“It’s like living in black and white… and then life’s full of colour”:
How do older British transfem people choose not to seek medical gender affirming care?

A Constructivist Grounded Theory Exploration

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I, Emma Petrova, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Acknowledgements

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Declaration of Powers of Discretion

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Glossary of Terms

AMAB – Assigned Male at Birth

AFAB – Assigned Female at Birth

Bottom surgery – several different types of gender affirmation related surgical procedures on a person's genitalia.

Cisgender – a gender identity whereby a person's biological sex corresponds to their gender identity (e.g., a biological male identifying as a man; a biological female identifying as a woman)

Cisnormativity – the idea that being cisgender is the norm. It refers to systems and society being structured around this norm.

Cross-dressing – the activity of dressing as another gender. The term falls under the transgender label but may include people who identify as cisgender. It is a form of gender expression and may or may not be related to erotic activity.

Gender affirming care – a range of social, psychological, behavioral, and medical interventions aiming to support and affirm an individual's gender identity. The term 'transition' is an older term that is contested by some trans people, but still widely used by other trans people and in academic writing.

Gender binary – the viewpoint that there are only two genders, (e.g., woman/girl and man/boy).

Gender dysphoria – the distress associated when a person experiences a mismatch between their biological sex and gender identity. This term is used by some medical professionals as a diagnosis.

Gender euphoria – the positive feelings experienced when a trans person's gender is affirmed and respected; the opposite of gender dysphoria.

Gender non-conformity – expressing one's gender in a way that differs from societal norms.

Heteronormativity – the idea that being heterosexual is the norm and other relationships are viewed as abnormal.

HRT – Hormone Replacement Therapy; the use of masculinizing or feminizing hormones (e.g., oestrogen, testosterone) with the aim of physical gender affirmation.

Non-binary – a type of transgender identity where a person experiences their gender identity outside the binary terms of male and female.

Passing – being seen as the gender a person wishes to be seen as.

TGNC – Transgender and Gender Non-Conforming

TNBI – Transgender and Non-Binary Individuals.

Top surgery – several different types of gender affirmation related surgical procedures on a person's chest (e.g., breast removal or augmentation).

Transgender – a gender identity whereby a person's biological sex does not correspond to their gender identity. The shortened term 'trans' can be used interchangeably.

Transphobia – the dislike of or strong prejudice against transgender and gender non-conforming people

This glossary has been adapted from *Trans 101: Glossary of Trans Words and How to Use Them* (2020), *Glossary of Terms: Transgender* (2024), and The World Health Organisation (WHO, 2024)

Throughout this portfolio, I have made a conscious effort to use language and terminology preferred by the LGBT community (dickey & Singh, 2016; Richards et al., 2014; Vincent, 2018). In the transgender field, terminology is varied and constantly evolving, presenting challenges in keeping up with this shifting lexicon (Burdge, 2007). Despite my best intentions, I recognize the possibility of inadvertently offending someone or a group by unintentionally using historically harmful language (Richards et al., 2014). To mitigate this, I have sought feedback from various sources on the terms used and adjusted accordingly. When referring to specific participants, I have always used their preferred personal pronouns.

Preface

This portfolio contains three components presented in fulfilment of the requirements for the Counselling Psychology Doctorate programme at City University of London. It is primarily focused on the theory and practice of counselling psychology and follows the overall theme of tolerating discomfort and growth from it.

This portfolio illustrates my progression towards becoming a counselling psychologist and my development as both a reflective practitioner and scientist-practitioner. It demonstrates my ability in integrating theory and practice in the clinical piece; developing, analysing, and producing doctoral-level original research; and disseminating the findings accessibly to a wide audience. I share details about each component below.

PART I: RESEARCH STUDY

The first component of this portfolio focuses on the original constructivist grounded theory exploration of the question **How do older British transfem people choose not to seek medical gender affirming care?**. It produces an explanatory theory on the process these participants underwent to construct and re-construct their identity in order to make this choice, demonstrating the interplay between external influences and internal processes. Given the high homogeneity of the sample, being older, transfem identifying individuals who grew up in the UK, I explore the impact of cis- and transnormative societal messages shaping individual identity. The findings from this study were placed in context of existing literature, and clinical and wider implications, as well as future directions, were also considered.

I was motivated to complete this research from my own reflections on my gender, identity, and how this has affected my existence in the social world.

I was born and spent my formative years in Bulgaria, a former socialist country in Eastern Europe. The patriarchy continues to be the dominant system of social

behaviour and I can now reflect on how this will have shaped many of my core beliefs about gender, society, myself, others, and the world around me. I can also understand how social norms are influenced by the country's decades-long history of socialism, poverty, and Soviet values, which inadvertently trickle down from a systemic level to individual and group psychology.

When I was 18, I moved to Scotland to study Psychology and Biology at the undergraduate level; upon graduating, I moved to London. I have spent my entire adult life in the UK, in the West, where many of my beliefs and worldviews about society, community, human rights and needs were challenged and progressively evolved. Admittedly, the UK is not immune to many of the social narratives as in Bulgaria (e.g. patriarchy), although I can recognize some level of shame and hiding of these otherwise direct aggressive messages in the group mentality that helps facilitate a greater sense of belonging and acceptance.

I had the opportunity to observe in real-time how the discrepancies between the UK and Bulgaria, the West and the East of Europe, evolve throughout time in my adulthood. I have conceptualized Bulgaria's social justice landscape as lagging approximately 10-20 years behind Western standards in terms of tolerance and acceptance of diversity. For instance, discussions and recognition of homosexuality are increasingly prevalent and gaining acceptance, albeit with persistent tensions. However, issues pertaining to the existence and rights of transgender people are still a long way away.

Having close people in my life from Bulgaria who identify within the LGBTQ+ community, I have grappled with a complex mix of feelings as they navigate and negotiate their identity and place in the world, in a society that seeks to invalidate their existence. I have felt very helpless in the face of this. I have thought with them on a philosophical, social, and psychological level around their experiences in the social world and have consumed much content on these topics from books, podcasts, YouTube channels from gender theorists. This led me to question the experience of existing in a world that either overtly or covertly denies one's existence and belonging. Around this time, I began the Counselling psychology training and recognized the opportunity to both address my own curiosity and contribute positively to the field,

while aspiring to challenge and broaden perspectives on the experiences of transgender people who choose not to pursue physical gender affirmation.

I was acutely aware of the stereotypical image of a white, cisgender woman advocating for social justice by depicting transgender individuals as excessively vulnerable and in need of protection. While my initial interest may have inadvertently originated from a similar perspective, my direct interactions with transgender individuals, and subsequently with the participants in this study, revealed their profound resilience, satisfaction, and strength. They did not perceive themselves as needing defense from anyone. Through these interactions, I discovered that the participants were content with their identities and lives, and their participation in this research likely stemmed from a desire to celebrate this contentment. I aimed for this study to affirm and highlight the positives of self-acceptance and I hope this message is communicated clearly and honestly enough to any reader of this research study.

PART II: PUBLISHABLE PAPER

The second component of this portfolio is the publishable paper, elected for submission to The International Journal of Transgender Health, and therefore follows the guidelines for submission dictated by this journal. It is a shortened version of the original research piece as I felt important to communicate the overall theory and process of decision making, including each category as an important piece of the puzzle.

I chose this journal as it is international, peer-reviewed and publishes original research, hoping to reach a wide audience of clinicians across fields, theorists, and non-professionals who may wish to learn more, or identify themselves with the process. I selected this journal as its considerable impact factor would fulfil the study's aims in widespread dissemination of the findings, reaching professionals across various specialties and disciplines – including counselling and clinical psychology, sociology, education, and public health – where the findings could be discussed, implemented, and further disseminated. The participants also informed me that they

stay up to date on transgender research findings within their close communities, so I plan to share the findings with them and others who might be facing similar experiences. I hope to later adapt a version of this article to a lay audience publication, so it can meet its final aim in providing a positive role model for people in the process of exploring and consolidating their gender identity.

PART III: CLINICAL PIECE

The final element of this portfolio is a combined case study and process report from my final year of training with a client presenting with depression and developmental trauma. The title of the clinical case study is **The Value of Acknowledgement in Providing a Reparative Therapeutic Experience** and it demonstrates my clinical ability to provide therapy as an integration of psychodynamic theory and Mentalization-based therapy (MBT). I chose this client, Jiya (pseudonym), as I first felt able to implement more advanced and creative approaches to psychological work in a less restrictive, non-NHS setting. I selected this particular session as it shows my ability to recognize and work with emotional avoidance, formulated to maintain the psychic pain of developmental traumas, which manifest into depression and relational rupture. This was also the first occasion I felt able to implement my theoretical knowledge of psychodynamic theory into real-life application. The relationship with Jiya was central throughout our work and I believe the main vehicle for change toward the end of therapy.

THE CORE THEME OF THE PORTFOLIO: GROWTH

Even though I had not verbalized this theme at the start of my training, I reflected on a subtle, ongoing feeling I experienced each time I engaged with the three components of this portfolio. It was a difficult emotion to sit with, one that was frequently challenging and ultimately very rewarding. Having completed the final write-up, I recognized it as growth – the final step of overcoming something very difficult, confusing, at times

painful, but ultimately meaningful. I can now label this process as growth and can identify how this theme emerged in my clinical work, the research project, and my own Counselling Psychology training.

Before our first meeting, Jiya had lived with intense feelings of anger and hatred toward her father, while dealing with the confusing grief and sadness after his passing. As seen in the process report, in therapy she had to sit with the pain of feeling abandoned by her unwell mother; alone in her relationships growing up and now; alone in not understanding and tolerating her emotions. She carried this pain throughout her life, unconsciously affecting her own wellbeing and her relationships. Toward the end of therapy, we were able to acknowledge her growth in self-validation, kindness, acceptance, and tolerance of both painful and pleasurable emotions.

Much in the same way, the participants of this study had to sit with the discomfort of their gender identity not being accepted for the majority of their lives, unconsciously impacted by a cisnormative, transphobic society. After identifying with a trans identity, they then had to sit with the discomfort of finding their place in their own identity, their personal relationships, the trans community, and wider society, when considering whether they wished to pursue medical gender affirming care. I had the privilege of encountering the participants at a stage in their lives where their capacity to tolerate distress had evolved into personal growth, benefiting themselves, their relationships, and their broader social contexts. The participants demonstrated the ability to integrate multiple aspects of their identities, achieving a reconciled and satisfying sense of self. They all perceived themselves to be in a better place in their lives, independent of any physical gender affirmation.

I finally acknowledge the results of my own discomfort throughout training, characterized by the acceptance of uncertainty, insecurity, and self-doubt, which eventually evolved into significant learning and growth. This journey involved managing multiple demands, culminating in my ability to complete this project and recognize my development as a counselling psychologist. I understand that my discomfort stemmed from both things within and outside of my control, and my process involved learning to cope with both.

I once described this training as ‘the best and worst thing I have ever done’. This was marked by the challenges of starting from a position of ‘not knowing’ to ‘knowing’, personal and professional development, and growth. The experience included uncertainty and the need to tolerate it, along with the stress and anxiety of meeting all the academic requirements, balanced by the sense of accomplishment and satisfaction from achieving them. The assessments, although demanding and rigorous, were invaluable in fostering my learning, reflection, and trust in my own abilities, particularly through the case study and process report.

This dichotomy also reflects my relationship with the research process: it was daunting and seemingly endless, filled with fear of making mistakes or unintentionally causing harm, yet it also introduced me to remarkable individuals, provided an opportunity to make a difference in their lives and possibly others, expanded my knowledge, and allowed me an avenue to challenge transphobic beliefs and preconceptions. I have much to be grateful for and I appreciate the opportunity I have had to complete this portfolio.

I hope you enjoy this read.

Part I: Research Project

How do older British transfem people choose not to seek medical gender affirming care?

A Constructivist Grounded Theory exploration

Abstract

There has been an increased interest in the study of transgender identity development, management, and affirmation processes in the last decade from a medical, sociological, and psychological perspective. Specifically, much of the research has highlighted the importance of medical transition and examined gender dysphoria from a pathological perspective. However, there has been little to no exploration of the motivation and experiences of transgender people who do not wish to pursue medical gender affirming care beyond recording the reasons behind this. This study explores the complex process of trans identity development and management that contributes to the decision not to physically transition, exploring the individual and social process underneath this choice.

The study used semi structured interviews to obtain data from 6 self-identified MTF transgender people aged between 60-70 years old who had chosen not to pursue medical gender affirming care. The data was analysed according to principles of Constructivist Grounded Theory methodology.

The findings of this study generated new theory exploring the process of how trans people make the decision not to pursue medical gender affirming care. It identified the process is mediated by two factors: external influences and internal process. Within the external influences, the impact of cisnormative and transnormative narratives contributed to identity development. The internal process entailed a series of reflections on personal costs, relevant needs, and negotiating identity, as a way to manage and affirm gender identity.

The study makes suggestions for future practice for mental health and healthcare professionals' practice, education, and training to better address the needs of a hugely diverse population. Further, it expands on existing theoretical literature and gives voice to an underrepresented and marginalized part of the trans community.

Chapter 1: Introduction and Literature Review

Overview

This chapter functions as an introduction to the topic and research question, as well as a review of recent literature. I first begin with an introduction to the topic of transgender people's experiences, showcasing important terminology, research, and information the reader needs to be aware of when engaging with the writing. I then present a critical literature review, exploring the factors influencing the decision whether to pursue medical gender affirming care, past and present models of transgender identity development and management, and the literature surrounding transgender people who have chosen not to pursue physical transition. I conclude this chapter by presenting the limitations of the current literature, developing the argument why this research is necessary.

1. Introduction

Before embarking on this research, it is important to define the terminology used throughout to share conceptualizations between myself and the reader. The below definitions are derived from current literature on gender theory and represent my understanding of concepts on a human, philosophical, and scientific level. This strategy has coloured the conduct of this research throughout the literature review, design, execution, and write-up process.

1.1. BIOLOGICAL SEX

According to the American Psychological Association (APA) (2015) sex is "a person's biological status and is typically categorized as male, female, or intersex" (p. 22). Sex is commonly considered dimorphic, with two viable gametes and two sexes whose functions determine the role they play in human reproduction (Griffin et al., 2021). Intersex describes a range of conditions whereby an individual possesses a variation of sexual characteristics ambiguous in the male/female sex binary (*Trans 101,* 2020). However, recent research indicates that sex and gender are distinct yet inextricably entangled, challenging traditional dichotomies (Restar et al., 2024). This interwoven complexity suggests that defining sex solely in biological terms may overlook the

nuanced ways biological, social, and psychological factors interact to shape one's identity and experiences.

1.2. GENDER

Gender, a fundamental aspect of human identity, encompasses the roles, behaviours, attitudes, and expectations a given society associates with individuals based on their perceived or assigned sex at birth (APA, 2015). Behaviours, including presentation, performance, and expression, compatible with the dominant societal norms are considered gender-conforming, whereas those viewed as incompatible with social expectations are deemed gender non-conforming. This approach acknowledges the fluidity and intersection of gender and biological sex, which are increasingly understood as not only separate constructs but also as deeply interconnected aspects of human diversity.

1.2.1. Culturally dependent views on gender variance

Gender variance, therefore, can be understood through the lens of the dominant culture's accepted versions of normativity. In western society, gender has been thought of as binary, "male" of "female", and the label is associated as soon as the genitalia become discernible, often before birth (Bornstein, 2013). In Western society, gender plays a pivotal role in shaping social interactions, cultural norms and practices, and institutional structures (Ridgeway, 2009). The dominant social system in much of the world is governed by the patriarchy, which inherently separates the sexes and dictates cultural norms and values through promoting traditional gender roles in institutions such as family, education, religion, and the legal system (Walby, 1990). This positions gender in a central role within our social reality, affecting our psychology and personal identity from before we are born.

In cultures around the globe, the definitions of gender and associated attitudes vary significantly. In India, *Hijras* are commonly biological male or intersex people who adopt a feminine gender identity, and are commonly referred to as 'the third gender' (Kalra, 2012). Culturally, they have carried positive connotations, believed to possess special powers that allow them to bless others with luck and fertility, however, changing societal values and perceptions have shifted attitudes towards them (Chaudhary &

Shukla, 2017). Hijras have been recognized and established for thousands of years in Indian culture and have received full legal recognition for the past 10 years (Khaleeli, 2014). As a result, gender can be shaped through developments in attitudes and legal frameworks within a given society.

In pre-colonial Native American culture, Two Spirit people have gender identities that transcend and combine the binary definition of gender. They describe possessing qualities, behaviours, and experiences of both the masculine and feminine (Lang, 2016). Historically, they have been held in a respected position and considered spiritually blessed in their community, however, they have also been subject to discrimination and attempts at erasure in recent years. Communities are undergoing a cultural shift toward adopting a multi-gender societal framework to manage the tensions (Robinson, 2020). These examples suggest that interpretations of gender can change and develop over time and are not a fixed phenomenon.

In Indonesia, the Bugis language recognizes five distinct genders and three sexes (Graham, 2004). Specifically, the *Bissu* people transcend the binary definitions of gender and are considered ‘a combination of all genders’ (Andaya, 2018). They are held in high esteem within their culture as they are believed to be mediators between humans and spirits. This shows how gender beliefs are grounded in language and culture, demonstrating a strong link between gendered attitudes and societal norms.

Given the evidence of the diversity of gender understandings and practices, the transient nature of gender interpretations, and the variance in support on an institutional level, gender is a culturally-dependent defined role and can be understood as a social construct (Burdge, 2007; Wood & Fixmer-Oraiz, 2019).

1.3. GENDER IDENTITY

If sex is defined as a biological concept, gender a social construct, then gender identity is a psychological phenomenon (Griffin et al., 2021). It is distinct from the rest as it is a deeply-felt, inherent sense of being a man, woman, or alternative gender (APA, 2015). As an individual interpretation of identity, it may not be visible to others and may remain unvoiced (Burnham, 2018).

A person whose gender identity corresponds to their biological sex is considered cisgender in the Western world (Moradi et al., 2016).

1.3.1. Gender identity links to biology

Neuroscientific studies have contested that gender identity is influenced by the social environment (Bao & Swaab, 2011). They have argued that it develops within the second trimester in utero and has a strong biological basis in the brain (Bao & Swaab, 2011; Savic et al., 2010). However, there is little to no robust neuroscientific evidence to support the idea there is a biological difference between the male and female brain (Joel et al., 2015). Considering the concepts of 'man' and 'woman' as solely defined by biological sex risks the definition of gender identity becoming circular (Griffin et al., 2021). Further, it risks becoming destructive, malevolent, and dehumanizing: in current debates, if gender identity is seen as separate from both biological traits and gendered socialization, it becomes understood as a mysterious, deeply personal, and strong experience, but difficult to prove or disprove. When people hold onto the idea of gender identity as their most fundamental sense of self, questioning it can be considered as a threat to their entire existence. Behaviours like 'dead-naming' or misgendering are understood by gender theorists as debasing and dehumanizing (Freeman, 2018). This might explain why recent conversations about gender identity have become inflammatory in the scientific, legal, and public discourse (DeJong et al., 2021; Foster, 2024; O'Connell, 2022).

1.4. TRANSGENDER IDENTITY

'Transgender' is an umbrella term for a diverse group of people whose gender identity, expression, or behaviour does not conform with the culturally-dependent conventional ideas of male or female (Stonewall Trans Advisory Group, 2017). The transgender group can include people who identify within the binary definitions of gender (e.g. transgender female or transgender male, drag kings or queens, crossdressers), as well as people who place themselves outside the binary definition of gender (e.g. non-binary, gender variant), or completely reject the notion of a fixed and limited gender identity (e.g. agender, gender-fluid, gender-queer, genderfuck) (Murjan & Bouman,

2015; Twist & de Graaf, 2018). A trans person's gender identity may change over time and they may identify with any sexual orientation (Levitt & Ippolito, 2014b).

The terminology is ever evolving, aiming to sensitively and accurately capture the diversity of identities and experiences, and is considered best to use self-chosen descriptors (*Glossary of Terms: Transgender*, 2024). Terms such as *transsexual* or *transvestite* are considered outdated and have been phased out of use due to the harmful historical connotations with which they were intended. For the purposes of this research project, I have been mindful to utilise appropriate terminology consciously and sensitively when describing the literature, as well as carefully using the preferred pronouns for participants' information (Richards et al., 2014). The term '*trans'* has commonly been used as a self-identifying label and abbreviation for '*transgender*', and can be used interchangeably (*Trans 101*, 2020).

1.4.1. Prevalence

The precise number of self-identified trans people within the United Kingdom and globally cannot be precisely calculated. Trans people are estimated to represent between 0.3-0.75% of the UK population (Government Equalities Office, 2018), or about 0.5% in England and Wales (Office for National Statistics, 2023). This has been reported as a 5-fold increase since the year 2000 (McKechnie et al., 2023), representing approximately 25 million people worldwide (Thomas et al., 2017).

1.4.2. History in research

Understanding the context and history of the way the medical community has framed transgender identities is essential in understanding how the scientific community and wider society places trans people.

The inclusion of Transsexualism and Gender Identity Disorder of Childhood (GIDC) in the DSM-IV was influenced by the rising demand for hormone therapies and sex reassignment surgeries starting in the 1960s. Benjamin's (1966) work with transgender individuals introduced a treatment approach and a classification system that separated "true" male-to-female transsexuals from transvestites and homosexuals, focusing on those who needed physical changes to match their gender

identity. Initially, this system did not consider female-to-male transitions because they were less commonly sought.

Benjamin's classification, while not directly part of the DSM criteria, influenced similar models in gender clinics. The "true transsexual" model, which emphasized the "born in the wrong body" concept, helped those who could afford it access hormonal and surgical treatments (Davy, 2015). However, many transgender individuals either did not seek or could not obtain these medical interventions due to various medical, economic, political, or social barriers (Davy, 2015).

To include those individuals, the DSM-IV introduced the diagnosis of Gender Identity Disorder Not Otherwise Specified (GIDNOS) (Bradley et al., 1991). This broader category allowed for the inclusion of transgender people whose gender expressions did not fit the strict criteria of "true transsexualism," such as those who did not feel a strong mismatch with their bodies or did not want surgical interventions. This extension helped validate a wider range of gender non-conforming identities and expressions.

Critics argue that this expanded approach replaced a narrow view of transitioning transsexuals with a more inclusive, but still clinically controlled, category that covered various forms of gender non-conformity. Billings & Urban (1996) noted that combining multiple gender disorders under one GID diagnosis helped maintain clinical control over different gender transitioning practices.

A common critique of the literature on transgender experiences is that most research is medically oriented, focusing on gender dysphoria from a pathological perspective (Bockting, 2009; Davy, 2015; Kronk & Dexheimer, 2021). Recently, however, there has been an increase in sociological research that contributes to broader gender studies theories and a shift toward an identity-based model, which acknowledges gender variance as an example of human diversity (Bockting, 2009; Nagoshi & Nagoshi, 2013) Psychological research, specifically relating to gender affirmation, has predominantly focussed on clinical populations, aiming to improve therapeutic experiences for transgender individuals (Applegarth & Nuttall, 2016; Austin & Craig, 2015; Doyle et al., 2023) However, in doing so, it risks neglecting important information about being a human who is trans and possibly further pathologizing the population.

1.4.3. Relevant issues affecting trans people

While this section is unable to capture the entire experience issues pertinent to trans people, I aim to describe the major factors impacting transgender people around the globe at the time of writing, in order to paint the picture of the social reality trans people have to navigate in addition to personal identity development.

Research indicates a strong correlation between social stigma and psychological distress in transgender individuals, who report higher levels of anxiety and depression compared to the general population (Bockting et al., 2013; Budge et al., 2013). Additionally, transgender individuals, especially youth, have high rates of suicide attempts, with physical violence related to their transgender identity being a significant contributing factor (Clements-Nolle et al., 2006; Maguen & Shipherd, 2010). It appears social views on gender (non) conformity play an important role to TGNC identity formation, maintenance, and quality of life.

1.4.3.1. Stigma and minority stress

Transgender individuals face significant stress and health risks due to gender-related stigma, which manifests in various forms. Stigma, as described by Goffman (1963), reduces an individual from a "whole and usual person" to a "tainted, discounted one," marking them as deviant and less valued (Link & Phelan, 2001). Four types of stigma processes have been hypothesised to contribute to increased stress among stigmatized groups: enacted, felt, internalized, and anticipated (Major et al., 2018):

- **Enacted Stigma**: This occurs at interpersonal and structural levels, including discrimination and unfair treatment, as well as laws and cultural norms that restrict opportunities and well-being.
- **Felt Stigma**: The perception of being socially devalued based on group membership, even without direct discriminatory actions.
- **Internalized Stigma**: When individuals adopt negative societal beliefs about their stigmatized status, consciously or unconsciously.
- **Anticipated Stigma**: The expectation of facing bias or discrimination before it occurs.

These types of stigma can lead to constant uncertainty and vigilance, influencing emotional, cognitive, behavioural, and physiological responses, leading to social isolation or exclusion. Stigma also affects family members of transgender individuals, who may face similar stigma types (Norwood, 2012).

Meyer's (2003) minority stress model provides a framework to understand the higher prevalence of mental health issues among marginalized groups, particularly sexual minorities, due to chronic stressors stemming from their stigmatized identities. This framework was extended by Hendricks & Testa (2012), who accounted for proximal, subjective, and direct, to distal, objective, and indirect stressors for transgender people, to outline four more psychosocial effects of stigma relevant to trans people:

- **Experiences of Discrimination**: Exposure to prejudice and harassment.
- **Expectation of Stressful Events**: Anticipation of harassment related to gender identity.
- **Internalized Transphobia**: Adoption of negative societal attitudes.
- **Concealment of Gender Identity**: Hiding one's gender identity or expression.

Chen et al. (2020) argue that belonging to a marginalised identity makes it more likely for people to experience or expect stigmatisation, which adds to the experiences in which people are forced to reconcile their own identity with the narrative projected onto them from others, thus reinforcing a stigmatized identity.

Research supports the role of minority stress in contributing to maladaptive coping and mental health issues among trans individuals (Breslow et al., 2015; Timmins et al., 2017). However, resilience is also observed in some transgender individuals despite minority stress (Bockting et al., 2013). Thus, understanding the dynamics between minority stressors and health outcomes is crucial as transgender individuals navigate their gender transition.

1.4.3.2. Intersectionality and systemic barriers

Research indicates that intersectional transgender individuals, particularly those from marginalized racial and ethnic backgrounds, endure increased gender discrimination (compared to White trans people), experience racism within the LGBTQ+ community (Levitt & Ippolito, 2014a), and suffer increased psychological distress (Millar & Brooks, 2022). Transgender individuals who are also members of racial or ethnic minority groups face compounded discrimination, which may result in poorer health outcomes and increased difficulty accessing legal and appropriate medical care. A study by Johns et al. (2023) in the US reported trans women consistently facing the most barriers to healthcare, as well as higher rates of marginalization and transphobia experienced by Black and Hispanic trans women, compared to their White counterparts (Sugano et al., 2006). The result of systemic and cisnormative barriers, particularly against trans people with multiple minority identities, can lead to some seeking unregulated healthcare options, including self-administering hormone treatments and surgeries (Metastasio et al., 2018).

Research has reported an increased vulnerability to inequality and discrimination on housing, economic status, employment, education, crime, citizenship, health and social care, particularly against trans women, further compounding intersectional barriers (Hendricks & Testa, 2012; Klemmer et al., 2018; Mitchell & Howarth, 2009).

Models of intersectionality have theorized that transgender people face social and health disparities that originate from power dynamics inside and between oppressive structures, institutional systems, and socio-structural processes (Wesp et al., 2019). As such, trans people's health is subject to changes in institutional power, which affects access to safe and legal healthcare. With the recent closure of one of the largest gender affirming clinics in the UK (Barnes, 2024), we can speculate the negative impact on healthcare provision, given the variable experiences of accessing non-specialist gender affirming care (Wright et al., 2021).

1.4.3.3. (Trans)gender-based violence

Trans people are at greater risk of experiencing sexual and gender-based violence (GBV) and aggression, based on stigmatization of non-conforming gender expression,

identity expression, and perceived sexual orientation (James et al., 2016; Langenderfer-Magruder et al., 2016; Peitzmeier et al., 2020). There is an estimated prevalence of GBV of up to 89% of trans people (Wirtz et al., 2020), however, these figures are likely under-representative due to experiences of systemic oppression, intimate partner violence not being captured appropriately by heteronormative systems, and victims less likely to be believed (Graaff, 2021).

Existing literature has highlighted higher rates of violence against trans women of colour (Bazargan & Galvan, 2012; Grant et al., 2011; James et al., 2016). However, Klemmer et al.'s (2018) findings showed that African Americans in their US sample reported lower rates of GBV compared to whites, potentially because they perceive the violence as racially motivated rather than transphobic (Meyer, 2012). The authors theorize this may also result in normalization and underreporting of racial violence, as pervasive racism becomes a routine part of daily life for people of colour.

A study by Lombardi et al. (2002) found a strong association between trans-specific economic discrimination and incidents of GBV. Further, gender identity-based violence rates have significantly increased in the US and are predicted to continue increasing, despite public investments in prevention strategies (Arayasirikul et al., 2022). These findings highlight the relationship between physical gender performance, public perception, and the compounding discrimination and threat on a social and economic level, affecting trans people daily.

1.4.3.4. Transnormativity

McLean & Syed (2016) introduced the Master Narrative framework to understand identity development in context. Master narratives are culturally shared stories that shape individual life stories by guiding thoughts, values, and behaviours (Hammack, 2008). These narratives are ubiquitous, largely unconscious, compulsory, and resistant to change, influencing personal identity through processes of negotiation and internalization (McLean & Syed, 2016). The master narrative framework can be useful to understand transgender identities since marginalized groups often need to create alternative narratives to validate their identities against dominant cultural standards (McLean, Lilgendahl, et al., 2017; McLean, Shucard, et al., 2017).

Cisnormativity is the expectations that individuals identify with the gender assigned at birth (Bauer et al., 2009; Bradford & Syed, 2019). In the Western world, cisnormativity functions as the dominant narrative in assuming that all people are cisgender. This concept, pervasive and rarely questioned, aligns with the invisibility and ubiquity principles of master narratives, thus marginalizing transgender identities and causing systemic issues in areas such as healthcare (Bauer et al., 2009).

Transnormativity, a concept introduced by Johnson (2016), is a dominant social framework that evaluates transgender identities based on a medicalized binary gender model. It effectively functions as a set of rules and expectations about 'the correct way to be a transgender person'. This framework creates a hierarchy, privileging transgender individuals who conform to binary gender norms and choose medical transitions, while marginalizing those who do not. Indeed, a study by Bradford & Syed (2019) concluded that transnormativity functions as a master narrative within the trans community and can be conceptualized as an alternative narrative to cisnormativity.

Binary transgender people may find it easier to align with transnormative standards, leading to greater social legitimization and perceived social support, as their identities fit within the expected binary framework. In contrast, non-binary transgender people, whose identities may be doubted more often due to transnormative biases, might experience less social support, potentially contributing to poorer health outcomes (Sevelius, 2013). Transnormativity can empower but also limit trans people in expressing their gender modality, including those not undertaking medical transition (Pullen Sansfaçon et al., 2024).

Transnormativity, therefore, may be understood as a mechanism further stigmatizing and marginalizing an already stigmatized and marginalized subsection of the community, namely non-binary people and those who do not wish to pursue gender affirmation. Indeed, a study by (Magalhães et al., 2020) reported that participants from a Spanish sample of 14-25 year old Transgender and Non-Binary Individuals (TNBI) named the negative effects of the imposed traditional gender binary on their wellbeing and desire for transition. They identified barriers to wellbeing during the gender affirmation process to be highly influenced by lack of social acceptance, social

rejection, discrimination. The study concludes that internalized transphobia, originating from cisnormativity and perpetuated by transnormativity, acts as a significant barrier to the transition process and the choice to pursue this, leading to self-hatred and constant self-doubt. Furthermore, societal attitudes and stigmatization significantly impact the individual's willingness to come out as transgender, affecting interactions with family, friends, and other trans people, contributing to overall difficulties in the process.

1.5. GENDER AFFIRMATION

Gender affirmation is the process by which a person aligns their birth assigned gender to their gender identity, and is sometimes the preferred term over *transition*, although in official writing these can be used interchangeably (*Trans 101*, 2020) (*Glossary of Terms: Transgender*, 2024). Transition can be social, legal, medical, or with any combination of these.

1.5.1. Social gender affirmation

Social gender affirmation is the process by which a person discloses their gender identity within their social circles, and may involve 'coming out' to others, choosing a new name, declaring a preference for being addressed with different pronouns, and expressing their identity in a gender-congruent manner through a change in dressing and grooming (Chen et al., 2020). Recent sociological studies have reframed coming out to focus less on linear identity development and more on the continuing process of identity management, in keeping with focus on coming out as a socially embedded phenomenon (Brumbaugh-Johnson & Hull, 2019). Even though coming out has been associated with improved psychological health and wellbeing (Hughto et al., 2020; Legate & Ryan, 2014), trans people choose when and how much they wish to disclose in each new social circumstance, in response to threats of stigma and alienation (Lewis et al., 2023).

Qualitative investigations, focusing on the LGB community, have challenged fixed beliefs about social transition and concept development, such as "strategic outness," (Orne, 2011), considering the political context of coming out (Armstrong, 2002), or the revelation of place-specific sexual identities (Brown-Saracino, 2015). Despite this

research focusing on identity navigation of sexual minority individuals, the understanding of social transition in trans identity development can be transferable since both groups are subject to similar levels of stigma, discrimination, and oppression (Bockting et al., 2013).

1.5.2. Legal gender affirmation

Legal transitioning involves changing one's gender on official legal documentation, such as passports and driving licenses (Murjan & Bouman, 2015). In the UK, in order to apply for a change in documents, a person must self-declare that they have been living in their actual gender for at least two years, as well as submit two written reports from independent medical practitioners confirming a diagnosis of gender dysphoria (*Gender Recognition Act*, 2004). There is no requirement that a person has pursued or obtained any form of medical gender affirming care to obtain legal affirmation.

Receiving full legal gender affirmation has been found to lower the prevalence of psychological distress and suicidal ideation or intent among a large sample of trans adults in the USA (Scheim et al., 2020). However, political discourse and uncertain social climates may still negatively affect trans people who have obtained full legal gender affirmation, in the context in policy change, such as the recently enforced ban of transgender women from female prisons in England and Wales (BBC, 2023).

1.5.3. Medical gender affirmation

In order to align one's sex characteristics with their gender identity, transitioning necessitates medical assistance. This may involve combinations of hormonal therapy (HRT), speech therapy, or surgical procedures on a person's chest, uterus, genitalia, vocal chords, among other areas (Factor & Rothblum, 2008). Medical transition can be obtained following a diagnosis of gender dysphoria and meeting criteria outlined in the DSM-5 or ICD-11.

Physical transitioning can be understood as any form of physical appearance alteration with the aim to present as one's gender identity (e.g., using binding materials on the chest to reduce the visibility of breasts; laser hair removal), thus making it distinct from medical transition. Throughout this research, I have aimed to make

distinction between the two terms for accuracy, however, at times, these have been used interchangeably, based on participants' individual understandings and preferences.

Gender non-conformity was first introduced in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM III) under the name *transsexualism* (APA, 1980), not long after homosexuality was removed as a mental illness diagnosis (Cooper, 1999), and was later changed to Gender Identity Disorder (GID) in the fourth edition of the manual (APA, 1994). In the 2013 publication of the DSM-5, following new scientific evidence, this was changed to Gender Dysphoria, thus moving away from framing the identity as the problem (APA, 2013). While many (De Cuypere et al., 2011; Drescher, 2010) have praised the DSM-5 changes as a significant improvement and a step towards depathologization, others have remained critical of the attempt, pointing out that a diagnosis of gender dysphoria still minimizes the complexity of trans people's lives and experiences (Davy, 2015). This further compounds the issue around accessing gender affirming care for people who may not meet psychiatrists' criteria for "clinically significant distress", thus raising issues around "gatekeeping" (Ashley, 2019).

In 2022, the ICD-11 has updated its classification of gender identity-related health, replacing "transsexualism" and "gender identity disorder of children" (previously classified under "Mental health disorders") with "gender incongruence of adolescence and adulthood" and "gender incongruence of childhood" (now classified as "Conditions related to sexual health") (WHO, 2021). This change aims to reflect current understanding that transgender and gender diverse identities are not mental health disorders and helps reduce associated stigma, ensuring better access to gender-affirming healthcare and appropriate health insurance coverage. Additionally, it acknowledges the connections between gender identity, sexual behaviour, violence, and sexually transmitted infections.

In the past, comprehensive psychological assessments were advised for people seeking medical interventions for gender affirming care in order to ascertain whether gender-related distress was a secondary concern or could be better explained by other mental health issues or sociocultural factors (Coleman et al., 2012; de Vries et al.,

2006). However, in recent years, intensive assessments and lengthy bureaucratic procedures have been experienced as overly intrusive, dehumanising, and taking away from patient autonomy (Ashley, 2019), leading to a revision of ethical practices and a shift away from "gatekeeping" medical interventions (Amengual et al., 2022; Coleman et al., 2022). In some parts of the western world, shifting ideas have challenged historical attitudes of transition as a way to treat 'an illness' (gender dysphoria) to realizing key parts of identity, and giving trans people autonomy of choice over their healthcare (Ashley, 2019; Coleman et al., 2022; Schulz, 2017).

1.5.3.1. Gender dysphoria

Gender dysphoria is referred to as the distress or discomfort related to the incongruence between a person's gender identity and sex characteristics (APA, 2013). In the DSM-5 it is considered a medical diagnosis. Gender dysphoria has been associated with increased prevalence of anxiety, depression, and suicidal ideation, and, to a lesser extent, comorbidities with substance misuse, eating disorders, and ASD, compared to the cis population (Paz-Otero et al., 2021).

In a qualitative analysis by Austin et al. (2021), the lived experience of gender dysphoria was described as "a living hell". Common themes emerging were related to the relationship with the body, experienced as fraudulent, torturous, and transient; having a severely strong negative impact on emotional and mental wellbeing; and invalidating interpersonal relationships.

Cole et al. (1997) reported that after acknowledging their gender dysphoria and receiving support, individuals felt happier, more confident, and more productive. According to McNeil et al. (2012), there was a considerable decrease in suicidal ideation and suicide attempts after receiving gender affirming care, with 74% of participants reporting improved mental health and only 5% reporting a drop.

While researching the process of pursuing medical transition in the UK, I noticed the language used in healthcare providers' informational pages, such as the NHS or individual Gender Identity Clinic (GIC) websites, includes strong superlatives, such as 'certainty' in gender identity or 'strong desire' to live in a different body. These

resources, aimed at people wishing to learn about the concept, possibly for the first time, emphasise an *extreme* or *intense* experience; suggesting a certainty about one's transgender identity and definite desire to pursue transition. Much of this may be attributed to the NHS' strategy in reducing the foot traffic in clinics in the context of limited resources, however, this choice in language creates the sense that medical transition is necessary when there is an undeniable *need*, which may create confusion, doubt, or further uncertainty among many people first exploring their gender identity.

Access to gender-affirming services has been found to alleviate dysphoria and significantly improve mental health outcomes (Coleman et al., 2022; Hughto et al., 2020). Specifically, HRT has evidenced a reduction in mental health outcomes, whereas surgical interventions demonstrated a moderate improvement in mental wellbeing after a 6-month follow-up (Shelemy et al., 2024). However, the existing evidence is stemming from quantitative analyses, leaving much room for speculation about the function of the relationship between medical gender affirmation and mental wellbeing, and highlighting the need for more qualitative explorations.

1.5.3.2. Gender affirming care in the UK

Medical transition in the UK can be self-funded privately or can be facilitated by the NHS. The private route is favourable due to the quick access and short waiting times, however, is notoriously known for its high financial burden, proving a barrier to access gender affirming healthcare to many trans people (Harrison et al., 2020).

In order to qualify for free access to physical gender affirmation under the NHS, a person must have socially transitioned for at least a year before a referral to a GIC is made. They then must attend a number of appointments with mental health professionals and receive a formal diagnosis of gender dysphoria (NHS, 2024). Following a written recommendation, typically from the diagnosing clinicians, gender affirming interventions, such as HRT or surgeries, may then be offered, if the person's physical health allows this safely. GICs follow strict guidelines for offering these interventions, often including a temporal component to qualification. For example, chest reconstructive ('top') surgery is only considered after a person has been living in their preferred gender and taking HRT for a minimum of six months.

The medically focused structure of service provision has been criticised for further perpetuating the pathologisation of the trans experience as an 'illness, requiring medical intervention for its treatment' (Ashley, 2019). Moreover, the system lends the majority of the decision to the mental health professionals, further skewing the power imbalance in the relationship. Being misunderstood by clinicians or not receiving appropriate medical and psychological attention at the assessment stage has further created a rift in trust and accessibility between service users and professionals (Harrison et al., 2020).

There are currently 7 GICs in the UK for adults and only one for persons under the age of 17 (NHS, 2024b). With the rise of referrals to GICs in the recent years, this has resulted in significantly increased waiting times for accessing healthcare, currently taking up to two years for a first appointment. With the recent closure of GIDS, the largest gender clinic for children and young people in Britain earlier this year, these are predicted to worsen (Barnes, 2024). Increases in wait times are not unique to the UK, with waiting list strategies aiming to reduce mental health distress while waiting have been introduced worldwide (Dahlgren Allen et al., 2021).

In addition to the negative experiences outlined above, waiting times and experiences of discrimination may confound minority stress and negatively impact on mental health, particularly impacting neurodivergent trans people (White et al., 2023).

1.5.4. Detransition

The process of ending or reversing a gender transition, frequently in conjunction with a shift in the person's identity or gender conception since the transition was started, is termed *detransition* (MacKinnon et al., 2023). This may include both social and medical detransition. After discontinuing or reversing gender care, some people who detransition maintain their transgender identity, while others re-identify as their sex assigned at birth or their sexual orientation (e.g. gay, lesbian, or bisexual) (MacKinnon et al., 2022; Pullen Sansfaçon et al., 2023). Among the factors that may influence a person to detransition are physical or mental health concerns due to HRT; gender affirming interventions being unsuccessful in resolving gender dysphoria; feelings of

dysphoria subsiding over time; external factors, such as discrimination; or previously misattributing other issues to dysphoria (Littman, 2021; MacKinnon et al., 2022; Vandenbussche, 2022).

Despite increased research into the detrans population in recent years, the prevalence cannot be accurately captured. Estimates of detransition range from less than 1% to 13%, suggesting it is a rare and occasionally temporary event (MacKinnon et al., 2022). A large portion of the variability in these estimates can be attributed to variations in methodology, sample techniques, and conceptual definitions.

The study of transition decisional regret is currently limited and controversial. One large longitudinal study of a GIC in Amsterdam demonstrated between 0.3%-0.6% of respondents disclosed experiencing regret of undergoing surgical gender affirming care (Wiepjes et al., 2018). However, the study fails to disclose the rates of regret for patients who pursued other forms of medical intervention, leading to criticisms in its findings. In the UK, a retrospective review reported 6.9% of patients in a GIC sought detransition, however, the study noted only half (56.1%) of patients completing the treatment pathway, suggesting services failing to meet needs (Hall et al., 2021). Jorgensen (2023) criticises the reported low rates of decisional regret in the literature. Noting generational shifts where medical gender affirming care was more strictly regulated and poor research methods, the paper highlights the uncertainties in reported findings. The current state of literature suggests more research is necessary into the detrans population to help form ideas about the individual and systemic needs of people considering medical gender affirming care.

These studies suggest the majority of people who pursue medical transition are likely to be satisfied with this choice and rates of regret, although still debated, are low. Perhaps this reinforces the idea that a level of certainty is deemed necessary when considering whether to pursue gender affirming care, both from clinicians and service users; this might be stemming from the perspective of healthcare professionals and thus influencing individuals' perspectives as well. Detrans people continue to experience stigma, discrimination from general society, healthcare professionals, or other trans people, possibly as a result of cisnormative and transnormative views on trans existence and legitimacy.

2. Literature review and critical analysis

In order to understand the motivation behind the pursuit of gender affirming care, I first present the factors contributing to and against the choice, as evidenced by the literature. I then explore if and how medical transition desire might occur in gender identity development theories, reviewing historical and current accounts, and making sense of the process of choosing not to medically transition. Finally, I consider what role the relationship with one's physical body might contribute to this decision. I present and evaluate the research from multiple perspectives and include my reflexivity throughout. I present tables summarizing the key findings after each section for clarity and ease of reading.

The Boolean terms used to find suitable articles were sourced from online trans terminology resources created by LGBT+ and trans-specific NGOs (*Glossary of Terms: Transgender*, 2024; *Trans 101*, 2020). The literature was chosen after a semi-formal review of research search engines such as PsycInfo, Web of Science, Scopus, and Google Scholar. The initial search focus was on trans people's identity development and experiences pursuing medical transition, which resulted in 179 research articles and book chapters containing theories about the process. This revealed that pursuing gender affirming care is not a typical practice for all transgender people, which prompted a focus on the specifics of life without physical transition. The second search included focused topics such as "trans," "medical transition," and "identity development and management," limited to English-language articles with relevant titles and abstracts, yielding 119 articles. Reference lists for relevant articles were also reviewed for related research. More contemporary literature was identified by using the search engines' tools to find papers citing original findings. Articles that closely matched the research topic were read in their entirety, and the findings were categorised into themes. The search yielded quantitative, qualitative, and mixed-method research, with a large number of results published during the last five years. The 47 articles included in this literature review were chosen for their relevance to the topic.

2.1. Factors influencing Medical Transition Decision

Below is a summary of the literature that has identified possible motivating factors influencing trans people's decision whether to pursue medical gender affirming care or not. A table summarizing the factors, descriptions, and their references, is uncluded at the end.

2.1.1. Reasons 'for' transition

2.1.1.1. Gender dysphoria experiences

Experiences of gender dysphoria are a significant reason for pursuing medical gender affirming care, both as a strong motivating factor and a legal requirement for its provision (de Vries et al., 2006; Gijs & Brewaeys, 2007; Zaliznyak et al., 2020). Austin et al. (2021) reported a motivating factor for pursuing medical transition was the intense negative experience of gender dysphoria, characterized by emotional and physical suffering, a sense of being unseen by others, and profound feelings of incongruence, all exacerbated by fluctuating pain. Research indicates that medical interventions can substantially alleviate this suffering, which explains why many transgender individuals seek medical transitioning (Becker-Hebly et al., 2021; Collazo et al., 2013).

2.1.1.2. Improving mental health

A review by Shelemy et al., (2024) determined that medical interventions targeting gender dysphoria, particularly HRT and psychological treatments, may positively affect transgender people's mental health. Indeed, much of the research supports the finding that body dissatisfaction is associated with poorer mental health outcomes (Klemmer et al., 2018; Tabaac et al., 2018) suicidality (Peterson et al., 2017) and that physical gender affirming care is associated with improved mental wellbeing among trans people who pursue it (Almazan & Keuroghlian, 2021; Swan et al., 2023; Tordoff et al., 2022).

2.1.1.3. Reducing threat

Trans people may pursue physical gender affirmation in order to reduce the systemic oppressiveness, discrimination, and GBV from appearing gender non-conforming. For

some trans people, the ability to ‘pass’ serves the function of authentically embodying their gender identity (Billard, 2019), and can also function as a way to reduce threat (Green, 2006; Snorton, 2009). Research by Peixoto et al. (2021) established that Brazilian trans women who were more likely to ‘pass’ experienced reduced police violence in their home neighbourhoods, as well as lower rates of transphobic violence in public spaces, suggesting passing, or being seen as the gender a person wishes to be seen as, serves as a protective factor. However, complicating matters further, the concept of passing has been weaponized by cisgender individuals to suggest that transgender people pass to deceive others about their gender and/or sex (Anderson et al., 2020), thus posing new threats trans people must navigate.

In a study by Klemmer et al. (2018) transphobia-based violence was found to be significantly associated with increased anxiety, depression, and decreased body satisfaction, which may account for a factor in pursuing medical transition as a way to reduce threat.

Passing has also been found to be identity affirming and an important factor for pursuing medical transition (Anderson et al., 2020). In original research on the importance of passing in transgender identity development, passing was described as a technique for self-affirmation and being seen by society as one wishes to be seen (Anderson et al., 2020). Respondents discussed using hormone treatment to alter their bodies' appearances, or change in behavior and social interactions in passing. However, not all transgender individuals prioritize passing, and there are differing perspectives on the concept and its implications for transgender recognition and acceptance.

2.1.1.4. Transnormativity and binary preference

The mainstream Euro-American values of gender are rooted in a cisnormative paradigm that enforces a binary view of gender, which stigmatizes genderqueer people as 'abnormal' due to their non-conformity (Bradford & Syed, 2019). This binary framework also influences transnormativity, defining what it means to be transgender in ways that rely on these same binary norms (Riggs et al., 2019). According to Bradford & Syed (2019), this transnormative perspective pressures trans individuals

to pursue medical transition in order to be deemed 'trans enough' within societal expectations, stemming from within and without the trans community. This aligns with findings that binary trans individuals are more likely to undergo medical transitioning than their non-binary peers (Factor & Rothblum, 2008; Kennis et al., 2022; Koehler et al., 2018; Nieder et al., 2020).

2.1.1.5. Achieving congruence

In a major qualitative exploration of trans identity development, Levitt and Ippolito (2014b) propose one of the primary motivators for trans people considering medical transition is attaining congruence between gender identity and physical sex. The study concluded that both internal and external variables drive this pursuit for congruence. Reducing internal turmoil regarding behaviour in social and professional contexts, as well as individuals' issues with their identity, were examples of internal factors. Additionally, after starting HRT, transgender patients consistently reported less symptoms of mental disorders and lower levels of body dissatisfaction, consistent with other findings (Mueller et al., 2017; van de Grift et al., 2016).

Managing others' gender expectations and reducing the negative effects of others' reactions toward them were reported external factors for pursuing medical gender affirming care. Further, practical and economic advantages of medical transitioning included decreased job search challenges and a decline in violence and safety risks, as consistent with other literature (Brumbaugh-Johnson & Hull, 2019). According to Levitt & Ippolito (2014b), a significant external element influencing the desire for physical intervention is seeing representation in intersectionality. One Black trans participant reported that learning about others' lived experiences that were similar to their own had an impact on their decision to transition, highlighting the social interdependence of gender identity formation and evolving perspectives on transition.

According to self-verification theory, it is an inherent human strive to achieve consistency in how individuals view themselves and how others react and respond to them (Gómez et al., 2009). As listed above, TGNC people experience invalidation through micro- and macroaggressions when their gender identity is not perceived accurately (Viehl et al., 2022). Achieving congruence is particularly relevant to trans

and gender diverse individuals who seek affirmation as a way to manage and strengthen their connection to identity (Doyle et al., 2021) and validation from others to improve resilience (Hetzel & Mann, 2021; King & Gamarel, 2020)

2.1.2. Reasons 'against' transition

Some transgender people may not feel the need to take any steps towards gender affirming care, whereas others, who may wish to, find themselves unable to access this. Research on transgender people's experiences without medical transition is limited, and there is a significant gap in understanding why some trans individuals choose not to seek physical gender affirming care. Despite the abovementioned evidence supporting the benefits of medical transition, it is crucial to explore the factors behind the decision to forgo this process. Existing literature identifies themes such as risk aversion to invasive procedures, lower engagement within the trans communities, and extended periods of living in one's biological gender to contribute to this decision.

Vitelli et al. (2017) found that 35% of trans participants in their Italian non-clinical sample did not plan to transition physically, but the study's quantitative design did not allow exploration into the reasons behind this choice. The use of a binary yes/no question format limited the depth of understanding and may have biased the results, highlighting the need for more nuanced qualitative research in this area.

2.1.2.1. Reducing threat

Transgender people are at an increased risk of GBV as a result of public perceptions of gender nonconformity. Identity concealment was found to be a predictor for improving trans people's life satisfaction through reducing exposure to stigma, everyday discrimination, and risk of violence (Bränström & Pachankis, 2021). Within this context, the process of undergoing hormonal or partial surgical interventions places trans people at greater risk of prejudice, discrimination, or gender-based violence, which, understandably, acts as a barrier to pursuing medical intervention.

Hiding identity can also explain lower engagement with the trans or wider LGBTQ+ communities, which further limits self-acceptance (Sherman et al., 2019), in-group solidarity and pride (Barr et al., 2016), related to developing resilience and protection

against the negative effects of stigma (Doyle et al., 2021; Valente et al., 2022). A stronger connection to a community has also been found beneficial in reducing the negative effects of discrimination on mental health and wellbeing (Barr et al., 2016) and acts as a protective factor against self-harm (Taliaferro et al., 2019) and suicide (Kia et al., 2021).

It is apparent that for those who choose not to pursue medical intervention the costs and potential risks to physical and emotional safety play a significant role in the decision outcome.

2.1.2.2. Fear of medical intervention complications

Fear of medical complications is a normal and valid concern to invasive physical intervention. To add to this, a recent review reported rates of complications related to 'bottom' gender affirming surgery in up to 66% of cases in the last decade (Blasdel et al., 2024), further contributing to negative expectations around intervention.

A study by van de Grift et al. (2018) hypothesised a correlation between dissatisfaction with medical gender affirming care and increased negative effects on psychological symptoms and overall quality of life, despite levels of dissatisfaction among the interviewed were low (6%). This suggests the viewpoint that medical intervention, if sought for alleviation of gender-related distress, might not just fail to satisfy this need, but even contribute to it.

While many trans people may not be privy to current medical research on the topic, subjective experiences not otherwise captured in the literature, such as hearing about medical complications or witnessing poor esthetical results among peers, might also impact the decision.

2.1.2.3. Non-binary preference

Research has suggested that non-binary individuals are less likely to pursue physical gender affirming care. Factor and Rothblum (2008) found that while all binary trans participants in their non-clinical sample were engaging in or willing to engage in HRT, 22% of genderqueer participants were not interested in this procedure. This study

controlled for interest in specific medical procedures and distinguished practical barriers, such as financial difficulty, from the desire to transition, indicating a robust research design. However, its quantitative nature limited the exploration of underlying beliefs and motivations. Additionally, many potential participants refused to engage in the study, fearing it would oversimplify their experiences. Taylor et al. (2018) further emphasized that non-binary individuals often view transition as a dynamic and ongoing process, highlighting the complexity of the phenomenon and the need for more in-depth qualitative research.

2.1.2.4. Personal and social affirmation

To the best of my abilities, I was able to identify only one study directly examining the experiences of transgender individuals who choose not to pursue medical gender affirming care. Nieder et al. (2020) conducted a mixed-method analysis by reviewing the literature and exploring the demographics and characteristics in a non-clinical German sample. They found that trans individuals not interested in medical transition were typically older, had spent more time not living in their actual gender, had fewer areas of their lives in which they lived in their actual gender, and had fewer connections to trans support groups. These findings align with Beek et al. (2015), which noted hesitations about full medical intervention due to risk aversion and fewer external pressures for transitioning. Nieder et al. (2020) also highlighted themes of lack of necessity and higher identity satisfaction as reasons for not transitioning, consistent with Levitt & Ippolito's (2014b) theory on internal factors influencing the decision to transition.

Nieder et al. (2020) used a community sample, which is beneficial for representing non-clinical experiences, thus reducing pathologisation, though convenience sampling limits generalizability. Participants were recruited online as part of a larger research project to inform trans healthcare provision in Germany, indicating possible self-selection and undercoverage bias. The study's strength lies in its detailed analysis method, including transcripts of self-reported reasons for not seeking medical transition, revealing themes such as previous engagement with medical and psychological services and geopolitical differences in healthcare provision. However, the predominantly quantitative design limited the exploration of these themes, and

reliance on researchers' interpretations and online blog posts for additional insights potentially compromised the validity of the findings due to the lack of direct trans voices and the anonymity of blog sources.

The abovementioned studies provide valuable insights into the prevalence of trans individuals who choose not to pursue physical gender affirming care and suggest various factors influencing this decision. However, the limited number of articles and inherent design limitations highlight a significant gap in the literature. Addressing this gap requires qualitative research that delves deeper into the experiences, attitudes, and needs of trans people.

Table 1. Summary of findings on factors influencing medical transition decision among trans individuals

Factor	Description	References
Reasons *for* medical transition		
Gender Dysphoria Experiences	Significant motivating factor for medical transition; alleviates emotional and physical suffering.	de Vries et al. (2006), Gijs & Brewaeys (2007), Zaliznyak et al. (2020), Becker-Hebly et al. (2021), Collazo et al. (2013), Austin et al. (2021)
Improving Mental Health	Medical interventions positively impact mental health, reducing body dissatisfaction and suicidality among transgender individuals.	Shelemy et al. (2024), Klemmer et al. (2018), Tabaac et al. (2018), Peterson et al. (2017), Almazan & Keuroghlian (2021), Swan et al. (2023), Tordoff et al. (2022)
Reducing Threat	Physical gender affirmation reduces systemic oppression and discrimination; ability to 'pass' can mitigate threats.	Billard (2019), Green (2006), Snorton (2009), Peixoto et al. (2021), Klemmer et al. (2018), Anderson et al. (2020)
Transnormativity and Binary Preference	Societal pressure to conform to binary gender norms may influence the decision to transition; binary trans individuals are more likely to transition than non-binary peers.	Bradford & Syed (2019), Riggs et al. (2019), Factor & Rothblum (2008), Kennis et al. (2022), Koehler et al. (2018), Nieder et al. (2020)
Achieving Congruence	Desire for alignment between gender identity and physical appearance; includes internal and external variables affecting identity and societal acceptance.	Levitt & Ippolito (2014b), Mueller et al. (2017), van de Grift et al. (2016), Gómez et al. (2009), Viehl et al. (2022), Doyle et al. (2021), Hetzel & Mann (2021), King & Gamarel (2020)
Reasons *against* medical transition		
Reducing Threat	Identity concealment can improve life satisfaction by reducing stigma and risk of violence; fear of gender-based violence can deter medical intervention.	Bränström & Pachankis (2021), Sherman et al. (2019), Barr et al. (2016), Taliaferro et al. (2019), Kia et al. (2021), Doyle et al. (2021), Valente et al. (2022)
Fear of Medical Intervention Complications	Concerns about complications from invasive procedures may deter individuals from pursuing medical transition.	Blasdel et al. (2024), van de Grift et al. (2018)
Non-binary Preference	Non-binary individuals may be less likely to pursue medical gender affirming care, viewing transition as an ongoing process rather than a binary outcome.	Factor & Rothblum (2008), Taylor et al. (2018)
Personal and Social Affirmation	Some individuals express satisfaction with their gender identity without the need for medical transition; connections to support groups influence this satisfaction.	Nieder et al. (2020), Beek et al. (2015)

2.2. MODELS OF IDENTITY DEVELOPMENT

The abovementioned findings show the factors trans people may consider in choosing whether to pursue medical gender affirming care and aim to answer the question *why* trans people might pursue this or choose not to. However, exploration of the question *how* do trans people make such a choice is instrumental in understanding the aspects of identity important to people, as well as the way of negotiating one's identity as a result of this choice. An understanding of transgender identity development is necessary to formulate a hypothesis of this interaction.

2.2.1. Early models of TGNC identity development

Early research into transgender and gender non-conforming (TGNC) identities began with Ellis (1945), who examined the discrepancies between socially assigned genders and experienced gender identities among intersex individuals. This study highlighted the significance of both internal and external influences on gender identity. However, the concept of "gender identity" itself was not formally introduced until Stoller (1968), whose psychoanalytic understanding asserted that threats to one's gender identity could be perceived as threats to their overall self-concept.

Hill's (1997) investigation into gender identity development highlighted the multidimensional nature of this process. Hill found that many participants felt forced to choose binary gender categories (e.g., "male" or "female") in everyday situations, despite these terms not resonating with their true identities. Hill concluded that there is significant diversity among TGNC individuals that remains underexplored, paving the way for future research intro trans identities and highlighting the diversity of experiences within the population.

Devor (2004) developed the first stage model of gender identity formation, drawing on previous models of multicultural identity, such as those related to racial, ethnic, and LGB identities (Cass, 1984; Cross Jr, 1971; Fassinger & Miller, 1997; Helms, 1990; Van de Meerendonk & Probst, 2004). Devor's model was pioneering in framing gender identity as a developmental process rather than biological or anatomical facts. However, it was critiqued for its assumptions about anatomical dysphoria and the ultimate desire for physical transition, which reinforces binary gender concepts and

incorrectly suggested that each gender has a specific physical form (Fiani & Han, 2018).

Brumbaugh-Johnson & Hull (2019) used identity theory, rooted in social determinants of identity development, to understand transgender people's motivator processes for social and physical transition. Identity theory suggests that individuals possess multiple identities based on the meanings they assign to their roles and social categories (Stryker & Burke, 2000). These identities guide behaviour, influenced by group membership and broader social categories like gender (Stets & Burke, 2000). Behaviour aligns with these internalized role expectations, and individuals adjust their actions to achieve 'identity verification' through positive feedback from others (Burke & Reitzes, 1981). For instance, a transgender man may adopt behaviours associated with masculinity to be recognized as a man, modifying behaviour based on others' appraisals to achieve this recognition. The researchers propose that this may account for pre-transition gender performance and the pursuit of physical gender affirmation.

This suggests that medical transition can be viewed as a way of negotiating and managing a transgender identity: embodying the gender identity one aligns with may help the experience and expression of identity, thus achieving congruence and influencing others' perception and validation.

Transgender identity theory has historically been framed through the lens of feminist and queer theories, discussing gender roles, identity, and sexual orientations. Feminist theory critiques the historical and cultural contexts of gender, often assuming a binary system based on biological sex (Hausman, 2001), and highlights the social reinforcement of traditional gender roles (Connell, 2002). However, it has faced controversy over questioning the binary nature of gender identity (Hesse-Biber et al., 1999; Heyes, 2007; Jagose, 2009). Queer theory, which emerged as a challenge to feminist theory, posits that both gender and sexual identities are social constructs that can be questioned and subverted (Butler, 1990; Halperin, 1995). Quuer theory highlights performativity, where repeated behaviors create the illusion of an inherent gender identity, integrating ideas from symbolic interactionism (Butler, 1990). While "queer" offers solidarity outside heteronormative norms, it lacks a definitive essence and, similar to feminist theory, may overlook the complex, socially constructed, and

embodied aspects of individual lived experiences, thus posing challenges for understanding and empowering transgender identities (Halperin, 1995; Shields, 2008; Sullivan, 2003).

2.2.2. Current views on TGNC identity theory

Transgender theory critiques both feminist and queer theories by proposing a more fluid and embodied understanding of gender identity (Roen, 2002). It argues that gender is not merely an expression of social constructs but involves a dynamic interaction between self-embodiment and social expectations. Transgender theorists emphasize the need to account for lived experiences and biological limitations on gender fluidity (Monro, 2000; Roen, 2002). Nagoshi et al. (2012) conclude that a relational model incorporating both embodiment and social constructionism can better capture the complexity of transgender identities and their intersections with gender roles and sexual orientation.

Contributing to trans theory from lived experiences, Nagoshi et al. (2012) completed a study of 11 TGNC individuals' understanding on trans identity development and management, gender roles, and sexual orientation. The study reported that the trans participants generally viewed gender roles as socially constructed behaviors, in contrast with their perception of gender identity as fluid, on a continuum, and capable of changing over time and contexts. While acknowledging the social construction of gender roles, many participants felt their gender identity was embodied in their physical being, with some seeing medical gender affirming care as necessary to align their body with their gender identity. Participants expressed the dynamic nature of gender identity and sexual orientation, with some rejecting any connection between the two, while others described a more intertwined relationship influenced by sexual attractions and social interactions. The findings emphasize the intersectionality of multiple oppressed identities, suggesting this intersection can be a source of empowerment against societal oppressions. This approach highlights the importance of understanding individual narratives and the dynamic interplay between self-construction and societal influences.

2.2.3. The Social Feedback Model

Contemporary understandings of TGNC identities in the social feedback model have been proposed as an interaction between personal identity development, psychosocial identity management, and interpersonal identity affirmation by others (Doyle, 2022). This model allows considering current socio-political contexts and individual differences in developing a comprehensive theory of transgender identity. Below, I explain the three different aspects, how they contribute to identity formation and maintenance, and how they interact with each other.

2.2.3.1. Personal identity development

Identity development in transgender people is often viewed through stage models, with key milestones typically emerging around puberty, around ages 10-13, when feelings of gender incongruence and dysphoria become critical (Steensma et al., 2011). These feelings frequently drive transgender self-identification (Pullen Sansfaçon et al., 2020), although recent critiques suggest that gender euphoria, or the positive feelings experienced when a trans person's gender is affirmed and respected, also plays a significant role (Austin et al., 2022; Beischel et al., 2022). Transgender identity awareness usually begins in puberty, but public self-identification tends to occur later (Tatum et al., 2020), with factors like ethnicity and exposure to discrimination influencing timing (Restar et al., 2019; Restar et al., 2021). Additionally, narrative approaches have been criticized for positioning transgender identity through the lens of cisnormative master narratives and these must be understood beyond traditional cisnormative and transnormative frameworks to recognize diverse trajectories as normal and valid (Doyle, 2022). Recent research on transgender youth who have accessed gender affirming care has identified three trajectories of trans identity development: early dissonance with early affirmation and transition; early dissonance with delayed transition; and delayed experience of dysphoria (Pullen Sansfaçon et al., 2020). The authors argue that the development process is inherently personal and social, and it is impossible to create a single model predicting trans identity formation.

2.2.3.2. Psychosocial identity management

The social feedback model considers the impact of continuous identity management on TGNC identity development. Identity management is important for understanding

transgender identity from a social and interpersonal lens, as demonstrated above, many of the decisional factors rely on social belonging and interpersonal relationships.

Trans individuals navigate disclosure based on each social situation, balancing authenticity with potential risks of stigma (Lewis et al., 2021; Lewis et al., 2023). *Passing*, or being perceived as cisgender, can be an important goal for some transgender people, reflecting their genuine gender identity (Billard, 2019), but it also involves complex decisions about disclosure to avoid prejudice and violence (Bränström & Pachankis, 2021). The pressure to pass or disclose can impact well-being and community involvement (Barr et al., 2016), with external expectations often leading to stress and concealment strategies that both protect and harm mental health (Bränström & Pachankis, 2021). Identity management for transgender people is a strategic and context-dependent process, highlighting the need to mindfully navigate social and political environments.

2.2.3.3. Interpersonal identity affirmation

The social feedback model also integrates the impact of affirmation by others on TGNC identity development. Social identities are shaped by both internal self-perception and external categorization by others, with alignment between the two promoting well-being and misalignment leading to social identity threats and distress, particularly for transgender individuals who experience misgendering (Branscombe et al., 1999; McLemore, 2015). Misgendering not only directly affects psychological health but can also trigger gender dysphoria, increasing psychological distress (Galupo et al., 2020; McLemore, 2015). Further, socio-political debates questioning the validity of transgender identities, such as those concerning public toilet usage, harm the psychological health and well-being of transgender individuals (Horne et al., 2022).

Affirmation of gender identity by others is essential for the mental health and self-concept clarity of transgender individuals, enhancing their overall well-being and developing resilience (Doyle et al., 2021). Transgender people actively seek supportive communities, both online and in person, to explore and affirm their identities, which is vital for healthy identity development (Lewis et al., 2021)

2.2.4. Identity development and management among non-binary persons

Rankin & Beemyn (2012) conducted a comprehensive analysis of research, involving 3,500 surveys and 400 interviews of transgender individuals, revealing that a singular gender transition trajectory did not apply to their respondents. They identified eight significant milestones in the journey toward gender identity acceptance, which varied among trans men, trans women, cross-dressers, and genderqueer/non-binary individuals, highlighting the non-linear and individual nature of these experiences, and thus illustrating the significant diversity in gender transition experiences.

These findings were supported by Tatum et al. (2020) who performed a qualitative analysis of differences in transition milestones between binary and non-binary transgender people, using Johnson's (2016) transnormativity framework to contextualise their findings. They reported that non-binary individuals noticed feeling different at a later age than their binary counterparts, and were less likely to pursue medical gender affirming treatments. This is possibly due to direct influences (i.e., not subscribing to transnormative expectations of committing to one gender physical presentation) and indirect ones, such as rejecting the concept of living full-time in their actual gender, which is in conflict with pre-requisites for gender affirming care (e.g. commitment to living in actual gender for a minimum of 12 months prior to starting HRT). They also reported how lacking representation of people with similar experiences further limits and delys the exploration and identity development processes. These findings highlight the difference in experiences within the community and suggest that applying a transnormative narrative to generalise and understand trans identity development may marginalize the unique experiences of a hugely varied population.

A recent study by Di Giannantonio et al. (2024) explored the processes of awareness and identity construction among trans people who do not identify within the binary gender narratives in Italy, constructing a model of identity development. By doing a qualitative analysis on interviews from twenty non-binary Italian participants, they reported that some participants in the study expressed satisfaction with their bodies and did not desire medical intervention, while others were ambivalent due to fears of

reinforcing binary gender norms. Common barriers included economic constraints, the stress of hormonal or surgical procedures, and the need for disclosure, compounded by healthcare professionals' lack of knowledge about nonbinary identities. Additionally, interpersonal relationships and access to queer spaces helped nonbinary individuals validate their experiences and achieve well-being, gender euphoria, and broaden their understanding of gender.

The study raises the point of how significant language is in determining social narratives about identity, given that Italian is a gendered language. Even though the sample is limited to a specific trans population, who may be influenced by political and healthcare influences unique to the country, their findings are not dissimilar to other studies exploring non-binary identity development (Galupo et al., 2017).

The findings of this study are significant as they highlight the important function of gender normativity; awareness of (non-binary) trans identities; gender dysphoria, and more specifically the impact of the physical and social aspects of body congruence; as well as holding the uncertainty and potential of an ever-evolving gender identity. This draws attention to the similarity of over-arching themes among trans identity development models, however, emphasizes the significance of different nuances among identities within the trans community.

2.2.5. Identity management and affirmation for people without medical transition

To date, I was unable to identify literature explicitly exploring the identity development and management for trans people who choose not to pursue medical gender affirming care. However, suggestions from existing literature might contribute to an understanding about this experience.

First, strength of transgender identity – the extent to which a person defines their identity as transgender and the extent to which they believe their gender transition is important to their self-definition – might be a contributing factor to this (Barr et al., 2016). However, there have been no identified theories exploring what predicts this outcome and how trans people manage their identity in the context of no medical intervention.

Second, from the above literature on non-binary individuals' narratives and lower rates of pursuing gender affirming care (Tatum et al., 2020), it can be hypothesised that medical intervention is deemed as a commitment to gender expression. Perhaps trans people whose views do not align to the gender binary, or have to strategically navigate social situations for need of safety and belonging, might perceive physical intervention as a burden too costly. Thus, the choice of pursuing medical gender affirmation becomes a choice of sacrifice between multiple aspects of identity and beliefs, and not pursuing this becomes another strategy of identity management.

However, the relationship with the body among trans people without medical transition remains underresearched.

2.3. The role of the body

It is important to consider the function and relevance of the physical body in trans people's identity development and management in order to better understand the function of medical gender affirmation. McGuire et al. (2016) conducted a qualitative study using a nonclinical, community sample to explore body image among transgender youth aged 15–26, including nonbinary individuals. By adopting a perspective that did not pathologize transgender experiences and avoided hetero-cisnormative assumptions, the study uncovered significant insights into both body satisfaction and dissatisfaction. Notably, some participants expressed a sense of liberation from traditional gender roles, societal norms, and conventional gendered body expectations, highlighting a significant social and interpersonal aspect to the function of the body, as well as the diverse and affirming experiences of one's physical characteristics (McGuire et al., 2016).

Some nonbinary trans people prefer androgynous body ideals, according to recent studies. Research by Cusack & Galupo (2021) concluded that nonbinary people may utilise distinct body-checking behaviours to reduce their risk of being misgendered or recognised by their assumed assigned sex, in addition to maintaining eating disorder symptoms (Shafran et al., 2007). Similar findings were reported by Galupo et al. (2021), who discovered that many nonbinary trans people embrace androgyny in order

to attain appearance congruence and more accurately reflect their gender identity. These findings emphasise the importance of androgyny in nonbinary people's body ideals and gender identities, as well as the distinct ways they experience and navigate gender dysphoria.

It appears interpretations of the physical body may function as a way of managing both personal identity and navigating social and interpersonal aspects of identity for some trans people, which provides insight into the decision-making process of whether to pursue medical gender affirmation for some.

Table 2. Summary of findings on historical and current models of transgender identity development

Section	Topic	Key Findings	References
2.2.1.	Early models of TGNC identity development	- Ellis (1945): Discrepancies between socially assigned genders and experienced gender identities among intersex individuals. - Stoller (1968): Threats to one's gender identity as threats to overall self-concept. - Hill (1997): Multidimensional nature of gender identity development; binary gender categories. - Devor (2004): First stage model of gender identity formation; criticized for anatomical dysphoria and binary assumptions. - Brumbaugh-Johnson & Hull (2019): Identity theory; social determinants of identity development	Ellis, 1945; Stoller, 1968; Hill, 1997; Devor, 2004; Cass, 1984; Cross Jr, 1971; Fassinger & Miller, 1997; Helms, 1990; Van de Meerendonk & Probst, 2004; Fiani & Han, 2018; Brumbaugh-Johnson & Hull, 2019; Stryker & Burke, 2000; Stets & Burke, 2000; Burke & Reitzes, 1981
2.2.2.	Current views on TGNC identity theory	- Roen (2002): Fluid and embodied understanding of gender identity. - Monro (2000): Interaction between self-embodiment and social expectations. - Nagoshi et al. (2012): Relational model; gender roles as socially constructed behaviors.	Roen, 2002; Monro, 2000; Nagoshi et al., 2012
2.2.3.1.	Personal identity development	- Stage models with key milestones around puberty. - Gender euphoria and positive feelings. - Trans identity awareness during puberty; public self-identification later. - Diverse trajectories of trans identity development.	Steensma et al., 2011; Pullen Sansfaçon et al., 2020; Austin et al., 2022; Beischel et al., 2022; Tatum et al., 2020; Restar et al., 2019; Restar et al., 2021; Doyle, 2022
2.2.3.2.	Psychosocial identity management	- Continuous identity management; balancing authenticity and risks of stigma. - Passing as cisgender; complex decisions about disclosure. - Impact on well-being and community involvement.	Lewis et al., 2021; Lewis et al., 2023; Billard, 2019; Bränström & Pachankis, 2021; Barr et al., 2016; Bränström & Pachankis, 2021
2.2.3.3.	Interpersonal identity affirmation	- Impact of affirmation by others; well-being and resilience. - Misgendering and psychological distress. - Seeking supportive communities.	Branscombe et al., 1999; McLemore, 2015; Galupo et al., 2020; McLemore, 2015; Horne et al., 2022; Doyle et al., 2021; Lewis et al., 2021
2.2.4.	Identity development and management among non-binary persons	- Non-linear and individual transition experiences. - Differences in transition milestones between binary and non-binary people. - Economic constraints, healthcare professional knowledge, interpersonal relationships, and access to queer spaces.	Rankin & Beemyn, 2012; Johnson, 2016; Tatum et al., 2020; Di Giannantonio et al., 2024; Galupo et al., 2017
2.2.5.	Identity management and affirmation for people without medical transition	- Strength of transgender identity. - Medical intervention and commitment to gender expression. - Strategic navigation of social situations for safety and belonging.	Barr et al., 2016; Tatum et al., 2020
2.3.	The role of the body	- Body satisfaction and dissatisfaction among transgender youth. - Androgynous body ideals among nonbinary individuals. - Interpretation of the physical body as managing personal identity and social aspects.	McGuire et al., 2016; Cusack & Galupo, 2021; Shafran et al., 2007; Galupo et al., 2021

3. Limitations and need for further research

While existing research provides valuable insights into the factors influencing transgender people in choosing whether to medically transition, gaps remain in understanding the diverse experiences within the transgender community. Future research should address methodological limitations (mostly quantitative studies which do not allow giving voice to trans people), explore intersections of identity and experience (how to navigate identity), and investigate long-term outcomes of different transition pathways.

In the last 10 years, there has been a significant increase in research on transgender individuals from various disciplines, including medical, sociological, philosophical, and psychological fields, aimed at enhancing professionals' understanding and support of the trans community. Nevertheless, there remains a lack of focus on the 'less visible' members of this community, especially those trans individuals who choose not to pursue medical transition or physical intervention.

In a novel research study aiming to develop understanding on TGNC identity development, using an intersectional approach, Kuper et al. (2018) emphasized the importance of individuals fully expressing their gender and having it accurately acknowledged by others. Based on this conclusion and the findings from the above literature review, it can be concluded that gender is a very important aspect of TGNC people’s overall identity formation and development and being accurately seen is of the highest importance. This raises the question, if gender affirmation is essential for identity development, and opting not to transition carries significant negative consequences for social acceptance, how do trans individuals who choose not to pursue physical transition navigate these challenges?

Although underresearched, the link between gender identity and the physical body appears to be relevant (McGuire et al., 2016). From the above findings about the overwhelming power of gender dysphoria, the strategic role in social identity management, and way of negotiating personal identity, it appears the relationship with the body becomes central for identity consolidation and management. This leaves the question, if the physical body plays such an important role in most aspects of a trans

person's identity, how do people who choose not to affirm their gender medically navigate this choice and the consequences of it?

The following research projects aims to explore these questions in sufficient detail in order to contribute to the limited existing literature, and generate new theory to expand understandings of existing topics. This may be useful in developing healthcare professionals' understanding and ability to provide affirming treatment, contribute to service need and provision among GICs or on a policy organisational level, as well as provide representation for trans people who are exploring their identities and do not have models of similar experiences. In doing so, this research aims to give voice to trans people whose experiences may have been marginalised in the context of transnormativity and appear to be significantly overlooked in academic literature.

Chapter 2: Methodology

Overview

In this chapter I demonstrate the research process of the study. I first contextualise the development of the research question, 'How do older British transfem people choose not to seek medical gender-affirming care?' and highlight the research aims. I then posit my interpretation of the philosophical underpinnings relevant to its development and continue by demonstrating my choice for its research design for investigation. I explore my reflections on my subjective stance with the topic and showcase the ethical considerations I employed to meaningfully conduct the study. Finally, I describe in detail the study's method and analytic procedure.

1. Development of Research Question

Looking back, I have always been interested in the philosophical issues of subjective interpretations of social reality. I felt particularly inspired by Audre Lorde's biography (Lorde, 1982) in which she recounts being labelled as legally blind from a young age, yet recalls memories and experiences imbued with colour. It made me reflect on the intersection between society's interpretations of reality and the social contract we subscribe to, and what happens when it contrasts with subjective experiences that do not fit within its norms. This led me to think about what it might mean to not fit into the narratives and practices of the majority, whilst holding an experience one may not have the words for. Having witnessed close people navigate LGBT+ identities within Western cis-heteronormative society, I felt a mix of emotions, drawing my philosophical reflections to real-life human experiences. My personal curiosity about experiences different to my own, as well as my feminist beliefs about social justice, subjective reality, and the socially imposed rules for living, drew my interest to topics relating to the transgender community.

Performing a brief literature review, I noticed an explosion of research about transgender people from a medical, sociological, and psychological perspective, aiming to facilitate professionals' knowledge and ability to support trans individuals. However, little attention has been paid to the 'less visible' members of the community, specifically those who do not present to gender identity services. Not wishing to further

pathologize the trans community, I became driven to explore issues relevant to the trans population that may not experience the 'over-researched' issues typically found in cisnormative research, thus shedding light on the diversity within this group.

Given the limited findings regarding transgender people who choose not to pursue medical gender-affirming care, I acknowledged the complexity of this decision that cannot be understood through quantitative statistics alone. It made me wonder not just 'why' but 'how' a transgender individual might choose this, as well as the 'what now?' consequence of this choice.

Upon reflection, I recognise how in the beginning of this research process my personal and professional motivations stemmed from cisnormative interpretations of the transgender experience. Through meeting the participants and really listening to their experience, I can now see how my cisnormative and transnormative beliefs played a major role in the conception of the research question, from the assumption that medical gender affirming care is desirable, to the curiosity of navigating life without it. My hope is that by the end of this thesis my views and interpretations of the final theory provide a wider, more balanced understanding of the process that can be accessible to readers of any identity and is authentically connected to participants' experiences.

1.1. Research Question

In Constructivist Grounded Theory (cGT), the research question drives the conduct of the study and its construction is an imperative part of the process (Urquhart, 2013). The current research study seeks to answer the question **'How do older British transfem people choose not to seek medical gender affirming care?'**

The initial research question posed for this study was "How do trans* people choose not to seek medical gender-affirming care?". However, during the data collection process, it became evident that the sample recruited was notably homogeneous: all participants were aged between 60 and 70 years and self-identified as non-binary transfem. Upon reflecting on the characteristics of this group, it became clear that the generational context played a significant role in shaping their understanding and identification of gender identity. As I progressed with the analysis, it became

increasingly apparent that the social and cultural influences of the era in which these individuals came of age – characterized by limited acceptance of gender diversity and prevalent societal attitudes that often punished gender nonconformity – had a profound impact on their self-perception and decision-making processes regarding medical transition.

The participants' formative years, marked by minimal visibility and support for transgender and gender-diverse individuals, likely contributed to their navigation of gender identity within more constrained and often stigmatized frameworks. These external factors – ranging from societal marginalization to lack of medical resources and understanding – played a central role in how they conceptualized their gender identity and made decisions about medical care. As I further explore in later sections of this thesis, these influences highlight the importance of understanding how external societal narratives shape individual choices about medical transition. I propose that had these individuals grown up in an environment with more inclusive and supportive narratives surrounding trans identities, their experiences and decisions might have been different. Given this, it is important to specify in the study's title the particular generational and social context, as it significantly impacts the findings and conclusions drawn about the decision-making process of individuals in this cohort.

Further, when first designing this study the question was phrased as 'arriving at a decision' and was later changed to 'choose not to seek'. This change in terminology came from my reflections from the interviews, which challenged my unconscious presumptions that not pursuing gender affirming care can be a single and final decision. I chose to change the title of this thesis as a way to better illustrate the point that the process is dynamic, ongoing, and may be subject to change, thus hoping to alleviate any potential pressure on the participants that their choice is final.

As a result, the following assumptions underlie the research question:

- Gender is different to biological sex and exists as a concept.
- Gender is a social construct and may be experienced and performed in different ways.

- Transgender people exist outside the Western cisgender interpretations and performances of gender.
- Trans people may seek to affirm their gender medically or may choose to reject this practice.
- Trans people have undergone a self-reflective process to construct, de-construct, and re-construct their identity in relation to their body and their subjective experience.
- Trans people can make the conscious decision not to pursue medically assisted gender-affirming intervention.
- Symbolic interactionism – I have a unique perspective on gender, given my experiences of the world. Other people may hold perspectives different to mine. Transgender people hold a different concept of gender than my own cisgender one.
- Trans people are willing and able to share their perspective and I am able to construct an interpretation of their accounts.
- The final theory will be an interaction between their interpretations and mine.

1.2. Research Aims

This study aims to explore the internal world of trans people who choose not to pursue medically assisted gender-affirming care. It attempts to produce theory to contribute to understandings of gender identity development and highlight relevant factors, beliefs, and experiences influencing making decisions about transition. Further, it aims to generate knowledge about trans identity negotiation and the navigation of inter- and intrapersonal processes as a result of making this choice.

1.3. Relevance to Counselling Psychology

This research can be beneficial in contributing contemporary psychological theory about gender diversity, trans identity development, and transition. Historically, theory on the experiences of trans people has originated from a medical, sociological, or philosophical standpoint, which has largely contributed to the pathologisation and stigmatisation of the community (Heng et al., 2018). Theory can aid psychologists, as

research practitioners, in delivering competent care to gender-diverse clients by promoting theory-practice links and encouraging reflexivity.

Hunt (2014) reported findings from a sample of transgender individuals seeking and receiving therapy outside GIC in the UK that only 43% of participant were satisfied with therapy and less than half (44%) felt understood by their therapist. This indicates a need to improve clinicians' awareness about trans-specific issues and improve the experience and benefit of therapy. Developing research from a psychological lens can improve engagement and access to psychological support on an individual and national level through influencing organisational policy (dickey & Singh, 2016).

Involving trans individuals in the design and conduct of this study gives opportunity to empower and give voice to trans people, consistent with the humanistic ethos of counselling psychology. Further, theory emerging from authentic accounts could be helpful to trans individuals at any stage of their identity development.

2. Theoretical Position

Establishing the study' theoretical position is vital for the construction of meaningful research and appropriately designing the methodology (Ponterotto, 2005). To quote Silverman (1993, p.9 in Willig, 2013), *"Without theory there is nothing to research".*

2.1. Ontological Position – Relativist

Ontology is the philosophical exploration of the nature of reality and being, as well as what can be known about reality (Ponterotto, 2005). It aims to answer the questions 'What exists and what can be known about it?'. On the two ends of the ontological assumptions scale are *positivism*, which contends there is one true, identifiable, and measurable, reality, and *relativism*, which posits there are multiple, subjective realities, influenced by individual context and perception.

Whilst biological sex is understood as an observable phenomenon based on realism, the feminist theoretical position conceptualises gender as a psychosocial construct, as it is learned from environmental and social cues (Järviluoma et al., 2003; Lindsey,

2015; Winter, 2015). Gender can also be understood as a construct due to different cultures' interpretations and performances of gender throughout history, starkly different from the Western binary views (Gainor, 2000; Kalra, 2012; Newman, 2002). Therefore, the experience of gender is highly dependent on the environment and context in which it was developed, thus making it a subjective experience.

This idea is most consistent with the relativist ontological position: there are multiple constructed realities and each individual's might differ, based on experience and social environment. The relativist position also allows the exploration of knowledge to be co-constructed between the participant and the researcher (Ponterotto, 2005).

2.2. Epistemological Position – Constructivist

Epistemology concerns the nature of knowledge and ways of obtaining it (Willig, 2013). It aims to answer the question 'What and how can I know?' and explores the relationship between the "knower" (the participant) and the "would-be knower" (the researcher) in the construction of knowledge (Ponterotto, 2005). Defining the study's ontological position helps elucidate the epistemological and methodological possibilities available (Mills et al., 2006).

It is important to determine what type of knowledge the research aims to create and the assumptions it makes about the world (Willig, 2012). Previous literature has contributed knowledge about possible motivations and deterrents to seeking medical gender-affirming care – the concept and knowledge already exists, to a certain degree. However, the literature is lacking exploration of individual *processes* of constructing meaning about transition, as these are likely to be influenced by context, experience, and attitudes on the topic. Therefore, the goal is generating new knowledge about an ongoing process.

Moreover, my position to the production and obtainment of knowledge is important for determining the epistemological position. As an outsider to the trans community, my experience and perception of gender will differ to the participants', which will impact the interpretation and analysis, regardless of my attempts to distance myself from this

position. Therefore, the knowledge produced from the interrelationship between participant-researcher will likely result in the co-construction of joint meaning-making.

Based on these two factors, the study's epistemological position most applies to constructivism (Mills et al., 2006).

2.3. Theoretical Lens – Pragmatism

The study's constructivist epistemology, which emphasizes the active role of individuals in constructing knowledge, and relativist ontology, which holds that reality is not absolute but contingent on individual perspectives, effectively fit my psychosociological understanding of gender as a social construct, influenced by interpersonal, historical, and cultural factors (Järviluoma et al., 2003). This theoretical framework emphasizes the significance of looking at how gender identities are formed and contested within social contexts in addition to acknowledging the flexibility and range of gender identities.

Furthermore, this approach allows a nuanced examination of issues relating to social justice, power dynamics, and subjective experiences associated with gender, as it embraces a pragmatist philosophy that places emphasis on practical consequences and the significance of context in comprehending truth (Charmaz & Henwood, 2017). This viewpoint recognizes gender as a dynamic and socially produced construct rather than a fixed and unchangeable trait, providing opportunities for critical investigation into the ways in which social norms and institutions shape people's identities and experiences.

Essentially, the theoretical foundations of the research give a strong framework for exploring the nuances of gender in modern society, providing insights that go beyond simple classification, to shed light on the complex interactions between people, culture, and power relations.

3. Methodology

3.1. Rationale for Qualitative

One of the main assumptions underlying this research is that gender is a social construct. Thus, exploring phenomena in this context from a quantitative perspective would make its exploration laden with ethical concerns and poor research practices (Wandschneider et al., 2020). The experiences of trans people must be explored with precision and sensitivity, given the diversity of gender understandings within the trans community (Barsigian et al., 2020; Factor & Rothblum, 2008). Quantitative research has been criticised for being neglectful of marginalised community groups by omitting essential context, exploration of important aspects of transgender identities, or not providing sufficiently substantive accounts of personal experience (Factor & Rothblum, 2008; Moradi et al., 2016; Richards et al., 2014). Further, it is important to develop affirming research challenge negative historical influences, emphasize the importance of affirming psychological care among scientist-practitioners, and foster resilience and autonomy for trans individuals (dickey & Singh, 2016), which qualitative research is uniquely positioned to accomplish.

Quantitative study approaches seek to deduce a phenomenon from existing evidence, thus limiting the generation of new, in-depth knowledge (Willig, 2013). With such limited research into trans experiences without transition, a quantitative approach is unlikely to produce meaningful new knowledge. Further, the relativist stance of the research question suggests the most appropriate investigation method is utilizing qualitative methodologies.

Qualitative research permits an in-depth exploration of personal experience, phenomenon interpretation and meaning-making, thus reducing the risk of further ‘outsider-researcher’ pathologization or reductionism of the trans community (Charmaz, 2006; Richards et al., 2014). Further, understanding the interaction between the researcher, context, and participant is a core concept of qualitative research, under the basic premise that the researcher is the study's instrument, and is particularly relevant to this scenario (Paulus & Lester, 2021). A qualitative approach provides opportunity to give voice to the trans community, thus benefitting it in providing perspectives of rich, detailed, and carefully considered accounts of personal stories coming from individuals, as has historically not been the case (Barsigian et al., 2020; Vincent, 2018; Willig, 2013). For these reasons, I chose the qualitative approach to best fit the study’s aims.

3.2. Assessing Methodologies

After choosing to adopt a qualitative approach, I considered various methods of investigation before arriving to a final method.

3.2.1. Thematic Analysis (TA)

I considered utilizing TA as a method of identifying themes and meanings across individuals' accounts to make sense of shared experiences (Braun & Clarke, 2006). TA's theoretical flexibility allows for appropriate investigation of the research question and giving more space to the participants in generating new knowledge. It offers an initial step into under-researched topics and underserved populations, which would be beneficial in the context of the limited literature base.

However, the aim of this study is to understand the process of identity (re)negotiation influencing a choice of being; further, it aims to produce theory useful to the trans community and psychological theory and practice. Therefore, TA was deemed insufficient in addressing these aims and serving its intended audiences in necessary depth.

3.2.2. Interpretative Phenomenological Analysis (IPA)

The research question aims to capture the intra- and interpersonal factors and consequences of negotiating trans identity through the practice of rejecting medical gender-affirming intervention. Initially, I considered using IPA as its examination of subjective meaning-making and bottom-up method of generating knowledge emerging from the data seemed relevant to the research question (Willig, 2013). The interpretative element of analysis allows for synchronising my outsider-unknowing position and the insider-knowing to produce rich, meaningful findings. Finally, IPA provides a deeper exploration of underlying themes participants themselves might not be aware of, which could address the complexity and uniqueness of subjective lived experience (Smith et al., 2009).

However, trans identity development and decisions about transition have been described as dynamic, ongoing processes, influenced by individual and social factors

(Levitt & Ippolito, 2014b; Taylor et al., 2018). Therefore, IPA would be inappropriate for this study as 'choosing to transition or not' cannot be distilled into a single event and not a process. Moreover, heavily relying on my own interpretivism of participants' accounts risks misconstruing or misrepresenting them (Smith et al., 2009), particularly considering my outsider status and differing conceptualization of gender identity (Rosenberg & Tilley, 2021). IPA would also be insufficient in embracing symbolic interactionism considering subjective cultural, sociological, and contextual experiences impacting the process (Smith et al., 2009).

3.2.3. Foucauldian Discourse Analysis (FDA)

Language has historically held significant importance in the transgender community and identity development (Zimman, 2020). I considered using FDA to understand how trans people create and enact activities and identities through the use of language (Starks & Trinidad, 2007), particularly relevant for considering the socio-political climate within which trans identitities exist (Burnes & Chen, 2012).

However, this approach would utilise a social constructionist epistemology, which would be incompatible with the philosophical account of the research question and its assumptions (Burr, 2015). Further, the method of analysis would shift the focus away from examining underlying processes and the original direction of the research question.

3.3. Choosing Constructivist Grounded Theory (cGT)

Grounded Theory (GT) is a qualitative research methodology that collects and analyses data to generate theories grounded in the data, using an iterative, inductive process that includes theoretical sampling, constant comparison analysis, and memo writing. Glaser & Strauss' (1967) original GT approach adhered to positivist principles by maintaining researcher detachment to prevent influencing the findings. In response to these limitations, Charmaz (2006) developed Constructivist Grounded Theory (cGT), which shifts towards subjectivism by emphasizing the active role of the researcher. Charmaz (2014) argued that a researcher's constructed meanings and worldviews inevitably interact with participants and the data throughout the research process.

Below, I outline the arguments that led me to choose cGT from a philosophical, ethical, and practical perspective.

3.3.1. Philosophical Underpinnings

The study's underlying assumptions, relativist ontology, and constructivist epistemology align with the philosophical underpinnings of cGT (Charmaz, 2017). cGT rejects the idea of an objective, external reality, as originally developed by Glaser & Strauss (1967), and acknowledges the researcher's subjective account (Mills et al., 2006). This is particularly relevant as the interpretation of findings will be the result of the interrelationship between my experience of gender and that of the participants. Further, cGT is inductive by nature, meaning the researcher does not hold preconceived ideas to prove or disprove, allowing knowledge to emerge from areas the participants deem relevant (Mills et al., 2006). This is particularly important for this study as it fulfils the aim of giving voice to trans people to guide further research, in the context of the limited literature to date.

Process, not structure, is fundamental to human existence and people create structures through engaging in processes (Charmaz, 2006). Theory in cGT explores how processes have been constructed in the context of reality, which aligns with the study's ontological and epistemological assumptions (Charmaz & Henwood, 2017).

3.3.1.1. Symbolic Interactionism

Another reason for choosing cGT is that it accounts for symbolic interactionism. Within the symbolic interactionism perspective, reality is a product of people's interaction and negotiation within the world and, as a result, is constantly changing (Frost et al., 2014). This interaction is interpretative and explores how individuals create, enact, and change meanings and actions (Charmaz, 2006). This perspective fits within the assumption of gender as a construct and allows the co-construction of knowledge between insider researched-outsider researcher.

3.3.2. Generation of Theory

cGT aims to generate plausible and useful theory to a phenomenon that is grounded in the data (McLeod, 2011), thus bringing authenticity and relevance to the topic. This

aligns with the study aim of contributing to psychological practice and healthcare provision and stems from participants' accounts on what is relevant (dickey & Singh, 2016; Rosenberg & Tilley, 2021), thus enhancing the experience of trans people accessing healthcare.

3.3.3. Practicality

Finally, GT can use a flexible approach, which allows for application within the timeframe of a doctoral thesis. The abbreviated version of cGT would achieve the aims of this study in the context of resource limitations (Charmaz, 2006).

4. Reflexivity – My Position to the Research

Maintaining a curious, reflective stance is encouraged in cGT to monitor the researcher's perceptions and biases and consider how the co-constructed findings are coloured by the subjectivities of the researcher (Charmaz, 2014). I acknowledge my positions of identity and professional roles, by virtue of their nature, prevent me from fully comprehending the experience of this population. I have also remained mindful how my positions of privilege and power may affect the participant group and have aimed to practice with the necessary sensitivity. I have kept a reflective log from the study's inception until final stages of write-up to note and unpick when, where, and why my assumptions emerge and observe how they impact on the research. This has helped me take proactive action to improve the quality of the study, such as seek consultation, or guide my thinking, as in theory development.

4.1. My Positions as a Counselling Psychologist and Researcher

My interest in the trans population originally stemmed from exposure to trans issues and debates online and from witnessing personal accounts about queer identity negotiation in my personal life. I purposely chose not to investigate clinical presentations as I did not wish to further add to the pathologization of queer experiences.

Throughout my training, most of the exposure to trans identities has been in the context of pathology, working therapeutically with issues of gender dysphoria, anxiety,

depression, trauma. My clinical experience highlighted to me the limited nature of therapeutic work I, myself, and many of my colleagues are equipped to support trans people with. I reflected on the differences in approach and multiple underlying assumptions in psychological work between cisgender and transgender clients. However, I was mindful that there are many issues around identity exploration, development, and negotiation faced by queer people which often go unacknowledged in clinical settings; as these experiences do not fit into heteronormative cis-dominant culture in the public healthcare sector, they can quickly be formulated as pathology.

My training as a counselling psychologist allowed me to develop a holistic, person-centred view of an individual, considering multiple identities factors (such as the social GRACES – gender, race, ability, etc., (Burnham, 2018)), and challenging my assumptions at the start of therapy. In this research, I chose to explore and showcase a phenomenon faced by trans individuals without the premise or assumption of needing help or care. My aim with this research question is to also add to psychological theory, independent of clinical practice, to help fellow psychologists develop understanding of identities different to their own, typically not found in clinical handbooks. Further, I aim to de-pathologize the trans experience, challenge pre-existing assumptions about trans beliefs and journeys, and demonstrate diversity in human identities.

As a researcher, I hold a lot of power in witnessing, interpreting the participants' stories, and making active choices in determining which elements to showcase in the final results. At times, this has been uncomfortable. I negotiated this with myself by aiming to focus the findings on this specific set of participants and to consider affirming experiences that can help build resilience (dickey & Singh, 2016). I also found myself worrying about producing a piece of writing that attempts to create a theory about a whole population. I was pleased that my attempts were met with gratitude, openness and honesty, from both participants and consultants, which led me to return to my original idea of bringing awareness of the trans experience, the validity and diversity of experiences within the community, to what could likely be a predominantly cisgender audience.

The abovementioned power element might have contributed to the type of individuals who reached out and consented to take part in the research – it is possible many viewed my recruitment flyer with negative expectations. I reflected on the lack of response from the majority of organisations I reached out to, thus affecting the final sample. I could, understandably, be seen as an intruder, so moderators would have chosen to protect their members by blocking my requests.

4.2. The Cisgender Researcher

My position as a cis researcher entering an over-researched and often exploited community, I felt uneasy at times about attempting to study this phenomenon in the first place. Reading about some trans people's negative perspectives on being the subject of academic investigation (Tagonist, 2009), I wondered about the usefulness and necessity of conducting this project to the trans population, as well as my personal and professional gains. As a cisgender person in a transphobic society, I hold a lot of privilege. As a woman in higher education, this expands further into positions of power, carrying a risk of exploitation. I am aware that, according to these defining characteristics, the research may cause harm or offence. However, I considered the need to demonstrate different perspectives, on an individual and wider level, and feel passionately about considerately sharing these findings, to my best efforts. I now feel better prepared to take responsibility for the outcome of this study.

Perhaps participants' perception of me as a woman had an effect on the research process and the resulting theory. Throughout the interviews, several participants noted feeling at ease in the company of women, compared to men; one specifically noted having had positive experiences of admiration from 'younger women'. Perhaps the participants who came forward to the research had favourable views of my status as a woman researcher, which enabled their willingness and ability to share their perspectives. It is possible potential participants who might have an unfavourable view of my position as a female researcher would be unwilling to speak with me altogether. I acknowledge there might be other factors I cannot be privy to influencing participant volunteering. I would therefore assume this will have coloured the overall research process and resulting theory.

4.3. The Use of Labels

During the process of conceptualizing my research question and performing the literature review, I was mindful of the balance I had to achieve between being considerate to trans identities and satisfying traditional research processes. From my learning and exposure to trans issues, I was mindful of the potential harm in using labels and strict definitions of complex concepts, such as gender identity, gender noncongruence and identity expression, whilst still needing to define the research terminology.

Reflecting on my philosophical views and values on the impact of the patriarchy, systems of oppression, and social justice, my main aim with this study was to stay away from labels and placing individuals' experiences into boxes. However, during the process of applying for ethical approval, I recognized the need for definition and specification in order to meet the practices for the research process. I reflected on this issue of balance with my peers, supervisor, and external consultants, and reached the decision to use broad language and definitions to encompass as diverse experiences as possible – the use of the encompassing 'trans' label being one of them. As a result, it is possible many people who may not strictly define their experience as 'transgender' but share a relevant decision-making process might have felt excluded from the study simply from seeing the label in the advertisement poster. Indeed, two participants felt ambivalent about their relationship with the 'trans' term during interviews; we were able to discuss this, but it made me wonder how many other potential participants I would not have been able to discuss this with. This led me to conclude that the final theory generation can be attributed to individuals who identify, to a certain degree, the use of the term 'trans', but may not account for the experience of all trans people or those who may be labelled as such by the cisgender majority.

5. Ethical Considerations

Ethical approval was granted by the City, University of London Psychology Research Ethics Committee in October 2022 (Appendix 1).

As with any human research, there are potential ethical risks that have been considered throughout all stages of the research design and execution. Of the utmost importance has been the consideration of protecting participants from potential emotional harm. I have adhered to the ethical guidelines issues by the British Psychological Society, the Health & Care Professions Council, and City University's confidentiality policy (BPS, 2021; HCPC, 2016).

5.1. External Consultation

As an outsider to the trans community, I had to critically reflect on the significance and power impact of my position as a cisgender researcher wishing to study phenomena within the trans community. I was particularly conscious of my limitations of knowledge on the lived trans experience, as well as ethical conduct within trans-focused research. Whilst developing my research question, I recognised the importance of involving community and professional stakeholders before proceeding further (Adams et al., 2017). This is why I sought consultation with self-identified transgender psychological researchers with expertise in transgender studies. I received written correspondence from three experts (Appendix 11), which helped develop my literature review, methodological, and ethical dilemmas. Further, I had an individual consultation meeting with a trans researcher and psychologist (Appendix 12), who greatly helped develop my thinking in the following ways:

- Helped amend my interview schedule to use more inclusive language, as well as acknowledge and reflect on gender-affirming experiences to help minimise potential distress and obtain further knowledge.
- Amending the language used throughout the research and writing process, as well as holding in mind the dynamic aspect of the process. This helped shift my study's requirements to 'holding no current plans' to pursue medical transition, as opposed to individuals who have 'reached a final decision'. I acknowledge how this perspective, although influenced by external consultation, addresses one of my personal underlying assumptions. However, I reflect on this later in this thesis, after discovering participants share their views of being open to changing their minds in the future and the use of the 'bus journey metaphor'.

- The consultation was also helpful in making me reflect and distinguish between different aspects of medical affirmation in order to make the topic more inclusive and capture a wider array of experiences. Further, it was helpful to reflect on racial and ethnic diversity limitations within my study and how to address this in the final write-up.
- Finally, consultation led me to reflect on the impact this study could have on the current socio-political climate in the UK regarding gender affirmation provision of care. I am privy to the fact that, while my intentions are to produce research that would be useful to the trans community, this information might have wider effects within the cisgender healthcare system, which inadvertently could negatively impact the trans community. I hope to mitigate this risk by specifying the findings cannot and should not be generalized to the trans community as a whole; exploring the unique participant context that have impacted their decision-making process and has made this right for them, specifically; reflecting on the impact of the patriarchal norms that govern society's perception of gender in general, rather than focusing on individuals' personal life choices. I hope this becomes evident in the next two chapters, where I explore the impact of being trans within a cisnormative society.

As a researcher interested in investigating trans-specific phenomena, I also reached out to charities to seek community consultation on the relevance, aim, and ethics of the research question. I met with two representatives of the Gender Identity Research and Education Society (GIRES) and discussed how to approach organisations in a sensitive manner, including the importance of sharing my personal and professional values with the charities I reached out to, as well as the participants who came forward. I was also reassured about the relevance of this research to the trans community as a whole and felt empowered to shed light on a part of the community which may otherwise have limited outlets to share experience and perspectives. I found that this not only helped deepen and reflect on my relationship with the topic and research question, but also facilitated trust and rapport during the interviews.

5.2. Informed Consent

Obtaining informed consent before participant recruitment is crucial for the ethical and meaningful production of research, particularly important when studying phenomena affecting vulnerable, intersectional, or marginalized communities (Adams et al., 2017). In order to obtain first level of consent, the research poster asked interested individuals to proactively reach out to me, via email; the same process was followed for participants recruited through word-of mouth. Prior to enrolment in the study, all potential participants were sent a copy of the study information sheet (Appendix 5) and were invited to a preliminary 15-minute screening call, for which they provided written consent (Appendix 6).

During the screening call, I informed them what participation involves, highlighted potential risks of participation, such as confidentiality issues, emotional distress, and over-research, and disclosed the steps taken to minimise these. I was also transparent about my identity as a cisgender woman, my motivations for conducting this study, and the interpretative nature of qualitative research, which will lead to a combined construction of their experiences and my interpretation. They were informed about the voluntary nature of participation, the right to withdraw at any stage without consequences or need for justification, and the audio recording of the interviews. The conversations were kept open and welcoming, encouraging to ask questions throughout, and providing the option to take 24 hours to consider their decision to participate. Following agreement, participants were given an informed consent for interview sheet (Appendix 8) before being invited to interview. All participants agreed to every point of the sheet, and they all received copies of the signed consent forms.

5.3. Emotional Distress

Participants were informed that, although the aim of the research is not to raise emotional distress, the nature of reflecting on past experiences with identity development may have the unintended consequence of causing this during or after the interview process. To reduce the risk of causing harm to vulnerable individuals, the eligibility criteria was designed to include participants who have not experienced moderate-severe symptoms of psychological distress, according to the CORE-10 measure, in the week before interview (Appendix 7). The cut-off score of 15 and below was determined from general population data and adjusted for respondents potentially

affected by issues of intersectionality, minority stress, or temporary mental health symptom deteriorations, such as stress or sleep (Draucker et al., 2009). Despite these preliminary measures, emotional distress could still have arisen at any stage of engagement, so I remained mindful of changes in affect and was prepared to use the distress protocol (Figure 1).

- Stop the interview.
- Offer support and allow the participant to regroup.
- Assess mental and emotional state:
  - "Can you tell me what you are thinking right now?"
  - "Can you tell me what you are feeling right now?"
  - "Do you feel you might be able to go about your day?"
  - "Do you feel safe?"
  - "Do you have someone you could speak to right now or spend the rest of the day with?"
- Construct crisis plan

Figure 3. Interview Distress Protocol

5.3.1. Screening

Upon completion of the CORE-10 measure, I explained the significance of the score. I informed participants that whilst this is not a diagnostic measure, it can be an indicator for symptoms of psychological distress, which may pose the risk of negatively affecting their wellbeing during the research process. I also explained the limitations of my role as a researcher, despite being a trainee psychologist, and the purpose of the meeting. Individuals were given the right to choose whether to continue with the process or withdraw. Even though none of the participants scored above the threshold, it was part of my protocol to provide individuals with general and transgender-specific mental health support organisations and encourage them to seek professional help, should the measure have become an excluding factor (Figure 2).

- 24hr National trans helpline - (07527) 524034
- Beaumont Society: 01582 412220 - www.beaumontsociety.org.uk
- Gender Trust: 01527 894838 - www.gendertrust.org.uk
- Samaritans – 116 123 – www.samaritans.org

Figure 4. List of trans-specific organisations for mental health support

5.3.2. Interview

The same protocol as in Figure 1 was utilised for the interview stage. Prior to starting, participants were reminded of their right to stop the interview at any time, decline being recorded, or withdraw their participation. Since online interviews reduce the ability to provide immediate face-to-face support, we constructed a collaborative and specific self-care plan for each participant to seek support after the interview.

I noticed one participant become emotionally affected during the interview and I offered a break to recollect themselves. They declined ending the interview and gave verbal consent to continue to completion. Thankfully, there were no other issues with emotional distress arising during the interview stage.

5.4. WITHDRAWAL

Across all stages of the research, participants were made aware their participation is entirely voluntary. They were informed they may request to withdraw at any stage until data analysis completion. I explained that the reason for this is omitting analysed data in qualitative research can be difficult to disambiguate and full omission cannot be guaranteed.

Participants were informed that, should they wish to withdraw, all personal data will be deleted from all records by erasing personal identifiable information, recordings, and transcripts from software, laptops, or physical notes. They were also reminded that withdrawal would not affect their status as members in any organisation they were recruited from as the research is being conducted independently and I am solely involved with City University.

5.5. DEBRIEF

Individuals were debriefed both verbally and in written form (Appendix 10) about the aims and strategies of the research. After data collection completion, I enquired about their experiences of recruitment and interviews. This gave the opportunity for participants to reflect and change their mind should they like to withdraw their participation. This also allowed me to begin reflecting on the procedure and analysis process, while the experience was fresh in my mind. Finally, participants were given

the opportunity to ask further questions or share concerns, before being provided with information about trans-specific support organisations.

5.6. Privacy and Confidentiality

Maintaining participants' confidentiality in research has been found essential for protecting individuals from negative consequences, building trust and rapport, and upholding research ethical standards (Baez, 2002). Private data, such as contact details and personal identifiable information, including that of participants' close ones, has been anonymised and kept confidential throughout all stages of the study. For the word-of-mouth element of recruitment, I was mindful not to request any personal information and instead encouraged participants to share my contact details to potential participants, thus also assessing motivation. All participants consented to the use of quotes and have been informed about the limitations to full confidentiality (BPS, 2021).

My initial plan was to fully anonymise participants' names within any final work. However, I reflected upon Vincent's (2018) accounts on transgender voice empowerment, guided by current trans identity theory, helping me consider my use of power as 'the researcher' in making decisions on behalf of the participants. I considered the fact that adopting an authentic name is an important part of trans identity development and social transition, and questioned whether it might do more harm to erase it from the study for the sake of confidentiality (Brumbaugh-Johnson & Hull, 2019). Therefore, I chose to consult each participant about their choice in level of confidentiality, in order to provide autonomy of choice and equality in dignity. Participants were asked during screening whether they would prefer their original and adopted names to be used, to choose a pseudonym, or opt for full confidentiality. All participants included in the study gave consent to use their original and adopted names for the purpose of this research.

5.7. Ethical Data Management

All participant information has been governed and stored securely, according to GDPR (2018) and Data Protection Act (1998). Materials containing personal identifiable information and transcripts have been stored in the encrypted platform OneDrive,

within a password-protected folder. Participants were informed interviews were audio recorded on a password-protected encrypted device before being transferred to OneDrive, and these will be stored securely for 10 years, in line with City University's research data storage policy. Individuals who wished to receive a copy of the completed publication have all consented to keep email contact, whereas everyone else's contact information has been deleted.

5.8. INCENTIVES

The diversity of literature on trans people's experiences is limited (MacCarthy et al., 2015), yet trans communities have reportedly experienced 'research participation fatigue' as a result of frequent invitations for participation in studies (Vincent, 2018). Owen-Smith et al., (2016) have named possible barriers to engagement to include historical alienation, objectification, and delegitimization through poor research design, and the ethical implications of free emotional labour without financial compensation. These findings encouraged me to involve the trans community in the research design and interview protocol through consultation. Further, to reduce the power dynamic between outsider-researcher and insider-researched (Rosenberg & Tilley, 2021) and encourage recruitment, I chose to offer financial incentives in the form of £15 Amazon vouchers to eligible participants.

6. Method

6.1. EXTERNAL CONSULTATION

As discussed in this chapter, 5.1, I sought external consultation from experts in the field of transgender studies (Appendix 2). I was mindful to select researchers who self-identify as trans to ameliorate the outsider-researcher insider-researched dynamic, recognising the importance of involving community and professional stakeholders (Adams et al., 2017). I reached out to four researchers who had published articles on the ethics of transgender research via email and social media. I received written responses from three and the final one agreed to meet with me online on two occasions. I implemented their recommendations into the research design. I was also

able to consult with two representatives of a third-sector trans-specific organisation who offered help with recruitment ideas and ways to establish rapport.

6.2. SAMPLING

The study utilised a purposive sample to find people who self-identify as transgender, as defined in Chapter 1, 1.4., and who do not currently plan to pursue hormonal or surgical intervention with the aim to affirm their gender. Table 1 outlines the inclusion criteria.

Table 3. Study inclusion and exclusion criteria

Inclusion Criteria	**Exclusion Criteria**
• Self-identify as transgender • Currently do not plan to pursue hormonal or surgical intervention with the aim to affirm gender • Over the age of 25 years • Currently live in the UK and have been brought up in the UK	• People who have undergone or plan to undergo hormonal or surgical intervention with the aim to affirm gender • Currently engaging in psychological treatment • Scored 15 or above on the CORE-10 measure, or score of 1 or above on Q6

Healthcare and legal procedures of pursuing medical gender-affirming care vary across countries. Within the UK, medical transitioning can be assisted through the NHS for free (*Gender Dysphoria Treatment*, 2020), which may become an incentivising factor for pursuing medical gender affirmation. Further, cultural differences may impact the findings. To account for these factors and preserve the homogeneity of the sample, people who currently live and have grown up in the UK were included in the study.

Research has determined the mean age trans people present to gender transition services is around 28 years (Fielding & Bass, 2018; Zaliznyak et al., 2020), with one study (Nolan et al., 2019) demonstrating the 18-24 year group had the highest representation in a UK gender-affirming clinic. This suggests a majority of transgender people have undergone the process of choosing to pursue medically assisted gender affirmation before the age of 25 years. Moreover, barriers to accessing gender affirming care can include family and living circumstances (Puckett et al., 2018). Therefore, the study's minimum age criteria were determined at 25 years to account for possible indication individuals have undergone the consideration process and have

had the opportunity to live independently. To increase inclusivity, there was no upper age limit.

To reduce the risk of causing undue psychological distress, only participants not currently engaging in psychological treatment were recruited. To increase inclusivity, participants who have not engaged in psychological therapy for at least 6 months prior to recruitment were included. Level of psychological distress was measured using the CORE-10 questionnaire with a cut-off score of 15 (‘moderate’) or scored 1 or above on the final question about suicidal ideation. The cut-off was determined from findings suggesting transgender people are at greater risk of experiencing poor mental health, compared to cisgender populations, as a result of intersectionality (Downing & Przedworski, 2018), so inclusion of ‘mild’ psychological distress scores adjusted the recruitment strategy.

The data collection process took place online, using the encrypted platforms Zoom and Microsoft Teams, in order to expand the search criteria to the entirety of the UK and to minimise the risk of health-related problems or delays in the context of the COVID-19 pandemic.

Determining an adequate sample size in qualitative research is challenging as its main goal is reaching data saturation. In the full version of GT, a reliable sample size has been determined to include 10-60 participants, however, this is outside the practical and timeframe scope for this study (Starks & Trinidad, 2007). Francis et al. (2009) comment an adequate number for sample size for theory-generating research, such as GT, would include 6-12 participants over both rounds of recruitment, which is the guiding number for the present study’s sample size.

6.3. RECRUITMENT

I contacted the administrators of 17 UK-based third-sector organisations, charities, and support groups promoting transgender rights, via email, requesting their consent to circulate the study’s recruitment flyer (Appendix 4). It was of the utmost importance to remain respectful of trans spaces, so I was transparent about my outsider status, the aims of the research, and the benefits and possible risks in involvement (Appendix

3). I received rejection correspondence from 5 organisations, 3 agreed to advertise the study flyer, and I did not receive a response from the rest. I was able to utilise word-of-mouth networking and a 'snowballing effect' from potential participants who reached out to me, with their consent, to share my recruitment flyer to their personal networks (Punch et al., 2000).

In the initial stage, I recruited 5 participants and completed the first round of data collection. Following transcription, I reviewed the data and began memoing themes and topics of interest. I then conducted a second round of recruitment, using the same procedure as above, and was able to identify 3 further participants. However, two individuals withdrew their consent for participation: one during the screening call, and the second just prior to interview. I attempted a third and fourth round of recruitment, however, was unsuccessful in securing further participants.

For the third round, I contacted the participants who already took part in the study, requesting to reach out to their networks and advertise the research. I received the contact information of two potential participants but did not receive a response from them.

For the fourth round of recruitment, I decided not to use the previous recruitment channels to reduce the risks of over-research (Ashley, 2021) and compromising the relationships with the participants and third-sector organisations. I reached out to researchers in the City University Counselling Psychology programme and my peers, asking to share my advertisement in their professional networks. Unfortunately, I did not receive further responses.

The final sample includes 6 participants. With the help of my supervisor, I resolved the issue of a small sample by engaging in the analytic process and reflected the collected data is rich enough to form a robust theory. Further, I also accepted this as a final sample size in line with Francis et al.'s (2009) and Charmaz' (2006) recommendations on student research projects.

6.4. PARTICIPANTS

Participant demographics were collected during the screening call (Table 2). All participants were born biologically male and identified as transgender, with three specifying a crossdresser identity. Ages ranged from 60 years to 70 years, and all identified as White British. Participants lived across England.

All participants had socially transitioned to some degree, i.e., came out as transgender to at least one other person, and lived, to some degree, in their acquired gender. There was a wide range of time since coming to terms with the decision not to pursue medically assisted gender affirming care.

Table 4. Participant demographic information

Participant	Preferred pronoun	Age	Ethnicity	Time since decision
Stephanie	She/her	60 years	White British	1 year
Joy	Any	61 years	White British	30 years
Jackie	She/her	70 years	White British	5 years
Evelyn	She/her	64 years	White British	10 years
Andrea	She/her	67 years	White British	6-7 years
Kay	She/her	66 years	White British	10 years

I was surprised about the homogeneity of the sample, despite the wide inclusion criteria. Embarking on this research, I expected the majority of the sample would consist of individuals self-identifying as non-binary and was surprised to find that everyone who approached me held gender binary views. I reflected on my assumptions and hypothesised these could be the result of two factors: previous research and my own cisnormative biases. Nieder et al., (2020) article had identified everyone in their sample who did not intend to medically transition identified as non-binary. Perhaps this led me to form expectations about how people who choose not to transition view their identity and reject the gender binary as whole. This also led me to develop assumptions about gender dysphoria and the expectations placed upon trans people that ‘the ultimate goal is transition’, which can be understood as a cisnormative frame to comprehend a non-cisgender experience. Through completing this research, my understanding about the diversity of views, social influences, and expectations placed on trans people helped widen my horizons, which is the impact I hope this study might have on others who read it.

6.5. PROCEDURE

6.5.1. Screening call

All potential participants were sent the study's information sheet and informed consent to screening call form. After obtaining written consent, I invited them to an individual 15-minute telephone screening call. I explained the purpose of the call is to introduce myself, provide opportunity to share questions and concerns, screen for eligibility, and conduct the CORE-10 brief measure to screen for recent psychological distress or suicidal ideation. The CORE-10 questionnaire is used for assessment of psychological wellbeing and its broad symptom range is useful in detecting common symptoms of mental health distress and suicidality in a single measure (Barkham et al., 2013). The screening call protocol is demonstrated in Figure 3.

- What are your pronouns?
- What questions do you have about this research or your potential participation in it?
- Do you have any concerns about potentially participating in this study?
- Are you currently, or have you in the last 6 months, been engaging in any form of psychological therapy?
- Would you be happy to complete this brief questionnaire about your mental wellbeing together?
- Would you be interested in participating in this research? Or would you like to take one day to consider your participation?

Figure 3. Screening call protocol

One individual chose not to proceed with the study after the screening call. They were thanked for their interest and were not included in the study. They were sent a list of contacts for trans-specific support organisations (Figure 2) and their contact details were erased.

Participants who were eligible and chose to participate were asked for their verbal, as well as written, consent. Individual virtual meetings were arranged within one week of the screening call to maintain the validity of the CORE-10 measure.

6.5.2. Interviews

Focus groups were initially considered to reduce the impact of my outsider identity, facilitate joint social meaning discussions, and improve the study's ecological validity (Kitzinger, 1995; Willig, 2013). However, to remain in line with the epistemological position of GT in co-constructing meaning, I opted for individual interviews. I reflected

this would also offer flexibility over arranging individual meetings, accelerate the data collection and analysis process, as well as minimise conflicts with confidentiality.

Data was gathered through individual semi-structured interviews, following a schedule with prompts (Appendix 9). This has been encouraged for improving novice researchers' confidence during interviews, allowing for my presence with participants, focusing on the content, and encouraging reflexivity (Charmaz, 2006). I adopted a 'directed conversation' stance to facilitate data collection and contain the participants to the original questions. All interviews lasted between 70-90 minutes and took place online.

I explained to participants that the interview schedule was designed to follow a logical order. The first section of questions explored individuals' unique context, their understanding of gender and being trans without physical transition. The next section investigated the specific decision-making process leading to not pursue medical gender affirmation. The final section explored the decision's impact and consequence on daily life now.

6.6. Debrief

After the end of interview, each participant was debriefed about the purpose and aim of the study, both verbally and in written form. Participants were invited to ask questions, share comments and concerns, as well as request information about the study following its completion.

7. Analytic procedure

7.1. Literature Review

Performing a literature review before engaging in the GT approach has been a long-contested question in the research community. In the early days of GT, Glaser's (1992) positivistic view of refraining from performing a literature review to reduce pre-existing bias impacting on the final theory was widely practiced. However, with the introduction of a more prescriptive, manualised coding paradigm by Strauss & Corbin (1998), the

researcher's interest is sensitised to identify processes and be mindful of possible categories. This encourages some level of familiarity with the research topic that can be obtained from a preliminary literature review. Indeed, Charmaz's (2006) analytic procedure of cGT encourages a level of familiarity with the topic before engaging in the process.

At the beginning of the research process, I was aware of my interest and inspiration to engage in a topic relevant to transgender people's experiences. I was curious about a range of issues, both on an individual and sociocultural level, finding myself generating several research questions. I felt it necessary to perform a brief literature review to ascertain whether the research questions are relevant and necessary for the body of literature and for the trans community, consistent with Fassinger's (2005) reflections on striking a fine balance between holding enough knowledge to design the study, yet avoiding full immersion in existing perspectives. As a result of this investigation, I was able to form a research question addressing a gap in the literature, fit my values about studying this as a process, as opposed to a 'true phenomenon', as well as address current issues relevant to transgender individuals.

It is important to maintain 'the difference of an open mind, as opposed to an empty head' (Dey, 1993, p.47 in Strauss & Corbin, 1998). This is why I was mindful to maintain my curious and open stance during the design and analysis of this study, allowing for confidence in my interpretations and co-constructions of concepts.

For example, investigating the concept of transnormativity emerged from reviewing the literature; as an outsider to the trans community, it is impossible for me to be privy to its existence. However, as someone with an own experience of gender and cisnormativity, I was able to make parallels and interpretations, relevant to the final theory. It was imperative I maintain my open and curious stance about similar concepts and allow the finding to emerge from the data spontaneously.

To mitigate the issue of biases from previous research impacting theory formation, a comprehensive literature review was completed after the data was fully analysed and a theory was generated.

7.2. TRANSCRIPTION

The audio recordings were initially transcribed using the built-in software of the Zoom and Microsoft Teams platforms. I then manually corrected the transcription and added details or context, whilst listening to the recordings. Each interview was listened to multiple times to ensure accuracy and help immerse myself with the data. This helped me get a sense of the overarching themes and points participants were making in response to the interview questions. I utilised memo writing and reflecting in my journal for novel ideas, observations, and similarities between interviews, emerging from the recordings.

7.3. INITIAL CODING

Following completed transcription of the interviews, I engaged in the process of initial coding: the detailed, line-by-line labelling of data that allowed me to begin conceptualizing ideas and identifying potential categories (Charmaz, 2006). Urquhart (2013) emphasises the importance of bottom-up coding in GT, so I used this approach of allowing codes emerging from the data, rather than literature, to prevent my pre-existing biases imposing on the data.

As a novice GT researcher, I relied heavily on Charmaz's (2006) instructional method of initial coding. I was mindful to keep the codes close to the data, define actions using gerunds, and begin to generate meanings and processes. I found myself significantly hesitant and unsure performing initial coding for the first two interviews but gained confidence for the rest through experience. After completing initial coding for all interviews, I returned to the first two coded transcripts and repeated the process to ensure accuracy and quality, and to reflect on any new emergent findings. I found an overwhelming number of initial codes but by staying close to the data and the meaning behind it, I was able to begin identifying themes by the end of this stage. An example of this process is demonstrated in Appendix 13.

7.4. FOCUSED CODING

The next stage of analysis was focused coding, whereby the initial codes were studied carefully, and possible links were established between them. Focused codes are

conceptual and directed, and allow for summarising and contextualising larger segments of data in a funnel approach (Charmaz, 2006). At this stage of the analysis, I felt deeply immersed in the data and found the process more manageable in identifying commonalities, contradictions, and overall processes. Nevertheless, I remained tentative during this to allow flexibility and organisation of hypothetical categories to emerge.

7.5. MEMO-WRITING

Recording memos helps with comparing data, exploring ideas about codes, and direct further data collection (Charmaz, 2006). I used memos throughout the research process, allowing me to record and reflect upon assumptions, generate theoretical or analytic ideas, and search for similarities or differences between participants' accounts (Charmaz, 2014). This was especially helpful during data collection as it allowed me to stay present with the narrative and ask clarifying questions, which significantly helped gather rich and expansive data.

It allowed me to make connections between codes and themes, especially when I found myself generating several interpretations of the same data. This allowed for careful engagement with the process and generating hypothetical categories, as well as organising these into a theory. Figure 4 shows an example of a memo written during the initial analysis stage of Joy's interview:

> It's interesting that Joy swings between saying 'I'm trans' but then later on rejects the term and falls into a 'I'm not trans' narrative. During the interview, I became nervous whether she fits the inclusion criteria. However, listening back to the recording, I notice she swings between these terms in the context of frustration or when talking about feeling rejected or threatened for not belonging. Perhaps this might be related to identity or it's reflective of a bigger social issue?
>
> It highlights the process of using labels; in the context of belonging (to the third-sector organisation, to this study, to having an explanation for her feelings and behaviour) identifying with the term 'trans' is useful. However, when finding herself not neatly fitting into a 'trans' definition (wherever this stems from) or beauty ideals (e.g. passing), this feels rejecting, punishing. This reminds me of Andrea's ponderings about 'where do we draw the line' on the definition of crossdressers – perhaps this narrative is thought about within the trans community?
>
> There might be a connection between 'the use of labels' and 'transnormativity narratives' – pay attention about potential relationships in the other interviews.

Figure 4. Example of a memo written after initial coding of Joy's interview

7.6. CATEGORISATION

After consolidating the focused codes, memos, and general reflections about the interview process, I began sifting, organising, and re-organising codes into larger categories, according to conceptual relationships and frequency of emergence in the data (Charmaz, 2006). At times, I returned to reorganise and readjust some of the focused codes to gain different perspectives and find better language to describe the process, which resulted in multiple versions of hypothetical theory, before arriving to the final one that best fits the data and my interpretation of it.

Coding relates to theory building as it allows for exploring the relationships between concepts (Urquhart, 2013). I used a coding paradigm, paying attention to processes stemming from within participants (internal) and outside influences (external) to form categories, and later theory (Corbin & Strauss, 1990). This was necessary as the context within which the consideration process occurred was relevant: evaluating the influences of being trans in a cisnormative society, as well as individual identity development.

An example of the analysis process, from initial coding to categorisation, is shown in Table 3 below.

Table 5. Example of the analysis process from transcription, through to initial and focused coding, leading to categorisation and theory generation for one participant (Jackie)

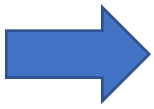
How do older British transfem people choose not to seek medical gender affirming care?				
Transcript	**Initial coding**	**Focused coding**	**Categorisation**	**Theory**
"I'd like to look better and, you know, makeup is fine. But I could get away with a hell of a lot of makeup. "	Wanting to look good / pass	Importance of passing	**Considering needs**	**Internal process**
"At the moment, I don't want to be a girl all the time."	Not wanting to be a woman permanently; Acknowledging dynamic process	Needing flexibility		
"If I don't do this, I get ratty. And I miss it."	Denying dressing is unhelpful	Needing freedom		
"It's like just mega life changing - five years ago, you know, I wore tights, and I thought I was a perv."	Acknowledging change in self-perception	Identity is dynamic	**Negotiating identity**	
"I feel whatever 'me' is when I'm dressed. I don't feel v*ery* different but it's like I'm inside somebody else's body."	Acknowledging change in identity	Consolidating identity		
"I feel like a different person. I am not the person that I was. This felt like what a girl felt like."	Experiencing gender anew	Gender as an experience		

7.7. Constant Comparative Analysis and Negative Case Analysis

I used constant comparative analysis and negative case analysis, with the aid of memos, to define and organise subcategories within the core categories (Willig, 2013). After identifying potential categories, I was able to return to the focused codes and re-familiarise myself with the data and its interpretation. I considered various ways the codes might relate to one another and re-conceptualized instances where the evidence appeared to relate to the same concept from opposite directions. This allowed for functional theory generation, highlighting with greater depth by recognizing the complexity and diversity of the data.

An example of the completed category 'Cisnormative narratives' as external influence, with details of the subcategory 'the use of labels', is shown in Table 4 below.

Table 6. Example of category and subcategory formation through the use of constant comparative analysis and negative case analysis

<table>
<tr><th>Transcript</th><th>Focused code</th><th></th><th>Category</th><th>Subcategory</th></tr>
<tr><td>“Having an awful lot of support from my wife, it gradually normalized, and I began to stop hating myself for having those ‘unnatural urges’” [Kay, 443-446]</td><td>Having support from cis close ones</td><td rowspan="4">Constant comparative analysis
 
Negative case analysis</td><td rowspan="4">Cisnormativity narratives</td><td rowspan="2">Levels of support
can be positive</td></tr>
<tr><td>“I found this seamstress and she was so into it; she was so respectful of who I was and so supportive and affirmative.” [Evelyn, 963-965]</td><td>Being affirmed by cis women</td></tr>
<tr><td>“Well, if you know my GP at the time, there was no chance of getting any help there [laughs].” [Andrea, 23-25]</td><td>Lacking support from cis healthcare professionals</td><td rowspan="2">Levels of support
can be negative</td></tr>
<tr><td>“The experience of my mother going crazy, who I adored, put me off for quite a while.” [Joy, 20-22]</td><td>Being punished by cis family for dressing</td></tr>
</table>

7.8. THEORETICAL SATURATION

A strong benefit to GT is its flexibility in returning to the data and developing new codes at any stage, should there be challenges with establishing relationships between codes. After completing analysis of the 6 interviews collected, I found sufficient evidence to construct a robust, rich, and comprehensive theory of the accounts, thus reaching theoretical saturation.

Theoretical saturation in cGT is considered the goal, however, Charmaz (2006) acknowledges this is rarely objective reality, largely due to the subjective and interactional nature of the analysis. Dey (1999) notes the researcher’s responsibility in subjective decision-making regarding the analytic rigour and generation of no new findings, thus reaching ‘theoretical sufficiency’. This is particularly relevant to interactional qualitative research, such as cGT. Due to the richness of the data and the sufficient number of categories uncovered to produce logical and comprehensive theory, this reinforced my decision to finalize data collection.

7.9. THEORETICAL DEVELOPMENT

According to Charmaz (2006), the aim of the analytic process is to formulate an explanatory model of how social processes unfold and explain the observed social phenomenon. I was able to develop a theory connecting the categories to provide an explanatory framework. I then constructed a diagram to illustrate the relational and interactional processes.

The next chapter presents the theory and explanatory framework.

Chapter 3: Analysis

Overview

This research aims to answer the question ‘How do older British transfem people choose not to seek medical gender affirming care?’. The following section is the analysis of data obtained from interviews. I begin by summarizing the process, explaining the overall theory, and then zoom into the categories within the bigger picture. I then present a diagram depicting how this process and its components interact with each other. Following this, I describe each category along the illustration sequentially, ending with an overall summary of the entire process’ interaction.

Overview of Theory

My analysis led me to conclude that participants’ decision-making process was influenced by two major categories – external factors and internal processes. Externally, the dominant societal narratives of cisnormativity and transnormativity have played a significant role in participants’ attempts to understand and explore their identities. These have influenced the timing and readiness to begin self-exploration. Following this, a series of internal consideration processes formed their personal decision-making process.

The overall process is temporally sensitive, which is why the external factors are considered first. Participants have grown up in and spent most of their lives exposed to the culturally-dominant cisnormative narrative, which has influenced their view of gender as a whole, gender roles and performances, and their own beliefs about society and their own gender identity. How they view the world has had an impact on how they view themselves and has influenced the process of trans identity exploration and thus, decision not to transition.

Upon accepting their trans identity, they comment on the more-recently explored transnormativity narrative causing a shift in their experience.

Since the 2010s, the trans movement has increasingly been gaining visibility in Western media and culture (Burns, 2019) and the proliferation of the Internet, which appears to have provided an alternative to the dominant gender narrative. Coupled with personal experiences of exposure to trans communities, participants' worldview started to change. They developed alternative beliefs to gender and what it means to be trans, thereby impacting their identity exploration and development. Consequently, this shift has coloured their personal, internal decision-making process.

After discussing external factors, participants turned to individual considerations about pursuing medical gender affirming care. This internal process followed a sequence of personal reflections on costs and benefits, considering individual needs, and negotiating and consolidating gender identity, that ultimately has led them to the decision that medical transition is unnecessary for them.

The theory depicts identity and decision-making as a dynamic, ongoing process. This is mirrored by participants' comments about being open to the possibility of changing their mind about transition in the future. However, at present, the conclusion was that medically-assisted gender affirming care is unnecessary. The fact that all reached this one conclusion provided an objective end to the overall consideration process, thus forming this theory.

My understanding from this analysis is that reaching the conclusion not to pursue medically-assisted gender-affirming care is a nested, temporally-dependent process. The internal meaning-making factors carry the most significance to personal choice and these have been significantly influenced by the shift within the two dominant gender narratives participants have been exposed to.

An illustration of the theory and categories is pictured in Figure 5 below. In the presented quotes, filler words (e.g., 'um') have been removed, and ellipses ('[…]') signify the omission of one or two sentences to condense the text, while maintaining the original meaning.

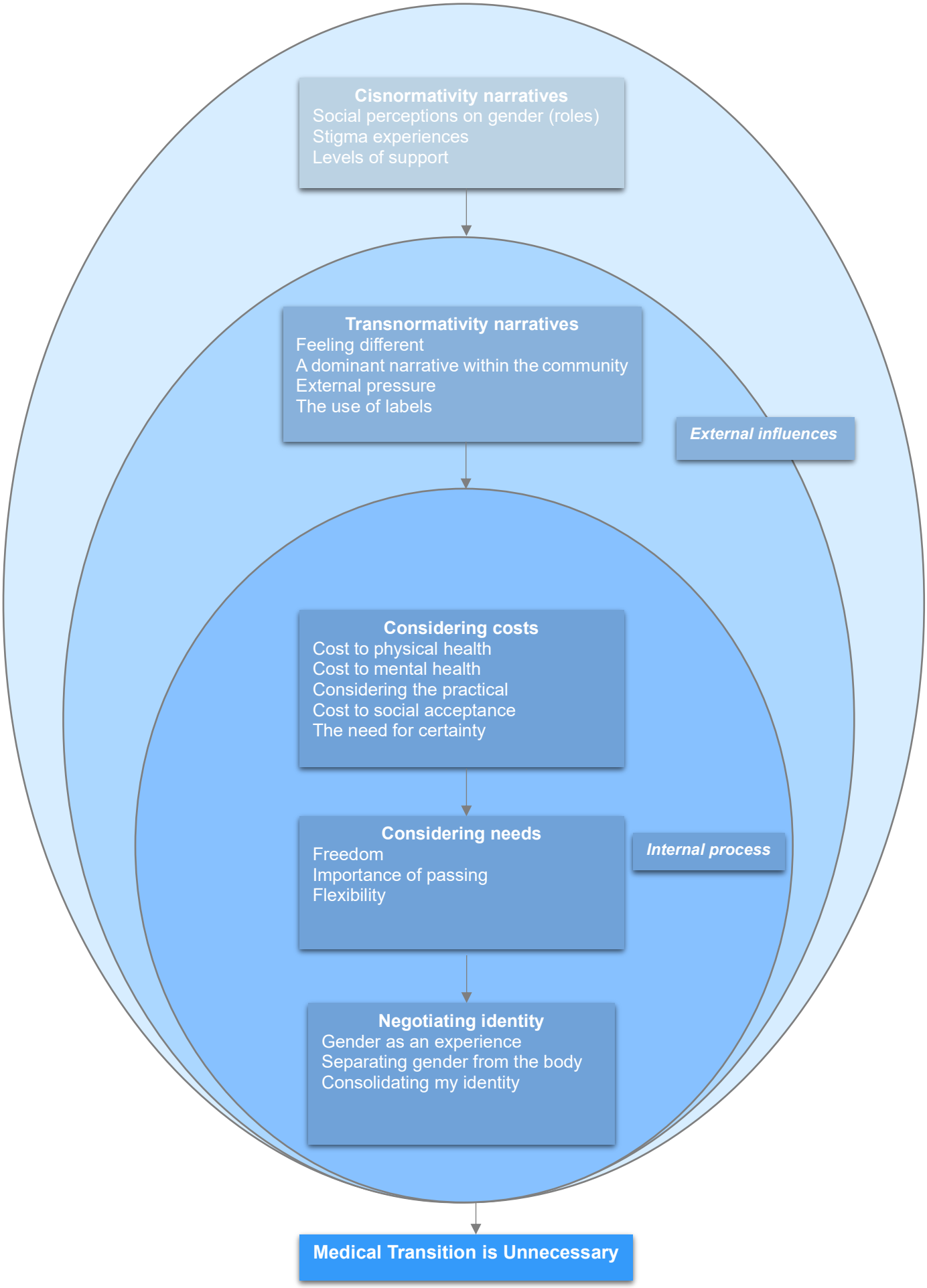


Figure 5. An illustration of the overall theory - the process participants underwent when considering whether to pursue medical gender-affirming care.

External influences

The first section of external influences is cisnormativity narratives, in which participants have lived most of their lives, and continue to live within, as the dominant social gender narrative. The context within which participants grew up has developed their attitudes and beliefs about gender, influenced by their own experience of difference. This had an impact on their ability and willingness to explore and develop their identity, form and maintain relationships, and navigate existential threats. These ultimately developed their attitudes to medical gender-affirming care and impacted the decision-making process.

Throughout the interviews, a theme of constant comparison emerged between life 'before' and 'after' accepting the trans identity, suggesting a shift in attitudes and perceptions and illustrating the dominance of the cisnormativity narrative in their lives.

1. Category I: Cisnormativity narratives

1.1. Social perception on gender (roles)

1.1.1. Gender binary views

This is the first category that emerged from the data and its importance lies in the development of worldview and meaning-making about themselves, other people, and the world. This refers to the initial construction of their own gender identity through the observation, internalisation, and imitation of surrounding expressions of masculinity and femininity when growing up, the premise of social learning theory (Bandura, 1977).

All participants had an experience of stark differentiation between gender roles from an early age. Perhaps this was representative of the time they grew up in, as well as their socioeconomic background. This is relevant to understand how gender has contributed to forming their global identity, and further, establishing their gender identity. Its relevance is also seen later within the chapter where identity management significantly influences the decision whether to seek medical gender-affirming care.

All participants were aware of the weight of social norms in the 60s-70s and through to today, and appear to have influenced participants' sense of selves, as they reflected on it at various points in the interviews.

"And society… conditions people to be what society deems is the right thing." [Andrea, 344-345]

The interviews illuminated that all participants had adopted a binary concept of gender, with distinct differences and separations between masculinity and femininity. All participants experienced this segregation in the family or in school and there was a shared understanding about the societal values of gender distinction and fulfilling gender roles to fit in:

"The end of 1955 and British society then was very gender binary." [Kay, 21]

Since all participants were assigned male at birth (AMAB), they had a closely personal, experienced relationship/reality with masculinity. It appears their experiences closely aligned with the imposed male characteristics as outlined by Brannon's (1976) model of traditional masculine norms, including 'avoiding all sissy stuff'. Whilst this theory was outlined more than 45 years ago, Thompson & Langendoerfer (2015) reported the influence of these ideas on men continue to be relevant today.

1.1.2. 'Macho man'

Four participants shared experiencing an expectation to play into the typical 'macho man' role, while the rest acknowledged this was considered the standard at the time:

"As a boy, you're brought up male and you'll be the macho man. You've got to do […] a manly-type job." [Andrea, 332-334]

"But I mean, I enjoyed helping dad in the garage. But there are other things that… I just wasn't that interested. I've never interested in football or that side of sport." [Stephanie, 123-126].

Jackie was aware her upbringing emphasised equality between genders, which she reflected was unusual for the time and environment she grew up in:

"I've got a non-standard [upbringing] to the macho, 'treat them like chattel and do the cooking' and whatever" [Jackie, 58-60]

She continued by acknowledging being used to non-conformity as it was normalized in multiple aspects of her life, which was a noticeable difference to the social environment around her. She described societal norms as boundaries or a ruleset which most people were expected to abide by:

"I had boundaries, but they weren't the real-world boundaries. Most people stuck to the rules, and I didn't have rules […]. My boundaries were different to the norm of the people around me." [Jackie, 302-314].

Participants shared they learned about this stereotype in the family home at first. Family relationships were built around this idea, creating a sense of heavy importance.

However, they acknowledged the significant influence gender roles had on their social lives, first experienced in school, and later in life when seeking work or establishing families of their own.

'Macho man' also highlighted the need for separating male and female not only for the jobs they were expected to complete, both within and outside the household, but the 'permissible' interests, personality qualities expected to exhibit, and life goals. In a way, the 'macho man' stereotype was communicated through various means and internalised as a rulebook mapping out the rest of their lives.

"So, it was very gender-biased. It was definitely a 'you're a boy, this is the route that you need to be going' and never the twain shall meet (laughs)" [Stephanie, 344-347]

1.1.3. Changes in social acceptance

There was reflection on how the times have changed and societal attitudes have facilitated a more accepting view of gender non-conformity, suggesting a level of comfort and acceptance of participants' identities. Joy reflected on the noticeable shift in social attitudes to gender non-conformity, while commenting on the overarching need to conform as much as the norms allow.

"A lot of us have had to harbour this for many, many years and maybe a lot of the sample that you have will be people of my kind of generation who had to repress it for a long, long time, whereas now it's almost fashionable to be trans. Back then it was worse than being gay. So, lots and lots of societal pressure to fight it, to ignore it. And to conform." [Joy, 133-139]

However, there was hesitation about the amount of societal norm progress and the levels of safety when being out in public:

"Is it different now? I don't know. Probably not that much different because you still got the manly men, the macho men in the pub. And people still raise an eyebrow when a girl wants to repair lorries for a living." [Andrea, 349-353]

"I go out, I go to the loo, I go to the ladies', cause I ain't going in the gents'. I'll get my head stoned in, maybe." [Jackie, 774-775]

Perhaps these lessons and experiences of cisnormativity narratives have developed the understanding of the characteristics what it means to be male and female. Witnessing others' mistreatment and stigmatization based on fulfilling gender roles leaves an unvoiced feeling of the attitudes and behaviours men and women should fulfill. Andrea highlights this through an example of a conversation with a friend:

"So, a female friend of mine's first marriage was to a very 'manly' man who ended up not treating her very well. And she now realises that's not what she ever wanted, but that's what she was brought up to expect." [Andrea, 346-349]

1.1.4. Personal beliefs about gender roles and gender

A significant theme in participants' relationship with gender was related to how they personally define gender, based on beliefs about masculinity and femininity. Despite growing up in the same generation, participants had very different experiences of witnessing gender role behaviours, from strictly conservative to progressively liberal, based on socioeconomic background, geopolitical environmental beliefs, and sociocultural environment.

Kay reflected on the influence of the socioeconomic environment on society's behaviour and subscription to gender roles:

"Growing up in that era, it would have been highly unusual in the working-class area, like where I was, to try to be different or not conform to the norms." [Kay, 214-217]

Nonetheless, there was similarity in the interpretation of masculine vs feminine personality traits and interpersonal behaviour among participants. Men were described as having to be emotionally 'tough', expected to be strong, muscular, the breadwinners of the family, whereas women were understood to be kind, gentle, emotional, caring, and grounded, while at the same time independent and strong-willed. I noticed an additional perception of freedom from high expectations entitled to women, compared to men.

"I think women are far better at expressing how they are inside. Outwardly, men present this face to the world, that kind of conceals everything. And we don't talk about how we feel. But women, because as I say, it goes back to openness, can be very open about their feelings" [Evelyn, 417-421]

Beliefs about femininity helped them understand their gender according to the feelings, thoughts, and behaviours they exhibited:

"You don't tell a 20-year-old man in the pub about your daughter's underwear! But we just had that sort of conversation, and it was just natural. And I think that's because the feminine side inside me showed out even though I was desperately trying not to be feminine." [Andrea, 1447-1452]

When exploring gender-affirming experiences, participants shared about moments of connection, vulnerability, humility, and empathy. While reflecting on their experiences in strictly masculine environments, they described issues of toxic masculinity, with experiences of competitiveness, ruthlessness, and hurtful interactions disguised as humour.

It is possible the abundance of negative experiences under 'masculinity' and exclusively positive 'feminine' experiences has shaped their view of gender, encouraging them to seek out ways to connect with their own femininity through crossdressing.

These findings suggest that participants have been exposed to two opposite and strictly defined models of gender from the dominant cis society, which have contributed to forming their beliefs about gender roles. It became evident there is a disparity around the "rules" governing the genders' behaviours, demeanors, and perceptions, which may be the result of experiencing the effects of toxic masculinity (Thompson & Langendoerfer, 2015). Jackie demonstrates this as understanding expectations for men and women being unequal, perhaps finding the burdens of toxic masculinity too demanding:

"I felt that it'd be nice to be a girl. But I always thought it was the easy option, cause the blokes had to do all the work and I was not very good at it. I was, you know, lousy." [Jackie, 405-408].

1.2. STIGMA EXPERIENCES

The impact of cisnormativity on participants' identity development emerged in stories of social stigma and non-conformity they experienced in school and the family home. Consistent with the adapted gender minority stress model (Hendricks & Testa, 2012), all participants spoke of witnessing and experiencing both external (experiences of discrimination, concealment of identity) and internal (expectation of stressful events, internalized transphobia) stigma.

The focused code of ‘stigma’ is relevant to understanding how past experiences may have unconsciously influenced participants’ decision-making process.

The environment participants grew up in contributed to their understanding of cisnormative social and gender norms. This has influenced their view of the world and finding their place in it, leading to the presumption that their experiences are abnormal. Experiencing themselves as different from the norm, existing in a transphobic culture, may have led to developing a self-stigmatizing identity, and thus anticipating further stigmatization (Chen et al., 2020). This may help explain some of the attitudes participants shared within the internal decision-making process, such as viewing medical transition as a threat to relationships.

1.2.1. Against difference and non-conformity

Participants spoke of having a sense of social norms and conformity from an early age. This came either from witnessing negative consequences of non-conformity in their environment, from childhood throughout adulthood, or personal experiences of these. The differences they observed ranged from global personality characteristics, such as sexuality, to smaller differences, such as hobbies or interests.

“At school, if you didn't support football team, you were the odd man out. So, it was marked out straight away.” [Andrea, 455-457]

“If you were queer, if you were different in any way, you were reviled, demonized, insulted, you name it. So, it was better not to even go there.” [Joy, 26-29]

The temporal context is important. Homosexuality was considered illegal in the UK until 1967 and punishable by imprisonment or chemical castration, signifying a very real threat from a structural standpoint and from a social acceptance perspective on any form of sexual, let alone gender, non-conforming behaviour. Unsurprisingly, social acceptance would require time to catch up, leaving individuals subject to shame, stigma, and violence from any indication of non-conforming experiences. Stigma and social exclusion are fundamental human threats, especially during formative years,

thus being unsurprising that participants were affected by these perceptions (Major & Eccleston, 2004).

Participants spoke of witnessing negative consequences of non-conformity, executed from the social environment onto individuals. Witnessing other people suffering discrimination acted as experiences of enacted stigma for the participants, contributing to internal stressors and internalizing stigma themselves. This relates to holding negative expectations for the future and developing internalized transphobia, acting as minority stress, and perhaps negatively influencing or delaying the gender identity development process.

It is evident participants' environment played a significant role in their ability to enact gender safely. Jackie highlights how impermissible it was to express difference, especially in gender non-conforming behaviours, such as crossdressing:

"I was fortunate that I only really came this way after I'd retired from work. I would have got a lot of grief at work." [Jackie, 1099-1100]

1.2.2. Against trans people

Participants commented on learning about the transphobic culture in their social environment. It is not surprising how these beliefs, conflicting with their own experience of difference and gender uncertainty, might have led to conflicting feelings of internalized transphobia.

"And it was just a no-no, because [work] is a macho environment. And therefore, you know, 'all trans people are weird' and 'all gays are weird'. And it's the environment that you live in." [Jackie, 1105-1108]

"There is still a lot of, a long way to go to get the people understand that because you're trans you're just... You like different things, it doesn't make you odd, or, weird, or, in some way, dodgy or threat." [Andrea, 471-475]

1.2.3. Self-stigmatization

Participants reflected on their change of awareness about transgender identity by being able to recall their first instance of learning about it. I interpreted this was due to the power of popular media in promoting negative depictions and lack of positive influence.

Participants first learned about transgender people from single-case studies, typically a sensationalised celebrity. For some, this was the first and only exposure to gender non-conformity for an extended period of time. Not having a positive role model for trans experiences and behaviour led participants to adopt ideas guided by a transphobic society, likely resulting in internalized transphobia. This idea emerged as a result of the high recurrence of initial and focused codes across all participants.

Andrea recalls first learning of April Ashley, the first trans person to pursue medical gender-affirming care in the UK:

"There was a magazine in the 60s, but it was very sensationalist reported. And if anything, it would put you off trying to do it." [Andrea, 776-777]

She demonstrates how these ideas led to self-shaming beliefs about her crossdressing behaviour:

"It was much later, before I realized [crossdressing] was more than just a kink or a quirk or something odd that I did." [Andrea, 25-26]

The visibility of the trans movement and becoming involved with trans-supportive online communities helped Andrea challenge this pre-existing belief.

"Before I realized [crossdressing] was more than just... A weird thing I did, if you like. And really coming to understand it was later still." [Andrea, 17-18].

British media since the 1960s has represented crossdressing in a negative light, either mocking or criminalizing this behaviour. This has further alienated society from gender non-conformity and difference, stigmatizing trans people as a joke or a threat.

Further, this prevented people from knowing transgender people really exist in the world:

“Because before, I’d just seen this character on TV. But this was moving it to a different level. I can't remember how it affected me, other than learning that people can change their gender if they want to” [Stephanie, 144-153].

Further, the lack of information or visibility reinforced misguided ideas compounding gender with sexuality. This further stigmatized transgender people:

“‘Trans’ wasn't even really a term. You were either a fairy or a sissy. Or you were bent - there were no differentiation back then. If you dressed up, you were definitely homosexual. “ [Joy, 549-552]

Most notably, the image of difference, and specifically crossdressing, instilled a sense of shame and self-punishment in individuals who experimented with their identity.

“I've always been deadly ashamed of the fact that I think [crossdressing]'s weird. It feels pervy to me. You can do lots of things. You can be gay. You can do anything you want. But wearing women's clothes has always been a ‘no-no’. And it took me a long time to get over the fact that maybe that wasn't as weird as I thought it was.” [Jackie, 146-151]

Joy reflected on the problem with lack of exposure on perpetuating stigma and hatred:

“I don't know, whether or not, as you rise in educational standards, perhaps you have wider experience of other types of people. Which is what I would rather say, because we're all people and I don't see why, just because I want to throw a frock on, makes me any different. “[Joy, 632-637]

1.3. LEVELS OF SUPPORT

The focused code relating to levels of support proved to be significant. It appeared the level of affirming social support available to participants played a role in their identity development and willingness to socially transition. This speaks to the significance of receiving the right level of support can have on a trans person whilst choosing whether to pursue medical gender-affirming care.

1.3.1. Lack of social support

Participants spoke of receiving negative reactions whilst first exploring their identity and being caught experimenting with dressing. This led to fear, self-judgement, and anticipating negative outcomes. Alternatively, some participants felt pressure to hide or repress gender diversity as a means to conform. For some, the lack of support stopped the self-exploration process for many years. Because of this self-punishment and avoidance, participants did not have the opportunity to question medical transition until later in life, where age appears to be a factor in the decision-making process.

Social stigma leads to fear of rejection and abandonment. Having been exposed to the negative consequences of stigma, it is no wonder the risk of rejection becomes too threatening and outweighs the desire to explore one's own identity. However, participants reflected the consequences of trying to stop results in emotional turmoil and hiding.

Lack of social support emerged in three ways: direct punishment, indirect social pressure, and lack of information.

1.3.1.1. Direct – punishment

A common experience was experiencing direct punishment and, consequently, anticipating punishment from others about dressing. This typically came from close family, in the form of verbal aggression. These experiences seemed to have significantly impacted participants, some recalling vivid memories from their childhood, or continuing to be ongoing threats in their present lives. This might have reinforced gender role messages by indicating there is only one 'correct' way of expressing gender identity.

Andrea spoke of feeling punished by her family for experimenting with women's clothes during childhood. This led to increased hiding and isolation:

"I never understood [crossdressing] and when I did get caught, was told I mustn't do it again. But of course, I did. Really, my life developed on my own, in many ways." [Andrea, 257-261]

Joy commented that direct punishment and rejection continue to be a reality:

"I'm pretty sure, from the conversation we've had, [wife] doesn't want to meet Joy. She doesn't want to ever see Joy. She doesn't want to see Joy's pretty things. She just wants to close her mind to it. So, therefore, I have a secret life at home." [Joy, 557-561]

1.3.1.2. Indirect – social pressure

Among the indirect forms of lack of support, participants were able to reflect on their behaviour abiding to the social norms, unconsciously experiencing pressure to conform.

"I suppose, in order to fit in […] I wanted to be masculine, then I would go over the top. So I wanted to be as masculine as possible and the thought of being feminine at that time was something that I would never have considered doing" [Kay, 90-102]

This may be the result of enacted stigma and witnessing the consequences of discrimination, which may be understood as a survival strategy. It appears likely, however, that this strategy suppressed the identity exploration process, as challenging the social norms is too threatening.

Alternatively, Joy feels the pressure to hide her identity from interpreting her family's reaction to dressing:

"Although both of my wife and son are accepting of the fact that I've been [crossdressing] off and on for many years, they just don't want to see it. So, I think their view is that 'I'd rather you were still a man.'" [Joy, 569-574]

Jackie reflected on lacking opportunity to freely explore and experiment with her identity. Resorting to hiding while dressing was a shared experience for all participants:

"The opportunity [to dress in secret] was never there and it might have been something that I would have liked to have done, but I just didn't. Because there's literally no way you could do." [Jackie, 1205-1208]

1.3.1.3. Lack of information

Participants have, and continue to, live in a predominantly transphobic society, in terms of judicial, healthcare accessibility, rights equality, and social norms, making them part of the gender minority. While they were able to reflect on the changing nature of this, through the help of trans rights and visibility movements, they have been and continue to be subject to minority stress

Lack of awareness and education about transgender identities, procedures, and available options also appeared to function as a lack of support. Participants attributed this as a significant factor to the delay in their own gender exploration, as well as societal awareness and acceptance.

Andrea noted the delay of understanding her experience was due to lack of access to information and support:

"Before I realized [crossdressing] was more than just… A weird thing I did and really coming to understand it was later still. But you gotta remember, when I was young, there was no Internet. There's no way of… There were support organizations, to be fair, but how you found them, I have no idea" [Andrea, 17-20]

She continues by highlighting the risks posed to trans people who might find inaccurate or dangerous advice:

"But the information needs to be out there that so people can understand that you shouldn't [self-administer]. […] there's really no reason why [GPs] shouldn't be able to have some specialist amongst the practice that can deal or help people. […] somebody who's considering this could talk to somebody and then understand the pros and cons. Because you got to understand the full implications of what you're getting involved with. And then take the time to make the decision yourself." [Andrea, 1224-1237]

Some participants had attended counselling to help understand their experience, however, others acknowledged that this is not widely available or advertised when it could be a useful source of support.

Jackie felt particularly let down by the lack of support experienced from her GP when searching for help, an experience echoed by Andrea:

"I'll talk to my GP and they basically just ignored the conversation. I said, look, you know the bloody Hell's going on in my head. But I'm turning into a bloody girl, you know, and they just ignored the conversation. It never happened. […] So they were a waste of space." [Jackie, 1275-1280]

"I certainly couldn't have gone to my GP and spoke to him about it because he just... Well, if you know my GP at the time, there was no chance of getting any help there [laughs]." [Andrea, 23-25]

Most participants identified accessing the Internet for information to be an invaluable resource. It appeared much of the participants' knowledge about trans identities, which later guided decisions, were from second-hand word-of-mouth stories.

1.3.2. Positive social support

Participants acknowledged the positive impact having affirming support can have on their identity formation and inner wellbeing. This emerged in two ways: direct gender-affirming support and indirect increasing societal acceptance.

1.3.2.1. Direct - Gender-affirming support

Participants also noted a number of positive gender-affirming experiences following their social transition, which allowed them to build confidence in their identity.

Kay spoke of finding affirmation and encouragement to experiment and explore her identity from close people:

"Through meeting other transgender people and having an awful lot of support from my wife, it gradually normalized, and I began to stop hating myself for having those 'unnatural urges'" [Kay, 442-446]

"And when I was presenting as a woman and I was in the company of other women, I felt that was probably the happiest I've ever felt in my life at that point" [Kay, 473-475]

Andrea felt empowered to continue building her confidence:

"When I've been out, I've always had positive comments. I've never had anything negative said to me. So, it just, and I just feel comfortable, so why not?" [Andrea, 1104-1107]

Gender-affirming experiences outside of the trans community were experienced as deeply validating. She reflected this allowed her to form meaningful connections, and find affirmation in her identity:

"They just regard me as one of the girls, as one of their friends, female friends.... And they've been very, very supportive. That just makes me more comfortable with who I am." [Andrea, 1119-1123]

"We talk about everything and anything. […] we talk about things that… Women wouldn't talk to a man about, normally. […] We confide in each other." [Andrea, 1136-1202]

It is evident the element of social support plays a key role in the need to belong and feel accepted.

1.3.2.2. Indirect – Increasing societal acceptance

Participants felt validated and accepted by noticing the shift in societal attitudes. They attributed the feelings of acceptance and progressiveness to trans visibility and reflected on the power generational beliefs can hold over people's expression:

"The younger generation are much more used to it - my daughters have friends that are trans and that's just the way they are. They don't mind, it doesn't matter to them. But the older generation, because of the way they were conditioned by society, they struggle with it." [Andrea, 477-481]

"So, that norm from the 60s and 70s generation with myself and my wife is still very much there." [Joy, 630-632]

A facilitating environment allowed participants to feel more able to socially transition:

"Things might have been better, but almost certainly would be worse. Because it was a different world... I wouldn't have been accepted then like I am now." [Andrea, 1323-1325]

1.3.2.2.1. Boundaries of support

A subsection on questioning the boundaries of social acceptance emerged while reflecting on affirming experiences in public. Andrea commented on needing to make adjustments to how she presents in public:

"But if you dress sensibly, there's no reason why you shouldn't [be accepted]. I've been Tesco's and I have never had any problem at all. In fact, it's been the opposite – I've been very well welcomed most time. But I think it does depend on how you act, and you have to be a bit respectful if some people might not like it. " [Andrea, 595-599, 657-658]

The trans movement has allowed increased acceptance and visibility of the trans community within the cisnormative society; however, the latter remains transphobic: transgender people are allowed to be themselves, but only within the parameters of what cisgender society allows them to be. Joy highlights this in the context of events organised by one trans community:

"Evidently, 1000 [trans] people turn up every month. Can you imagine? If you think about it, it's not that underground. It's just that people choose their time and their place, and maybe that's a sensible way to do it. It's what happens behind closed doors, goes on behind closed doors." [Joy, 1741-1746]

This creates the illusion of an accepting and tolerant society, however, in reality, it is experienced as continuous microaggression, functioning to keep the gender status quo.

Perception of freedom has limits – 'you are allowed to exist, but only in certain circumstances'. The idea that expressing identity in public is accepted within the limits of social acceptance creates an interpretation of boundaried freedom. This limitation reflects broader societal rules and norms that apply to everyone, regardless of gender identity. Alternatively, it could be the result of internalized transphobia as it mirrors the arguments for tolerance experienced by the gay community ('what happens behind closed doors, stays behind closed doors'). In this context, transition can be perceived as a threat to social belonging, especially coupled with the potential risk of not passing. This fear is addressed in Category IV: Considering Needs, where the participants' concern about the social implications of their gender expression is discussed.

SUMMARY OF CATEGORY

Participants spoke about their first experiences with gender and identity development, establishing how these were influenced by the cisnormative context they spent the majority of their life in. Developing binary views, perceptions of stigma, and experiences of social support affected their relationship to gender, leading to experiences of self-shame, denial, and secrecy behaviours, and for some resulted in

stopping the gender exploration process for many years. These factors ultimately influenced the process of shaping their identity and later deciding whether to pursue medical transition.

2. Category II: Transnormativity narratives

The second external influence derives from messages and experiences received from being exposed to transnormativity narratives. After beginning to explore their identity, participants had various levels of exposure to the trans community, which then changed their views on gender, expression, and what it means to be trans, thus re-forming their gender identity. I argue the transnormativity narrative is understood to be within the cisnormative narrative as it is borne out of the latter and the consolidation of both perspectives impacts the decision on pursuing medical transition.

2.1. FEELING DIFFERENT

All participants commented on perceptions of either 'feeling different' or 'not feeling different' to other trans people. They communicated this through examples of early age experimentation with dressing, self-discovery practices, or gender dysphoria feelings. Jackie described it as a 'script' many trans people appear to follow in their self-disclosure stories:

"Because the ones that want gender reassignment have a rule book and they've got to get past the hurdles as marked out. And so, they all say the same stories. 'I've been doing this since I was 12, the only thing I ever want to be'. But it's all the same script. I mean, I'm just making it up as I go along." [Jackie, 601-606]

Since this gerund emerged from the text unprompted, this suggests participants developed an impression of a common, universal trans identity development experience. This relates to the concept of transnormativity, thus indicating all participants were influenced to certain degrees by transnormative narratives (i.e., *'this is how you know you are trans'*) whilst still exploring their gender identity.

This finding suggests there is a dominant narrative within the trans community in the UK, which may set the expectation of a 'correct' way to be transgender. This is important to consider as it may influence identity development and the decision of pursuing medically assisted gender affirming care. Evelyn reflected on the feeling of expectations of having a universal, shared trans experience, which felt invalidating, and ultimately alienated her from the community:

“There's a lot of things you're supposed to subscribe to. You're also supposed to subscribe to things like, ‘Well, of course you've always had gender dysphoria and you didn't know it.’” [Evelyn, 494-496]

It appears, upon entering the trans community, participants learned there is an expectation for pursuing medical gender-affirming care under specific conditions.

Further, these feelings of difference mirror the negative effects of nonconformity and self-stigmatization within the cisnormative narrative. This further segregates participants into a minority group within the already minority group of transgender people, setting precedent for further intersectionality. Feeling different within all external environments created identity doubt for participants, which also affected feelings of belonging and questioning whether medical transition is right for them.

2.2. A DOMINANT NARRATIVE WITHIN THE TRANS COMMUNITY

2.2.1. Bus journey metaphor

Contrasting views about the narrative within the trans community emerged from the text. For some, it was a valuable resource that helped them find themselves, whereas for others it felt too prescriptive. Kay described the general view of the universal trans identity journey, explained through the bus journey metaphor:

“The bus journey being transgender, as you get on the bus that's when you discover there's something about you that is connected with the trans experience. And then the bus takes off, and depending on what happens in your life, what you experience, things change, relationships, etc., you can go to the full way to the end of the bus journey or get off at any point.” [Kay, 785-791]

Kay’s metaphor reflects the modern view of the gender spectrum transpiring within the trans community, promoting empathy, inclusivity, equality, and acceptance. It functions to provide reassurance that there is a place for everyone, regardless of the stage in their journey. However, Kay contradicts this belief system when evaluating her own

journey to be ‘different’ or ‘unusual’, thus segregating herself from the majority; a sentiment shared by four other participants in this sample.

On second reading, the metaphor raises questions about the journey’s direction and end destination. With the help of other participants’ views adding context, it appears to hint at full medical transition being the end of the bus journey and the factors preventing that are life events or outside influence acting as barriers.

2.2.2. The ‘orthodox’ belief about transition

Evelyn spoke of ‘the orthodoxes’ within the trans community, namely those who subscribe to the pro-medical transition idea that gender is biologically determined, fixed, and transition seen as the end goal; she adds, any other perspective is deemed as denial. She counters the bus journey metaphor with her own view:

“There's another thing that people go on a lot about, ‘your journey’, and I think behind it, there's a feeling that everyone really must want to transition, that's the Holy Grail. And you're always on a journey until you've done that, whether you want to or not.” [Evelyn, 504-507]

Kay supported this with the notion that, commonly, trans people have always ‘known’ they were trans:

“Up until I discovered that I was transgender, in my mid 30s, I'd always strongly identified as a boy, and I think I'm very unusual within the transgender community in that respect” [Kay, 12-14]

Perhaps these contrasting views demonstrate division within the trans community in the UK. It is unclear whether this ideology is formed by the majority or by the loudest, however, it appears to serve an ongoing function of rejection, invalidation, and focus on labels, which provide certainty in what may otherwise be an uncertain journey. This relates to the need for belonging, whereby the trans community’s narrative acts as a double-edged sword: providing a common space for belonging but also invalidating different views through its high expectations of a universal transness.

Moreover, three participants (Joy, Jackie and Evelyn) outwardly commented on the negative experience of feeling pressure to subscribe to the narrative promoting medical transition.

"I get the feeling there's a sort of package that you're supposed to sign up for. […] if that Orthodoxy takes hold, that you've got to do this, you've got to do that. […] 'your transness is genetic'. […] if that becomes the orthodoxy, then I cease to be trans, don't I? Then what do I become? What am I? Does that mean I'm out of the club? I worry about that." [Evelyn, 577-586]

Even though there is some evidence of a genetic component for gender dysphoria (Boucher & Chinnah, 2020), it appears Evelyn's focus is on the social construction of gender and identity. It is possible what she is suggesting that among those 'Orthodoxes' the biological and social aspects of gender are combined, leading to feelings of rejection, dismissal, and abnormality.

When discussing where this belief might have originated and perpetuated, Andrea reflects on the messages received from engaging with the community:

"From some within the community, without a doubt. There are some that perhaps have transitioned and consider that if you don't transition, you're not worthy." [Andrea, 1660-1663]

She highlights that one of the functions of transition being the end goal may be to mask other difficult feelings and highlights the dangers in transition being seen as the solution:

"And think it through, is [transition] what you really want or is that what you think you want? You've got to understand and be really [certain] that is what you want to do, and not use it, hoping it's going to cure other problems." [Andrea, 1545-1549]

Evelyn reflected that another consequence of this narrative is division between the trans and cis communities:

"I've spoke a lot about the trans community's expectations of trans people. As I say, to me, in my limited experience out in the world, it feels like you're pushing it an open door." [Evelyn, 649-652]

2.2.3. Gender dysphoria

All participants referenced gender dysphoria as an all-round agreed phenomenon within the trans community as an indicator for pursuing medical gender-affirming care. They referenced this by comparing their experiences to others within the community or disclosing never felt 'being born in the wrong body' – narrative created and perpetuated by cisnormative understandings of a different gender experience (Garrison, 2018). This suggests the dysphoria narrative is widely used within the community, with messages it is the most valid and certain reason to pursue medical transition:

"I've never thought I was born in the wrong body. So, it's not like I want to get rid of my penis. Some do. Some are desperate to, but I don't feel I need to do that. […] Perhaps I'm different to everybody else, I don't know." [Andrea, 1010-1016]

This message may influence the decision to pursue medical affirming care through the process of rejection – if gender dysphoria is seen as a prerequisite for medical intervention, then its absence must indicate the lack of need for transition. Multiple participants noted the intensity of dysphoria feelings and desperation for medical intervention to be important for the decision-making process, suggesting these are direct indicators for pursuing transition. Stephanie demonstrated this through a spontaneous causal link in her reflections:

"I don't need to have surgery to be who I am right now. I've never had the strong feeling of being born in the wrong body… Obviously, I've never been counselled for it, but I don't think, I'm almost certain of it, I haven't had gender dysphoria." [Stephanie, 1004-1008]

Throughout the text, she minimizes her gender experience, possibly indicating a hierarchy of needs that is being indirectly communicated within the trans community, a sentiment shared with other participants.

It appears the expectations encountered from the trans community played, and continue to play, a significant role to the evaluation of need for medical transition.

2.3. EXTERNAL PRESSURE

Throughout the interviews, the transnormativity narrative emerged to also be perpetuated from outside the trans community. Multiple participants commented on the change in societal impression of trans people bordering experiencing pressure to seek medical transition.

2.3.1. Cisgender society

Andrea highlights the belief about transition being the end goal is also perpetuated from the cis community, creating pressure for certainty, and 'knowing' from an early age:

"But, also, [cis] people get the assumption that, 'OK, you're gonna dress like this, the next stage would be transition, automatically'. But of course, it's not. Not for a lot of people, probably not for most, in truth" [Andrea, 1666-1669]

She cautions about the possible negative effects this may have on people exploring their identity:

"The more people find out and understand not everybody wants to transition, it's not a given that because I want to live like this that I want to fully transition. And I think, particularly nowadays, some people are almost pushed into transition. Or pushed into 'my son, my daughter's trans' […] As soon as the child shows an inclination that a boy wanting to put a dress on, or a girl wants to be a bit more boy-like… They just jump on the trans bandwagon." [Andrea, 1564-1587]

The concern about the effects of this attitude on young people was echoed by Evelyn:

"I think there is now an issue that's openly acknowledged that perhaps we've been rather experimenting with young people." [Evelyn, 670-672]

Participants claim that within the cisnormative community, questioning gender identity equates to wanting medical transition, which results from the transnormative belief of the end of the journey. However, this then impacts the trans community by perpetuating this belief as the dominant one, which gets fed back into cisnormative narratives. The idea that trans people should want medical transition is maintained by a never-ending loop, bouncing back and forth between the cis and trans communities.

Evelyn builds upon this idea with her view on the trans community's responsibility to this:

"I think there is a bit of an expectation in the general public about [transition] and the bit that bugs me is that If they see me, they'll probably assume that I sign up to all the things you see in the media that the trans community says it's all about." [Evelyn, 658-661]

2.3.2. The healthcare system

Perhaps the dominant narrative of a fixed, pre-determined gender identity, and particularly gender dysphoria, stems from the medical model governing the definition of transgender. Jackie acknowledges the pursuit of medical transition within the community stems from the structural obstacles to qualifying for medical gender-affirming care:

"Because the ones that want gender reassignment have a rulebook and they've got to get past the hurdles as marked out. And so, they all say the same stories." [Jackie, 601-603]

However, she continues by implying that this is not the sole reason for the commonality of shared experiences:

"I don't do lots of things that the sort of 'normal trendy bit' say I should do. I just don't do them that way." [Jackie, 607-609]

The pressure created by having strict criteria for medical transition sets a precedent: the NHS criteria for gender reassignment treatment become experienced as requirements. Moreover, these ideas might be perpetuated by media representations of medically transitioned trans people, both from the past and present. The influence of a 'success' story can impact perceptions of medical transition in a positive light, perpetuating the belief it is to be desired.

The division within the trans community might be influenced by the demands of a transphobic healthcare system: In trying to satisfy the need to belong within the trans community, transgender people are inadvertently trying to conform to the cis system. This then creates division between the cis and trans communities, whilst also perpetuating division within the trans community, further stigmatizing participants. This reinforces the idea that medical transition is the end goal, setting a polarizing expectation for many transgender people.

2.4. THE USE OF LABELS

A common finding between interviews was the use of labels participants used to develop their identities and understand their experiences. Labels were found to be both helpful and unhelpful.

2.4.1. Labels can be helpful

Labels were found to be helpful by providing definitions and a 'framework' for understanding one's experience. They also reduced the stress of uncertainty around one's identity.

Labels helped participants establish contact with the trans community, contrasted by the feelings of alienation growing up with no access to information. Andrea spoke of belonging to a group, unified by an umbrella term, to be helpful in developing confidence and resilience, as well as feeling safe enough to explore her identity:

"I used to go to a trans club. It's a good place to start because it's very safe and there are plenty of crossdressers there, so you're not on your own. And you can build up confidence, which is why I went." [Andrea, 1025-1028]

2.4.2. Labels can be harmful

Alternatively, participants reflected on the downsides of labels. For some, the abundance of information and categorization resulted in confusion and ambivalence about their own identity:

"I'm still slightly confused about the multifarious number of genders that now are […] [previously] there was nothing in between, where you had a specified title or box to put people into which we now seem to have." [Joy, 1291-1296]

Further, over-focus on the accuracy of labels appeared to reinforce division within the trans community, contributing to a hierarchical belief of being transgender:

"For some, it's more a fetish than a lifestyle. For me it's the way I live, but to many, it is a fetish, so is that crossdressing or is that something different? It's difficult as to where you would draw a line on it." [Andrea, 1752-1756]

The need to draw a line and continuously define one's experience signals of a gatekeeping mindset, possibly shared within the community. This further perpetuates stigma and separation. Joy shared first-hand experience of the negatives effects of this belief:

"I met a couple of transgender people who really had a go at me because I don't want to go the whole hog and I just said 'Well, that's me. I'm a fetish.'" [Joy, 1427-1430]

The impact of labels appears to have sifted down to the belief that gender dysphoria and seeking medical transition are requirements to identify as trans, leading to continuously question her identity:

"When you have your appraisals and they have, 'what would you categorize yourself as male, female or trans', I still put 'male' because I'm not trans. I'm not emotionally… 'a female trapped in a man's body'. I would like to adapt that male body to be more feminine. But I don't want to be a female, so I don't know where that would fit in with all these." [Joy, 1312-1318]

Finding labels and agreeing on one dominant transgender theory provides certainty in what has otherwise been a very uncertain and destabilizing experience. Many people are, understandably, looking for an answer and a community, which provides belonging and protection. However, the use of labels inadvertently creates division as not everyone shares the general belief, risking further rejection.

SUMMARY OF CATEGORY

Participants commented on messages both from inside and outside the community that there is a 'correct' way of being transgender, where medical gender-affirming care is seen as the end goal. They explored the interaction between the cisgender and transgender communities, as well as the negative impact of not sharing this belief. The impact of exposure to transnormativity messages appears to be significant in defining their own trans identity, as well as the requirements or need for pursuing medical transition.

Internal processes

Following from the understanding that external influences shape participants' belief system on gender, trans identity, and medical affirming care, all participants reflected on their individual internal consideration processes that led to the decision not to pursue transition.

Participants first obtained practical information about the medical transition process and available options. Upon gaining new information, they engaged in a process of considering the costs to aspects of their life medical transition may bring. They then explored their current needs and evaluated how medical transition may fulfil or deny these. Finally, they explored the nature of their identity, questioning whether medical transition fits within their context. All participants concluded that pursuing partial or full gender confirmation treatment is unnecessary to fulfil their current life values. Most participants remained open to the possibility this decision may change in the future suggesting the overall process remains dynamic and ongoing.

3. Category III: Considering costs

3.1. Cost to physical health

A major factor all participants noted as deterrent to pursuing medical transition was the possible risks to their physical health and wellbeing. Consideration of age was mixed with concerns about their past and current physical health and the threats any medical involvement could pose to their lifestyle.

Half of the participants shared concerns about the implications of HRT and surgical intervention on physical health:

"I'm 70. I've been on three heart attacks. Would I go for any serious surgery?"
[Jackie, 651-652]

Jackie continues by highlighting the fear associated with medical intervention. She concludes the desired effect could still be achieved through non-invasive practices; an opportunity she has with crossdressing:

“But a lot of it is major, you know, heroic surgery. I mean it's a big job. And it's bang for buck. I think I could get more from doing a decent makeup.” [Jackie, 1493-1495]

This response was echoed by Stephanie:

“I'm just 60, I wouldn't want to do anything to affect my physical health.” [Stephanie, 976-977]

Further, some participants held fears about the implications to physical health through witnessing others’ negative experiences:

“Being a cyclist for so many years, I came across a lot of drug abuse, performance enhancing drugs. […] I saw the effects it had long-term. And I suppose I've always been a bit nervous […] they might cause serious long-term damage to their health” [Kay, 917-926]

Joy noted the aftereffects of medical intervention on libido and sexual function acted as a strong consideration factor, highlighting the possible sacrifice to quality-of-life:

“Diminishing the testosterone level would be a bit of an anathema to me because I really do enjoy having a libido” [Joy, 1893-1896]

These two comments about unwanted effects of medical intervention may relate to the code of ‘Lack of information’ as it is unclear where this knowledge is stemming from. For example, sexual desire is thought to diminish in the initial stage of using feminizing HRT, however, it has been found to significantly increase over a longer period of time, resulting in a net increase in libido (Defreyne et al., 2020). It is possible this knowledge, which appears to be held as a fear and functions against the decision to seek transition, to be reflective of the generation the participants grew up in and the internalization of transphobic narratives.

As physical health was a major theme in their consideration process, it appeared to carry significant weight on the decision, suggesting the idea that risk to personal health and wellbeing strongly outweighs any benefit medical transition may bring.

3.2. Cost to mental health

Another element discussed by all participants was concerns about the mental and emotional strain of pursuing transition. This code also emerged from a mixture of personal experience and witnessing others' stories. Andrea spoke of being the support for other people in the community whose mental health had been affected by the process, and showed concern about others who may suffer:

"You've got to be very strong and determined to go through with it." [Andrea, 882]

Evelyn shared her struggle with coming to terms with her identity, highlighting the personal cost to emotional wellbeing transition may bring:

"I mean, for me it will be impossible because of age, because of health, and it's incredibly long-winded process and a very painful process." [Evelyn, 769-771]

She questions whether the benefit of pursuing transition, if any, would be worth the mental health cost. It appears she remains doubtful:

"Then I got to the end of [counselling] and somebody said, 'you'll need to see a gender-specific counsellor'. I can't go through this again. I can't start from scratch and tell my whole story to someone else again. And what magic ingredient will they have that's gonna change my life?" [Evelyn, 775-779]

3.3. Considering the practical

Participants considered the practical issues related to pursuing medical transition as a factor in the process. Within the personal contexts of age and health needs, the themes of uncertainty and lack of autonomy emerged as barriers.

Perhaps this category also relates to Transnormativity narratives since there could be a general narrative of mistrust and avoidance of healthcare from within the trans community, backed by research findings (Bauer et al., 2014; Romanelli & Hudson, 2017), and from general negative expectations from the British public regarding NHS waiting times (Calnan & Sanford, 2004). In sum, practical considerations about the barriers of accessing medical gender-affirming care appeared to be a significant factor for all participants and appeared in every participant's internal decision-making process.

3.3.1. Waiting times

Participants acknowledged the long timescale acting as a limiting factor in pursuing medical intervention. They considered the context of age, money, and extensive waiting times impacting on the achievability of this route.

"There's a long-time scale, whichever way you do it. Unless you got vast amounts of money and could afford to pay for the medical work that's needed. Going through the NHS can take years." [Andrea, 807-810]

Andrea connects the obstacle of time and living in uncertainty as a limit to her identity acceptance and general wellbeing. She has weighed up the decision and presents it as a choice between self-acceptance and continuing waiting:

"Do I wait another, I don't know, could be 6, could be 10 years, to transition at my age? Or do I start enjoying my life now?" [Andrea, 985-987]

This idea is not surprising in the context of the emotional, intellectual, and physical labour involved in pursuing medical transition through the NHS – the process appears to be a significant investment, which comes at the cost of enjoying her life.

3.3.2. Financial dependency

All participants made reference to the financial component to gender affirming care, to varying degrees, possibly based on the amount of research invested into learning more about the practicalities of medical transition. Participants identified the financial

disparity between NHS and private routes, highlighting the limited options available, being a factor in the decision-making. Being financially dependent on the public health system, related to waiting times, results in a lack of autonomy and decisions about care.

"But surgery costs a lot of money, and I don't have a lot of money, and maybe that's the main thing that's stopping me doing anything to myself. " [Joy, 543-545]

Within this context, Joy is including aesthetic interventions, such as laser hair removal and Botox. However, in considering the financial implication of pursuing (private) medical gender affirming care, the sentiment was shared among all participants.

3.3.3. Distrust in care

Andrea reflected on hearing firsthand experiences of extended waiting times, poor aftercare, and the negative psychological impact this can have on individuals:

"You hear some horrendous stories even from NHS, […] Where the operation didn't quite go to plan, or the aftercare wasn't what they should have had. So that's another thing to put you off." [Andrea, 876-879]

She continues by sharing concerns about the quality of the result, highlighting ambivalence whether surgery might even meet her needs:

"And some [breast augmentations] that I've seen are absolutely horrendous. […] You just look like a freak, so I wouldn't want to do that…" [Andrea, 1005-1008]

Jackie echoes this concern, demonstrating her weighing up process that dressing has the potential to satisfy the need to look good with more certainty:

"People who have cosmetic surgery, you see all these things on the Internet and how a lot, lot worse now than if they just left it alone. And I've seen people do good makeup, and I know makeup is magic, and if it can, it can improve me by no end." [Jackie, 891-894]

Joy connects the risks of improper results to the bigger aspect of regret:

"If you do something that goes wrong, you then have room for regret. I don't think taking that risk would have ever been part of my persona." [Joy, 2011-2013]

3.4. COST TO SOCIAL ACCEPTANCE

Another aspect participants considered as a cost was the consequence to personal relationships medical transition could have. Underlying fears of rejection and abandonment appeared to bring substantial concerns and were significant factors against the decision for most:

"[Wife]'s the love of my life, I'd never want to do anything that would jeopardize that relationship. [Wife] signed up for being with me as a male, so I wouldn't want to do anything that would upset [her]." [Kay, 903-908]

Stephanie reflected on exploring the boundaries of expression within her relationships as a factor. This would suggest choosing a more invasive and possibly permanent change to her expression means renegotiating the acceptance, thus threatening her newfound freedom:

"I'm understanding the boundaries in a funny sort of way. I think [wife's] feelings might change if I was getting dressed every day, going out all the time. I think that would be different." [Stephanie, 1472-1475]

3.4.1. Need to belong

A common theme for most participants was the underlying need for freedom and acceptance, which was not guaranteed should they pursue medical transition. Joy connected this experience to social aspects of conformity and response to difference:

"You have to be aware of the perceptive problems that other people have about you as an individual or trans as a group. And I think that's general to transgender,

crossdressers or anybody who dares to be a little different. It's not they that have the problem. It's the outside looking in that have the problem." [Joy, 1605-1611]

Alternatively, Jackie saw her social transition as an opportunity to pursue freedom:

"I outed myself […] the wife said, 'I can't handle it'. And therefore, we're getting divorced, so that left me the opportunity to say, 'Well, I'll go for it then, I'll lose you'. At that stage there was nothing to lose, and it was like everything on red. And we'll roll the dice and if it doesn't go up red [shrugs]" [Jackie, 474-481]

Later in the interview, she reflected on the threat to physical safety transition might bring:

"Part of me is scared. […] I'm moving 2 miles down the road to what is a less desirable area, I'm not sure that I'll feel safe, comfortable, going out in a different part of the world girlified." [Jackie, 1344-1347]

Perhaps for Jackie the threat of losing close relationships does not impact her decision as much as for other participants. However, the overall threat of social rejection still carries the risk to physical and emotional safety. It is evident that perceiving threats to social belonging as a result of medical transition are a significant factor for the decision-making process.

3.5. THE NEED FOR CERTAINTY

This consideration process highlighted the uncertainties and unanswerable questions medical intervention can bring for issues around health, relationships, and satisfying their needs. As participants reflected, they realized pursuing medical transition is filled with uncertainty and too many factors out of their control, the risks of which come at a steep cost:

"It's the fact that it's such an outlay for an uncertain result." [Joy, 546]

The abovementioned aspects, fundamental to one's life and wellbeing, bring underlying concerns about lack of security and safety if pursuing medical intervention. By rejecting further medical involvement, participants cope with these threats by shifting their focus to the benefits and needs dressing alone can satisfy. This commonly appeared as the response "I don't need it":

"[Transition]'s not gonna give me anything I can't have" [Andrea, 900]

"If I can be happy being me as I am right now, I have no desire or need to have medical intervention." [Stephanie, 1193-1194]

Joy demonstrates her belief that having certainty is the strongest indicating factor for pursuing intervention; therefore, in the absence of certainty, the decision is influenced that medical transition is unnecessary.

"I think if you if you're going to go and do it, you must be pretty convinced that that is the course of action that's right for you. It wouldn't be for me." [Joy, 2005-2007]

Since this belief was shared among participants, it is possible it has emerged from narratives from others who have 'successfully' obtained gender confirming interventions. Evelyn reflects that looking for certainty might be a hopeless task:

"I don't know how would you ever be certain [the decision] was right. I think it must be right for some. "[Evelyn, 825-826]

This draws the attention to the next phase of the internal consideration process, exploring their current lifestyle needs, and evaluating whether medical transition would satisfy these.

SUMMARY OF CATEGORY

Participants first considered the risks of pursuing medical intervention and evaluated the costs to their quality of life this might bring. Among the factors considered were the practical daily consequences to health and relationships, as well as the existential

need for certainty and knowing this would be the correct choice for them. The initial process of finding ‘reasons against’ appeared to act as a strong deterrent to exploring transition further.

4. Category IV: Considering needs

After considering the personal costs and barriers, participants acknowledged medical transition would not meet their needs, deeming it an unattractive option. They then began exploring what their needs are, thus weighing up some of the difficulties they continue to face without transition, while also acknowledging the elements they are satisfied with their current situation.

4.1. FREEDOM

The need for freedom emerged as a category in all interviews. Participants shared stories of the discomfort having to hide and deny their identities before coming out. For Jackie this felt like a life-or-death choice:

'I figured [hiding]'s either gonna kill me or I'm gonna have to do something different. I can see why people top themselves. Because they've got nowhere else to go. And they're so scared.' [Jackie, 1096-1099]

For Joy, coming out felt like a rebellious and liberating act:

"So just for once, it'd be nice to have something of my own. And, let's face it, the only thing you really do own is your body." [Joy, 885-887]

"I want to be me, and I want to be free. Little rebellion." [Joy, 953]

In this context, social transition and dressing alone satisfy the need for freedom and identity expression, whilst allowing space for euphoria and identity exploration. This explains how medical transition might appear futile as an attempt to freedom, if not actually limiting. Dressing, alternatively, allows for flexibility, experimentation, and expression.

"I think it's amazing that you can do it with makeup and just having the confidence to go out there." [Jackie, 1829]

4.2. IMPORTANCE OF PASSING

A major code was identified in the importance of passing as a woman. This appeared to be a strongly gender affirming experience. Participants commented on two rewarding aspects of passing: self-affirmation from enjoying 'looking pretty', and affirmation from others from receiving recognition and respect. They also acknowledged the negatives of not passing, including feeling pressure to present well, as well as threats to emotional and physical safety from looking like 'a bloke in a dress'.

4.2.1. Self-affirmation

Kay explains how dressing allowed for a novel experience that helped connect with her identity and gain satisfaction:

"I'm a lot better looking as a woman than I am as a bloke and I think that was another thing I wasn't used to, seeing myself looking reasonably attractive in the mirror." [Kay, 382-385]

It appears embodying femininity through dress, movement, and self-perception allows for meeting the need to feel like a woman, regardless of the physical characteristics. From this perspective, it appears the focus of expression has turned internally, emphasising own feelings and needs, rather than presenting to the outside world.

This idea was supported by ongoing themes of pursuing beauty. Participants fantasized about cosmetic alterations, however, their function appeared to be related to wanting to look pretty, rather than gender affirmation.

"There's aspects of modification that I would be quite happy with. I'd love to be pretty – simple." [Joy, 2007-2009]

"The only thing I've done is I've had some laser treatment to remove some hair and, in all honesty, that's probably as far as it's going to go. Might get my eyebrows done. (laughs)" [Stephanie, 897-900]

Jackie reflected on the possible connection between beauty and the pursuit of youth acting as a more compelling factor than gender affirmation:

"Because you'd be chasing the youth side of things. And it's always nice to be young. It's always nice to be pretty. But that's not what people who are trans tend to want. They're just in the wrong body, and they don't care what it looks like." [Jackie, 902-906]

4.2.2. Affirmation from others

Being affirmed in their gender from others acted as a powerful factor in the importance of passing, satisfying the need for recognition, acceptance, and belonging.

Kay recalled a notable gender-affirming experience whilst presenting in public:

"The feeling of happiness, the fact that this little girl thought I was a lady carrying these shoes […] gives you a feeling of kind of euphoria. […] when you're out and people treat you as a woman, that's one of the most important things to helping you feel self-happiness, to feel good about yourself. Good about life in general." [Kay, 1111-1156]

Stephanie shared a strongly affirming experience getting a bra fitting. This helped her reflect on the satisfaction she gained from feeling accepted and welcomed, thus inspiring her to share her experience, reaching out and encouraging others:

"Not only am I enjoying being Stephanie and me, I'm enjoying the other parts, too. I'm enjoying sharing Stephanie with other people; I'm enjoying sharing my stories with other people." [Stephanie, 1797-1799]

From this perspective, participants reflected that dressing alone satisfies the need for gender affirmation, thus reducing the need to pursue medical intervention.

4.2.3. Pressures of presenting well

The importance of passing also appears to carry downsides to participants' wellbeing. Whilst passing can be an extremely validating experience, the issue of *not passing* was highlighted as a risk to physical and emotional safety. Participants commented on the pressures of needing to always look good, as well as the negative consequences to safety.

Jackie names the pressure she has felt to present 'polished', attributing this as normalized within the trans community:

"And the whole image you get of trans people is they tend to be really pretty and perfect, just like most stuff for women. It's a line – because in the real world, people don't always look perfect. And so, I think, there's added pressure to do that." [Jackie, 1782-1785]

This was echoed by Evelyn's observations through her interactions with the trans community on the pressures for trans women to appear overly feminine:

"Women come in all shapes and sizes. But there's kind of 'the ideal' that has been pursued. And it's very, as I say, cosmetic." [Evelyn, 801-803]

This is perhaps reflected in the social need to conform within the cisnormative narrative of beauty ideal and internalized transphobia from the transnormative one. Perhaps those able to achieve traditional feminine beauty are on the privileged side of the social standing, whereas others may suffer negative consequence from not being as 'lucky':

"This guy is about the same build as me but could pass as a woman. He's very, very lucky." [Joy, 760-761]

4.2.4. 'A bloke in a dress'

Threats to safety emerged as a code under the label of looking like 'a bloke in a dress'. Participants used the phrase to signify not passing and being recognized as a man

wearing women's clothing, bringing the derogatory essence to view. Participants noted this as a personal self-perception, connecting it to being afraid of mental or physical abuse, emphasizing the added importance of passing.

Kay elaborates by noting this was an important consideration when first expressing her identity:

"It was very important that I could present as a woman and not have too many people thinking 'Could that be a bloke in a dress?'" [Kay, 1087-1089]

She commented on the tangible fear associated with being misgendered, indicating a threat to emotional safety:

"If somebody suspected it was a bloke wearing a dress […] people felt it was OK to make fun of you in public" [Kay, 359-362]

This fear appears to be common among participants, with Jackie using the same phrase:

"And what I don't want to do is look like a bloke in a dress" [Jackie, 508]

Stephanie shared the same concerns; however, she reflected that receiving encouragement and normalization of these fears helped her consciously overcome them:

"So, you shouldn't be worried about other people looking at you. And after reading that I just came to the decision that I'm happy being the way I am at the moment" [Stephanie, 1000-1003]

Stephanie's account suggests that the level and access to support from others plays an important role in managing the threat of not passing. Furthermore, a conscious evaluation of the number of affirming experiences outweighing the negative ones has consistently helped participants feel safe enough to present in public.

4.3. FLEXIBILITY / TRANSITION IS PERMANENT

Participants reflected on the need for flexibility and autonomy, which appeared to be a mechanism for accepting identity. For some, the ability to embrace their feminine side whilst also retaining their masculine role was essential for maintaining relationships:

"If I had the opportunity to dress all the time, would I? I don't know. Because there's still the male part of me that does the things that dads do." [Andrea, 1338-1340]

Moreover, participants found themselves adjusting to newly developed opportunities to dress, exploring to what extent they wish to dress:

"I just have a… It's more than a 'like' (laughs) for being Stephanie from time to time. I don't need to do it every day." [Stephanie, 1008-1010]

Stephanie was able to distinguish the parts of her life she prefers engaging in her masculine role, such as choir practice.

"Because I have other friends and other things that I enjoy doing as Paul, I'm happy to be living the two lives that I'm living at the moment." [Stephanie, 889-891]

"I sing in two choirs. And… I'm happy singing, […] that is something that I am more happy doing as Paul. There isn't any need for me to go as Stephanie." [Stephanie, 1202-1206]

Having flexibility between the two roles emerged as an argument for maintaining the status quo whilst also having freedom to express identity. This was often reconciled as leading two lives. In this context, seeking medical intervention is viewed as 'permanent', it would deny this freedom and may threaten relationships.

"Somebody said, 'Well, you could just have breast augmentation.' And I said, yeah but then when I'm Paul, I would have to hide it." [Stephanie, 1600-1602]

This process of hiding mirrors past experiences of having to hide their identity, which could explain why medical intervention would be viewed as a threatening option. Further, it poses the threat to passing as a man, which could bring the same threats to relationships and personal safety.

SUMMARY OF CATEGORY

Participants considered what their current needs are and evaluated how pursuing medical intervention would affect those. Most notably, the need for freedom, flexibility, and affirmation were among the highest importance. In this context, pursuing medical transition is viewed as a permanent choice, having to sacrifice the newly acquired feelings of freedom and flexibility, and thus denial of needs.

The final step of the internal process led participants to reflect on their identities, understanding they do not fit into the traditional paradigms of cisnormativity or transnormativity, but rather something unique. It appeared they had engaged in the process of re-negotiating their identities to better fit their experiences, relationships, lifestyles, and outlooks on life, helping them reach satisfaction. This had solidified the conclusion that medical gender-affirming care would be unnecessary.

5. Category V: Negotiating identity

5.1. GENDER AS AN EXPERIENCE

Participants explored their stories from a perspective that does not fit into traditional cisnormative narratives. Participants felt better able to connect with parts of the self which they defined as 'feminine', according to their own interpretations of the term. It emerged they struggled to define their gender identity according to traditional understandings during the interviews. They commonly resorted to using stories or describing feelings in an attempt to communicate their experience. This led me to hypothesise that for these participants, gender is an experience, a novel sensation that sits uniquely distinct from any previous experiences before coming out.

This category emerged as a result of studying the expressions of speech most commonly used by participants to describe their gender identity. They often found it difficult to find the words to define it and resorted to naming feelings. Participants also spoke in different parts of the self while aiming to describe their experience.

5.1.1. Struggling to find words / resorting to feelings

Commonly, participants struggled to find words to describe how they define their gender identity. They were able to describe the feelings following social transition they observed to be different:

"It's a lot more serious. I think a lot more deeply about things. I do feel more empathetic with people too. […] I want to help people basically. And that feeling when I'm presenting a female is even stronger." [Kay, 1474-1480]

"I can't get my head around how it feels different. It's softer. I've got more empathy." [Jackie, 522-523].

Evelyn summarizes her experience as an overall identity satisfaction:

"I would have had a much better life as a woman, I think. And also I would have been a much better person. I certainly feel like a better person now." [Evelyn, 376-378]

5.1.2. Speaking in parts of the self

Another focused code was describing identity by speaking in parts of the self among all participants. This was seen in distinctions such as using different gendered names, 'modes', and speech expressions.

Separating the identities had a temporal function, whereby participants distinguished time before and after their social transition:

"So in my 20s, in 'male mode', I would be sitting in the pub talking to people…" [Andrea, 1437-1438]

Initially, I interpreted this as ambivalence to change or acceptance of a trans identity. However, upon reflection, I realised my interpretation was stemming from a cisnormative narrative, with a harmful expectation to have a complete and unified identity across all aspects of life. I later understood separating the parts of the self as developing an entirely new identity and way of living that does not fit into the existing cisnormative narrative.

In line with the theme of meeting their own needs, participants appeared to have developed a new identity, merged from the past experiences of being male, with a newfound relationship to being female.

For some, this led to a complete separation of the two identities, described as living two lives simultaneously:

"I cope by being two completely separate people. […] I lived for 35 years, completely happy as a male, the only way I can live with myself as compartmentalized too. And I'm still quite happy in the mix." [Kay, 1441-1444]

"I don't feel the need to transition surgically because I have other friends and other things I enjoy doing as Paul, I'm happy to be living the two lives I'm living at the moment." [Stephanie, 888-891]

"It's almost like I'm a split personality. It's keeping two separate lots of thoughts and feelings going at the same time, having to juggle them and make sure they don't cross over." [Evelyn, 1268-1271]

Earlier on, Evelyn had explored her identity on a more general note, separating the physical body from the experience of womanhood:

"Later in life, you can't just so magically become a woman when you haven't led the life of a woman." [Evelyn, 672-673]

Participants described feeling there are two parts to their identities: the male part perhaps represents their past and their relationships, whereas the female part represents their present, future and connection with themselves. The pursuit of medical transition can then be viewed as a disconnect from the past and present.

Kay identified the importance of keeping this connection flexibily using the metaphor of colour:

"And I'm still quite happy in the mix. It's like living in black and white, and I like black and white, but when I become Kay, life's full of colour and I'm happier as an individual. But I still wouldn't change it." [Kay, 1444-1449]

Although not necessarily adopting a non-binary label, participants describe fluctuating between two genders, highlighting their experiences of gender diversity rather than a strictly trans identity. The generational context may have influenced the use of identity

labels like non-binary during formative years, as society and the medical field were not yet familiar with or accommodating of non-binary identities at that time. Perhaps this relates to the code of 'Lack of information' and highlights that participants are trying to understand and define their identity with the limited, and possibly biased, information available to them.

5.2. SEPARATING GENDER FROM THE BODY

Participants continued by reflecting on the distinctions between their experience of gender and the physical body. Evelyn reflects on her identity experience being independent of the physical body she inhabits, regardless of its sex:

"It's not just a question of whether I want to transition or not. I just don't believe it's possible. What medical intervention would be undertaken on me to become a woman? I don't know what I would become, some sort of strange Chimera, but I wouldn't become a woman. Because it's not all about physicality." [Evelyn, 664-669]

Jackie reflected on how she perceives the women in her life as feminine, regardless of the bodies they inhabit. She identifies womanhood in the way people present and carry themselves, rather than the external features:

"You see past the looks because they still look totally feminine, totally girly, and it shines it." [Jackie, 755-756]

She continues by sharing this is the attitude she has adopted for her own experience of gender:

"Some of it is trying to appease people looking in and seeing me. I don't think I'll pass. That's not what I'm after. And as I can't see me, I can only say what I feel, and I sometimes feel very feminine" [Jackie, 983-986]

This sentiment was echoed by Evelyn who recognizes femininity in the way people exist in the world instead of the aesthetics of the bodies they inhabit:

"But I used to watch women [dancing]. I think, How do they know what to do and it marks how they feel like… one way I put it is that they're in touch with their whole bodies" [Evelyn, 307-310]

In this context, participants' gender identity is a negotiation between the male and female parts of their experience. Physical intervention is then framed as unable to make a difference to *the experience* of identity, so it is deemed unnecessary.

5.2.1. Dressing alone is gender-affirming

Consistent with this code, Kay reflected how her behaviour changes based on the clothes she is wearing, helping her connect with the feminine experience:

"If you're wearing a skirt, you can't take long paces. And if you're wearing heels, you tend to, again, walk in a different way." [Kay, 470-472]

Jackie spoke of the gender-affirming feeling dressing brings out, helping her embody the female part of her identity:

"I get the girly mannerisms and when I'm fully dressed are a bit more feminine, a bit more girly hands and a bit more, [gestures] Ooh!" [Jackie, 502-503].

She continues by noting that her current lifestyle of crossdressing satisfies the need for gender affirmation without the negatives of permanent medical transition:

"I felt girly. One of the things that, you know, typing, computer chatting, and I look and I notice nail varnish and I feel girly." [Jackie, 471-473]

She concludes that physical alterations would not further add to this experience:

"I'm happy with my body. I was happy with my male body. I feel happy in me because part of me says, well, that's what you've got. To enhance it and mess with it Is […] not gonna give you much more." [Jackie, 884-887]

5.3. CONSOLIDATING MY IDENTITY

Perhaps the biggest change participants have noted is the merging of the separate parts of their gender into one whole identity. This code emerged from reflections on the negotiation of male and female identities and how they navigate these in day-to-day life. Participants noted a significant change in their experience after coming out; perhaps this was connected to a newfound acceptance of a new, unique gender identity that allows them to embrace both their masculine and feminine sides:

"I've come to terms with who I am. I am this. But I also have a male side. […] I do like dressing. But it doesn't change the inner person. The inner person is still the same." [Andrea, 1350-1360]

"I'm happy with the boy bit, but the boy bit's moved. I don't feel like John anymore. I feel like a hybrid." [Jackie, 612-613]

"[Life] is not all about dressing but it does help incredibly to stay in touch with that person inside you. So, it's terribly frustrating, a lot of the time, that I can't even be me more." [Evelyn, 1242-1245]

Evelyn commented on her identity acceptance by acknowledging the relationship with her new identity:

"I would say about 80% of the time in my head I'm Evelyn. About 1% of the time, I'm outwardly Evelyn. And there always will be that identity, 'full-on-man', for 63 years, that would never go away. And I wondered, even if I had all the surgery and hormones and implants, wouldn't you still have that in your head? [Evelyn, 1273-1278]

Perhaps the best way to navigate the amalgamation of their past and present lives is to develop a new, fluid, identity, which is able to satisfy their needs at present. In this sense, medical intervention is seen as unnecessary since it would create a ridge in this newly negotiated way of living.

SUMMARY OF CATEGORY

The final element of the internal consideration process involved a re-evaluation and re-negotiation to participants' gender identities. They noted a distinction between the experienced gender and the physical body. The overall conclusion reached is they have developed a new, fluid gender identity allowing overall acceptance and self-satisfaction. This explains how considering the option to pursue medical transition is not only unnecessary, but may be detrimental to their life as it threatens the carefully negotiated identity they have reached.

Chapter Summary

The analysis chapter presented the findings I have theorized to represent the process these trans participants underwent while deciding whether to pursue medical gender-affirming care. I concluded that the process follows a chronological direction and continues being dynamic and ever-evolving.

Participants were first influenced by external factors, specific to the narratives of the world they have existed within. First, I demonstrated how factors of the cisnormative world they had lived in shaped their initial worldview and highlighted what they consider to be important. Then, once their identity transition begun, they entered a new narrative of transnormativity, and I explored how their beliefs and values had changed following this exposure. I argue that how their worldview was shaped is instrumental to the decision outcome, and essential to the overall process.

An internal process of consideration then followed that helped participants arrive to their decision independently. They first considered the risks and downsides to medical transition. This then led to a process of evaluating needs and reflecting on the positives of their current situation. Finally, they explored their new identity, establishing its fluidity and flexibility to be instrumental for their satisfaction and acceptance. This led to the conclusion that medical transition is unnecessary, if not harmful, to their identity coherence and lifestyle at present.

Chapter 4: Discussion

Overview

In this final chapter, I begin by reviewing and discussing the findings from this research. I first comment on the overall analysis and theory and then discuss the individual core categories, comparing similarities and differences from existing literature. I then discuss the implications of this research for Counselling psychology and the wider audience, followed by an evaluation of the strengths and limitations of the project. I comment on potential future uses of this study and share my overall reflections from the entire process. I conclude this chapter and thesis with a general conclusion.

1. Discussion of Findings

The purpose of this study was to explore the process behind transgender people's choice not to pursue medical gender affirming care and develop a theory using the Constructivist Grounded theory approach (Charmaz, 2014). This aimed to support psychological and wider health professionals by contributing to transgender theory and affirmative clinical practice, as well as increase visibility and normalization of this otherwise underrepresented group of people.

Most notably, no previous research has been identified exploring the identity construction and decision-making processes of transgender people who choose not to pursue medical gender affirming care. This study, therefore, had the potential to give this less visible population a voice to articulate their experiences and produce new knowledge which can be useful to them, and others like them. cGT was chosen because it gives the most potential to capture the essence of the process through a co-constructed account between experts by experience and myself as a Counselling psychologist with knowledge of psychological theory, to help generate new theory. Five main categories were identified, revealing a consequential sequence in which each category was influenced by the previous one, leading to novel findings. These are explored in greater detail next.

1.1. EMERGENT THEORY

My analysis revealed that the decision-making process for participants was governed by two major categories: external factors and internal processes. Externally, societal narratives of cisnormativity and transnormativity played crucial roles in how participants constructed and explored their identities. Growing up within a culturally dominant cisnormative framework shaped their views on gender, gender roles, and their own identities, impacting their readiness for self-exploration. Construction processes seemed to involve social observation and learning from others, as well as integrating cultural and societal beliefs and behaviours, in shaping one's own identity and worldviews, particularly during childhood and adolescence (beyond being told *'you are a boy'*). Participants appeared to rely on social learning (Bandura, 1977) in the absence of direct teachings about gender identity and from observations of the negative consequences of non-conformity. For example, participants shared personal experiences of gender role modelling at home, in school, and in social (e.g., at the pub) and work activities (e.g., job type and work environment), as well as the socioeconomic and cultural environment they grew up in. These observations were internalized and contributed to the first formation of their gender identity, becoming a core aspect of their self-concept. As they explored and accepted their trans identities, through the increased visibility of the trans movement and access to new information via the Internet, they were introduced to transnormativity narratives, which offered alternative perspectives on gender and trans identities, reshaping their identity development.

Internally, participants first reflected on the costs and benefits of medical gender-affirming care, then considered their personal needs, and finally re-negotiated their gender identities. This internal decision-making process acted as re-construction of their identity through the need to manage and affirm their social identity, leading them to conclude that medical transition is unnecessary at this time. Their decision-making was dynamic, with an openness to future changes. However, the consensus that medical transition was not needed provided a definitive conclusion to their consideration process, forming the foundation of the theory. Overall, the decision not to pursue medical transition emerged as a nested, temporally dependent process,

significantly influenced by evolving gender narratives and internal meaning-making factors.

This process closely aligns with contemporary theories of transgender identity development, affirmation, and management, recognizing the multifaceted and complex interactions between individuals and their proximal and distal social environments (Doyle, 2022). The construction and re-construction of identity involved a complex interplay between personal identity development (‘Who am I?’), social identity management (‘How can I be who I am?’), and interpersonal identity affirmation (‘When can I be who I am?’). All of these questions were raised and reflected upon during the consideration process and ultimately contributed to the decision about not pursuing gender affirming care.

However, key distinctions lie in the foundational belief systems and worldviews shaped by their social environments, particularly through external factors such as cisnormativity and transnormativity narratives. The study highlights the significance of the transnormativity narrative, which served as both a source of crucial support and a point of conflict among participants. Incorporating the impact of transnormativity within the broader framework of this theory challenges the narrow and restrictive perspectives that psychological theorists have traditionally used to define trans identity development (Riggs et al., 2019). However, it still recognizes how important sources of support, such as the trans community, have internalized these messages and continue to reinforce them. For half of the participants, transnormative messages were perceived as affirming, providing a helpful, containing, and guiding framework for considering and exploring internal factors such as costs, needs, and identity. Conversely, others experienced these messages as a form of rejection, finding the prescribed *'right way to be trans'* unhelpful and even deterrent. Both responses to the transnormativity narrative prompted personal reflection and exploration regarding whether medical gender-affirming care was the right choice for them.

The theory generated from this study can be understood through Breakwell's (2015) Identity Process Theory (IPT), which explains that identity is a product of the interaction between the person and the social environment, and that it is always evolving as new experiences stimulate change. Identity is maintained through two core

processes: assimilation-accommodation, which refers to the incorporation of new components and the modification of existing identity; and evaluation, which involves assigning meaning and value to identity elements. These processes help individuals to integrate new information and experiences into their existing identity structures while maintaining a positive self-concept, thus continuously re-constructing identity. IPT also recognizes the role of identity threat, which occurs when these processes are unable to comply with the identity principles, thus challenging the stability and continuity of an individual's identity. Coping strategies are then deployed to respond to threats and maintain a positive self-concept and identity coherence. In the context of these participants' accounts, wanting to cross-dress earlier in life can be understood as a cisnormative identity threat, which participants likely responded to by embracing their transgender identity later in life. In the same way, the concept of pursuing medical gender affirming care can be viewed as a threat to overall identity, and the coping mechanism is the internal process outlined in this research's theory. Concluding that medical transition is unnecessary could be understood as a way to protect the psyche and overall identity coherence.

1.2. External influences: Societal narratives and identity construction

The process of initial (gender) identity construction appeared to be significantly influenced by existing social narratives during participants' formative years. Considering their environmental circumstances (where they grew up) and experiences of witnessing stigma and discrimination against non-conformity, participants were subjected to pervasive cisnormative messages that shaped their identities. Their gender identity was later re-constructed through obtaining new knowledge through positive role modelling and experiences of safe experimentation, solidified by gaining affirming support from being part of a trans community. Inherently, both of these processes were a combination between personal exploration and external social influence.

1.2.1. Cisnormativity and identity formation

Exploring early life experiences and attitudes towards gender identity offered valuable insights into participants' foundational worldviews and initial constructions of gender. Participants were aware of their gender from an early age, based on their biological

sex. For instance, Stephanie recounted being told she was "just as much a man as anyone else" after undergoing surgery to remove a testicle. All participants reflected on being taught that gender was linked to their sex, without questioning it during childhood and adolescence, likely due to the lack of positive gender diverse role models at the time. As a result, they accepted the belief that gender is binary and inherently tied to biological sex, thus initially constructing their cisgender identity.

Participants' definitions of gender originated from observations of the people around them – witnessing masculinity through their fathers, grandfathers, and male peers; and witnessing femininity from their mothers, partners, or female friends. It appeared participants were subjected to and subscribed to constructions of 'toxic masculinity' and era-relevant beliefs on gender role stereotypes and equality (Harrington, 2020). The ideas and values internalised for masculinity and femininity are oppositional – men *must be* strong and emotionless, whereas women *must be* gentle, empathic, caring. Strength was understood in different ways as well – a more literal, powerful, dominant sense for men, and a more subtle, gentle, passive form for women. This resulted in very strong oppositional variations: participants felt they had to accept and embody masculinity due to their biological sex, therefore making the qualities associated with femininity unavailable. Perhaps these rigid and narrow definitions were further constrained by witnessing the negative impact of stigma, violence, and discrimination towards any form of non-conformity. This could also explain the fascination with womanhood and femininity most participants directly disclosed; it is possible their concept of a woman had been mysticised, fantasised, and, in many ways, glorified under the guise of something separate and unattainable. This was suggested through their understanding of acceptable topics for conversation between men and women:

"You don't tell a 20-year-old man in the pub about your daughter's underwear!" [Andrea, 1447]

Participants may have perceived these forms of communication as a distinct means of social bonding. Having encountered predominantly crude or superficial conversations with other men, they possibly experienced emotional isolation and alienation, aligning with the idea within toxic masculinity, that "men don't talk about

their feelings." Consequently, by exploring their feminine side through dressing, they may have felt ‘allowed’ to connect more deeply with their emotional selves, a prospect that became increasingly appealing over time.

All participants discussed being punished, either directly or indirectly, for expressing stereotypically feminine qualities and behaviours, possibly contributing to their glamorization of femininity. Some who had experimented with dressing were explicitly told this behaviour was forbidden, likely leading to feelings of shame and an aversion to exploring their gender identity. Coupled with pervasive societal messages that gender non-conformity is unacceptable, this possibly solidified their initial identity construction and significantly delayed their curiosity and willingness to explore their identity until much later in life.

Messages received about the world during formative years tend to be pervasive and more resistant to challenge (Bandura, 1977). Due to the deeply internalized societal messages about gender, the participants developed two distinct versions of themselves after re-constructing their gender identity: the familiar male identity they had traditionally embodied for the majority of their lives, and the female identity they got to access when presenting as female. Accepting their transgender identity allowed them to explore and express previously inaccessible aspects of femininity. The appeal of experimenting with gender expression was perhaps partly driven by a perceived sense of 'permission' to embody and experience the full spectrum of gender without sacrificing one aspect of identity for another. Embracing the ‘forbidden’ feminine qualities through dressing perhaps contributed to the sense of freedom, which later emerged within the ‘considering needs’ category. Being able to reflect on and challenge deeply internalized concepts about the social world (from a generation that has been taught to ‘keep calm and carry on’) speaks tremendously about these participants’ bravery and tenacity.

1.2.2. Transnormativity and Identity re-formation

Participants reflected on the messages and beliefs they gained through interactions with the broader trans community. When directly asked about the existence of a dominant narrative, most participants denied its presence. However, through the

sharing of stories, beliefs, and experiences, it became evident that they had some awareness of such a narrative, albeit to varying degrees. This suggests that these transnormative messages are subtle yet pervasive, rarely acknowledged or questioned, at least within the communities to which these participants belong. Participants consistently commented on 'feeling different' within the trans community, highlighting their experience was perceived as outside the norm, thus implying the presence of a dominant narrative. This highlights the internalization of community norms and expectations, which can both support and constrain identity exploration.

Participants navigated transnormativity narratives that significantly influenced their identity reconstruction. The increased visibility of the trans movement and exposure to transnormative perspectives reshaped their understanding of gender and trans identities, creating a renegotiation and reformation of their gender identity through assimilation-accommodation (Breakwell, 2015).

Participants referenced ideas originally developed by cisgender academics, adopted and normalized into cis popular culture, to explore and define their gender identity, such as the 'born in the wrong body' narrative (Davy, 2015):

"*I'm not emotionally… 'a female trapped in a man's body'" [Joy, 1315]*

These notions appeared to have constructed their understanding of what it feels like to be trans, leading to exploring these experiences within themselves. Perhaps this contributes to self-invalidation and continuous identity re-construction. This process is likely reinforced by the limited representation of transgender people without physical transition, indicating the strong need for more varied and inclusive research permeating social narratives.

Further, participants sought ways to continuously manage and affirm their transgender identity through their various levels of engagement with the rest of the community – some became actively involved, whereas others rejected it as a way of consolidating identity coherence. This is consistent with the management and affirmation aspects of the social feedback model of trans identity (Doyle, 2022). This was perceived both positively and negatively among the participants. For those who likely benefitted from

the transnormative hierarchy by subscribing to its 'orthodox' messages, the associated rules and expectations provided a sense of containment and belonging. However, transnormative values create conflict when there is the decision not to pursue medical transition. This decision has been rationalized through the bus metaphor, which provides alternatives to the 'traditional' trans narrative (disembarking at any stop), but does not go beyond questioning what the ultimate 'end destination' of the bus is. This might be rationalized through confirmation bias as a mechanism to manage cognitive dissonance. This became apparent through an ambivalent view of labels ("*It's difficult as to where you would draw a line on [cross dressing vs fetish]." [Andrea, 1756])* and questioning others' 'transness' ("*is [transition] what you really want or is that what you think you want? [Andrea, 1546]).* Perhaps this highlights a process of internalized transphobia that remains unwavering and unresolved, thus unconsciously and unintentionally reinforcing the transnormative view through gatekeeping (Hendricks & Testa, 2012). As a result, those who held a more critical view of the transnormative narrative likely experienced a sense of alienation, rejection, and threat, which further creates a rift within the community (*"Well, that's me. I'm a fetish." [Joy, 1430])*. This is reminiscent of Chen et al.'s (2020) suggestion that belonging to a marginalized identity leads to experiencing or anticipating stigma, forcing individuals to reconcile their identity with external narratives, thereby reinforcing a stigmatized self-image.

Participants frequently referenced medical gender affirmation as a direct remedy for gender dysphoria, subsequently assuming that the absence of gender dysphoria equated to a lack of necessity for physical transition. It is possible this functioned as a way to rationalize and seek external validation for their choice. The decision to pursue medical gender-affirming care, as with any invasive physical intervention, is substantial, challenging, and intimidating. This reliance on external validation perhaps reflects the complexity and fear associated with such significant decisions. Additionally, the concept of being trans without undergoing medical transition might relate to the notion of seeking 'permission' to be recognized as valid (Bradford & Syed, 2019). Participants reported feeling that through dressing they are 'allowed' to access, explore, and express thoughts, feelings, and experiences that might have been previously inaccessible as 'macho men.' Within the trans community, perhaps they felt safer to engage with this aspect of their identity, anticipating that it would be an affirming experience.

The use of labels such as 'transgender,' 'male,' and 'female' was a contested issue among participants. For half of the participants, labels provided helpful vocabulary and points of connection, facilitating integration and support within their communities. These labels served as a guiding compass for navigating confusing thoughts, feelings, urges, and experiences, offering a sense of grounding and containment. This positive function of labels was particularly evident among the three participants who were more actively involved with the community and can be understood as a 'reward' for accepting and identifying with the label.

Conversely, for the remaining participants, labels were experienced as alienating and dismissive, creating a rift between them and the community. For some, like Joy, this even led to a quiet rebellion against her own identity, as observed during the interview where she alternated between embracing and rejecting the 'trans' label. The use of labels functioned in parallel with the human need to belong and feel accepted, thereby reducing shame and self-stigma. The dynamic use of labels to justify or normalize experience permeated the internal consideration process and ultimately impacted the decision-making regarding medical transition.

1.3. Internal Process: Identity re-construction and decision-making

After reflecting on the outside influences that have played a part in their gender identity construction, participants spoke of the individual, personal factors they considered important in making the decision not to seek medical gender affirming care. This consideration functioned as a re-construction of their personal identity through the management and affirmation of their social and interpersonal identity.

Participants' internal process reflected consideration and satisfaction of the emotional needs for safety (considering costs), belonging (considering needs), and self-esteem and confidence (negotiating identity) in the context of making the decision not to pursue medical gender affirming care.

These participants concluded that although fulfilling their emotional needs is important and liberating for their identity satisfaction, other life priorities took precedence, thus

making the sacrifice unjustifiable. This finding contrasts with literature reports that individually developed gender identity is one of the central aspects of identity for transgender people (Kuper et al., 2018).

1.3.1. Considering costs

When reflecting on their first steps in the decision-making process about the pursuit of medical gender affirming care, all participants shared personal reasons why they perceived it as costly, and therefore undesirable. They initially focussed on the imagined risks and potential losses associated with physical transitioning, including concerns about their physical and mental health, safety, loss of relationships and time. Compounded by a general distrust and uncertainty in the healthcare system, Andrea framed this choice as a net loss to wellbeing:

"Do I wait another, I don't know, could be 6, could be 10 years, to transition at my age? Or do I start enjoying my life now?" [Andrea, 985-987]

Ultimately, the final step of this deliberative process involved their uncertainty about the anticipated benefits of medical transition. This conflicted with the prevailing cis- and transnormative messages suggesting that desire for medical gender affirming care should be undoubted and unmistakable.

Thoroughly considering the costs aligns with a desire to make an informed decision. Understanding the potential negative consequences ensures that individuals are fully aware of what medical transition entails, allowing them to make a choice that is best suited to their personal circumstances and goals. It appears medical gender affirming care is perceived as a threat to the body and the mind, highlighted by the need for certainty. Previous information about harmful of unsuccessful results of medical intervention (either through witnessing hormonal self-administering and misuse, or unappealing surgical interventions) also seemed to add to this fear.

Participants implied there was a need for certainty in their gender identity and desire for gender-affirming care throughout their interviews. This need is reinforced by messages from the trans community and the NHS, emphasizing the necessity of

strong conviction in one's identity in order to pursue medical intervention. As all participants continuously questioned their identity, and some fluctuated in accepting the 'trans' label, the prospect of physical transition likely seemed unappealing, unnecessary, or threatening. Evelyn reflected on this process, questioning how realistic of an expectation this could be:

"I don't know how would you ever be certain [the decision] was right. I think it must be right for some. "[Evelyn, 825-826]

In addition, the awareness that medical gender-affirming interventions are invasive, labour-intensive, time-consuming, and life-changing further supports the need for confidence in this decision, its absence thus serving as a deterrent.

It appears medical gender affirming care is conceptualised as a threat to the body and mind for these participants. In addition, medical intervention can be experienced as a threat to identity by perceiving loss of the masculine self, in line with IPT (Breakwell, 2015). Considering that participants primarily conceptualize their gender identity in binary terms, and all have lived personal experiences where a gendered aspect of themselves was denied or restricted to conformity with one gender, it is understandable why medical intervention, and 'commitment' to one gender role, might appear profoundly threatening to them.

The physical body holds significant importance in identity formation for these participants and is a point for consideration in the decision-making process. However, the reasoning behind this appeared to be different to existing theories focusing on the affirming role of the body on transgender identity (McGuire et al., 2016). These participants placed paramount importance on the health, safety, and overall well-being of their bodies, suggesting a prioritization of these values over the need to align with or affirm a specific gender identity. This highlights a nuanced perspective where bodily integrity and general health considerations take precedence, diverging from conventional frameworks that predominantly emphasize gender identity satisfaction as the key motivation for medical intervention in transgender individuals (McGuire et al., 2016).

1.3.2. Considering needs

After outlining the concerns, perceived risks and costs of pursuing medical transition, participants engaged with the process of re-evaluation of their past and current needs and values. This process took place 'live' during the interviews with them reflecting this consequentially in conversation with me, and might be interpreted as mirroring their internal consideration process when first making this decision. It appeared that considering their needs involved heavily factoring in their social environment and interpersonal relationships, which resulted into the strategic management of their trans identity (Doyle, 2022).

Participants went back and forth between recalling past experiences of hiding, secrecy, and being limited to explore their gender identity, and appreciating their newly established freedom, lightness, and affirmation in openly exploring and expressing their identity now. It became evident the need for freedom was held in high importance for all participants. This is where the framing of medical gender affirming care again became conceptualized as a threat: for most, the commitment of living in one gender was seen as a return to limitation, which would jeopardise the newly acquired sense of freedom. This led to the conceptualization that commitment to either of their felt gender identities would be experienced as permanent inflexibility, thereby highlighting the need for flexibility, which dressing alone can fulfil. The process of considering threat-desire mimics the previous category's function of considering costs and expands on it by considering their current needs and values. This fortifies the decision-making process into questioning what further needs could medical gender affirming care satisfy, leading to self-affirmation and the conclusion that it is unnecessary.

Participants were also able to acknowledge their emotional need to belong, satisfied through accessing affirming social support. Whilst having social support is important for all people, a review by Brown et al. (2020) concluded that family coping ability, appreciation, affection, and positive communication enhance the well-being of TGNC individuals. Additionally, gender affirmation through family support and voiced micro-affirmations have also been found to be important for the well-being of transgender people (Bhattacharya et al., 2021; Pulice-Farrow et al., 2019). All participants in this study spoke of extensive periods of negotiation of their identity with their spouses and families; for half, the 'agreement' for acceptance was understood as a barter:

“I'd never want to do anything that would jeopardize that relationship. [Wife] signed up for being with me as a male, so I wouldn't want to do anything that would upset her.” [Kay, 905]

The remainder of participants reflected that, after not receiving familial support, their needs for freedom and authenticity outweighed the cost of losing close ones. The need for belonging remained of high importance, however, and led them to pursue affirming social support elsewhere within the cis and trans community: friends, communities, restaurant and shop staff. This is consistent with earlier studies that emphasised the value of social support for transgender affirmation and demonstrates their desire to pursue this from any affirming source (Lev, 2013; Singh et al., 2011).

Finally, participants underwent the process of negotiating their need for passing in the context of not pursuing physical transition. Being able to pass through dressing, makeup, and change in behaviour was experienced as extremely affirming. This was found to be satisfied through both a personal felt sense and receiving external validation. Perhaps this need acted as the strongest argument for being curious about medical gender affirming care, consistent with previous literature (Anderson et al., 2020). However, participants acknowledged that passing was contingent on its success: ‘not passing convincingly enough’ due to poor medical expertise was experienced as increased threat to violence and stigmatization. Participants expressed needing to be wary of their surroundings and navigate their identity according to context to ensure their physical and psychological safety. In this context, medical gender affirming care might be perceived as another unpredictable risk, thus seeming unattractive as an option.

1.3.3. Negotiating identity

These participants reframed their gender identity as an experiential phenomenon, separate from bodily characteristics. This conceptual separation allowed for a more fluid understanding of gender identity, challenging traditional cisnormative binary perspectives. This was found to be consistent with other studies describing

transgender people's gender identity re-conceptualization as hybrid, non-binary, fluid, or 'blended' (Galupo et al., 2017; Nagoshi et al., 2012).

As a novel conceptualization of this re-construction of identity, they struggled to find the words to describe this experience and often resorted to emotional and sensory experiences; it became evident, in their attempt to describe the experience to me, they were actively exploring and defining their identity for themselves. Interestingly, as this process emerged toward the end of every interview, each participant appeared to feel more affirmed in their decision not to pursue medical gender affirming care by the end of our meetings, suggesting that I also witnessed the identity re-definition "live". This also highlights the lack of appropriate vocabulary to describe an experience different to the norm, as normalised by cisnormative conceptualizations of gender identity.

The process of consolidating identity involved integrating diverse aspects of self-concept into a coherent whole. Participants engaged in ongoing reflection and negotiation of gender affirming feelings without medical transition; they were much more likely and willing to share examples of belonging, gender satisfaction, euphoria, and freedom, acting as net positives and antitheses to seeking intervention. This demonstrated how they managed their identity between different values, settings, and relationships. For all participants in this study, the balance in their current lifestyle and ability to express their identity was deemed sufficiently satisfying and affirming, thus discovering a novel way to manage their gender identity. This fluidity in identity formation, management, and affirmation aligns with contemporary theories of gender identity development and management (Doyle, 2022).

The participants' identity development can be conceptualized as an integration of various parts of the self. They embody their individual understandings of masculinity and femininity, as well as a blend of both, creating a multifaceted identity. Most notably, upon consolidating this newly formed holistic identity, they re-evaluated and re-prioritized their gender identity within the broader context of their overall sense of self. For some, their identity as a loving father, a caring husband, a choir singer, a person who is free, a person who is fun-loving, a person who is safe, or a person who gives back to their community took precedent over their identity as a man, woman, or any other definition of gender identity. This process reflects a dynamic and

comprehensive approach to identity construction, emphasizing the fluid and integrative nature of trans gender identity development (Nagoshi et al., 2012).

“I'm happy with the boy bit, but the boy bit’s moved. I don't feel like John anymore. I feel like a hybrid.” [Jackie, 612-613]

Within the context of this process, the idea of medical gender affirming intervention may not only be seen as unnecessary, but even jeopardising one or more of the prioritised identities, thus being viewed with aversion.

This process challenged my assumption from Chapter 1 that trans people’s gender identity is a fundamental aspect of their being. This analysis led me to conclude that although gender identity is important, it is prioritised less highly than other parts of identity for those who choose not to seek medically confirming care. This is instead based on individual needs and the availability of affirming social support.

2. Implications of the Study

2.1. Recommendations for counselling psychologists and therapists

Exploring the process of how transgender people choose not to pursue medical transition has significant implications for counselling psychology. This qualitative research can provide deeper insights into the diverse experiences and needs within the transgender community, informing more tailored and empathetic therapeutic practices. Wester et al. (2010) emphasise the importance of demonstrating empathy while working with transgender clients, as they may consider their therapist as part of a culture that rejects their gender variation. Understanding the process behind the decision not to medically transition can help psychologists and wider healthcare practitioners offer more relevant support and interventions that respect and affirm clients’ identities and choices. Counselling psychologists should therefore ensure their clinical and cultural competence in considering the effects of stigma and marginalization, cultural and social narratives influencing identity, and effectively integrating positive support for trans people. This might take form in reflective practice

spaces within multidisciplinary teams, supervision, and additional culturally sensitive training.

One of the primary implications is the need for psychologists to recognize and validate the legitimacy of non-medical transition paths (Chavez-Korell & Lorah, 2007; Elder, 2016; Hunt, 2014; Lev, 2013). Traditional narratives often emphasize medical transition as a central aspect of transgender identity, or 'the final step' in trans legitimacy, potentially marginalizing those who choose different paths (Johnson, 2016; Tatum et al., 2020). By highlighting the varied reasons why some transgender individuals opt out of medical transition – such as personal satisfaction with their bodies, negotiating social identity, or social and financial barriers – this research encourages healthcare professionals to adopt a more informed, inclusive, and nuanced approach. Still, these motivators might not be relevant to many gender diverse clients, so adopting an "informed not knowing" stance can be a useful approach when working with trans clients (Carroll et al., 2002). This shift can help in creating a supportive environment where all forms of transgender identity are acknowledged and respected.

Additionally, the findings from this research can inform the development of specialized therapeutic techniques and interventions. This research highlighted the importance of considering one's own needs and values, and how these have changed across the lifespan, which supports the value on helping individuals process and foster their emotional needs to improve wellbeing. Psychologists equipped with a deeper understanding of the non-medical transition experience can better address the specific psychological and social challenges these individuals may face. For instance, they can provide targeted support for dealing with societal expectations and pressures, navigating social and familial relationships, and fostering self-acceptance and resilience. This personalized approach can significantly enhance the therapeutic alliance and effectiveness of interventions.

Moreover, this research highlights the importance of involving transgender individuals in the therapeutic process as active collaborators. Obtaining and integrating input from a wide variety of gender diverse perspectives about their experiences and preferences can lead to more effective and respectful therapeutic practices, reducing mistrust in

services, and promoting a stronger therapeutic alliance, all of which contribute to improved therapeutic outcomes (Applegarth & Nuttall, 2016). This collaborative approach not only empowers clients but also enriches the therapist's practice with authentic, lived experiences.

In conclusion, the findings of this study have profound implications for counselling psychology. It challenges existing paradigms, promotes inclusivity, and encourages the development of more nuanced and effective therapeutic practices. By validating diverse transgender experiences and fostering collaborative therapeutic relationships, counselling psychologists can better support the mental health and well-being of all transgender clients, regardless of their transition choices.

2.2. Recommendations for Gender Identity Clinics

The findings of this research also provide insights for GICs. Clinics should adopt more holistic approaches when assessing the needs of trans people, including exploring motivations and identity management with and without medical gender affirming care, and reducing gatekeeping (Ashley, 2019). By considering the full spectrum of an individual's experiences, desires, and circumstances, clinics can better support those who wish to explore their identity in making informed and realistic choices about their bodies and identities. A holistic approach can also help identify and mitigate non-medical factors, such as financial and practical barriers, that might influence decisions about transitioning. This comprehensive assessment can reduce dissatisfaction with medical procedures and lower the rates of detransition by ensuring that individuals are fully aware of and prepared for the potential outcomes and implications of their choices.

In addition to broadening their assessment methods, GICs could expand their service provision beyond the traditional medical model. Integrating psychologically informed approaches, such as trauma-informed, systemic, and person-centred approaches, can significantly enhance support for gender-diverse people and their families (Sciolla, 2017). This might include offering individual and family therapy, support groups, and educational resources that address the psychological and social aspects of gender identity. Such services can help individuals and their close ones navigate the

complexities of gender identity development and management, fostering a supportive environment that promotes overall well-being. By addressing both medical and psychological needs, clinics can provide more comprehensive and effective care, improving the quality of life for transgender individuals.

However, it is essential to acknowledge that implementing these recommendations may be challenging due to limited funding and governmental support. The lack of resources is a significant barrier to expanding services and integrating holistic and psychological approaches. Advocacy for increased funding and policy changes is crucial to overcoming these obstacles. By raising awareness about the importance of comprehensive care for transgender individuals, stakeholders can work towards securing the necessary support to enhance service provision. Despite these challenges, it is imperative for GICs to strive towards a more inclusive and supportive model of care, ensuring that all transgender individuals have access to the resources and support they need to live authentic and fulfilling lives.

2.3. EDUCATION AND TRAINING FOR NON-SPECIALIST PROFESSIONALS

Some participants shared negative experiences with their GPs and disclosed a hopelessness about receiving affirming support, highlighting the need for improved awareness and understanding of trans issues among wider healthcare professionals as a first line of support. Incorporating more comprehensive gender diversity training into medical, nursing, and allied health professional courses would be beneficial, as it would ensure at least a basic awareness of gender identity issues among practitioners. Consistent with previous research, it is recommended that clinicians working with this population take steps to familiarize themselves with the available literature and actively seek out information regarding the process of transitioning (Chavez-Korell & Lorah, 2007; dickey & Singh, 2016).

Participants also reflected on the change in society's understanding and acceptance of gender diversity acting as a powerful support element in examining and accepting their identity. Nonetheless, transphobia continues to be a pervasive problem in Western society. Appropriately educating children and adolescents about gender diversity, identity, and transition can foster a widespread positive shift in attitudes from

an early age. This approach can also help normalize trans identities and reduce societal stigma and also start to challenge the cisnormative narratives that remain very strong today. Moreover, it can provide reassurance to young people grappling with gender identity issues, encouraging them to seek support.

3. Evaluation of the Study

3.1. STRENGTHS

One of the key strengths of this doctoral research study is the homogeneity of the sample. All participants were White British, AMAB, and aged between 60-70 years. The similarity of ages and eras within which participants grew up allowed for the analysis to focus on the sociological attitudes of the times they grew up in and reasonably explore the impact of environmental messages to developing one's gender identity. By focusing on a specific, well-defined, and demographically aligned group of transgender individuals, the study ensures a high level of internal validity. This homogeneity allows for a more precise understanding of the phenomena being studied, as variations in external factors that could potentially confound the results are minimized. It also facilitates a deeper exploration of the shared experiences and perspectives within this specific group, providing insights that are both detailed and relevant to the participants' unique contexts.

The use of cGT as the methodology for this investigation is another significant strength. Constructivist grounded theory is particularly well-suited for research that seeks to understand complex social processes and the meanings individuals attach to their experiences (Charmaz, 2014). This methodology allows for the development of theories that are firmly rooted in the data, ensuring that the findings are both robust and reflective of the participants' realities, whilst also contributing to filling a gap in the literature. By systematically generating theory through rigorous data collection and analysis, this approach enhances the credibility and applicability of the research outcomes.

Furthermore, obtaining and integrating input and consultation from key stakeholders, specifically transgender people and transgender researchers, significantly enhances the study's validity, execution, and relevance. Engaging transgender individuals throughout the conception of the research question, ethical considerations, critical literature analysis, and execution stages of the research process ensures that their voices are heard, and their experiences accurately represented. This collaborative approach not only enriches the data with authentic insights but also fosters trust and respect between researchers and participants. It helps to ensure that the research addresses the actual needs and concerns of the community, thereby increasing the practical impact and ethical integrity of the study.

Finally, one of the aims and strengths of this research is to increase representation of the spectrum of gender diversity. Being reminded of the account from one participant in Levitt & Ippolito's (2014) study of the positive impact of seeing representation, it is important to shed light on the experiences of transgender people who are underrepresented in academic literature. Indeed, all participants in this study mentioned the absence of positive trans role models growing up and reported feelings of affirmation from the normalization and visibility of transgender people in society today. Offering a non-pathological account of being a transgender person without medical gender affirmation can contribute to the acceptance and normalization of the diversity of gender experience for people exploring their identity and for reconstructing ideas about trans people within cis popular culture.

Overall, these strengths contribute to a comprehensive and nuanced understanding of the research topic, ensuring that the findings are both scientifically sound and socially meaningful. The combination of a homogeneous sample, a robust methodological framework, and active stakeholder involvement positions this doctoral research study as a valuable contribution to the field of transgender studies and beyond.

3.2. LIMITATIONS

Despite the strengths of this research study, several limitations need to be acknowledged. One major limitation is the homogeneity of the sample, which, while

ensuring internal validity, means that the findings can only be attributed to a very specific set of presentations. This homogeneity limits the generalizability of the results, as the experiences and perspectives of the six participants may not represent the broader transgender community. The specific contexts and characteristics of these individuals mean that the insights derived from this study might not apply to transgender people with different backgrounds or in different settings.

All participants were self-selecting and recruited from two organisations, which might impact on the messages and support received from their particular communities, thus forming specific beliefs about social and personal identity. It would be interesting to obtain perspectives from people from various communities across the UK, or those who are not engaged with an organised community, and explore if these elements impact one's identity negotiation and decision making processes.

Perhaps broadening the sample to include people across different ages, more diverse gender presentations, ethnic and socioeconomic backgrounds, people who have socially transitioned longer, people from different trans and mainstream communities, might yield more varied experiences or perspectives in the data, thus altering the final theory.

Further, the decision to exclude participants currently in psychological treatment was made with the aim to reduce risks of emotional distress and potentially capture participants who have had the ample time to distance themselves and reflect on their choice not to pursue medical transition. However, upon reflection, excluding such individuals introduces significant selection bias, contributing to an unrepresentative sample. This exclusion overlooks the influence of mental health on decision-making processes, as well as the roles of support systems and socioeconomic factors, which are important in understanding the comprehensive experience of those seeking gender-affirming care. Consequently, the study's findings may be skewed and less applicable to the broader trans population, failing to capture the unique challenges and motivations of a substantial subset. Including those in psychological treatment in future research would provide the opportunity for a more thorough and accurate understanding of the diverse factors that influence decisions regarding medical transition.

Another significant limitation is the small sample size. With only six participants, the study is unable to draw broader conclusions or to explore a wider range of experiences within the transgender community. The sample size of this study is smaller compared to typical grounded theory studies, which usually include 10-60 participants (Charmaz, 2014) and, indeed, smaller than the 25-30 interviews recommended for robust grounded theory research (Dworkin, 2024). This discrepancy may be conflated by studies recruiting participants until theoretical saturation is achieved. However, this study aimed for theoretical *sufficiency* rather than *saturation,* considering the impracticality of determining the exact number of participants needed to reach saturation from the start, and due to practical constraints of extended recruitment. The decision not to aim for theoretical saturation aligns with recent arguments that saturation should focus on meaning rather than merely on codes or categories. Hennink et al. (2016) define meaning saturation as "gaining a comprehensive understanding of the issues raised in the data" (p. 599), suggesting that saturation occurs not when all information is heard but when it is thoroughly understood. Malterud et al. (2015) further support this by emphasizing the importance of "information power," which considers the quality of dialogue between the researcher and participants. Indeed, the high homogeinety of the sample might have significantly aided reaching sufficiency at a lower number of interviews; if participants were more diversely represented, according to age, gender identity, or race, this might have brough a diversity in the findings, thus indicating the need for further research.

The study recruited an average number of participants for qualitative research, which typically reports sample sizes of 3-10 participants (Mthuli et al., 2022). Resource and logistical constraints indeed played a role in determining the sample size, which should be more openly acknowledged. Conducting this research as a doctoral study limited the scope and depth of the investigation due to restricted time and resources. While the study's sample size falls within the range accepted for qualitative research, a larger sample would provide a more comprehensive understanding and potentially reveal patterns and variations that did not emerge within this limited number of participants. A larger organization with more extensive resources could conduct a more powerful study, employing a more extensive and varied sample and incorporating more rigorous and diverse methodological approaches. Such an organization might also have the

capacity to conduct longitudinal studies, providing deeper insights into the processes and long-term outcomes of transgender people's experiences.

The small sample size also heightens the risk of bias, as the experiences of these few individuals may disproportionately influence the study's outcomes. This is further emphasized by the qualitative design and constructivist paradigm of this study, which posits that researchers *construct* rather than *discover* grounded theory (Charmaz & Henwood, 2017). Therefore, the findings represent one possible construction, and different results might emerge under other circumstances, whether by the same researcher, a different researcher, different participants, or by using alternative methods (e.g., focus groups) and methodologies (e.g., thematic analysis).

As a novice researcher, my own lack of experience may also introduce certain limitations to this study. While every effort has been made to ensure methodological rigor and ethical integrity, the nuances and complexities of conducting high-quality research might not be fully realized in this initial endeavour. Future studies could benefit from the involvement of more experienced researchers to refine the methodology and enhance the overall quality of the findings.

Lastly, it is important to acknowledge my position as a cisgender woman, which inherently means that my experiences and perspectives are different from those of the transgender community. This positionality will influence the way I interpret and present the data, despite my best efforts to remain objective and empathetic. While I have sought to include and respect the voices of transgender individuals throughout this research, my understanding and insights are inevitably shaped by my own identity and experiences, which could introduce unintended biases into the study. Further exploration of these are addressed later in this chapter, 5.2, Personal reflexivity.

In conclusion, while this research offers valuable insights into the experiences of a specific group of transgender individuals, these limitations highlight the need for further research. Future studies should aim to include larger and more diverse samples, be aided by the expertise of more experienced researchers, and ideally involve researchers who are part of the transgender community to ensure a more comprehensive and authentic exploration of the topic.

4. Future Directions

As research on the topic of transgender people who choose not to medically transition is scant, a range of methodological approaches and designs would contribute to the literature base, providing findings from different perspectives. For instance, the use of focus groups, or qualitative research methodology that uses non-fiction books, blogs, and social media as sources (netnography) can elicit a more rich and nuanced conception of trans people's attitudes, beliefs, and desires and might negate the limitation of the group sampling or reduce potential shame and stigma from disclosing one's experience to a researcher. Further, research conducted *by* transgender researchers might yield different results by improving engagement, a different co-construction and interpretation of data, or a richer insight into trans community culture, which I do not have access to as a cisgendered woman.

Moreover, this study's highly homogenous group acts as both a strength and a limitation. Findings from a more diverse set of participants according to age, gender identity, ethnicity, socioeconomic background, location, and cultural heritage might support or disprove this theory. The fact that participants in this study are older adults, raised in a different era, is a crucial factor that frames the results, particularly in terms of how they approach or decide against medical transition. These participants were raised in a time when transgender identities were less understood and less accepted by society, and when medical and psychological resources for gender-affirming care were less available or even nonexistent. As such, they may have internalized societal stigmas, experienced a lack of support, or faced considerable barriers to care, which could influence their decision-making in unique ways compared to younger generations.

For older trans individuals, the decision not to pursue medical transition could be influenced by factors such as fear of discrimination, medicalized gatekeeping, or a lack of awareness of available treatments. These individuals appear to have developed coping mechanisms and found other ways to navigate their gender identity within the confines of their historical context. In contrast, younger trans people today are likely to have access to a broader range of gender-affirming resources, more visibility of

diverse gender identities in society, and a more supportive environment for medical transition, including more progressive medical approaches that do not pathologize trans identities. This generational difference could result in younger people being more likely to seek medical transition, as they may not have the same level of historical stigma or medical gatekeeping to overcome.

Additionally, younger trans people may also benefit from more open discussions about gender fluidity, non-binary identities, and the range of possible medical and non-medical transition options, which could influence their decision-making processes differently. The framing of gender as a spectrum, the emergence of non-binary identities, and the increasing recognition of gender diversity in medical settings might lead younger individuals to feel more empowered to pursue individualized transition paths, whether medical or otherwise.

Given that persons of colour are frequently underrepresented in trans research, this is especially important to provide a more holistic and representative theory (Henrickson et al., 2020). A similar study conducted with people from a culture with different social conceptualizations of gender could contribute to a more nuanced and robust theory of identity development and management: for example, in India, where a third gender has been legally recognized (Khaleeli, 2014).

Finally, using elements of the findings of this research can expand upon its results and contribute to a more robust and rounded understanding of issues affecting transgender people who do not physically transition. For example, themes that emerged from this study, but were not within its main focus, include a deeper exploration of negotiating the importance of passing without medical transition; living in a gendered body ‘part-time’; or the psychological implications of being deemed ‘not trans enough’ by the trans community, would provide valuable insights into identity construction processes and contribute to practitioner’s skillset in providing affirming psychological care.

5. Reflexivity

I begin by acknowledging how honoured I am by the participants in this study who willingly and bravely shared their personal stories and experiences involving their

identity development and management. Reflecting on the interview process, I recognize that participation may have been a challenging yet rewarding and affirming experience. Considering the intimate and sensitive nature of the research topic and what might have been a polarizing experience, I feel privileged to have earned their trust and been welcomed into their worlds. In return, I hope I have offered them a positive experience of an outsider who is genuinely interested and dedicated, and have been able to portray their perspectives accurately.

5.1. METHODOLOGICAL REFLEXIVITY

As the researcher, I had an undeniable impact on the research trajectory, as well as the co-constructed and reported findings (Charmaz, 2014). Throughout the research process, I was acutely aware of my responsibility to accurately grasp and represent the participants' accounts. This awareness motivated me to conduct the analysis with diligence and precision, even when the work proved demanding. As a novice researcher, I relied heavily on Charmaz's (2014) guidelines on effectively conducting cGT and utilized external sources of support in consultation, supervision, and a peer research group, especially in the early phases of the analysis. Initially, I felt daunted by the recognition of my potential power and influence on the data. I drew upon my Counselling Psychology training, which promotes continuous self-reflection, and keeping a curious and questioning stance. This led me to gradually embrace my active role as the researcher and to include my voice in the co-construction of this research, fostering an increased ability to critically evaluate both my academic and clinical work.

As an outsider to the trans community, my identity and role in the production of this research needs to be acknowledged. As a cisgender researcher, I enjoy a lot of privilege that the findings might be perceived as 'objective' as I am distanced from the topic, however, through my biases and interests, I may inadvertently be doing harm to another part of the community. My position as an observer peering into the lives of a stigmatized group of people might be received as reinforcing harmful historical practices of 'doing to', rather than 'with' (Tagonist, 2009). I suspect that if I had been trans myself, this might have provided alternative insights and perspectives that, as an outsider, I could never have access to. My identity as a cisgender researcher introduces potential biases that influence the formulation of research questions, the

selection of measures, the phrasing of interview questions, participants' perceptions and willingness to participate, the interpretation of results, and the reception of my research within the field. Additionally, my identity may have contributed to participants feeling more (or less) at ease during interviews, potentially influencing their responses. More of the voices of trans researchers need to be publicised to meaningfully contribute to the understanding of TGNC people's experiences.

Being a cisgendered woman might have positively impacted the willingness of the participants to speak openly and honestly. Participants spoke of feeling more at ease with other women and disclosed being more likely to discuss intimate topics than with men. Indeed, one participant mentioned commonly enjoying admiration and fascination by younger cisgendered women. Alternatively, my position as a cis female researcher might have deterred others from taking part. Depending on individual biases and experiences with cis women, it is possible many thought it could feel exposing or invalidating being interviewed by a woman. The same could be argued for my position as a researcher and psychologist: it is possible many felt uncomfortable to speak to 'a psychological professional' due to shame or fear of stigmatization.

Moreover, I was mindful of the assumptions and language I used throughout the entire research process and endeavoured to promote an inclusive, holistic, and affirming position to anyone involved. As Heckert (2011) argues, asserting the authority to speak on behalf of another undermines their ability to voice their own narratives. Therefore, I was mindful to carefully consider the impact of my language when interpreting individuals' accounts throughout all stages of this research (Richards et al., 2014). One of my main concerns throughout this research was the risk of potentially doing harm to the individuals and community as whole when interpreting the findings. I have actively taken steps to demonstrate that the analysis and concluding theory are constructions between my outsider perspective and the disclosures from these specific participants; while they may appropriately portray the processes for these participants, they are unable to and should not be used to generalize the experience of the whole trans population. Continuously highlighting the diversity within the trans community makes it impossible to accurately capture every account. More visibility within popular culture and academic literature of the range of perspectives, attitudes,

and opinions trans people may hold is necessary to continue building a richer picture of the range of trans experiences.

5.2. Personal reflexivity

As a researcher, I have also been impacted *by* the study. I can now recognize how my own perspectives going into this research have been framed by the cisnormative view of physical transition being the ultimate goal. Reflecting on what motivated my research, I was aware of the 'bus journey' metaphor and gender identity being placed on a spectrum, however, I can now recognize how these conceptualizations have been influenced by cisnormative theories and skewed by my interpretation of my own gender identity.

Most notably, after performing the brief initial literature review, I anticipated that the participants who would wish to take part in this study would identify as non-binary and/or altogether reject the concept of their gender related to the body. I was surprised to meet people who still view gender as binary and do not subscribe to transition being the end goal. This led me to actively listen and be curious to the participants' stories, and to immerse myself more deeply into the data, perhaps more so than I would have if my initial expectations were met and I unintentionally allowed my biases to influence the findings. I can now see how my assumptions and limited exposure to the diversity of TGNC people framed my view of medical gender affirming care. This has increased my awareness of my preconceived notions about transgender individuals and when these biases are activated.

As a Counselling psychologist engaged in this research, I found it impossible to completely separate my role as the researcher from the narratives shared by participants, which often touched upon themes of stigma, alienation, confusion, and curiosity. These disclosures evoked a personal reaction of empathy and a sense of injustice rooted in my professional commitment to supporting others. The participants engaged actively in the study, not merely as passive informants, but as individuals who questioned and challenged societal norms, sharing candid and vulnerable insights into their personal and impactful experiences. Consequently, I developed a compassionate approach that guided the co-construction of findings reflecting their

expert perspectives. Integrating my identity as a Counselling psychologist with an ethos of holistically understanding a person into the analysis enhanced my sensitivity to nuanced aspects of the data that might otherwise have been overlooked. Particularly my awareness and curiosity about participants' emotional needs, which resulted as substantial themes in the final analysis, have significantly been co-constructed by my identity as a Counselling psychologist and curiosity about participants' emotional realities. This emphasis on emotional dimensions emerged prominently in the co-construction of the final findings, contributing to a more holistic understanding of the research outcomes.

I am currently working in a specialized eating disorder service where discussions about body image and relationships with the body are integral to every session. Reflecting on how the physical body can serve as a means of self-protection, communication, and a major source of both self-confidence and distress, has deepened my understanding of the profound and lasting impact the decision not to pursue medical gender affirming care can have on an individual's sense of self. It has led me to appreciate the bravery and hard work these participants have had to put into the entirety of their gender exploration, construction, re-construction, negotiation, and decision-making processes to reach a point of contentment and self-affirmation.

Conclusion

This thesis set out to explore the question 'How do transgender people choose not to pursue medical gender affirming care?' and aid a more comprehensive development of gender identity theory for TGNC people with less representation and healthcare practitioners working with the trans community.

This research contributed to existing gender theories by considering the impact of dominant social narratives in the construction, re-construction, maintenance, and affirmation of identity, all of which played an integral role in guiding the decision-making process whether to pursue medical gender affirming care. It created a new theory, integrating external and internal factors that developed the participants' decision not to seek physical intervention to negotiate their identity.

Most importantly, the study highlighted the most relevant and desired emotional needs for these participants. They spoke of needing freedom and flexibility. They reflected on needing acceptance and affirmation. They disclosed needing to feel accepted in whichever way they choose to present to the outside world, without concern about their emotional and physical safety and fear of stigma and transphobia. It is not a coincidence that these basic human needs are applicable to everyone, regardless of gender identity. My hope is through this research to highlight to people within and without the community that social narratives play a powerful role in impacting individuals and that people seek to be allowed to exist freely.

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APPENDICES

APPENDIX 1 – ETHICS APPROVAL

Dear Emma

Reference: ETH2122-0325

Project title: How do trans people arrive at the decision not to seek medically-assisted gender-affirming care?

Start date: 21 Oct 2022

End date: 29 Sep 2023

I am writing to you to confirm that the research proposal detailed above has been granted formal approval from the Psychology committee: medium risk. The Committee's response is based on the protocol described in the application form and supporting documentation. Approval has been given for the submitted application only and the research must be conducted accordingly. You are now free to start recruitment.

The approval was given with the following conditions:

- That the interviews take place on either Zoom, Microsoft Teams or Skype Business

Please ensure that you are familiar with City's Framework for Good Practice in Research and any appropriate Departmental/School guidelines, as well as applicable external relevant policies.

Please note the following:

Project amendments/extension

You will need to submit an amendment or request an extension if you wish to make any of the following changes to your research project:

- Change or add a new category of participants;
- Change or add researchers involved in the project, including PI and supervisor;
- Change to the sponsorship/collaboration;
- Add a new or change a territory for international projects;
- Change the procedures undertaken by participants, including any change relating to the safety or physical or mental integrity of research participants, or to the risk/benefit assessment for the project or collecting additional types of data from research participants;
- Change the design and/or methodology of the study, including changing or adding a new research method and/or research instrument;
- Change project documentation such as protocol, participant information sheets, consent forms, questionnaires, letters of invitation, information sheets for relatives or carers;
- Change to the insurance or indemnity arrangements for the project;
- Change the end date of the project.

Adverse events or untoward incidents

You will need to submit an Adverse Events or Untoward Incidents report in the event of any of the following:

a) Adverse events

b) Breaches of confidentiality

c) Safeguarding issues relating to children or vulnerable adults

d) Incidents that affect the personal safety of a participant or researcher

Issues a) and b) should be reported as soon as possible and no later than five days after the event. Issues c) and d) should be reported immediately. Where appropriate, the researcher should also report adverse events to other relevant institutions, such as the police or social services.

Should you have any further queries relating to this matter, please do not hesitate to contact me. On behalf of the Psychology committee: medium risk, I do hope that the project meets with success.

Kind regards

[redacted]

Psychology committee: medium risk

City, University of London

APPENDIX 2 – CONSULTATION FLYER

Department of Psychology
City, University of London

TRANS* PARTICIPANTS NEEDED

Would you like to share your opinions on an upcoming study about trans people's experiences of choosing not to seek medical transition?

We are looking for volunteers who self-identify as transgender
to take part in a focus group to comment on the study's research question, aims, and ethical procedures.

The current research question seeks to investigate:
How do trans people arrive at the decision not to seek medical transition?*
What influences this process?

This study aims to give voice to trans people to better understand transition experiences, which can help trans individuals and contribute to psychological healthcare provision.

As a participant, you would be asked to participate in a focus group of 4-5 individuals over Zoom, lasting 30-60 minutes.
Participation can be anonymous, and you will have the right to withdraw at any time.

For more information, or to take part, please contact:
Emma Petrova
[Supervised by Dr Kate Scruby]
Department of Psychology
at
[redacted]

This study will be reviewed by the Research Ethics Committee, City, University of London, to obtain ethics clearance prior to its commencement.

If you would like to complain about any aspect of the study, please contact the Secretary to the Senate Research Ethics Committee on [redacted] or via email: [redacted]
City, University of London is the data controller for the personal data collected for this research project. If you have any data protection concerns about this research project, please contact City's Information Compliance Team at [redacted]

APPENDIX 3 – RECRUITMENT INTRODUCTORY EMAIL

Introductory email

To whom it may concern,

I am a final year Trainee Counselling Psychologist with City, University of London and I am conducting my doctoral research on the experiences of trans* people who have chosen not to seek medical gender-affirming care. I am emailing to enquire whether it would be appropriate to send out a request for participant recruitment from your organisation, whereby participants will be compensated in the form of Amazon vouchers.

This study aims to explore the experiences of trans* people who have chosen not to pursue medical transition of any kind (hormonal, surgical, or any combination). The findings can be beneficial in contributing to understanding of the process of being trans and not medically transitioning, gender identity development theory, highlighting relevant factors to decisions about transition. It also aims to highlight the diversity within the trans community and illuminate beliefs and personal experiences in the gender-affirming journey, which can be helpful to individuals at any point of their life. Furthermore, the findings can expand upon the consequences of choosing not to medically transition on an intra- and interpersonal level. The study has received Ethical clearance from the Psychology Department Research Ethics Committee, City, University of London.

Personally, I have an avid interest in gender as a social construct, social justice, and the cultural influences on self-expression, identity, and wellbeing, which is what led me to explore this topic. As a cis-gendered heterosexual woman, I have sought consultation from self-identified trans psychological researchers to comment on the ethical procedure and practices of conducting this study. I hope to include members of the trans community who are not professional researchers to comment on these issues as well.

I would like to interview approximately 5 participants in order to learn about their individual experiences. I wonder whether you would consider supporting this project and helping me recruit from within your organization? Please find my recruitment flyer attached.

I would be grateful for any help and advice that you might be able to offer me.

Thank you very much for your time and attention.

All the best,
Emma Petrova

APPENDIX 4 – RECRUITMENT FLYER

TRANS* PARTICIPANTS INVITED

Do you identify as trans*?

Do you plan to NOT seek gender-affirming medical care?

Are you over the age of 25 years?

Have you been brought up and live in the UK?

Would you like to share your experience of choosing not to pursue medical gender affirmation?

We are looking for volunteers who identify as transgender to take part in a study of your experiences and opinions behind your decision not to seek medical gender-affirming care.

What is this study about?

This study aims to give voice to trans* people to better understand attitudes and experiences about transition, which can help other trans individuals going through the same process and contribute to better psychological healthcare provision.

What will be asked of me?

As a participant, you would be asked to participate in a brief telephone call and complete an interview over Zoom or Teams, lasting 60-90 minutes.
Participation can be anonymous, and you will have the right to withdraw from the study at any time.

You will be thanked for your time in the form of a £15 Amazon voucher.

For more information about this study, the research team, or to take part, please contact:

Emma Petrova *(she/her)*
Supervised by Dr Kate Scruby (she/her)
Department of Psychology
at
[redacted]

This study has been reviewed by Katy Tapper and received ethics clearance through the Psychology Department Research Ethics Committee, City, University of London.
If you would like to complain about any aspect of the study, please contact the Secretary to the Senate Research Ethics Committee on [redacted] Email: [redacted]
City, University of London is the data controller for the personal data collected for this research project. If you have any data protection concerns about this research project, please contact City's Information Compliance Team at [redacted]

APPENDIX 5 – PARTICIPANT INFORMATION SHEET

CITY UNIVERSITY OF LONDON EST 1894 **ETH2122-0325** **25/10/2022** **version 1**

How do trans* people arrive at the decision not to seek medically-assisted gender-affirming care?

Emma Petrova

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. You will be given a copy of this information sheet to keep.

What is the purpose of the study?
The purpose of this study is to increase understanding about trans people's experiences that have led them to the decision not to seek medical transition. It aims to develop theory to better serve the community in increasing healthcare providers' understanding of issues faced by trans people.

The study is part of a professional Doctorate in Counselling Psychology and will be submitted as part of the researcher's thesis at City, University London.

Why have I been invited to take part?
You have been invited to take part because you meet the following criteria:

- You self-identify as trans
- You have made the decision not to pursue medical transition (hormonal, surgical, or any combination)
- You are over the age of 25
- You have been brought up and currently live in the UK

Do I have to take part?
Participation in the project is voluntary, and you can choose not to participate in part or all of the project. You can withdraw your participation at any stage of the project prior to interview without being penalized or disadvantaged in any way. You may withdraw your data within 5 weeks of the interview taking place, before the analysis is integrated into the findings. It is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to sign a consent form. If you decide to take part, you are still free to withdraw within 5 weeks after the interview without giving a reason.

What will happen if I take part?

- You will be invited to a brief telephone screening call, where the aims and procedure of the research will be discussed. You will be asked to complete a brief questionnaire about your mental wellbeing with the researcher, and you will have the opportunity to ask questions throughout.
- Personal information, such as your name, pronouns, email address, will be collected, and you will be invited to an individual semi-structured interview, which would last approximately 60-90 minutes.
- The interview will take place online, using an encrypted platform, such as Zoom or Microsoft Teams.

- The study will be using a qualitative research method. This means that information will be gathered through interviews and will be later analyzed for common themes.
- The study approach requires two separate rounds of interviews, dependent on the initial findings. You may be asked whether you would be willing to participate in the second round of interviews, should the study approach deem this necessary. You are under no obligation to participate in the second interview and this will not affect your participation in the first round.

What are the possible disadvantages and risks of taking part?
It is possible that you may find parts of the discussion distressing. Your wellbeing is of the utmost importance, so interviews will be conducted with sensitivity to how you are feeling. You may find additional contact information for organizations that can provide additional support below:

24hr National trans helpline - (07527) 524034
Beaumont Society: 01582 412220 - www.beaumontsociety.org.uk
Gender Trust: 01527 894838 - www.gendertrust.org.uk
Samaritans – 116 123 – www.samaritans.org

The final published work may use direct quotes from the interview and the findings may be published in a peer-reviewed academic journal following completion of the thesis.

During the research process, at screening and interview stages, you will be asked whether you would like to provide your real name, a pseudonym, or remain fully confidential in regard to the use of quotes. As the process of choosing a name can be a significant part of a person's life and identity, the use of real names in research can be a validating experience. However, once the research has been published in the public domain with the participant's real name, then the participant will be forever attached to their comments and people may take your quotes out of context. It is possible that a participant may come to regret their decision. There may be other implications of using your real name that may be unforeseeable. It is your choice whether you wish to use your real name, a pseudonym, or remain anonymous, and you have the right to change your mind at any point before publication, without this affecting your participation. Should you wish to provide a name, you will be provided with the final draft for approval, so you can see which quotes you are being connected with. You will be requested to confirm consent for your name being used and attached to the quotes. If the researcher is unable to reach you for approval within three weeks of sending the final draft, pseudonyms will be used instead. Your choice either way will not influence your participation.

What are the possible benefits of taking part?
- The opportunity to have your voice heard
- Although the purpose of the interview is not intended to have therapeutic aims, you might find it helpful to reflect on your experiences
- Contributing to novel theory development in service of the trans community and those who aim to provide support to trans people, such as healthcare providers and psychological counsellors
- You will be compensated for your time in the form of a £15 Amazon voucher following the completion of the interview.

How is the project being funded?
The project is being completed in fulfilment of the researcher's Doctoral level thesis, funded by City University, London.

Conflicts of interests
No conflicts of interest have been identified

Data privacy statement
City, University of London is the sponsor and the data controller of this study based in the United Kingdom. This means that we are responsible for looking after your information and using it properly. The legal basis under which your data will be processed is City's public task.

Your right to access, change or move your information are limited, as we need to manage your information in a specific way in order for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personal-identifiable information possible (for further information please see https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/public-task/).

City will use your name and contact details to contact you about the research study as necessary. If you wish to receive the results of the study, your contact details will also be kept for this purpose. The only person at City who will have access to your identifiable information will be Emma Petrova. City will not keep identifiable information about you from this study for after the study has finished.

You can find out more about how City handles data by visiting https://www.city.ac.uk/about/governance/legal. If you are concerned about how we have processed your personal data, you can contact the Information Commissioner's Office (IOC) https://ico.org.uk/.

Will my taking part in the study be kept confidential?

- The only person who will have access to your personal data before being anonymized will be the main researcher.
- Changing your name might have been a significant part of your life, so you will be asked whether you would like to be quoted using your real name in the final write-up of the thesis. You may choose to use your real name, a pseudonym, or request full anonymity, whereby no name would be included and may be quoted as *'anonymous'*.
- The only reason confidentiality might be breached is if there is serious concern for your safety or that of others. We may need to contact your GP or a relevant protection body to ensure your safety. This will be discussed with you before any action is taken.
- Records will be anonymized and encrypted on a secure device and will be stored on an encrypted and password-protected online platform. As per City's policy, these will be stored until they are transcribed, after which they will be deleted. Transcribed text will be kept for 10 years, following that they will be destroyed.

What will happen to the results?
The data will be published as part of the researcher's thesis in the City University Library. All names and identifying information can be changed to preserve confidentiality.

Who has reviewed the study?
Approval has been provided by the City, University of London Psychology Department Research Ethics Committee.

What if there is a problem?
If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone [redacted]. You can then ask to speak to the Secretary to Senate Research Ethics

Committee and inform them that the name of the project is: How do trans people arrive at the decision not to seek medical transition?

You can also write to the Secretary at:

[redacted]
Research & Enterprise Office
City, University of London
Northampton Square
London, EC1V 0HB
Email: [redacted]

Insurance

City holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study, you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Thank you for taking the time to read this information sheet.

APPENDIX 6 – INFORMED CONSENT TO SCREENING CALL SHEET

Informed consent for screening telephone call

Emma Petrova
ETH2122-0325

How do trans people arrive at the decision not to seek medically-assisted gender-affirming care?

		Please tick or initial box
1	I confirm that I have read and understood the participant information form dated 25/10/2022 for the above study. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily.	
2.	I understand that I will be asked questions relevant to my eligibility for the study and I agree to discussing them.	
3.	I understand that I will be asked questions by the researcher to complete a brief questionnaire about my mental wellbeing, and I agree to complete this during the telephone call.	
4.	I understand that my participation is voluntary and that I am free to withdraw my participation without giving a reason at any point of the project, without being penalised or disadvantaged.	
5.	I agree to take part in the screening telephone call.	

_____	_____	_____
Name of Participant	Signature	Date
_____	_____	_____
Name of Researcher	Signature	Date

When completed, 1 copy for participant; 1 copy for researcher file.

APPENDIX 7 – CORE-10 MEASURE FOR PSYCHOLOGICAL WELLBEING

CLINICAL OUTCOMES IN ROUTINE EVALUATION
CORE-10

Therapist name:		
Patient name:	Date:	Trust ID number:

IMPORTANT – PLEASE READ THIS FIRST

This form has 10 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.

Over the last week…	Not at all	Only occasionally	Sometimes	Often	Most or all of the time
1. I have felt tense, anxious or nervous	☐ **0**	☐ **1**	☐ **2**	☐ **3**	☐ **4**
2. I have felt I have someone to turn to for support when needed	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
3. I have felt able to cope when things go wrong	☐ **4**	☐ **3**	☐ **2**	☐ **1**	☐
4. Talking to people has felt too much for me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5. I have felt panic or terror	☐ **0**	☐ **1**	☐ **2**	☐ **3**	☐ **4**
6. I made plans to end my life	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7. I have had difficulty getting to sleep or staying asleep	☐ **0**	☐ **1**	☐ **2**	☐ **3**	☐ **4**
8. I have felt despairing or hopeless	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9. I have felt unhappy	☐ **0**	☐ **1**	☐ **2**	☐ **3**	☐ **4**
10. Unwanted images or memories have been distressing me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Total (Clinical Score*)					

* **Procedure:** If all items completed, add together the item scores. If some questions left blank, add together the completed item scores then divide by the number of questions completed to get the mean score, and multiply by 10 to get the Clinical Score.

Thank you for your time in completing this questionnaire

APPENDIX 8 – INFORMED CONSENT TO INTERVIEW SHEET

Emma Petrova
ETH2122-0325

How do trans people arrive at the decision not to seek medically-assisted gender-affirming care?

		Please tick or initial box
1	I confirm that I have read and understood the participant information dated 25/10/2022 for the above study. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw without giving a reason without being penalised or disadvantaged.	
3.	I understand that I will be able to withdraw my data at any point within 5 weeks of interview, until data analysis completion, without being penalized or disadvantaged in any way.	
4.	I agree to the interview being audio recorded.	
5.	I agree for the researcher to use quotes in the final write-up.	
6.	I agree to be contacted again for the second round of interviews, should the study approach be appropriate.	
7.	I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) explained in the participant information and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR).	
8.	I would like to be informed of the results of this study once it has been completed and understand that my contact details will be retained for this purpose.	
9.	I agree to take part in the above study.	

_____	_____	_____
Name of Participant	Signature	Date
_____	_____	_____
Name of Researcher	Signature	Date

When completed, 1 copy for participant; 1 copy for researcher file.

APPENDIX 9 – INTERVIEW SCHEDULE

Proposed list of interview questions

What made you want to take part in this research?

Questions exploring the core phenomenon of being trans and not physically transitioning (context)

- To start with, I would want to get an idea about your background and some of the messages about gender you might have received growing up.
- When did you first become aware of your gender?
- When did you first become aware of your gender and your body?
- How was that similar or different to your family (parents, siblings, cousins, etc)?
- What messages were there around what boys and girls did growing up?
- Did you feel anything was expected of you because of your gender?
    - *Prompt:* Were there specific women's/men's roles?

Questions exploring the process of reaching this decision:

- Have you ever considered seeking medically-assisted gender-affirming care?
- Can you tell me about that process?
    - *Prompt:* How long ago? *(if applicable)*
    - *Prompt:* What was going on in your life, at the time? *(if applicable)*
    - *Prompt:* What factors influenced your decision not to physically transition?
- What was most important to you at the time? (identity, job, relationships, safety, etc.)
    - *Prompt:* What factors influenced your decision to socially transition? *(if applicable)*
- Can you tell me what experiences during the process of deciding made you feel affirmed in your gender?
- What or who helped you make this decision at the time?
- Looking back, what could have helped you/supported you during that time?
    - *Prompt:* What kind of support, awareness, charities, individuals, healthcare?

Questions exploring the impact and strategies of navigating this decision:

- Looking back on your decision-making journey, is there anything you would have done differently?
- What is day-to-day life now without medical input?
- What are some positives to life without medical input? Any particular memories stand out, as you're thinking about it now?
- If you could go back and talk to your younger self, what might you tell yourself?
    - *Prompt:* What advice would you give to someone else going through this process?

- Do you have anything else to tell me in relation to your experience or how it happened, that I may have missed?

APPENDIX 10 – DEBRIEF SHEET

Version 25/10/2022

How do trans people arrive at the decision not to seek medically-assisted gender-affirming care?

DEBRIEF INFORMATION

Thank you for taking part in this study. Now that it's finished, we'd like to tell you a bit more about it.

In order to develop theory to better understand trans people's individual experiences it is helpful to hear from individuals like yourself. Your insights will help develop a theory to better understand processes affecting trans people' identity development, factors affecting their choice for or against medical gender affirmation, and the effects this has on their social relationships.

It is expected that this research will help healthcare providers and psychological counsellors gain a better understanding why some trans people might choose not to transition, so that they can provide better support for their needs.

If you would like any additional support after taking part in this study, you can contact the following organisations:

24hr National trans helpline - (07527) 524034

Beaumont Society: 01582 412220 - www.beaumontsociety.org.uk

Gender Trust: 01527 894838 - www.gendertrust.org.uk

Samaritans – 116 123 – www.samaritans.org

We hope you found the study interesting. If you have any other questions, please do not hesitate to contact us at the following:

Emma Petrova [redacted]
Dr Kate Scruby [redacted]

Ethics approval code: ETH2122-0325

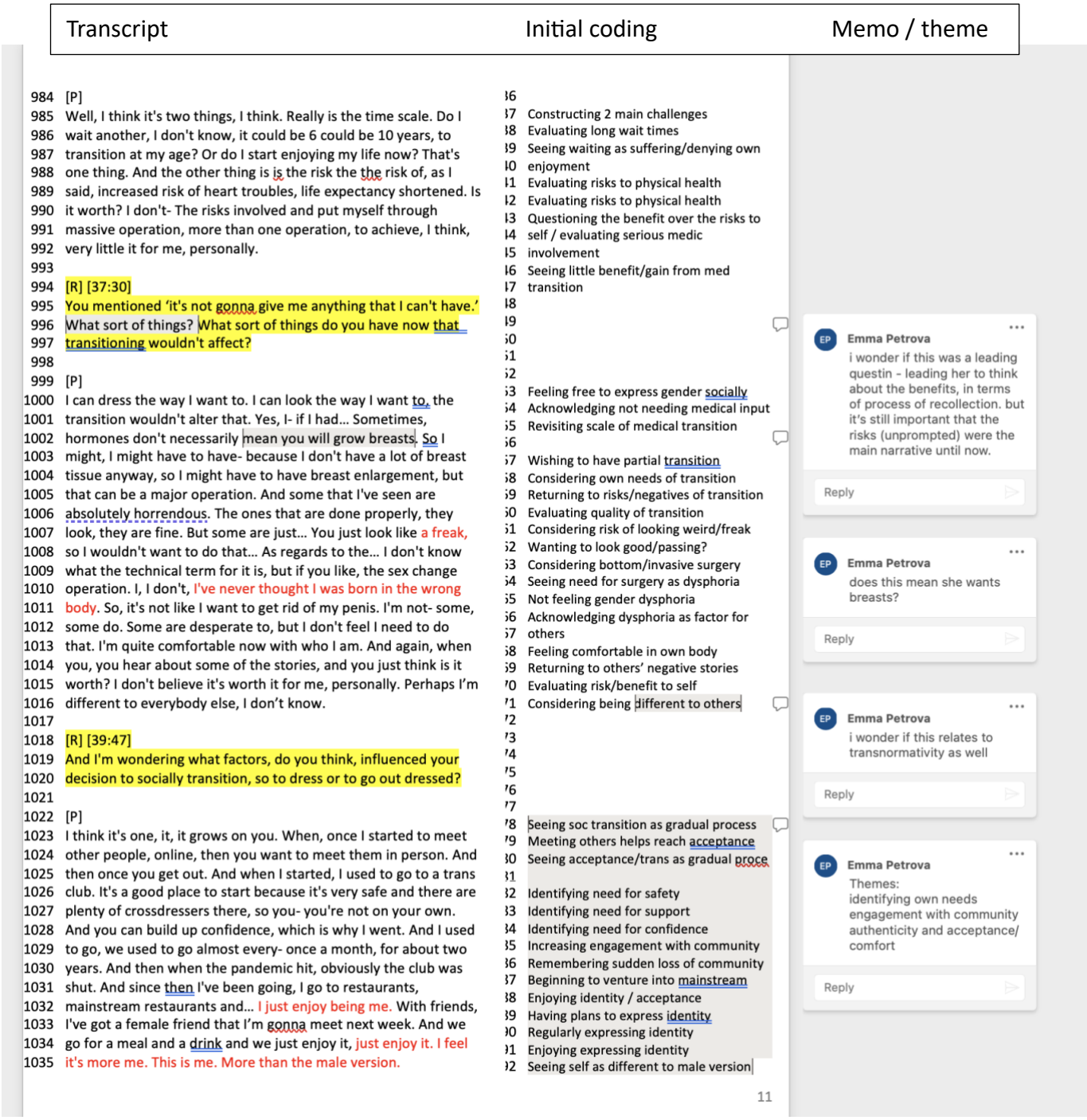
APPENDIX 11 – COMMUNICATION WITH EXPERTS

This content has been removed for confidentiality purposes

APPENDIX 12 – INDIVIDUAL CONSULTATION SESSION WITH EXPERT

This content has been removed for confidentiality purposes

APPENDIX 13 – EXAMPLE INITIAL CODING WITH MEMOS AND FOCUSED THEMES



Transcript	Initial coding	Memo / theme

984 [P]
985 Well, I think it's two things, I think. Really is the time scale. Do I
986 wait another, I don't know, it could be 6 could be 10 years, to
987 transition at my age? Or do I start enjoying my life now? That's
988 one thing. And the other thing is is the risk the the risk of, as I
989 said, increased risk of heart troubles, life expectancy shortened. Is
990 it worth? I don't- The risks involved and put myself through
991 massive operation, more than one operation, to achieve, I think,
992 very little it for me, personally.
993
994 [R] [37:30]
995 You mentioned 'it's not gonna give me anything that I can't have.'
996 What sort of things? What sort of things do you have now that
997 transitioning wouldn't affect?
998
999 [P]
1000 I can dress the way I want to. I can look the way I want to, the
1001 transition wouldn't alter that. Yes, I- if I had... Sometimes,
1002 hormones don't necessarily mean you will grow breasts. So I
1003 might, I might have to have- because I don't have a lot of breast
1004 tissue anyway, so I might have to have breast enlargement, but
1005 that can be a major operation. And some that I've seen are
1006 absolutely horrendous. The ones that are done properly, they
1007 look, they are fine. But some are just... You just look like a freak,
1008 so I wouldn't want to do that... As regards to the... I don't know
1009 what the technical term for it is, but if you like, the sex change
1010 operation. I, I don't, I've never thought I was born in the wrong
1011 body. So, it's not like I want to get rid of my penis. I'm not- some,
1012 some do. Some are desperate to, but I don't feel I need to do
1013 that. I'm quite comfortable now with who I am. And again, when
1014 you, you hear about some of the stories, and you just think is it
1015 worth? I don't believe it's worth it for me, personally. Perhaps I'm
1016 different to everybody else, I don't know.
1017
1018 [R] [39:47]
1019 And I'm wondering what factors, do you think, influenced your
1020 decision to socially transition, so to dress or to go out dressed?
1021
1022 [P]
1023 I think it's one, it, it grows on you. When, once I started to meet
1024 other people, online, then you want to meet them in person. And
1025 then once you get out. And when I started, I used to go to a trans
1026 club. It's a good place to start because it's very safe and there are
1027 plenty of crossdressers there, so you- you're not on your own.
1028 And you can build up confidence, which is why I went. And I used
1029 to go, we used to go almost every- once a month, for about two
1030 years. And then when the pandemic hit, obviously the club was
1031 shut. And since then I've been going, I go to restaurants,
1032 mainstream restaurants and... I just enjoy being me. With friends,
1033 I've got a female friend that I'm gonna meet next week. And we
1034 go for a meal and a drink and we just enjoy it, just enjoy it. I feel
1035 it's more me. This is me. More than the male version.

Constructing 2 main challenges
Evaluating long wait times
Seeing waiting as suffering/denying own enjoyment
Evaluating risks to physical health
Evaluating risks to physical health
Questioning the benefit over the risks to self / evaluating serious medic involvement
Seeing little benefit/gain from med transition

Feeling free to express gender socially
Acknowledging not needing medical input
Revisiting scale of medical transition

Wishing to have partial transition
Considering own needs of transition
Returning to risks/negatives of transition
Evaluating quality of transition
Considering risk of looking weird/freak
Wanting to look good/passing?
Considering bottom/invasive surgery
Seeing need for surgery as dysphoria
Not feeling gender dysphoria
Acknowledging dysphoria as factor for others
Feeling comfortable in own body
Returning to others' negative stories
Evaluating risk/benefit to self
Considering being different to others

Seeing soc transition as gradual process
Meeting others helps reach acceptance
Seeing acceptance/trans as gradual proce

Identifying need for safety
Identifying need for support
Identifying need for confidence
Increasing engagement with community
Remembering sudden loss of community
Beginning to venture into mainstream
Enjoying identity / acceptance
Having plans to express identity
Regularly expressing identity
Enjoying expressing identity
Seeing self as different to male version

11

EP **Emma Petrova**
i wonder if this was a leading questin - leading her to think about the benefits, in terms of process of recollection. but it's still important that the risks (unprompted) were the main narrative until now.
Reply

EP **Emma Petrova**
does this mean she wants breasts?
Reply

EP **Emma Petrova**
i wonder if this relates to transnormativity as well
Reply

EP **Emma Petrova**
Themes:
identifying own needs
engagement with community
authenticity and acceptance/ comfort
Reply

[R] [41:22]
Can you tell me of any experiences during the process of deciding that made you feel affirmed in your gender?

[P]
Well, we've been to a restaurant at [city]. And we were very well looked after when we went there. And then we went back, and I was having a drink in a bar in the afternoon. And the waitress that served us… six months earlier came to speak to- came *specifically* in as she came on shift to speak to me, to say hello. And she just, she was so welcoming. And I just think, well, I'm sure they don't talk to [laughs] all their customers like that, but we... When I've been out, I've always had positive comments. I've always had, I've never had anything negative said to me. So, it just, and I just feel comfortable, so why not?

[R] [42:44]
I'm wondering what or who helped you make this decision at the time?

[P]
Well, I had a, there was a group of friends that I used to go around with, crossdressers. So, we're all in a similar situation. We all just enjoyed each other's company. But since then, I've, I have got two female friends. And they both regard me as female. They've, they've, they've never met each other, so it's not something they've discussed between themselves. They just regard me as one of the girls, as one of their friends, female friends. And that's how they talk to me and That's how they... And they've been very, very supportive. And that just makes me more comfortable with who I am.

[R] [44:08]
I'm kind of curious, your understanding of- what does that mean to you, 'One of the girls'. How do they talk that might be different, if they were talking to a guy?

[P]
Well, they don't talk to me like they would if they were chatting to a man in the pub. They just talk to me- when we talk about absolutely anything. My friend talks to me about her menopause. We talk about… periods. Not that I have periods, obviously, but I don't understand some of these things, so she helps, she talks me through that. We talk about everything and anything. One of my friends tells me about her night out with her boyfriend, and, you know, we talk about things that… Women wouldn't talk to a man about, normally. The more that I think, you correct me, but more than the sort of conversation women would have between themselves. That seems to be… but we talk about everything and anything. And it's just… And they they don't… They don't consider me as anything different, so they don't… They don't make allowances for me being male or it's, you know, I'm just another

Remembering specific example
Feeling accepted in mainstream comm
Remembering specific example
Recalling example of being accepted
Recalling example of being accepted/welcomed
Being aware receiving special treatment
Being aware receiving special treatment
Receiving acceptance/positivity
Never experiencing negativity
Enjoying expressing identity / not seeing negatives to expressing

Engaging with ppl w similar identities
Engaging w ppl w similar identities
Enjoying being together/with similar ppl
Making connections outside community
Being seen as female
Having doubted their attitude
Feeling accepted as female/identity
Feeling difference in others' attitude once expressing identity
Feeling supported by close friends
Enjoying/accepting identity

Differentiating others' attitudes acc to gender
Identifying differences in freedom of topic
Seeing differences in topics acc to gender
Learning new info about womanhood
Feeling free to discuss everything/ feeling some topics off-limit due to gender
Recalling learning specific stories
Seeing difference in attitude/acceptance

Feeling accepted/belonging to female community

Feeling accepted/belonging by females
Not feeling discriminated against
Acknowledging own gender difference

Emma Petrova
Themes:
positive vs negative feedback
expecting discrimination?
visibility
comfort
Reply

Emma Petrova
Themes:
being seen and accepted
belonging
friendship/support
Reply

Emma Petrova
feeling affirmed in her gender
Reply

Emma Petrova
feeling accepted and included. Makes me wonder what all the conversation she's had with 'a man at the pub' would've been emotionally
Reply

12

One of their friends and we talk. We confide in each other. Yeah, I think that's that's. It's about as good as it gets, really.

[R] [46:11]
So, looking back on the whole decision-making process around choosing not to medically transition, what do you think could have helped you or supported you during that time?

[P]
I think the lack of information is the biggest problem. There is some information. It's, to my mind, it's not clear. And also, the process is so dragged out and long-winded. I'm not saying you should, you should rush this thing, cause obviously you shouldn't. But I think it needs to be a more of a... It seems to be different parts of the country get it different. I suppose it's like most things with the National Health Service. But I think there needs to be a bit more of a coordinated approach to it and I think they need better, more detailed information about the positives, but also the negatives. You need to know that if... Because I've seen things on forums of people 'ohh just take hormones'. In fact, some people recommended take this hormone, you can get it on the Internet and it'll work. That is very. That can be very dangerous. We shouldn't be self-administering. But the information needs to be out there that so people can understand that you shouldn't do this. And GP's need to, I suppose, they're better than they were, but. Now that they've these GP's tend to work in in Group practices, large group practices, there is really no reason why they shouldn't be able to have some specialist amongst the practice that can deal or help people with it. Doesn't have to be a, a medical doctor. But somebody, a counselor or something, access to it. You know, that that should be available this day and age. But... somebody who's considering this could talk to somebody and then understand the pros and cons. Because you got to understand the full implications of what you're getting involved with. And then take the time to make the decision yourself.

Feeling safe with female friends
Appreciating safety in relationships

Needing more information
Needing clearer information
Feeling disheartened by length and bureaucracy
Acknowledging necessity of time
Acknowledging location discrimination
Feeling disappointed by NHS
Needing more coordination in provision
Needing more balanced information

Being concerned about dangers of online information/lack of regulation
Learning about others trans ppl's attempts at med transition / concerned
Feeling concerned for other trans people
Looking for just/fair solution to issue
Looking to address misinformation
Looking for just/fair solution to issue
Identifying need for more info access
Identifying need for more specialists/HPs
Seeing need for human help/integrating need for professional help
Identifying need for psychological help
Highlighting importance of human help
Identifying need for support/less isolation
Identifying need for balanced decision-making
Identifying need for more/balanced info
Identifying need for reflection
Consideration being a process

EP Emma Petrova
it's interesting that she's looking at government/NHS responsibility and not individuals' attitudes as barrier

Reply

Section II: Publishable Paper

For submission to The International Journal of Transgender Health

How do older British transfem people choose not to pursue medical gender affirming care?

Author: Emma Petrova

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Keywords: psychology; transgender; transition; identity management;

Conflict of Interest: The author declares that they have no conflict of interest.

The author reports there are no competing interests to declare.

Informed consent: Informed consent was obtained from all individual participants included in the study. Additional informed consent was obtained from all individual participants for whom identifying information is included in this article.

Acknowledgements: I would like to extend my gratitude to the resilient transgender and gender diverse people who shared their stories and experiences

Word limit: up to 8000 words all-inclusive

Abstract word count: 236 words

Article word count: 6040 words

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Part III: Combined Client Study and Integrative Process Report

The Value of Acknowledgement in Providing a Reparative Therapeutic Experience

An integration of psychodynamic therapy and Mentalization-based therapy

THIS CONTENT HAS BEEN REMOVED FOR DATA PROTECTION REASONS