for ensuring people get the care they need and want (Coulter & Collins, 2011).

The age criteria for hormone blockers and cross-sex hormones are currently under debate (Cohen-Kettenis et al., 2008; Delemarre-van de Waal & Cohen-Kettenis, 2006; Ehrensaft, 2016; Hidalgo et al., 2013; Vrouenraets et al., 2015; Wren, 2000). Although they appear to have worked well for the majority of the young adults in this sample, continued research is needed to determine factors (identifiable pre-puberty) that would predict the continuation of a gender diverse identity into adulthood (Steensma et al., 2011). What is much needed, but absent from the current literature, are longitudinal prospective studies looking at a diversity of pathways, and exploring individual experiences, choices, gender identities and expression.

The fact that most AFs were satisfied with top surgery, and not many intended to have bottom surgery potentially supports the idea that passing/public perception is a priority (Kailas et al., 2017). However, looking at the reasons people cited for being undecided about genital surgery, the picture is more complex. While some people did comment on not feeling dysphoric about their genitals, the main reasons people gave for being undecided linked to dissatisfaction with current surgical methods and outcomes, and concern about potential complications and pain. Other reasons cited related to people still being in the middle of their medical transition process, and, as such, people were still weighing up the risks and benefits, learning about different surgical options, and waiting to see how they felt after starting cross-sex hormones. These findings highlight the complexities of how people reconcile their gender identity with their physical body, and may reflect the developmental stages and processes they were going

through (i.e. connected to evolving social, physical, emotional and relational experiences and understandings).

Lower satisfaction ratings were related to psychological support, timings and length of process, post-surgery hormone advice, and in people who had not taken hormone blockers. When looking at psychological support it is firstly important to note that the numbers of participants who had received the different types of support were very small. Secondly, psychological support varies widely across intervention type and service, in terms of its focus, content, frequency and length. For example, decision-making about interventions is not the focus of the group sessions at GIDS. In group sessions they use cognitive behavioural techniques and systemic approaches to manage mood and relationships; and (post-assessment) in individual therapy at GIDS, people are only seen quarterly; whereas at CCGIC individual therapy could be more frequent and focussed on a range of factors; and private therapy could be weekly or even more frequent than that. With this information in mind, caution should be taken in interpreting these findings.

While the satisfaction ratings for psychological support were not low per-se (40-58% of participants strongly agreed or agreed that psychological support helped them to make decisions about their transition process), these satisfaction ratings were lower than those for other interventions. These findings are similar to those found in previous studies (Costa et al., 2015). Clinical psychologists are often seen as arbiters of who has access to gender affirming intervention and when (Bockting et al., 2004; Davies et al., 2013). Many of the people in this sample reported feeling clear about what they wanted (in terms of medical and surgical intervention) and may have seen the requirement to meet with a clinical psychologist as a barrier to this.

The aim of psychological support at GIDS is to provide a non-judgemental therapeutic environment in which to support young people to ameliorate any behavioural, emotional, and relationship difficulties associated with their gender identity difficulties. Support, problem solving, communication and acceptance, from therapists and parents/carers, can enhance a young person's understanding

of their identity; help them to fully consider the choices available to them; and allow time for exploration and self-acceptance of any number of authentic gendered selves – in identity and/or expression (Costa et al., 2015; Hidalgo et al., 2013). But psychologists are also required to write letters of referral to endocrinologists and surgeons; and the ‘gatekeeping’ role of psychologists may make it difficult to establish a trusting therapeutic relationship between therapist and client, which constitutes a barrier to client satisfaction (Bockting et al., 2004). The gatekeeper role may also prevent clients from feeling able to fully disclose the full range of their experiences, fears and wishes. For example, they may believe that presenting as non-binary, more curious, or more gender fluid may mean they will not be put forward for medical intervention as quickly as if they would if they presented in a binary way (Eyssel et al., 2017). Importantly, this may prevent young people from fully engaging in support that could be extremely valuable (i.e. not with a goal of dissuading people from physical intervention, but to support them through the process, and help them fully engage in a process of understanding and exploring the complexities involved).

As gender identity and expression continues to evolve in a non-binary way (Eyssel et al., 2017), and in a world that largely still views gender as binary, there could be an even greater role for clinical psychologists to play in assisting young people to explore their gender identity, navigate their coming out process, and consider complex decisions about physical interventions. With so many more trajectories possible (within a non-binary view of gender), it is important to reduce the barriers to engagement with psychological support wherever possible, and client satisfaction in this area should be continually assessed (Bockting et al., 2004).

The highest levels of dissatisfaction with the intervention process were with regards to the timings and length of process of interventions, with a large majority of participants stating that the process took too long and that interventions were accessed too late. There are no previous studies in adolescents or young adults with which to compare these findings. An earlier earlier UK study on satisfaction with two adult gender identity clinics found higher satisfaction rates, with 52% of clients being pleased or very pleased with the wait

time for the first appointment (Davies et al., 2013), but a lot has changed in the past 5-6 years since this data was collected (in terms of increasing numbers of referrals), and frustration with waiting times is now well known and documented in gender identity services in the UK and overseas (Ellis et al., 2015; Eyssel et al., 2017).

The Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (Coleman et al., 2012) state that adolescents are eligible for puberty suppressing hormones once pubertal changes have begun; for cross-sex hormones at age 16 (although increasingly the start depends on the duration the person has been taking hormone blockers and the psychological wellbeing of the adolescent; Cohen-Kettenis & Klink, 2015); and for genital surgery at 18 (if person has lived continuously for 12 months or more in the gender role congruent with their gender identity). However, the age at which the young people in the sample obtained these interventions were much later than this (i.e. 16.5 years for hormone blockers, 18.0 years for cross-sex hormones, 20.0 years for top surgery, and 21.0 years for bottom surgery). We do not know definitively why; but the current sample highlighted multiple barriers to accessing services (and physical intervention), many of which are supported by the literature; these include a general lack of services, the rising numbers of referrals to existing services (increasing wait times), appointments being rescheduled or referrals being delayed due to staff leaving or administrative errors, and a lack of specialists in the field (Davies et al., 2013). The current waiting time for the GIDS is 14 months, and for the CCGIC it is also 14 months. The findings in the current study suggest that the long waiting times and delays to intervention due to waiting times were experienced as particularly distressing to some. More resources and specialists in the field, and greater awareness of gender diversity (within schools, communities, and organisations), are much needed.

People who had not taken hormone blockers were largely dissatisfied with their decision not to take hormone blockers, their level of involvement with the decision, and with the information/advice received from clinics. Much of the dissatisfaction related to the long waiting times and delays to accessing intervention. By the time they reached services, many (incorrectly) thought or

were told it was too late for them to take hormone blockers. Adolescents who have matured physically, but who are not ready to make a decision about cross-sex hormones can use hormone blockers to inhibit unwanted physical functions, such as menses in assigned females and erections in assigned males (Cohen-Kettenis & Klink, 2015). Furthermore, hormone blockers can also be used to induce a hypogonadal state prior to starting cross-sex hormones, which means cross-sex hormones can be given in lower doses than ordinarily needed to suppress endogenous sex steroid production (Cohen-Kettenis & Klink, 2015). It seems prudent that young people have access to this information while they are on the waiting list for GIDS, but not necessary for those waiting for the CCGIC as adult services do not titrate cross-sex hormones the way paediatric services do.

With regards to post-surgical hormone advice, the vast majority of people (almost 90%) who had undergone bottom surgery agreed or strongly agreed they were satisfied with the post-operative hormone advice they had received. However, less than half of those who underwent top surgery (all AFs) agreed or strongly agreed that they were satisfied with the post-operative hormone advice they received. The lower satisfaction rates in those who underwent top surgery could reflect the diversity of the professionals involved, and perhaps it is not well coordinated. However, the numbers of people who had surgical intervention are small and so caution must be taken in interpreting the findings.

Due to the differing socio-cultural contexts young trans people grow up in, the findings from the current study can only be generalised to young British trans people. It would be beneficial to replicate the study in other countries to see if the patterns and observations are similar.

4.4.4.2. Reflections on previous decisions.

When asked if any previous decisions would be different a minority (14.7-32.8%) across the interventions, said yes. A majority of those who said yes made reference to wishing to have started interventions sooner, particularly hormone blockers, but also cross-sex hormones, surgery and counselling/therapy. As mentioned previously, delays to interventions can arise for many different reasons, and this is a useful area to focus on in future research. Two people

spoke about how their understanding of gender changed over time, and cited this as the reason why some of their decisions about interventions might be different. Regret is not a word they used, nor would it be an accurate way to describe their reflections. These findings support the emergence of a more nuanced and less binary conceptualisation of gender identity, and point to the complexities of how people reconcile their gender identity with their physical body (Steensma et al., 2011).

4.4.5. Research Question 4: What are the Longer-Term Outcomes for the Former GIDS attendees?

4.4.5.1 Gender identity and body image. The majority of the sample were satisfied with their gender identity, and majority were somewhere between dissatisfied and neutral with their body image. Previous studies in a cohort of Dutch young adults found that body image difficulties persisted through puberty suppression, but remitted after taking cross-sex hormones and undergoing gender affirming surgery (de Vries et al., 2014). However, the Dutch study was a prospective follow-up study of young adults at particular times post-intervention; and thus it is difficult to draw direct comparisons with the finding of the current study, which may have been an artefact of the cross-sectional nature of the study (i.e. in that many participants were only part way through their intervention journeys). Nevertheless, the pattern of responses do appear to bear on the semi-disjunction between the social-cognitive framing of gender, and the material reality of an embodied experience (e.g. a transman may be happy with his masculine gender identity, yet feel that his body is a poor match to an ideal he happens to hold). This is a potentially interesting area for further research. Furthermore, AMs reported greater satisfaction with their body (in relation to their gender) than AFs, but the effect size was small so the clinical relevance of this is questionable, and the numbers/sample size are also small so interpretation warrants caution.

4.4.5.2 Psychological wellbeing. The majority of the sample reported average levels of wellbeing. Compared to the average scores of the validation sample (population sample median = 51; student sample median = 50; Tennant et al.,

2007b), the current sample was only slightly lower in wellbeing (median = 48) but samples from both studies were all in the average range (40-59). While the measure was useful in providing a broad measure of wellbeing in the current sample, it is generic. Development of a trans-specific wellbeing measure could be warranted given the unique factors that have the potential to contribute to wellbeing in this population.

4.4.6. Research Question 5: What Impact do Interventions Have on body image and wellbeing?

I originally intended to look at the impact of the different interventions on wellbeing and body satisfaction, as this would have been useful in determining whether some interventions, or combination of interventions, had a greater impact on body image and wellbeing than others. Unfortunately there were not enough numbers in the sample to do this. Initially I decided to combine individual therapy, group sessions and family therapy to make a 'psychological intervention' variable; combine hormone blockers and cross-sex hormones to make a 'medical intervention' variable; and combine top and bottom surgery to make a 'surgical intervention' variable. However, after considering the conceptual variation within the psychological intervention category, I decided against this. The focus, content, frequency and length of sessions vary widely across intervention type and service, so conceptually, it did not feel appropriate to create and analyse the impact of a combined psychological intervention category.

The positive association between surgical intervention and body image and wellbeing is congruent with previous research in adults (Owen-Smith et al., 2018). However, there are a number of factors to consider that mean caution should be taken when interpreting these findings. First, it was not possible to calculate the interactions between medical and surgical intervention as no-one in the sample had undergone surgical intervention but not taken cross-sex hormones. This finding makes sense in light of the staged approach to intervention taken at the GIDS, whereby reversible treatments are provided before irreversible treatments (Coleman et al., 2012; Delemarre-van de Waal & Cohen-Kettenis, 2006; Hembree et al., 2009, 2017). However, as illustrated by one of the participants

(who self-identified as partly a man, partly a woman), due to increased variation in the ways people identify, intervention pathways may not always follow this linear, staged approach (i.e. this participant wanted to consider hormone blockers as a long-term treatment, not cross-sex hormones, but still wanted to have top surgery). Not being able to determine whether there were any interaction effects, means caution must be taken when interpreting the main effects of medical and surgical interventions on body image and wellbeing.

Second, the sample size calculations suggested there was not enough people in the groups to detect a significant effect (should one exist to detect), providing another reason for being tentative when interpreting the observed effects. Third, the effect sizes and differences in body image and wellbeing between groups were small, and all still within average range, and thus may not be clinically relevant. Future longitudinal studies, with much larger sample sizes and with people who have completed their intervention journeys, are needed in order to draw more definitive inferences about how interventions impact body image and wellbeing,

4.2. Strengths and Limitations of the Research

The use of an online questionnaire represents a strength of the current study as it potentially reduced interviewer bias, item non-response/missing data due to skipping errors, minimized data transcription and transfer errors, and offered a high degree of privacy and anonymity, which likely led to increased self-disclosure and less social desirability bias (De Leeuw, Hox, & Kef, 2003). The questionnaire format relies on self-report data, which can be subject to bias due to systematic misreporting (e.g. over reporting of normative behaviour and under reporting of stigmatized behaviour due to social desirability) or forgetting. However, various techniques have been shown to reduce socially desirable responding, including self-administration and assurances of anonymity and confidentiality (Tourangeau & Yan, 2007). Due to the steps taken to reduce socially desirable responding, it is unlikely that misreporting made a substantial contribution to the results.

The use of a quantitative online questionnaire was appropriate as facilitated the collection of data that answered the research questions. However, without context, much information is missing. For example, we do not know about experiences prior to referral, the existence of comorbidities, experiences at school and at home, levels of parental support etc., all of which are critical in providing a comprehensive picture of young people's experiences. The inclusion of comment boxes, and text that encouraged people to provide context to their answers was a strength of this questionnaire as it provided valuable contextual information to the quantitative data. While people often skip past comment boxes in questionnaires, the high response rate in the text boxes of this study suggests that people wanted to be heard and had a lot to say.

As with all cross-sectional data, it was not possible to make causal inferences from the data (e.g. with respect to associations between stage/type of gender affirming intervention and body image satisfaction or wellbeing). However, the main aim of the study was to determine the intervention pathways chosen by the ex-GIDS clients and their satisfaction with the intervention process, and the current questionnaire was well-suited for these purposes.

The response rate (24%) was on the lower (but acceptable) end for survey research (Hess, Rossi Neto, Panic, Rübben, & Senf, 2014). However, in the context of the population of interest, the response rate was considered an achievement. Historically, trans-identified people have had a difficult relationship with psychology/psychologists, due to the historic (and ongoing) pathologising of gender identity; and studies indicate that trans individuals can be distrusting of trans-related research in that it may result in reinforcing pathological perspectives on trans identities (Eyssel et al., 2017; Richards, Barker, Lenihan, & Iantaffi, 2014; Tebbe & Budge, 2016); and some people may have had unresolved issues with services due to long waitlists and delayed access to intervention (Davies et al., 2013). None of the population of interest had any ongoing contact with GIDS and many would have had no further contact with the CCGIC either; after transitioning it is common for people to move away from the area to avoid people who had known them in their gender assigned at birth (Khoosal, Grover, & Terry, 2011).

Multiple efforts were made to maximise the response rate, including piloting the questionnaire for length and language acceptability, offering an incentive to participate, ensuring anonymity, informing participants of the approximate completion time, including a progress bar, using skip logic to cut down the completion time, offering to send a summary of the results to participants, and extending the duration of the survey's availability. Nevertheless, the lower response rate may have introduced non-response bias, which is variation between the responses of people who were sent survey invites and the responses of the actual respondents. This type of bias is usually created by refusals to participate and/or an inability to reach potential respondents. Unfortunately one cannot know about that which one does not know, and that is a limitation of any research where there are non-responders. The sample was broadly representative of the population in terms of age and assigned gender, but caution should be taken in interpreting the findings due to not knowing anything about those that did not respond. The recruitment is set to continue to the end of 2018, which should increase the response rate; and the study may also be opened up to ex-GIDS clients who were referred to other adult clinics throughout England, which will likely increase the sample size considerably.

Participants were asked to estimate the age they first became aware of a difference between the gender they were assigned at birth and their expressed/experienced gender. In recognition that this might be a difficult question to answer, a text answer format was provided. During the analysis of the data it became apparent that people seemed to want to answer the question in two ways – 1. When they first became aware of a difference themselves, and 2. When they first had the language to be able to talk about it with others. Future research should consider this. Furthermore, data collected about early childhood thoughts, feelings and behaviours are subject to potential recall bias, which is why it is important for future studies to explore these factors in prospective longitudinal studies.

Satisfaction with gender identity and body image were measured using a single item question – 'In general, how do you feel about the following aspects of yourself? 1. Your gender identity, and 2. Your body in relation to your gender

identity. Participants could answer with 'very satisfied', 'satisfied', 'neither satisfied nor dissatisfied', 'dissatisfied', 'very dissatisfied', and 'I prefer not to say'. It might have been preferable to use standardised measures of gender dysphoria and body image, such as the 12-item Utrecht Gender Dysphoria Scale (UGDS), and the 30-item Body Image Scale (BIS). However, using these standardised measures was prohibitive, because they would have added considerable length to a questionnaire that was already quite long, and doing so may have increased the participant drop-out rate (which was quite low in the current study). Also, the findings involving gender identity and body image in the current study, approximated findings found in previous studies that had used more comprehensive, standardised measures. The current study is not an outcome study; it is a cross-sectional snap-shot with the primary aim of capturing the intervention pathways of young people referred to an adult gender identity clinic. With that in mind, the use of a single item measure about gender identity and body image was deemed appropriate to address the broad research questions of the current study.

The relatively small sample size ($N = 72$) prevented running inferential statistics that would have allowed predictions to be made. However, given that the study was the first of its kind, the research was in many ways exploratory, and as such, it is prudent to first know what it is you are looking at before you start attempting to make predictions. In an attempt to work around the small sample size (and the corresponding small numbers in the cells), interventions were combined to make intervention types (e.g. hormone blockers and cross-sex hormones were combined to create 'medical interventions' and top and bottom surgery were combined to create 'surgical interventions'). While analysis of each individual intervention (e.g. cross-sex hormones or top surgery) would have been more informative in terms of knowing how they impact wellbeing and body image, the existing questions were adequate in capturing the extent to which interventions (more broadly) impact wellbeing and body image.

The study sample ($N = 72$) constitutes a select group, within a select group ($N = 365$ young people referred from the GIDS to CCGIC), and therefore the findings have limited generalisability. These data describe a proportion of young adults

who wanted to, and were able to, access services providing support for gender dysphoria and gender affirming medical/surgical interventions. These results may not generalise to all who access support, or to gender diverse young adults who are not receiving trans-related care, and who do not wish to transition with the use of cross-sex hormones or surgery.

4.3. Reflections of the Researcher

I was initially drawn to this area of study because of my own experiences, and exploration of my gender identity as a pre-pubescent child; and my later coming out as a gay woman. At around the age of seven or eight I held a strong desire to *be* a boy (I did not feel I *was* a boy). For several years, I dressed in boys clothes, had a short haircut, sometimes used a boy's name, and had a clear preference for activities stereotypically deemed 'boy's activities' (i.e. playing football, play fighting, climbing trees, jumping off ramps on bikes, having mud fights etc.). I grew up in a family and community that accepted me as I was, and I do not ever recall feeling self-conscious about my 'cross-gender' behaviour and preferences. Just after puberty, I began to strongly identify as a girl, and disliked being mistaken for a boy. I grew my hair long and started wearing 'girl's clothes'. Shortly after that, I had my first experience of same-sex attraction, and in my early 20s I came out as gay. I grew up in the 1970s/80s, and wonder, if I had a grown up today, would I have felt as comfortable to explore my gender identity as I did back then? Or would people have 'rushed in', asked questions about my gender identity, and referred me to a gender identity clinic? As a child, I was never discouraged from or made to feel ashamed of exploring my gender identity, and (as research suggests) I believe this was part of me developing my own identity.

So my interest in this area pertains very much to an interest in how families, societies, and cultures frame and constrain people's experiences and expressions of their own gender (across the lifespan). As a (gay) woman, I am acutely aware of how societal expectations and sanctions have constrained my ability to express my gender identity. Even now, as comfortable as I am with my sexuality, my outward expression of my gender identity will, at times, depend on where I am and who I am with. So it is with that knowledge and experience that I

wonder about the stigmatizing context that society creates, and how it might give rise to the dysphoria felt by some gender diverse young people. If families, societies and cultures had less rigid gender binaries (i.e. did not sanction people so heavily for challenging/subverting gender norms), would people (with and without gender identity concerns) feel more able to express their gender in whichever way they choose? And in the context of gender affirming intervention, would we see fewer requests for intervention?

As the research project began to take shape, I became conscious of language and the power it gave me, as the researcher, to frame the research in a particular light. I also became aware that I was ‘working’ with a population who have (historically) had a difficult relationships with clinical psychology/ psychologists due to the historical (and ongoing) pathologising of gender identity; and that many had felt let down by previous researchers due to personal and political agendas fuelling problematic and potentially damaging writing and research without reflecting on how it might impact those being written about (Davies et al., 2013; Eyssel et al., 2017; Richards et al., 2014; Tebbe & Budge, 2016).

Although quantitative research is often seen as ‘objective’, in that it deals with ‘facts’ and figures, the language the author uses can position people/the data in a particular light to fulfil a particular agenda. I hoped that by being mindful and attentive to language, including as much of the ‘voices’ of the participants as possible (albeit from text box data), and using supervision well, and I could produce a piece of research that the participants would feel accurately represented and benefitted them. However, in future projects, I would prefer to work in complete partnership with people from the trans-community; making service-users a more integral part of the entire research process (from design and data collection to analysis and dissemination). I feel this more strongly than I have in previous research projects with cis-gender populations.

4.4. Implications and Recommendations

4.4.1. Implications for Clinical Practice

In a climate where patients/clients are increasingly seen as consumers of healthcare, patient/client satisfaction has become a key indicator of quality and success, and one that is integral to evolving relationships between services users and clinicians (Bockting et al., 2004). Measurement of client experiences and satisfaction provides an opportunity for reflection on and improvement of care. Timely access to medical and surgical interventions is critical to the wellbeing of some trans people, and the palpable frustration regarding waiting times and delays to support and intervention found in the current study are already well known and documented in gender identity services in the UK and overseas (Davies et al., 2013; Ellis et al., 2015; Eyssel et al., 2017). Waiting times have risen in recent years (Davies et al., 2013), and are set to continue rising. Recommendations and measures that could be implemented to address long wait times and reduce associated distress include:

- Increasing funding for existing and new satellite services
- Increased training of specialists
- Providing appropriate training to other health professionals (i.e. clinical psychologists working in CAMHS, IAPT and school settings, and GPs). A large number of gender diverse young people will never desire or seek medical intervention, and therefore providing training to other health professionals will make support more accessible and free up GI clinic staff to support clients with a higher level of need, and those who do wish to pursue medical and surgical intervention
- Providing trans-awareness training more broadly to all professionals who work with young people (e.g. teachers, social workers, support/youth workers etc.)
- Incentivise existing professionals to increase retention of current specialists
- Implement routine measures of service quality and client satisfaction regarding waiting times
- Increase the ways in which people on the waiting list can contact the clinic (i.e. email, phone, online form etc.). The adult gender identity clinic in Nottingham have a support line that is run by Gendered Intelligence (a

non-profit community interest company whose aim is to increase public understanding of gender diversity), which is a model that could be replicated

- Increase the number of resources available to those on the waiting list (i.e. support groups, mentors, information on networks of counsellors and therapists with further education and training in gender identity issues etc.)
- Set up a user-group advisory board to improve partnership with the local trans community (Eyssel, 2017)

While the satisfaction levels for psychological support were good for two thirds of the sample, there is room for improvement for the remaining third. In line with the WPATH Standards of Care (Coleman et al., 2012) a clinical psychologist referral is currently needed in order for young people to access medical and surgical intervention, which is why clinical psychologists are often seen as arbiters of who gets access to medical and surgical intervention and when (Bockting et al., 2004; Davies et al., 2013). Many trans people take issue with the perceived need for someone other than themselves to decide whether they are eligible medical and physical intervention (Bockting et al., 2004); and although it is designed to promote quality of care, this gatekeeping role can create an inherent barrier to client satisfaction by making it difficult to establish a trusting therapeutic relationship between therapist and client; without which it is difficult to set and achieve therapeutic goals (Bockting et al., 2004). Furthermore, the gatekeeping role might prevent young people from speaking openly and honestly about their thoughts, feelings and experiences due to the perceived impact it might have on their access to medical and surgical intervention (Ellis et al., 2015). Not only does this represent a barrier to satisfaction, but importantly, it represents a barrier to people fully engaging in a process of understanding and exploring all the complexities involved, and of receiving much needed support throughout the transition process. Recommendations and measures that could be implemented to improve client experience of, and satisfaction with, psychological support could include:

- Separating assessment from support (i.e. providing psychological support that is not linked to assessment and referral for medical and surgical intervention)
- Setting up a trans community advisory board (involving former clients who have experienced the process) to inform young people, early in the process, about what to expect from psychological support (Bockting et al., 2004)
- Providing continuing professional development (CPD) training to deepen clinicians' knowledge of non-binary gender identities (and how to work effectively with this population in the context of medical and surgical intervention)
- Implementing ongoing quality improvement measures to explore the gatekeeping role and assess how it can be managed within therapy to facilitate a positive therapeutic outcome
- Providing high quality supervision where clinicians can reflect on the complexities of, and how to balance (personally and professionally), the dual roles of 'gatekeeper' and therapist
- Exploring with service-users what people want from psychological support, in terms of timing, content, frequency and duration
- Implementing a formal mechanism by which clients can provide feedback about psychological support that will be actively responded to and monitored over time (Bockting et al., 2004)

4.4.2. Implications for Research

The study identified the weighing of risks and benefits of medical and surgical intervention as a key factor that influenced people's decisions about interventions. Unfortunately, we do not know how participants assessed the risks and benefits of gender affirming interventions, or what sources they used to make these evaluations. Studies suggest that risk assessments are often driven by emotions rather than facts (Ropeik & Clay, 2002). Effectively communicating risk to patients is a key part of insuring that consent is informed (Paling, 2003), but many doctors do not have adequate training in how to effectively communicate risk information to patients (Paling, 2003). Further qualitative research is needed to thoroughly

explore that ways in which gender diverse people evaluate the risks associated with medical and surgical intervention, and the ways in which health professionals involved in trans-related healthcare communicate risk information to patients. This information could be usefully incorporated into written materials, online information sources, and risk-communication training for professionals. Questions for future research might include:

- How do gender diverse people conceptualise and evaluate the risks, challenges and benefits of medical and surgical interventions?
- What sources of information do people use to make these evaluations?
- When is the optimum time for people to receive risk information?
- How do different professionals involved in trans-related healthcare conceptualise the risks involved in medical and surgical intervention?
- When and how do different professionals involved in trans-related communicate risk information to clients?

The study identified online sources of information as another a key factor that influenced people's decisions about gender affirming interventions. Although some NHS websites were cited as being influential online sources of information when making decisions about interventions, the majority of online sources cited were largely unregulated websites (i.e. blogs, photo and video sharing websites, social networking sites, bulletins boards etc.). While these websites might be ideal sources of information on people's transition experiences, due to being unregulated, they may not contain accurate and reliable health information. Increasingly, we are exposed to a huge amount of health information online (Morahan-Martin, 2004), but people often report finding it difficult to know which internet sources to trust (Morahan-Martin, 2004). Further qualitative research is needed to thoroughly explore the nature and content of trans-related health information online. Questions for future research might include:

- Why do people look online for information about gender affirming interventions and related issues?
- What online sources of information about interventions and related issues do people find most helpful and why?

- What types of information can be found on the websites people cite as most helpful?
- What are people's perceptions of the information they find and how to they make assessments about the quality, authority and trustworthiness of the information they find?

Our understanding of experiences and outcomes in adolescent and young adult clinic populations is based on a small number of retrospective and prospective studies, with small sample sizes and short follow-up periods. The current study adds to this small body of literature by exploring intervention pathways and satisfaction with the intervention process. However, due to the aforementioned limitations of the current study, larger scale, prospective, longitudinal studies are much needed as they will facilitate inferences and enable us to draw more definitive conclusions in this population.

4.5. Conclusion

The thesis findings provide a unique contribution to the small body of existing literature on gender diverse adolescents and young adults, and have succeeded in filling some gaps in the literature in this area. The study shows that a higher number of young adults who are referred from child and adolescent services to adult services do pursue (or intend to pursue) the different stages of medical and surgical intervention, and many of those that do are largely satisfied with the intervention process. Despite the various limitations of the thesis, the findings help provide a clearer picture of the intervention pathways and satisfaction of with the process of these young adults; and areas requiring improvement have been highlighted. Taken together, these findings will enable better tailoring of gender identity services for young people, and are an important step towards ensuring that the support and intervention provided meets the needs of this diverse and growing population.

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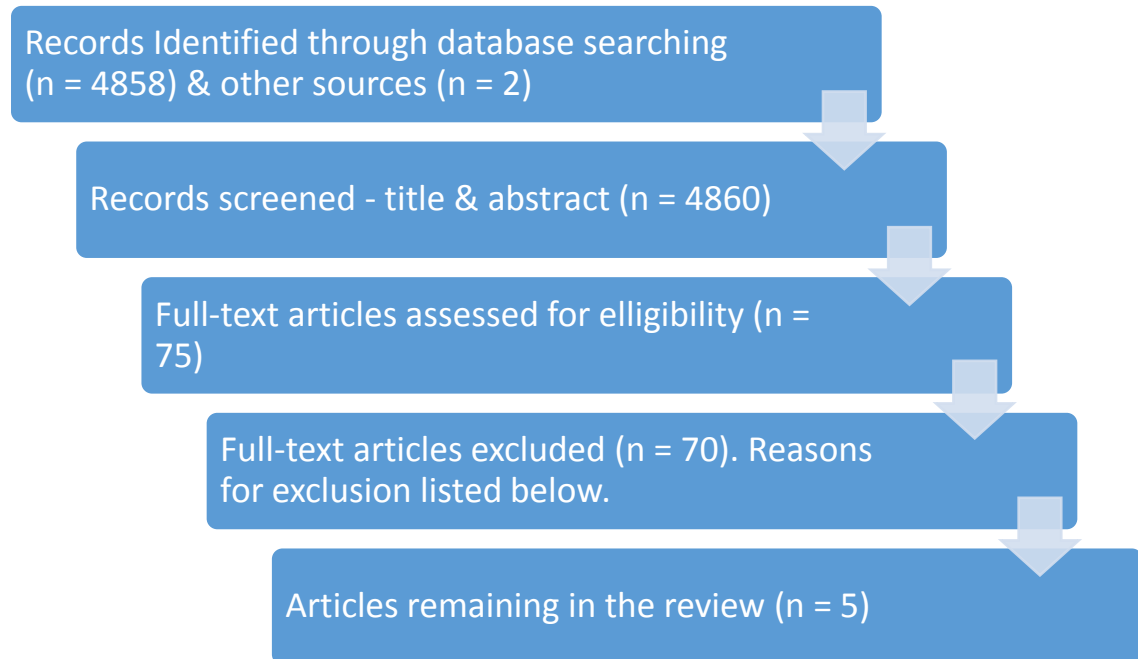
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APPENDICES


Appendix A. Flow chart for literature search



Reasons for exclusion (n = 70):

- 58 = >25 at follow-up
- 10 = no gender affirming intervention received
- 1 = not trans population (mixed population who underwent vaginoplasty)
- 1 = not published in English (published in French)

Appendix B. NHS ethical approval letter (first page)


Health Research
Authority

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

12 October 2017

Dr Lorna Hobbs
Trainee Clinical Psychologist
Camden and Islington NHS
University of East London
Water Lane
Stratford
E15 4LZ

Dear Dr Hobbs

Study title: What Happens to Gender Diverse Young People who are Referred to Adult Gender Identity Services from Child and Adolescent Services? A Cross-Sectional Look at Treatment Choices and Outcomes

REC reference: 17/LO/1674

IRAS project ID: 225974

The Research Ethics Committee reviewed the above application at the meeting held on 02 October 2017. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact hra.studyregistration@nhs.net outlining the reasons for your request. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Appendix C. Sponsorship and indemnity letter (first page)



18th May 2018

Dear Lorna,

Project Title:	What Happens to Gender Diverse Young People who are Referred to Adult Gender Identity Services from Child Adolescent Services? A Cross-Sectional Look at Treatment Choices and Outcomes
Researcher(s):	Lorna Hobbs
Principal Investigator:	Lorna Hobbs

I am writing to confirm that the application for the aforementioned NHS research study reference 17/LO/1674 has received UREC ethical approval and is sponsored by the University of East London.

The lapse date for ethical approval for this study is 18th May 2022. If you require UREC approval beyond this date you must submit satisfactory evidence from the NHS confirming that your study has current NHS R&D ethical approval and provide a reason why UREC approval should be extended.

Please note as a condition of your sponsorship by the University of East London your research must be conducted in accordance with NHS regulations and any requirements specified as part of your NHS R&D ethical approval.

Please confirm that you will conduct your study in accordance with the consent given by the Trust Research Ethics Committee by emailing researchethics@uel.ac.uk.

Please ensure you retain this approval letter, as in the future you may be asked to provide proof of ethical approval.

With the Committee's best wishes for the success of this project.

Appendix D. Information sheet

Information Sheet

Title of Project: What Happens to Gender Diverse Young People who are Referred to an Adult Gender Identity Service from a Child and Adolescent Service? A Cross-Sectional Look at Treatment Choices and Outcomes

This study has been approved by the NHS Research Ethics Committee.

Project ID Number: 225974

Protocol reference number: Version 2; Date 10.11.2017

- **We would like to invite you to take part in our research study.**
- **Before you decide whether to take part we would like you to understand why the research is being done and what it would involve for you**
- **Part 1: Tells you about the study and what will happen if you choose to take part**
- **Part 2: Gives you more detail about the conduct of the study**
- **Please ask if there is anything that is not clear (by sending email to u1534920@uel.ac.uk)**

Part 1

Why are we doing the study?

There has been a substantial increase in the number of people seeking assessment, support and treatment from gender identity services for children and young people. However, there has been very little research in the UK on the longer-term outcomes and journeys of gender diverse young people. In order to adequately meet the needs of young people in this area, it is important to explore these longer-term outcomes.

Why have I been chosen?

We have written to everyone who was discharged from the Gender Identity Development Service (GIDS) between 2011 and 2016 and referred to Charing Cross adult gender identity clinic, and invited them to take part in the study by filling out a questionnaire about their treatment choices and longer-term outcomes since leaving GIDS.

Do I have to take part?

No. It's up to you to decide whether or not to participate in the research. Your usual health care will not be affected by whether you choose to take part or not as your participation will be completely anonymous. Take as long as you need to reach a decision, and please do talk to others about the study if you wish. If you do decide to take part, you will be asked to sign an online consent form.

What will happen to me if I take part?

If you decide to take part in the questionnaire study you will be directed to an online questionnaire that will ask you about the decisions and choices you've

made and outcomes since leaving the Gender Identity Development Service (GIDS).

Will I benefit from taking part?

Reflecting back on your experiences can be an informative and thought provoking experience, and as a thank you for your input in the study, each participant who completes a questionnaire will be invited to enter a prize draw to win a £100 Amazon voucher. Entry into the draw is completely optional.

Are there any risks involved?

We hope that you will find reflecting on your experiences an informative and thought provoking experience. However, you may find this process difficult, or upsetting and so will be provided with a list of support services you can contact should you feel you need some support extra support.

What happens when the study ends?

The results of this study will be written up and submitted for publication in academic journals and presented at conferences. We hope the findings will lead to improved services for children and young people.

Will my GP and/or clinic care team know I am in the study?

No (only if you choose to tell them yourself).

Will the information I give in the study be kept confidential?

Yes. We will follow all ethical and legal guidelines, and all information about you will be handled in confidence. Detailed information on this is given in Part 2.

Can I withdraw from the study once I'm in it?

Yes. You can withdraw from the study at any before the data has been analysed.

Part 2: Detailed information about the conduct of the study

What will happen to the information I provide?

All information about you will be treated confidentially and in accordance with the Data Protection Act 1998. We will keep any personally identifying information (e.g. your email address if you decide to go into the prize draw or wish for a summary of the study results to be sent to you) separate from the rest of the study information about you. Your study data will only be identifiable by a unique participant identification number. All anonymised data will be kept on a password protected file on a password protected computer. Only authorised persons (the research team and the regulatory bodies that monitor researchers in the UK) will have access to your personal data. The information you provide will not be shared with your care team or GP.

What if there is a problem or what if something goes wrong?

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated by members of staff due to your participation in the research, National Health Service or UEL complaints procedures are available to you. Please contact the researcher if you would like more information on this. In the unlikely event that you are harmed by taking part in this study, compensation may be available. If you suspect that the harm is the result of the

Sponsor's (University of East London) negligence then you may be able to claim compensation. After discussing with the researcher, please make the claim in writing to Lorna Hobbs who is the Chief Investigator for the research and who is based at UEL: School of Psychology, The University of East London, Stratford Campus, London E15 4LZ. The Chief Investigator will then pass the claim to the Sponsor's Insurers, via the Sponsor's office. You may have to bear the costs of the legal action initially, and you should consult a lawyer about this.

What will happen to the results of this study?

The results of this study will be written up as a Clinical Psychology Doctoral thesis, and will also be submitted for publication in academic journals and presented at conferences. We hope the findings will lead to improved services for children and young people. We would be happy to send you a summary of the results – if you would like us to do so please enter your emails address in the appropriate box on the consent form.

Who is organising and funding the study?

The study is being run by The University of East London. It is funded by the NHS as part of a Clinical Psychology Doctorate thesis. It is sponsored by The University of East London. The research team are: Dr Lorna Hobbs (Trainee Clinical Psychologist); Dr Kenneth Gannon (Educational Supervisor); and Dr Sarah Davidson (Clinical Psychologist).

Who has reviewed the study?

To protect the interests of participants, all research in the NHS is looked at by an independent group of people, called a Research Ethics Committee. This study has been reviewed and given a favourable opinion by the London Riverside Research Ethics Committee (REC reference: 17/LO/1674. IRAS project ID: 225974).

Is there an independent contact point where I can get general advice about taking part in research?

Yes. INVOLVE is a national advisory group that supports greater public involvement in NHS, public health and social care research. They provide advice and information on public involvement in research. You can find more information on their website: www.invo.org.uk or you can contact them at: INVOLVE, Wessex House, Upper Market Street, Eastleigh, Hampshire, SO50 9FD or Telephone: 023 8065 1088.

Is there a contact point where I can find out further details about the study?

Yes. If you have any questions or would like more information please contact Lorna Hobbs at _____

Appendix E. Consent form

Consent Form

(Please hover over and click on each answer)

I confirm that I have read and understood the information sheet on the previous page.

I have received satisfactory answers to any questions and been told who to contact in the event of any concerns or problems relating to the research (i.e. Lorna Hobbs at [REDACTED]).

I understand that data collected during the study may be looked at by individuals from authorities that regulate research. I give permission for these individual to have access to my data.

I understand that the research will be published in a report but that it will not be possible to identify any participants in any publications.

I understand that I am free to withdraw from the study, at any time before the data has been analysed, without having to give a reason.

I agree to take part in the study.

Summary of the Results (optional)

If you would like us to send you a summary of the results once the study is finished please provide your email address below **(this information will be stored separately, and will not be linked in any way to the other data you provide).**

Prize Draw (optional)

If you would like to be entered into a prize draw to win a £100 voucher for the store of your choice please provide your email address below **(this information will be stored separately, and will not be linked in any way to the other data you provide).**

Future Research (optional)

If you would like to be contacted to participate in any future research projects please provide your email address below **(this information will be stored separately, and will not be linked in any way to the other data you provide).**



Appendix F. Invitation letter to participate in the study



University of East London
Water Lane, Stratford,
London, E15 4LZ

[Enter date]

Hello,

My name is Lorna Hobbs and I am a Clinical Psychology Doctoral Researcher at the University of East London. In recent years you were discharged from an NHS child and adolescent clinic in North London. I am writing to you to invite you to participate in a research survey I am conducting. The aim of the survey is to follow-up previous young people who attended the clinic to see if the advice, treatment, and decisions they made have been helpful in the longer-term.

I would be extremely grateful for your help and participation in the survey. Little is currently known about the longer-term outcomes of the young people who attended the clinic. With your input we will gain a better understanding of these longer-term outcomes and this will enable the service to better tailor support for the increasing number and diversity of young people seen at the clinic.

If you would like to participate please follow this link to find out more and to access the online questionnaire [web address]. The questionnaire will take approximately 10-15 minutes to fill out. Your responses will be completely

anonymous (as no identifying information is collected), and any clinicians you see will be unaware of your participation in this research (unless you speak to them about it yourself). As a thank you for participating, you will be entered into a prize draw to win £100 worth of Amazon vouchers. Your participation is very much appreciated and valued.

If you have any questions at all please do not hesitate to contact me via email at _____.

Kind regards,

Lorna Hobbs

Appendix G. Questionnaire

On the electronic version of the questionnaire the option 'I do not wish to answer' was available for each question. Note: The actual format differed in the online questionnaire as there were skip patterns embedded into the questionnaire to avoid people having to read information/questions that were not relevant to them.

1. Age_____
2. What was your assigned gender at birth?

3. Age you first became aware of a difference between your assigned gender and your gender/gender identity_____
4. Age you were first referred to the Gender Identity Development Service (GIDS)_____
5. Age you started socially transitioning _____
6. How would you describe your gender identity?
 - a. I identify as a man
 - b. I identify as a woman
 - c. I identify as a trans-man
 - d. I identify as a trans-woman
 - e. I identify partly as a man, and partly as a woman
 - f. I identify neither as a man or a woman
 - g. I identify as non-binary/gender fluid or similar
 - h. I don't know what my gender identity is (yet) or I am questioning my gender identity
 - i. Other (please specify)_____
7. Ethnicity
 - ☐ White British/Irish
 - ☐ White other
 - ☐ Black/African/Caribbean/Black British
 - ☐ Asian/Asian British
 - ☐ Mixed/multiple ethnic groups
 - ☐ Other (please describe)_____
- ☐ Rather not say

8. Relationship status

- ☐ Married/civil partnership
- ☐ Living with partner
- ☐ In a relationship(s)
- ☐ Single
- ☐ Divorced
- ☐ Widowed
- ☐ Other (please describe)

☐ Rather not say

9. Employment status (tick any/all that apply)

- ☐ Working (full or part-time)
- ☐ At College or University
- ☐ In training
- ☐ Unemployed
- ☐ Retired
- ☐ Other (please specify)

☐ Rather not say

10. Have you ever received any of the following in relation to your gender diversity?

Counselling/therapy (tick all that apply)

Individual counselling/therapy sessions ☐

Where did you attend the individual counselling/therapy sessions?

☐ GIDS

Approximate number of sessions: 1-6 ☐ 6-12 ☐ 12-18 ☐ 19+ ☐

Attending this type of counselling/therapy helped me to make decisions about my transition process (strongly agree, agree, neither agree/disagree, disagree, strongly disagree)

☐ Adult Gender Identity Clinic

Approximate number of sessions: 1-6 ☐ 6-12 ☐ 12-18 ☐ 19+ ☐

Attending this type of counselling/therapy helped me to make decisions about my transition process (strongly agree, agree, neither agree/disagree, disagree, strongly disagree)

☐ Other NHS service

Approximate number of sessions: 1-6 ☐ 6-12 ☐ 12-18 ☐ 19+ ☐

Attending this type of counselling/therapy helped me to make decisions about my transition process (strongly agree, agree, neither agree/disagree, disagree, strongly disagree)

☐ Private

Approximate number of sessions: 1-6 ☐ 6-12 ☐ 12-18 ☐ 19+ ☐

Attending this type of counselling/therapy helped me to make decisions about my transition process (strongly agree, agree, neither agree/disagree, disagree, strongly disagree)

☐ Other _____

Approximate number of sessions: 1-6 ☐ 6-12 ☐ 12-18 ☐ 19+ ☐

Attending this type of counselling/therapy helped me to make decisions about my transition process (strongly agree, agree, neither agree/disagree, disagree, strongly disagree)

Comments _____

Group sessions ☐

Where did you attend the group sessions (tick all that apply)

☐ GIDS

Approximate number of sessions: 1-6 ☐ 6-12 ☐ 12-18 ☐ 19+ ☐

Attending this type of counselling/therapy helped me to make decisions about my transition process (strongly agree, agree, neither agree/disagree, disagree, strongly disagree)

☐ Adult Gender Identity Clinic

Approximate number of sessions: 1-6 ☐ 6-12 ☐ 12-18 ☐ 19+ ☐

Attending this type of counselling/therapy helped me to make decisions about my transition process (strongly agree, agree, neither agree/disagree, disagree, strongly disagree)

☐ Other NHS service

Approximate number of sessions: 1-6 ☐ 6-12 ☐ 12-18 ☐ 19+ ☐

Attending this type of counselling/therapy helped me to make decisions about my transition process (strongly agree, agree, neither agree/disagree, disagree, strongly disagree)

☐ Private

Approximate number of sessions: 1-6 ☐ 6-12 ☐ 12-18 ☐ 19+ ☐

Attending this type of counselling/therapy helped me to make decisions about my transition process (strongly agree, agree, neither agree/disagree, disagree, strongly disagree)

☐ Other _____

Approximate number of sessions: 1-6 ☐ 6-12 ☐ 12-18 ☐ 19+ ☐

Attending this type of counselling/therapy helped me to make decisions about my transition process (strongly agree, agree, neither agree/disagree, disagree, strongly disagree)

Comments _____

Family sessions ☐

Where did you attend the family sessions (tick all that apply)

☐ GIDS

Approximate number of sessions: 1-6 ☐ 6-12 ☐ 12-18 ☐ 19+ ☐

Attending this type of counselling/therapy helped me to make decisions about my transition process (strongly agree, agree, neither agree/disagree, disagree, strongly disagree)

☐ Adult Gender Identity Clinic

Approximate number of sessions: 1-6 ☐ 6-12 ☐ 12-18 ☐ 19+ ☐

Attending this type of counselling/therapy helped me to make decisions about my transition process (strongly agree, agree, neither agree/disagree, disagree, strongly disagree)

☐ Other NHS service

Approximate number of sessions: 1-6 ☐ 6-12 ☐ 12-18 ☐ 19+ ☐

Attending this type of counselling/therapy helped me to make decisions about my transition process (strongly agree, agree, neither agree/disagree, disagree, strongly disagree)

☐ Private

Approximate number of sessions: 1-6 ☐ 6-12 ☐ 12-18 ☐ 19+ ☐

Attending this type of counselling/therapy helped me to make decisions about my transition process (strongly agree, agree, neither agree/disagree, disagree, strongly disagree)

☐ Other _____

Approximate number of sessions: 1-6 ☐ 6-12 ☐ 12-18 ☐ 19+ ☐

Attending this type of counselling/therapy helped me to make decisions about my transition process (strongly agree, agree, neither agree/disagree, disagree, strongly disagree)

Comments _____

Hormone blockers

a. Yes (currently taking them)/Yes (but no longer taking them)/No

b. If no:

I am satisfied with my decision not to take hormone blockers
Strongly agree (1), Agree (2), Neither agree nor disagree (3),
Disagree (4), Strongly disagree (5), NA

Comments _____

c. If yes or no:

I felt involved in the decision-making process about whether or not to take hormone blockers

Strongly agree (1), Agree (2), Neither agree nor disagree (3),
Disagree (4), Strongly disagree (5), NA

Comments _____

The information/advice I received about hormone blockers from the clinic(s) I attended helped me make a decision about hormone blockers

Strongly agree (1), Agree (2), Neither agree nor disagree (3),
Disagree (4), Strongly disagree (5), NA

Comments _____

d. If yes:

Age you first started hormone blockers _____

Where did/do you obtain hormone blockers? (tick all that apply)

- ☐ Child/adolescent gender identity clinic
- ☐ Adult gender identity clinic
- ☐ GP
- ☐ Private clinic

- ☐ Online
☐ Overseas
☐ Other
-

Comments

I am satisfied with my decision to take hormone blockers
 Strongly agree (1), Agree (2), Neither agree nor disagree (3),
 Disagree (4), Strongly disagree (5), NA
 Comments _____

- e. If yes (but no longer taking them):

Age you stopped hormone blockers _____

I am satisfied with my decision to stop taking hormone blockers
 Strongly agree (1), Agree (2), Neither agree nor disagree (3),
 Disagree (4), Strongly disagree (5), NA
 Comments _____

Cross sex hormones

- a. Yes (currently taking them)/Yes (but no longer taking them)/No
 b. If no:

I am satisfied with my decision not to take cross-sex hormones
 Strongly agree (1), Agree (2), Neither agree nor disagree (3),
 Disagree (4), Strongly disagree (5), NA
 Comments _____

- c. If yes or no:

I felt involved in the decision-making process about whether or not
 to take cross-sex hormones
 Strongly agree (1), Agree (2), Neither agree nor disagree (3),
 Disagree (4), Strongly disagree (5), NA
 Comments _____

The information/advice I received about cross-sex hormones from
 the clinic(s) I attended helped me make a decision about cross-sex
 hormones
 Strongly agree(1), Agree (2), Neither agree nor disagree (3),
 Disagree (4), Strongly disagree (5), NA
 Comments _____

- d. If yes:

Age you started cross-sex hormones _____

Where did/do you obtain cross-sex hormones? (tick all that apply)

- ☐ Child/adolescent gender identity clinic
- ☐ Adult gender identity clinic
- ☐ GP
- ☐ Private clinic
- ☐ Online
- ☐ Overseas
- ☐ Other _____

Comments

I am satisfied with my decision to take cross-sex hormones
Strongly agree (1), Agree (2), Neither agree nor disagree (3),
Disagree (4), Strongly disagree (5), NA
Comments

e. If yes (but no longer taking them):

Age you stopped taking cross-sex hormones _____

I am satisfied with my decision to stop taking cross-sex hormones
Strongly agree (1), Agree (2), Neither agree nor disagree (3),
Disagree (4), Strongly disagree (5), NA
Comments

Surgery

a. yes/no

b. If no:

I am satisfied with my decision not to have any surgery(s)
Strongly agree (1), Agree (2), Neither agree nor disagree (3),
Disagree (4), Strongly disagree (5), NA
Comments

c. If yes or no:

I felt involved in the decision-making process about whether or not
to have any surgery(s)
Strongly agree (1), Agree (2), Neither agree nor disagree (3),
Disagree (4), Strongly disagree (5), NA
Comments

The information/advice I received about surgeries from the clinic(s)
I attended helped me make a decision about surgery

Strongly agree(1), Agree (2), Neither agree nor disagree (3),
Disagree (4), Strongly disagree (5), NA
Comments

a. If yes:

What surgery(s) have you had?

1. Top/chest surgery(s)

Age you had this/these surgery(s)? _____

Where did you have this/these

surgery(s)? _____

I am satisfied with my decision to have this/these surgery(s)
Strongly agree (1), Agree (2), Neither agree nor disagree (3),
Disagree (4), Strongly disagree (5), NA

I am satisfied with the quality of the post-op hormone advice I
received? Strongly agree (1), Agree (2), Neither agree nor
disagree (3), Disagree (4), Strongly disagree (5), NA (I didn't
receive any post-op hormone advice).

Comments

2. Bottom/genital surgery(s)

Age you had this/these surgery(s)?

Where did you have this/these

surgery(s)? _____

I am satisfied with my decision to have this/these surgery(s)
Strongly agree (1), Agree (2), Neither agree nor disagree (3),
Disagree (4), Strongly disagree (5), NA

I am satisfied with the quality of the post-op hormone advice I
received? Strongly agree (1), Agree (2), Neither agree nor
disagree (3), Disagree (4), Strongly disagree (5), NA (I didn't
receive any post-op hormone advice).

Speech and Language therapy

- a. Were you offered Speech and Language therapy? yes/no
 - b. If no:
Would you like to have been offered Speech and Language therapy? yes/no
 - c. If yes: Did you have Speech and Language therapy? yes/no
 - d. If no:
I am satisfied with my decision not to have speech & language therapy
Strongly agree (1), Agree (2), Neither agree nor disagree (3),
Disagree (4), Strongly disagree (5), NA
Comments
-

- e. If yes or no:
I felt involved in the decision-making process about whether or not to have speech and language therapy
Strongly agree (1), Agree (2), Neither agree nor disagree (3),
Disagree (4), Strongly disagree (5), NA
Comments
-

The information/advice I received about speech & language therapy from the clinic(s) I attended helped me make a decision about speech & language therapy
Strongly agree (1), Agree (2), Neither agree nor disagree (3),
Disagree (4), Strongly disagree (5), NA
Comments

- f. If yes:
Age you started speech & language therapy _____
How long did you attend speech & language therapy? _____

I am satisfied with my decision to have speech & language therapy
Strongly agree (1), Agree (2), Neither agree nor disagree (3),
Disagree (4), Strongly disagree (5), NA
Comments
-

11. To what extent did the following factors influence the decisions you made regarding your treatment choices? Rating scale 0 (not at all) to 10 (influenced greatly)

- a. Information provided by staff at the Gender Identity Development Service
0 1 2 3 4 5 6 7 8 9 10
- b. Information provided by staff at an adult gender identity clinic
0 1 2 3 4 5 6 7 8 9 10
- c. Information provided by staff at another NHS service (which one?)
0 1 2 3 4 5 6 7 8 9 10
- d. Information from third sector organisations
0 1 2 3 4 5 6 7 8 9 10
- e. Opinions/advice of family members
0 1 2 3 4 5 6 7 8 9 10
- f. Opinions/advice of significant others
0 1 2 3 4 5 6 7 8 9 10
- g. Information on the internet (which sites?)
0 1 2 3 4 5 6 7 8 9 10
- h. Thinking about the risks and benefits of taking hormones and/or having surgeries
0 1 2 3 4 5 6 7 8 9 10
- i. Other (please specify)_____

12. What did you think of the timings of the interventions you had?

- a. Counselling/therapy/groups (n/a, too soon, about right, too late, not sure, other)
- b. Hormone blockers (n/a, too soon, about right, too late, not sure, other)
- c. Cross sex hormones (n/a, too soon, about right, too late, not sure, other)
- d. Chest surgery (n/a, too soon, about right, too late, not sure, other)
- e. Genital surgery (n/a, too soon, about right, too late, not sure, other)
- f. Other surgery (please specify_____)
(n/a, too soon, about right, too late, not sure, other)
- g. Speech & language therapy (n/a, too soon, about right, too late, not sure, other)

Comments

13. What did you think about the length of the process (from the point you were referred)?

- a. Counselling/therapy/groups (n/a, too short, about right, too long, not sure, other)
- b. Hormone blockers (n/a, too short, about right, too long, not sure, other)
- c. Cross sex hormones (n/a, too short, about right, too long, not sure, other)
- d. Chest surgery (n/a, too short, about right, too long, not sure, other)
- e. Genital surgery (n/a, too short, about right, too long, not sure, other)
- f. Other surgery (please specify _____)
(n/a, too short, about right, too long, not sure, other)
- g. Speech & language therapy (n/a, too short, about right, too long, not sure, other)

Comments

14. Which interventions (if any) do you intend to have in the future?

Counselling/therapy/groups

- a. Yes/no/undecided/NA (already had/having counselling/therapy/groups)
- b. If undecided, why? _____
If yes,
- c. What age do you intend to have counselling/therapy? _____
- d. Where do you intend to have counselling/therapy? _____

Comments

Hormone blockers

Yes/no/undecided/NA (already taken/taking)

- a. If undecided, why? _____
If yes:
- b. What age do you intend to start hormone blockers? _____
- c. Where do you intend to get this intervention? (tick those that you are considering)

- ☐ Adult gender identity clinic
- ☐ GP
- ☐ Private clinic
- ☐ Online
- ☐ Overseas
- ☐

Other _____

Comments

Cross sex hormones

Yes/no/undecided/NA (already taking)

- a. If undecided,
why? _____

If yes:

- b. What age do you intend to start cross sex hormones? _____
- c. Where do you intend to get this intervention? (tick those that you
are considering)

- ☐ Adult gender identity clinic
- ☐ GP
- ☐ Private clinic
- ☐ Online
- ☐ Overseas
- ☐ Other _____

Comments

Top/Chest surgery

Yes/no/undecided/NA (already had surgery)

- a. If undecided,
why? _____

If yes:

- b. Specify
type(s) _____

- c. What age do you intend to have this surgery? _____
- d. Where do you intend to have the surgery?

Comments

Bottom/Genital surgery

Yes/no/undecided/NA (already had surgery)

- a. If undecided,
why? _____

If yes:

- b. Specify
type(s) _____

- c. What age do you intend to have this surgery? _____

d. Where do you intend to have the surgery? _____

Comments

Other intervention(s)

Yes/no/undecided

e. If undecided, why? _____

If yes:

f. Specify type(s) _____

g. What age do you intend to have this intervention? _____

h. Where do you intend to have the intervention? _____

Comments

Speech and Language therapy

Yes/no/undecided/NA (already had/having S&L therapy)

a. If undecided, why? _____

If yes:

b. What age do you intend to have speech & language therapy? _____

c. Where do you intend to have speech & language therapy? _____

Comments

15. If you were making decisions about interventions now, would any of your previous decisions about interventions be different? Tick all that apply and please explain how they would be different

☐ Hormone blockers – Yes/No/NA

If Yes, in what way would your decision(s) about Hormone Blockers be different?

☐ Cross sex hormones – Yes/No/NA

If Yes, in what way would your decision(s) about Cross sex hormones be different?

☐ Top/chest surgery – Yes/No/NA

If Yes, in what way would your decision(s) about Top/chest surgery be different?

☐ Bottom/genital surgery – Yes/No/NA

If Yes, in what way would your decision(s) about Bottom/genital surgery be different?

☐ Other (please specify – Yes/No/NA

In what way would your decision(s) be different?

16. How do you feel now about your gender identity? (Very satisfied, Satisfied, Neither satisfied nor dissatisfied, Dissatisfied, Very Dissatisfied)

Comments _____

17. How do you feel now about your body in relation to your gender identity? (Very satisfied, Satisfied, Neither satisfied nor dissatisfied, Dissatisfied, Very Dissatisfied)

Comments _____

18. Below are some statements about feelings and thoughts. Please tick (✓) the box that best describes your experience of each over the last 2 weeks:

- a. I've been feeling optimistic about the future (None of the time/Rarely/Some of the time/Often/All of the time)
- b. I've been feeling useful (None of the time/Rarely/Some of the time/Often/All of the time)
- c. I've been feeling relaxed (None of the time/Rarely/Some of the time/Often/All of the time)
- d. I've been feeling interested in other people (None of the time/Rarely/Some of the time/Often/All of the time)
- e. I've had energy to spare (None of the time/Rarely/Some of the time/Often/All of the time)
- f. I've been dealing with problems well (None of the time/Rarely/Some of the time/Often/All of the time)
- g. I've been thinking clearly (None of the time/Rarely/Some of the time/Often/All of the time)
- h. I've been feeling good about myself (None of the time/Rarely/Some of the time/Often/All of the time)
- i. I've been feeling close to other people (None of the time/Rarely/Some of the time/Often/All of the time)

- j. I've been feeling confident (None of the time/Rarely/Some of the time/Often/All of the time)
- k. I've been able to make up my own mind about things (None of the time/Rarely/Some of the time/Often/All of the time)
- l. I've been feeling loved (None of the time/Rarely/Some of the time/Often/All of the time)
- m. I've been interested in new things (None of the time/Rarely/Some of the time/Often/All of the time)
- n. I've been feeling cheerful (None of the time/Rarely/Some of the time/Often/All of the time)

19. Is there anything else you would like to say?

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE

Appendix H. List of resources for participants



List of Resources

The Beaumont Society – Largest transgender support group in the UK. Offers a 24/7 information line, who can point you in the direction of the best resources for you

- 01582 412220
- www.beaumontsociety.org.uk/

LGBT Helpline – provides listening, support and information via phone or instant messaging

- 1890 929 539 (trans-specific shifts are 6-9pm)
- www.lgbt.ie/our-services/instant-messaging-support-service?gclid=CI7Qh7z54tlCFVIYGwodJkMKIQ

Mermaids – is a support group for trans-identified people aged 19 and under. Their information line is open Monday to Saturday from 3pm till 7pm

- 0208 1234819
- www.mermaidsuk.org.uk

Gendered Intelligence – is a not for profit group that works with the trans community, and those who impact on trans lives. Gendered intelligence specialises in supporting young trans people under the age of 21.

- www.genderedintelligence.co.uk

FTM London – is a support group for transmen and anyone who identifies on the trans-masculine spectrum.

- 07717 140461
- www.ftmlondon.net

[The Queer Youth Network](http://www.lgbtyouth.org) – online forums discussing everything LGBT related.

- www.lgbtyouth.org

The Mix – An online community where you can chat anonymously to other young people about how you're feeling on [their message boards](#).

- www.themix.org.uk/sex-and-relationships/sexuality/young-and-trans-5178.html?gclid=CMHkk8b44tICFRATGwodiPcDng
- Freephone support line 0808 808 4994

If you are in crisis and need help when other services are closed please contact one of the following:

- The Samaritans on 116 123
- Your GP
- Go to A&E
- Contact the emergency services on 999

Appendix I. Study leaflet for adult clinic



Did you attend the Gender Identity Development Service (GIDS) at any time during the last 6 years?

We are interested in hearing about your experiences.

- We are conducting a short online survey of previous GIDS clients to find out whether the advice, treatment and decisions they made have been helpful in the longer-term.
- Your participation is valued, as with your input we will gain a better understanding of the longer-term outcomes of people who attended GIDS, and this will enable better tailoring of services to the increasing number and diversity of young people seen at the clinic.
- Your responses will be completely anonymous, and any doctors or clinicians you see will be unaware of your participation in this research (unless you speak to them about it yourself).
- You will be entered into a draw to win a £100 Amazon voucher
- If you would like to participate and/or have questions about the survey please feel free to contact Dr Lorna Hobbs via email at _____

Appendix J. Participant explanations of 'other' (regarding gender identity)

1. I am a dysphoric female. I don't believe in gender identity
2. I identify both as a 'man' and as a 'trans man'
3. Mostly as a trans man, but sometimes genderless
4. "I am a woman", "I am a trans woman"
5. I don't identify as any specific gender, I have just overcome insecurities and misunderstandings of how I have thought about myself in the past and how that might have made me think I had a female brain or whatever the popular reason is right now. I know I am male

Appendix K. Reasons cited for being undecided about taking hormone blockers in the future (full quotes)

UNSURE – BLOCKERS (8)

1. I am currently taking Oestrogen and will take blockers if it is required to get my hormones to the right levels for transition.
2. Too late for it, as far as I know? Not that any services have been helpful
3. No comments
4. I am eligible for them, if my periods begin to distress me again. But at the moment I feel I can cope with them.
5. not sure if I need blockers with HRT
6. I don't think my adult gic offers them
7. I'm already taking cross-sex hormones and resources seem to have conflicting opinions as to whether or not hormone blockers in addition would help
8. I'd rather be on testosterone if possible but would jump at the chance of this too if it was offered at this point

Themes

- Unclear if any additional benefit above CS hormones alone (3)
- Unsure whether it's too late (i.e. person is too old) (1)
- If distress levels associated with periods worsen (1)
- Person not sure if blockers are offered in adult clinic (2)

Appendix L. Reasons cited for being undecided about having genital surgery in the future (full quotes)

UNSURE – GENITAL SURGERY (26)

1. No comments
2. Plan to see how I feel about it after transitioning
3. No comments
4. No comments
5. No comments
6. I don't think I could mentally or physically handle the pain of either method available. There are also various complication risks for the surgeries too which severely worry me.
7. No comments
8. If technology improves to have a more functional and natural-looking penis (without skin transplant) then I would definitely consider it
9. Do not currently feel the need to however I am not ruling it out as a future option.
10. Really not sure. will need to decide in the future
11. Currently I feel the results for FtM transsexuals are poor and they wouldn't satisfy me. I'd only get surgery if the results improve immensely.
12. Weighing out the risks and benefits
13. I am fairly sure I do not want genital surgery. I do not really have bottom dysphoria (or any dysphoria these days), I do not want to risk the sexual function which I currently have, and I am not very encouraged by the current surgical results pictures. I have put 'undecided' here because it is an ongoing consideration, maybe in 20 years there will be better techniques, or maybe in 5 years I will have dysphoria about it, I can't predict the future.
14. I need to learn more about this to make a decision.
15. Probably not, but depends on advances in genital surgery as currently I find the result unsatisfactory
16. No comments
17. not the current surgery options
18. It depends on the progress of surgical procedures and the aesthetic results in the future. right now I am not too fussed over it, but who knows, maybe in the future I will want surgery.
19. No comments
20. It is likely, but I am not entirely certain as I must do more research on procedures.
21. Right now surgery on my very sensitive, hardly ever seen genitals seems like a waste. Also phalloplasty is still very risky so why bother. I don't want to be sterile, either.
22. The complex surgeries are a lot to think about.
23. Unsure about which surgery. Have other priorities like chest surgery so I haven't thought of it as a real possibility yet.

24. I haven't spoken to my counsellors much about bottom surgery as it's so far away. I do get bottom dysphoria, but I use packers which really helps it.
25. Unsure which surgeries would be ideal
26. No comments

Themes

- Weighing risks and benefits (5)
- Pain (1)
- Outcomes (results poor/not good enough/results unsatisfactory) – methods may improve future advances in surgical methods and results (6)
- Waiting until results of transitioning – focussed on current surgery/transition (1)
- Too soon to make a decision (3)
- Not needed/not dysphoric (2)
- Don't know enough about it – need to do more research – complex (2)

Appendix M. Reasons cited/contextual information for why people had not taken hormone blockers (full quotes)

Satisfaction with the process in people who have never taken hormone blockers – comments (20)

Unhelpful information/advice (2)

Decision made by clinicians/service (7)

Too late (12)

Felt pressured to take them by clinicians/services (2)

Family dissuaded (1)

Went private to get T (1)

Wanted to take them (11)

1. When attending [service] the information was unhelpful, confusing and inaccurate.
2. There was no option given to make hormone blockers available to me whatsoever, despite my clearly expressed desire to pursue medical transition as soon as possible
3. No comment
4. No comment
5. No comment
6. It was too late for me to take hormone blockers by the time I was referred to [service], but I wish I had taken them earlier so they could've made a difference.
7. As I was already past puberty I wasn't allowed to go on hormone blockers.
8. I had been referred for hormones blockers and was about to start before being discharged despite being told I would not be discharged as I was under [hospital].
9. I asked [service] for hormone blockers and they refused to because 'It wasn't worth it' me personally It would have been like a starting point to Transition and could have made me feel better about the situation i was in, It could have made me feel better about myself.
10. No comment
11. In hindsight it would have been great to have been on hormone blockers so that I didn't develop breasts, however, it was too late for them by the time I got to the children's services
12. No comment
13. When I tried to bring up the subject I felt as though I wasn't able to ask any questions about them or their effects, as the doctors I saw expected me to already know everything about them. Eventually I was promised hormone blockers while under [service], but this was then redacted and I was later told I wouldn't be given them due to my age.

14. By the time of referral I was **well into puberty**, so there wasn't really any point in the blockers.
15. As I was pretty much **all the way through puberty** by the time they decided to give me medical assistance it was **no longer an option**
16. Reaching [service] at 17 I had pretty much developed my female body, my boobs only got partially (minutely!) bigger since. So to take hormone blockers would visibly be **a bit redundant seeming as there was no growth to stop**, my hips and breasts had already developed etc etc. But I remember going to my GP (think I asked 2 or 3 different ones) for something to stop my periods and **I mentioned hormone blockers**, contraception, if they knew anything else. And they were all written off quickly, even contraception just because I didn't have sex, but it's often used on biological women for period control. My doc said it was because she wasn't sure about how it would affect my hormones and didn't want to skupper when I can go on to testosterone (3 years later...!). When mentioning wanting to stop my periods at [service] the focus was around that I wasn't dysphoric about them so just live with them and I put a brave face on like yeah it's fine. But surely now you'd think it would be fine to prescribe contraception for it. Anyway, what surprised me was the **lack of knowledge my doc** had on what could be done pre-testosterone to stop periods.
17. I was **pressured at the child services to take** hormone blockers but I didn't want to due to my own research on the side effects.
18. When this conversation about hormone blockers came up I had **already finished puberty** so all that it would do is stop periods. I'd already gone on a contraceptive to stop periods so I didn't see the point in changing medicine.
19. I **asked for blockers** and was **turned down** - I'm still angry about this!
20. My **family** are not supportive of my transition so **they stopped me** talking blockers
21. **I was told i had to go on them for 12+ months before receiving HRT. i was 17, i should not have to go along with the protocol in place to protect much younger children.**
22. When I was referred to [service], I was told I was already **too old** to start taking hormone blockers.
23. **No comment**
24. **No comment**
25. Started T **privately** as I am still waiting for my first appointment with [service]
26. **No comment**
27. I went to the [service] **hoping to be put on blockers** until I could start HRT, however they explained to me that there was **no point** taking hormone blockers as I was 17 and there would be no point.
28. I was **too close to adulthood** anyway
29. **No comment**

Appendix N. Comments on reflections on previous decisions about interventions (full quotes)

Current Reflections on Previous Decisions about Interventions (28)

1. I've somewhat de-transitioned now, medically speaking (not socially). I would now put more emphasis on the emotional support I could get from therapy. I would consider hormone blockers as a longer term treatment rather than a precursor to hormones. I would not be on cross-sex hormones. But I would still have wanted top surgery.
2. I'd like to have started therapy when I was younger so I could have started hormone blockers.
3. I just want to go back in time so I can start physical transition sooner.
4. I would have applied to an adult's clinic first so I could actually have access to the hormones and surgery I need, instead of having to sit and wait in a clinic that couldn't even give me anything physically.
5. I would have chosen to take blockers sooner. I did not realise that the clinic would use my decision to hold off against me. My whole experience with the clinic was a waste of time.
6. No comments.
7. I would have been happy to take hormone blockers if i was given the option and I would have had speech therapy if the option was closer to home.
8. I would have taken birth control instead of hormone blockers to stop my menses. Some aspects of hormone blockers are wonderful - there's no fluctuations in my masculinity and femininity like I used to have due to my cycle, and it feels great to feel simply neutral, but the cost has been quite high. I know depression is a common side effect and it's difficult to tell whether I've experienced it as a result or whether my mental health has struggled because I've been so tired that I've felt like I have no future.
9. Although I was too old to be put on hormone blockers by the time I reached the children's services (due to the lengthy waiting process, as I was put through CAMHS first), this is something I wish I had had access to sooner.
10. The criteria that you must be on hormone blockers for 12 months before you are able to receive cross sex hormones from the NHS just seems rather long especially for those who are certain.
11. The wait is so long that I would have preferred to have something between like blockers. Therapy was a waste of time. They don't help or offer any advice whatsoever.
12. Would seek counselling sooner. Would want blockers & T much sooner to help prevent the last stages of puberty that i had to go through while waiting. Would have had chest surgery 2 years ago.

13. If I'd been confident enough to come out earlier in life, I have jumped at the chance to prevent female puberty
14. I think the mandatory hormone blockers are unnecessary, and I now no longer want bottom surgery.
15. As said in my previous comment, it's to do with not knowing the gender binary was so large when I was at [service]. I saw transitioning as going from one extreme to the other. Like I knew I was never gonna be a 'manly man' but I never thought about potentially being gender queer, or transmasculine. Without being graphic or tmi, I didn't have sex til I was 20, and I think that helped me come to realise I'm more transmasculine than just a man. Now I'm here I think I could reconsider chest surgery, but I don't regret it. I can't wait to have my first summer where I can take my top off, and where a binder won't rub me and suffocate me.
16. No comment.
17. I would have liked to have been offered genital and chest surgery at a younger age, as I was much more confident. 16 onwards my life completely fell apart, due to not feeling at home in my body. The counselling/therapy from such a young age was probably detrimental to my mental health.
18. No comment.
19. I'd try to come out and seek therapy and counselling sooner possibly, but I am quite happy with things and how they turned out, so really, I have nothing to complain about
20. I'd have preferred to be started on blockers at an earlier age
21. I would have definitely started cross-sex hormones, had I had the confidence to ask during my earlier sessions. And I would've started hormone blockers a lot earlier than I did.
22. Which I'd have come out earlier so I could have had more time for fantasy to get use to ur so I can start blocker
23. I'd ask them to talk to me like an adult and not a scared child, and I would take the blockers because menstruating is causing me so much stress on top of all the other stresses of this process.
24. Send the patients waiting for counselling, updated statistics and information leaflets about their condition and options. Don't let people have surgeries and drugs based on the whim that they aren't happy being the sex they are.
25. No comment
26. I would have paid for the hormones myself earlier. As far as the surgeries go, I would pay for them now if I had the money, I've known exactly what I've wanted for years now.
27. I initially waited to request hormone blockers because of my family and felt it would have benefitted my mental health had I just requested it when I wanted
28. Counselling/therapy should've continued between child and adult services

Appendix O. Comments on the timings and length of process of interventions (full quotes)

1 - LENGTH OF PROCESS

Reason for the wait

Wait too long (initially, between clinics, for interventions)

Not enough services

Appointments rescheduled & referral problems due to admin errors/staff leaving

Waiting for signatures

Other mental health issues

Not offered services

Steps or processes seen as unnecessary

Impact of the wait

Privately

Delays treatment

Process caused distress

Made surgery necessary

Other comments

Hormones & surgeries too easily obtainable

Unsupportive clinicians

More therapy should be offered

1. The services in the NHS take far too long and are so difficult to come by. The only reason I have had counselling and am on Estrogen is because I paid to go privately. I was never offered any support or services from Tavistock. I am currently looking into private Speech and Language therapy and laser hair removal as the waiting times for these are ridiculously long and I was never referred to them in the first place.
2. Ridiculously too long, for everything. I am desperate to begin hormone therapy, and it's not even within the foreseeable future that I get to, after 3 years.
3. I didn't need counseling or therapy, so I feel that should have been omitted. Being treated by the NHS was a process of relieving dysphoria at the cost of profound trauma. The denial & gatekeeping of treatment, the requirement to fulfill gatekeepers' fantasies of a trans woman, was like no

- abuse I have ever experienced. The genital examination required to obtain estrogen, something that could be easily self-performed & reported, was akin to sexual assault in the pain and psychosis it left me with. I began healing only in the aftermath of my surgery.
4. I was offered genital surgery when I was 21. Many years after I first attended the [service]. I turned it down, due to other mental issues I currently face.
 5. Waiting times for appointments, surgery and hormones are too long and cause much stress for the patient.
 6. I feel like a lot of people who say they are trans and want hormones, decide so even before they have been to an identity clinic, and that they should need answers and someone to talk to about issues concerning them wanting to transition very quickly, so that they are not in turmoil for very long about their condition. Therefore, I think the waiting time for therapy is too long, but the surgeries and drugs people often strive for as an ultimate solution to their problems, which far more often than not can be treated otherwise, are far too easily attainable, considering their irreversible effects.
 7. I waited around two years to get into the children's clinic. I was there for around a year before being kicked out because I was over 18. I'll now have to wait another year and a half to get my first adult clinic appointment and my second appointment will likely be 6 months after the first. Once I'm on hormones, I'll likely have to wait another year before I can get top surgery.
 8. The waiting list is a joke and not helped by unsympathetic clinicians. More therapy should be offered.
 9. The only reason it took such a long time to get on testosterone (it took 7 months longer than I was told to expect) was because an endocrinologist had left the clinic, so there was more time pressure on fewer staff and my appointment was set back.
 10. I do think there does need to be a strict process to determine whether or not a patient should receive hormones/surgery due to aspects of them being irreversible (especially if they are adolescents). However, the wait for me personally was far too long because of the referral error where I was meant to be referred to adult services from the children's services but for some reason wasn't.
 11. The wait time is over a year for initial assessment and +7 for any other help so it makes it very difficult to keep any therapy questions in mind and it made me incredibly depressed and anxious to wait that long to be seen.
 12. It took too long to get blockers and then to get T afterwards. the waiting list for charring cross was over 1 year. then it took another year to be referred through to even see a surgeon.
 13. Aside from empty promises that were later redacted, I was never promised hormone blockers or cross-sex hormones. As I'm still on a waiting list to begin attending adult services (after 2 years) I've still never been offered any sort of surgery. I was never offered speech and language therapy.
 14. I'm still waiting to get the signatures for the reassignment surgery's

15. I have put 'not sure' for Counselling/Therapy because the [service] length was good, but the [service] length abysmal. I do feel that, in general, people should be able to have hormone blockers sooner. If I had had hormone blockers before I hit puberty, I would not have needed top surgery. However, specifically for me, this would not have been possible, as I hit puberty around age 8-9, before I had words to describe my gender identity.
16. Due to the backlog of paperwork in [service] I felt delayed a couple of months starting hormones (also just the wait for my first appointment to [service] was over a year, so that ontop of 6 months between appointments there etc) With Chest Surgery it would have been 'About Right' if they hadn't made a mess of the paperwork. After a backlog of letters they sent my referral to the Private Hospital that [name of worker] worked at. So I had to do a lot of chasing up on it. So quite late, it got sorted. But I know that on the surgeon's side of it it was all fine, it's [service's] fault. ## the counselling one was a local nhs service and late because of my deteriorating mental health not to do with [service] In regards to the below question 'the timings of when you had the treatments/interventions' I'm assuming this is their timing in relation to each other. Hormones just late as explained above Chest surgery late because the guide line is the surgery to be had '6 months or more' after starting hormones. So when talking about chest surgery at [service] I had been on hormones for 4/5 months (despite there being 6+months between appointments, their fault) the doc didn't want to start the referral yet. not accounting for the waiting time of the referral, and the time between consultation and actual surgery.
17. Having to wait until I was 18 made it a lot harder for me.
18. I am still yet to receive top surgery, I was on a waiting list from nearly a year but have been taken off it due to the surgeon being unable to now do the surgery as he has moved. I'm now unaware of when I will be getting surgery.
19. At the start when I was referred by [service] I felt the process was too long and it would take 12 months from being referred to receive the blockers. Then after being on blockers for another 12 months, I would then have the decision to go on hormones. But the process of upping my dosage of my hormones has not felt dragged out or long, it has come steady and regular which is how I am happy with it.
20. Would have liked to have received hormones earlier rather than having to attend appointments at adult services to assess whether I was "ready" to take them, and being required to change my legal name before I could even get a recommendation
21. I desperately needed counselling and asked for it and was not offered it
22. I have received no treatment other than some patronising counselling sessions. I am diagnosed, why am i being forced to wait and beg? what if I was less stable? this process would have killed me a long, long time ago.

23. Still waiting for an appointment with the adult clinic, still waiting to medically transition
24. As a Welsh individual they appear to make the waiting time longer which appears very unfair.. I've seen people who've been in the system less time than me get the help quicker. Where is the logic. It's not like this was greatly impeding my well-being or life, or anything.... I have a lot of grievance toward the service as a whole. Very disrespectful and very uneducated and very lengthy process'.
25. The length of time I had to wait in between appointments at the adult clinic were inexcusable, as I had 2 cancelled appointments which led to a year and 1/2 wait before I was seen again after the first meeting. With no contact or apology from the clinic, at one stage I had to get my GP to contact them to issue me with another appointment letter, it was as if I'd been forgotten about. By the time I was seen again, I was told that my first appointment (1 and 1/2 years previously) was no longer valid as a doctors' approval for surgery, as that doctor had now left the clinic. As a result I had to wait another 6 months and come back again causing me to wait even longer for my chest surgery referral. Hence, when I waited around 2 years longer than I should have to even get referred. On the other hand, I had no issues at all with cancelled appointments or long waits at the [clinic], and they were much better at keeping in contact/returning calls when needed.
26. I was supposed to have top surgery a few years ago but my name was dropped of the list by accident several times and now finally is getting sorted
27. As of now I am still waiting for chest surgery which I thought would take place in May, but has been moved back again. I made the decision that I wanted bottom surgery a long time ago, but I have absolutely no clue when that will happen. The fact that I transitioned ten years ago but still have not had access to these surgeries is appalling.

2 – TIMINGS

1. I've been in the NHS system for 5 years without the offer of any psychological or medical interventions. The system let me down and the only reason i'm in a good place now is because I had the chance to go privately, I worry about those who don't have that chance. ***From the first appointment it felt that I had to fit into a box before I could get any treatment and that I had to be completely sure and totally confident about my decision, which was an impossible task at the time.***
2. If you aren't like most people involved in trans care, my gratitude is utter, and I hope you can forgive me if my tone is harsh.
3. ***If it wasn't clear by my answers so far, I no longer think transgenderism is real, and is rather people trying to find happiness by transitioning and labelling their emotional dissatisfaction and mental issues with fancy words and terms (genderfluid, transgender***

umbrella, bigender, transgender, gender dysphoria) that allow them to express themselves, but don't actually help them dissolve the issues and dissatisfaction.

4. The immense wait for treatment is somewhat understandable due to the failing budget of the NHS, but given the importance of getting treatment as soon as possible where trans persons are concerned, improving this should be a priority. It can mean the difference between life and death, as someone that struggles greatly with the physical side of the problem, I would be much happier in my general life if I had gotten the treatment I needed when I asked for it. A potentially more troubling issue is the barriers one faces when trying to get treatment, it is categorically insufficient to truthfully explain your struggles. My experience was being interrogated about the way I present, being told I have to 'be a woman all of the time, not just some of the time'. The criteria for being judged as correctly transgender seem very specific, and god help me if I didn't figure out the rough criteria and start lying. This is criticism given because otherwise I am greatly in the debt of the [service], and would very much like to see it improve so that better treatment is available to those that follow. Thank you.
5. I can't speak for trans feminine people, but the fact that trans masculine people are denied referrals for top surgery until they've been on HRT for a certain amount of time is cruel and ridiculous. Binding is painful, unpleasant, and can be traumatising. Many people can't pass as masculine because of their chest, meaning that physical changes they may experience from HRT (esp. facial hair) make it even more dangerous to exist as a trans person due to how visible discrepancies from gender norms are received.
6. I wish I'd been offered physical transition options at [service].
7. Without a doubt, there needs to be more clinics, especially children's ones. There were people there travelling 4+ hours for their appointment because there are just no clinics near them. The lack of clinics also lead to being able to help less people, and in the meantime people are suffering because they're not being seen.
8. I was due to start testosterone treatment mid 2015, however due to my GP repeatedly refusing the first injection due to supposed complications despite telling him I wasn't allergic to anything, I wasn't able to start the treatment until June 2016. The injection was done by a local hospital and only then was I allowed to have the continuing injections done at the surgery. The year wait before I was able to start testosterone caused me to become suicidal and depressed.
9. ***The [service] treated me awfully. I filed a complaint but the reply confirmed that they don't actually care about their patients. The clinic acts dangerously and recklessly, I was lied to many times by my clinicians and blamed for their incompetency. I hope improvements are made because many trans young people are not in a place where their futures should depend on the whims of careless***

clinicians who simply don't understand our experiences. The discharge experience was horrible - I was left alone with no support and I have realised how little dignity the clinic affords its patients. I wonder if this is because of our vulnerability. I hope that change will come soon.

10. Overall I feel that the counselling sessions for me didn't give me anything. I always dreaded going because I found them pointless and just made me feel like something was wrong with me. Still to this day me and my parents joke that it was pointless. But as I've said before, I can 100% see how they can help a lot of people. Unfortunately I wasn't one of them. Maybe it was because I was already so sure of what I needed.
11. Offered group therapy and speech therapy, but never received a letter or confirmation despite requesting this twice.
12. The overall factor in me having a negative experience with these services is due to the error of not being correctly referred to the adult services, meaning I wasted approximately 2 years and subsequently had to pay for expensive private services which I struggled and still struggle to afford
13. I understand why the process is long and that a lot of it can't be helped by people involved in the services however it is my life and a lot has to be put on hold because I couldn't/can't get access to treatment for example I am currently waiting for top surgery which would ease a lot of dysphoria and allow my life to really begin but currently I am just waiting with no sense of when it could happen.
14. ***Overall the 'treatment' I received from [service] was extremely poor. I felt constantly lied to and manipulated, and as though they weren't taking my personal situation into account.*** If I hadn't have been able to scrape together the money to start taking hormones from a private clinic, I wouldn't have been able to start transitioning at all.
15. My waiting for hormones was very long , and resulted in multiple suicide attempts
16. When I first got referred to [service] I knew there was cisgender, transgender, but I saw it as male or female, not a large binary scale which I've come to learn. And I wish I had known more about this back then, because I think I identify as transmasculine now, and I wasn't very dysphoric about my breasts, but I hated having to wear binders due to the discomfort of them, and passing was difficult. If I started my transition now I might rethink top surgery. But I would defo have HRT and a hysterectomy. I'd also like to apologise if a lot of my comments are negative about my experience with [services] but that's because there's not a lot of positive things I have to say about them.
17. Had I not gone private I'd be waiting for testosterone still now. [service] did not listen to me or my needs - I asked for counselling directly. I am happy that I transitioned but I can't see how [service] impacted that apart from making it harder. I saw them perhaps three times and we never discussed medical transition.

18. I am an 18 yr old trans man who's been seeing [service] since I was 15, I feel the support and talking side has always been very good and helpful, but whereas I could've started blockers at a younger age and then smoothly moved to hormone therapy, I had to wait til I was 17 to even be introduced to the idea of blockers, which I am currently still on. I also think that if [service] are going to send a referral to an adult service with a very long waiting list, they should have the authority to send said referral before a patient is 18 because this way the wait will eat away less at adulthood
19. this whole process is upsetting and horrible. the waits are too long and [service] protocols need to be addressed and fixed to suit older teens. i feel completely hung out to dry by this whole thing and its not fair to myself or my family who have to watch me suffer.
20. I waited months to attend the [service], where I was falsely told that I would be able to skip the waiting list for the adult clinic, influencing my decision to stop attending [service] when it would have probably been more beneficial for me to stay.
21. I haven't actually even made it to adult services yet. The [service] said they would send off my referral when I was 17 and half (the age requirement) and they didn't send it until 3 months after my 18th birthday. Now I'm still being seen in a paediatrics ward covered in Winnie the Pooh acrylics and walking around London with Finding Nemo plasters on my arm. The state of the service is shocking and it's a shame it's so under-funded. 14 months waiting periods for an appointment. That's just to be seen. Let alone the years long waiting lists for surgery that you can't get onto until you've been seen. I'm going to have tits well into my 20's unless I can magically find the money to go private. So fantastic. By the time I'll actually transfer into adult services I'll have been in the GIDS programme 6 years.
22. Since 15 when i first started identifying as male, I feel like I've been waiting an extremely long time for counselling, and physical treatment. However I was unlucky with my timing, I was first referred to the [service] when I was 16, and by the time I was being seen at the [service] (10 months after) I was nearly 18 so I didn't have many sessions there, I was referred to the [service] back in June and I'm currently waiting for my appointment there. I feel like the system is a waiting game, however in some ways I'm quite grateful for it, as it's meant that I've had to learn to cope with my body and learn how to deal with my mental health regarding the wait, and has also certified my feeling that I am Trans and I do feel like I'm in the wrong body. Just excited to start with sessions at [service]!
23. I'll reiterate how imperative, I believe it is for the service to be understanding and caring toward transgender individuals in relation to their body or their identity. It comes across as very disrespectful when doctors, psychiatrists or other staff are referring to body-parts or other such things with the incorrect terms, or just not taking their time to use gender neutral one. By doing so they're impacting mental health of the individual. I know I dread going to the [service], I always have and always

will. However, if I thought i wouldn't have to encounter words that make me want to cut myself up I could deal with the process that bit easier.

24. Overall my experiences at the [service] were good from start to finish, whereas my experiences at [service] have been awful. Some of the doctors were rude and insensitive in the manner with which they spoke to me and asked me personal questions. The number of cancellations I had meant my transition was made much longer than it should have been and every single call I made and message I left was neglected over the course of a 2 year period.
25. The [service] once cancelled my appointments consecutively for a year and a half. That's a year and a half delay in my treatment- plus no reason was given. At this stage in my life I thought I would have finished my transition and enjoying my twenties, but the clinics had other ideas. Every time I think I'm getting close to progress, things get messed up by the services.