Doctoral Thesis

Examining the caregiver-child dynamic on youth disclosure of transgender identity

Debbie Helen Wood

Doctorate in Clinical Psychology

Division of Health Research: Lancaster University

Word count

	Text	Appendices*	Total
Thesis Abstract	230	0	230
Literature Review	7987	8196	16183
Research Paper	7959	6003	13962
Critical Appraisal	3963	955	4396
Ethics	4749	11319	16068
Total	24880	24590	50839

*includes tables, figures and reference lists as well as appendices

Thesis Abstract

This thesis examines the subject of parent-child dynamic when a young person discloses that they are transgender to their parents, or alternative caregiver, and forms the beginning of a project which has the long term aim of designing an intervention to help smooth what can be a bumpy road for all concerned. Chapter one comprises a metasynthesis which gives voice to transgender youth on their perceptions of caregiver reaction when they have disclosed their transgender identity. This includes parents, foster parents and homeless shelter staff. Four key messages result along with a message of hope where that reaction is not a positive one. Chapter two describes a grounded theory study resulting in a burgeoning model of family dynamics as children consider and then make their disclosure. A four stage model is suggested but such was the richness of the data that the chapter is restricted to the first two stages of pre-disclosure contemplation by both children and parents followed by the disclosure and its' sequelae as both parties react to one another. Finally, chapter three reviews both articles and considers both their individual and joint contributions to the subject of this thesis. Initial thoughts about an intervention and next steps in the development of the model are considered, methodological concerns are discussed and finally the author reflects on the influence of bias and their learning from the exercise.

Declaration

This thesis records research activity completed between August 2019 and November 2020 for the Doctorate in Clinical Psychology at Lancaster University. The work presented in this thesis is my own except where reference to authors is made. The work has not been submitted for any other academic award.

Debbie Helen Wood

Date: 28th November 2020

Signed:

Dedication

Principally I want to dedicate this piece of work to my parents, Eileen Wood (nee Robinson), (February 26th 1945 – August 17th 2004) and Ian Scott Wood (8th November 1941 – 12th August 2020).

My Mam never knew about any of my ‘gender malarkey’ (as far as I know), dying before I made my own disclosure. But I know that I would have had her support and also that she would have been thrilled by my completing this doctorate. She was strong, determined, set me on a path to academia and laid a solid foundation of love and support which has helped me through times of adversity. I wish she had lived to see this. My Dad almost got to see it, but not quite. Consequently he will not get to see me graduate as a doctor – but then he would have went to the graduation, been proud of me, but probably have felt uncomfortable in the setting and somewhat bored with the proceedings. After all, people get to see their offspring for about five seconds at these things... What he did do though was to shape me and support me. I share his political leanings ‘to the left of Arthur Scargill’, albeit with a good deal more sensitivity to diversity. I share his irreverent sense of humour, his willingness to challenge the rules, to fight for what he believed in, his stubbornness, his inability to relax, his wanderlust and his love of Liverpool F.C. I benefitted from his love, not least when I shared with him my own struggle with a gender identity at odds with the rest of the world. He didn’t ever really understand it, it was something way beyond his experiences, but he trusted me, accepted me and supported me.

I’m not sure I’d have been able to write this if it hadn’t been for both of you. I thank, and love, you both so much for that.

Acknowledgements

Of course there are others who deserve acknowledgement, not least my participants - I couldn't have done this without your generosity. My Supervisors; Suzanne Hodge, Bill Sellwood and Igi Moon – thank you for feedback, encouragement, humour, support and a good deal of your time. My friends who kept me going, despite my neglecting them badly over the last three years – in particular Karen Pollock, Tara Jones, Carol Doherty and Jane Angus. I love you all. Not forgetting my cohort of fellow trainees… shared experiences with good people. My (feline) research assistants past and present – Sooty, Oscar, Emma and Bonnie. Not least, of course, the long suffering Amanda who has kept me going and managed not to kill me during the writing of this, and during lockdown… albeit I anticipate a price to be paid now it is finished ☺.

Contents

Chapter 1: Literature Review

Title Page 1-1
Abstract 1-2
Introduction 1-3
Method 1-5
Study Selection 1-6
Eligibility Criteria 1-6
Search Terms 1-7
Quality Appraisal 1-7
Author's Relationship with this Research 1-8
Results 1-10
Resulting Articles 1-10
Expressing the Synthesis 1-11
Category 1: Message: We're OK – You're not OK 1-13
Your gender identity is not real 1-13
We will put obstacles in your way 1-14
We will fix you 1-16
We will abuse you 1-17
We will reject you 1-18
Category 2: Message: We're not OK – You're not OK 1-19
Category 3: Message: We're not OK – You're OK 1-20
Category 4: Message: We're OK – You're OK 1-20
We accept and value you 1-21
We will support and help you 1-22
We will protect you and advocate for you 1-23
Alternative caregivers 1-24
Category 5: There may be hope 1-24
Category 6: OK, or not OK, it's not always about gender 1-25
Discussion 1-26
Implications for Practice 1-28
Limitations 1-30
Conclusion 1-32
References 1-33
Tables 1-38
Table 1: Noblit and Hare's 7 Phase Metasynthesis Procedure 1-38
Table 2: SPIDER Search Terms 1-39
Table 3: Study Details 1-40
Table 4: CASP Quality Approval of Studies 1-46
Figures 1-47
Figure 1: Filtering Studies 1-47
Figure 2: Viscosity Model of Youth Perception of Caregiver Messages 1-48
Figure 3: Parent-Adult-Child (PAC) Model 1-49
Appendices 1-50

1.1 Author guidelines (for both papers) 1-50
1.2 Article Translation 1-61

Chapter 2: Research Paper

Title Page 2-1
Abstract 2-2
Introduction 2-3
Method 2-7
Design 2-7
Epistemology 2-7
Author Connection to the Topic 2-8
Ethical Considerations 2-8
Participants 2-9
Data Collection and Analysis 2-10
Results 2-12
Stage 1: Contemplation 2-12
Youth Contemplation 2-12
Parental Contemplation 2-14
Stage 2: Disclosure and Reaction 2-16
Youth Disclosure 2-16
Parental Reaction 2-18
Youth Reaction (to Parental Reaction) 2-24
Discussion 2-29
Limitations 2-34
Future Directions 2-35
Conclusion 2-35
References 2-36
Tables 2-41
Table 1: Youth Participant Demographics 2-41
Table 2: Parent Participant Demographics 2-41
Figures 2-42
Figure 1: Trans Family Dynamics Model (TFDM) 2-42
Figure 2: Youth Contemplation 2-43
Figure 3: Parental Contemplation 2-44
Figure 4: Youth Disclosure 2-45
Figure 5: Parental Reaction 2-46
Figure 6: Youth Reaction 2-47
Appendices 2-48
2.1 Research Diary Extracts 2-48
2.2 Coding: Stage 1: Contemplation 2-50
2.3 NVivo coded transcript extract 2-56
2.4 Participant Narratives 2-60

Chapter 3: Critical Review

Title Page 3-1
Project Summary 3-2
The Literature Review 3-2
The Research Paper 3-3
A Family Intervention: Considerations 3-3
Next Steps 3-7
Expanding the Model 3-7
Grounded Theory - Methodological Concerns 3-8
Recruitment 3-8
Reliability, Validity and Generalisability 3-9
Reflexivity 3-12
Final Reflections – My Learning 3-15
References 3-17
Figures 3-20
Figure 1: Trans Family Dynamics Model (TFDM) 3-20

Chapter 4: Ethics Proposal

Title Page 4-1
Introduction 4-2
IRAS (FHMREC) Form 4-3
Appendices: Supporting Documentation 4-28
4.1 FHMREC Approval Letter 4-28
4.2 Research Protocol 4-29
4.3 Participant Letter 4-43
4.4 Consent Form 4-44
4.5 Participant Information – Transgender People 4-45
4.6 Participant Information – Family Members 4-48
4.7 Participant Information – Professional 4-51
4.8 Demographics Form 4-54
4.9 Interview Guide 4-56
4.10 Debrief Sheet 4-61
4.11 Confidentiality Agreement 4-62
4.12 Publicity Poster 4-63

Chapter 1: Systematic Literature Review

Transgender youth: perception of caregiver attitudes and actions following gender identity disclosure: A metasynthesis

Debbie Helen Wood

Target Journal: *Journal of GLBT Family Studies*

Word count: 7987 of 8000 words

References, Tables, Figures and Appendices word count = 8196

Abstract

The mental health and wellbeing of trans youth benefits when caregivers support authentic gender expression. However, perception of caregiver attitude shapes experience of support, so it was decided to investigate those perceptions. A systematic search found 14 articles employing interviews (12) or surveys with thematically analysed open questions (2), giving voice to trans youth on caregiver reaction to their gender identity. Caregivers included parents, foster parents and institutional homeless shelters. Existing themes were synthesised and re-interpreted using Noblit and Hare's meta-ethnographic approach. Four key messages were perceived aligning to Eric Berne's 'life positions' of we (the caregiver) are ok - you (trans youth) are not ok; we're not ok - you're not ok, we're not ok - you're ok and we're ok - you're ok. Messages five and six were that unsupportive caregivers can change with time and that not all issues betwixt trans youth and caregivers relate to gender. The expressed line of argument traversed perception of unsupportive investment in cisgenderism[1] to supportive acceptance of trans identity. Merits, limitations and implications for practice are discussed.

Keywords: trans*, non-binary, caregiver, family, youth, metasynthesis

[1] Cisgenderism is the social mechanism maintaining the assumption that trans identities are invalid. See also (Serano, 2020)

The last two decades have witnessed significant attitude change towards people who challenge the ‘cisgender’ norm that gender identity is immutably dictated by genitals. This has been demonstrated by progressive legislation affirming legal recognition of trans people, e.g. in the UK (*Gender Recognition Act*, 2004), Argentina ("Gender Identity Law," 2012) and Malta ("Gender Identity, Gender Expression and Sex Characteristics Act," 2015). Subsequent proliferation of, particularly younger, people openly identifying as transgender (trans[2]) is reflected in the upsurge of referrals to specialist gender services. E.g., the UK NHS Gender Identity Development Service (GIDS) has experienced a 28 fold increase in referrals between 2010 and 2020 (GIDS, 2016, 2020) and the USA has seen a ‘tsunami’ of referrals (Ehrensaft, 2017).

This liberation has facilitated exploration of gender and in addition to moving between traditional genders, increasing numbers of people now occupy middle ground between binary cisgender options of ‘man’ or ‘woman’ including gender expressions of non-binary, gender fluid (where gendered presentation fluctuates) and agender (rejection of gender altogether) amongst others (see Serano, 2020 for a regularly updated glossary). Even people not identifying on the trans spectrum are relaxing of rigid gender boundaries with Joel, Tarrasch, Berman, Mukamel, and Ziv (2013) reporting 35% of cisgender respondents feeling some ambivalence toward the gender binary.

---

[2] In line with common practice, ‘trans’ will henceforth be used as an umbrella term for any identity which breaks cisgender norms.

Despite this gender revolution, trans people still transcend societal norms and find it necessary to disclose trans identity, or 'come out', or be assumed cisgender (Klein, Holtby, Cook, & Travers, 2015). This carries fears, particularly for young people who may lack agency and be reliant on parents for security, intimacy and to realise their identities (Lev, 2004). Although parents generally wish to protect their children (Lev, 2019), distress or prejudice (Reed, Cohen-Kettenis, Reed, & Spack, 2008) means they may sometimes react with hostility (Lev, 2004) or denial (Reed et al., 2008) to the disclosure. Evidence suggests that parental reaction affects the mental health of trans youth, who already experience a worse mental health profile than their cisgender peers in terms of depression and anxiety (Grossman & D' Augelli, 2007; Stonewall, 2017),with approximately 50% of trans youth reporting self-harming and making at least one suicide attempt (Stonewall, 2017). However, parental gender affirmation has been demonstrated to be protective to mental health (Durwood, McLaughlin, & Olson, 2017; Simons, Schrager, Clark, Belzer, & Olson, 2013).

To paraphrase Beck, Rush, Shaw, and Emery (1979), the perception of being supported is as important as support. Trans youth fear their disclosure will disappoint family, resulting in rejection (McDermott, Hughes, & Rawlings, 2016). Testa et al. (2017) found that suicidal behaviour amongst trans people is predicted by perceived burdensomeness and delayed disclosure based on fear of non-affirmation. This becomes more significant when considering that parents of trans youth are perceived as helpful only about 50% of the time (McDermott et al., 2016). This is not a baseless perception given that, e.g. in the USA, lesbian, gay, bisexual trans and queer (LGBTQ) youth are twice as likely to end up in foster care (Wilson, Cooper, Kastanis, & Nezhad,

2014) and approximately four times as likely to be homeless (Robinson, 2018) than their non-LGBTQ peers. This equates to a homelessness rate between 5-8% for LGBTQ youth, which may be higher for trans youth alone, but is not anywhere near 50% suggesting approximately 40% of parents who are perceived as unhelpful but who are not outright rejecting. It is likely that there will be a continuum of unhelpful responses and that some may be perceived as more unhelpful than they actually are. However, the consequences to mental health centre on perception of rejection so it seems important to investigate how trans youth receive the words and actions of parents when they disclose identity. Given a disproportionate number of trans youth are rejected by their parents, or feel unable to stay in the family home, it is also important to consider alternative caregiving via foster parents and homeless shelters. It was therefore decided to review existing literature which gives voice to trans youth on the subject of their caregiver's reactions to disclosure, in order to answer the question:

"*How do trans youth perceive caregiver communications and actions following gender identity disclosure*"

Method

The object of this review was to uncover the meanings which trans youth inferred from the words and actions of their caregivers, which could then help guide clinicians in their work with families of young trans people. The Noblit and Hare (1988) seven phase meta-ethnographic approach (Table 1) was chosen because it utilises studies using qualitative techniques which better capture subjective meaning

(Silverman, 2013). Further, it goes beyond the summation of a narrative literature review in allowing for the re-interpretation of findings from previously published journal articles, collected with other research aims in mind (Britten et al., 2002).

Analysis involved reading and re-reading articles to extract second order (article author) interpretations, or themes, alongside first order (participant) descriptions (Appendix 1.2). 'Determining how the studies are related' involved compiling a list of keywords and phrases from extracted information as basis for third order interpretations. Phase five 'translating the studies into one another' saw formation of third order themes and overarching categories emerging from immersion in the data and experimenting with coherently fitting it together (Appendix 1.2). Phase six 'synthesising translations' was to express themes and categories, justifying them with evidence from the articles.

Study Selection

Eligibility Criteria

Studies were eligible if; (i) data were experiential, from interviews, surveys employing open questions, focus groups or case studies analysed using qualitative methods, (ii) the article had explicit research aims, (iii) the sample consisted of people who are trans, non-binary or gender non-conforming, (iv) studies included voices of young people to some degree dependant on adults speaking about their interactions with caregivers OR the voices of adults talking about their experiences as young people, (v) peer reviewed journal articles, (vi) published in English, (vii) published between January 2000 and the present day. This date is timed to coincide

with changes in attitude leading up to legal recognition in the UK (*Gender Recognition Act*, 2004). There were two exclusion criteria; (i) articles discussing amalgamated experiences of LGBTQ people were not included as these may differ from experiences of trans people exclusively, (ii) articles to be excluded if youth voices are not separable from those of their family.

Search Terms

The above criteria informed terms used to search on Title (TI) and Abstract (AB) in the following databases; PsycINFO, Academic Search Ultimate, CINAHL, SocINDEX with Full Text. The SPIDER tool (Cooke, Smith, & Booth, 2012) was utilised to organise search terms (see Table 2). 'Sample' terms were sourced from Lee, Ylioja, and Lackey (2016) review of LGBT search terms. However, LGB specific terms were dropped and others added (non-binary, genderqueer," cross dress*", transman, transwoman (no space), "trans masculine*", and "trans feminin*"). Perhaps controversially 'intersex' was retained. There is some tension in intersex circles between intersex people who also identify as trans, and others who do not (Diamond, 2000; Griffiths, 2018). In addition 'design' terms were included from the University of Washington online guide ("Finding qualitative research articles," 2020). The full search was carried out in February 2020.

Quality Appraisal

The Critical Appraisal Skills Programme (CASP) was employed to appraise quality using a modified scoring system (Duggleby et al., 2010). Questions 1 and 2 mirrored inclusion criteria (i) and (ii), while questions three to ten were scored as weak (1), moderate (2) or strong (3) and scores summed to give an overall rating.

However the overall CASP score includes measures of researcher relationship to topic and ethics where absence in the report is not indicative of poor rigour but perhaps just space constraint. For this reason each study was given a 'review relevance' rating of 1-3 on insight afforded to this review, as judged for this study by the author based on 'presence of trans voice' and quantity and quality of material relevant to the research question, where; 1 = low, 2 = medium and 3 = high. This information is summarized in *Table 4.* This appraisal was carried out to provide a guide to the relevance of findings to the metasynthesis rather than as a further exclusion criterion.

Author's relationship with this research

The author has lived and professional experiences connected to the topic. As a genderqueer trans person they have their own experience of 'being' a trans youth and of disclosure, albeit later in life. Professionally the author has worked with trans people as a psychotherapist, delivered training on gender diversity and chairs the board of a UK LGBT charity. These experiences inevitably generate expectations from research into such a familiar topic. In terms of this review these expectations included that trans youth – having considered their identities long and hard before disclosure - will be both impatient to make progress and will find it hard to empathise with their parents' reactions to news which is most likely unsettling and, possibly, beyond their current understanding of gender. It also seemed likely that poor communication flowing in both directions was likely to be an issue. In addition, there may have been expectations set up by the work carried out for Chapter 2. From this awareness, and by employment of phenomenological epoché, or 'doubt' (Husserl, 1960), the author bracketed their experiences and considered other possibilities

during the analysis. Bracketing potential bias towards participants' narratives was also something to retain in conscious awareness during the writing of this review.

Results

Resulting Articles

The initial search yielded 3120 papers. Three stages of duplicates checking left 1655 papers which were collated using EndNote X9 software. Checking title and abstract against inclusion and exclusion criteria left 97 papers; followed by full text review which left 13 papers. Reference lists of the final 13 papers yielded one additional paper resulting in a total of 14 papers for the synthesis (Table 3). See also Figure 1.

Twelve studies employed face-to-face interviews and two used online surveys. No case studies were included. The two surveys included open and closed questions. Open questions were thematically analysed and only this data was utilised in the review. The 14 studies interviewed 151 and surveyed 10 trans youth aged between seven and 26 years old and surveyed 100 trans people aged over 26 about their experiences as young people. Of the 261 people who contributed; 112 (43%) identified as trans female or female, 89 (34%) as trans male or male, 17 (7%) as non-binary or genderqueer and 43 (16%) identified their gender in a variety of other ways. Geographically, 201 (77%) people resided in the USA, and 40 (15%) in Australia. Ethnically 120 people came from two studies which did not record ethnicity. Of the remaining 141 people, 55 (39%) people said they were white, 35 (25%) black or African American and 51 from other backgrounds. Five studies (numbers 4, 9, 10, 11 & 12) were centred on homelessness and therefore mainly foster or institutionalised caregiving. These studies included 34 participants, of whom only four were white. Some studies looked at different aspects of the same cohorts of participants (number

6 and 7, and numbers 9, 10, 11 and 12). This has been accounted for in the above figures and considered in the analysis.

Expressing the Synthesis

Six third order categories were identified in total (Appendix 1.2). There was a preconception that key categories would form a narrative describing how supportive trans youth believed their caregivers to be. This emerged from the data as a set of four dualities which described how youth perceived caregivers' view of their own standpoint and that of their young person via inductively constructed second order themes. In naming these the terminology from Eric Berne's four 'life positions' (Berne, 1962) seemed to fit, and were adopted as follows. Forty-three second order themes mapped onto the perceived message 'we're ok, you're not ok' (category 1). In other words we are 'stuck' in our cisgender worldview and your gender diversity is not real, not acceptable etc. In contrast, eighteen third order themes mapped onto a perceived message of 'we're ok, you're ok' (category 4). This message was coming from the 'free' position where caregivers accepted gender as a wider concept, supported and protected their gender diverse youth. Two intermediate positions were also found. Two second order themes resulted in a perceived message of 'We're not ok, you're not ok' (category 2), which recognised that caregiver fears were preventing them from supporting their young person. Three second order themes resulted in a perceived message of 'We're not ok, you're ok' (category 3), which highlighted that caregivers were willing to try to support their young person despite reservations.

There were two further categories which made sense of data not directly connected to parental attitude towards gender expression, communicating slightly different messages by adding a temporal element and an alternative explanation for caregiver reaction. Three second order themes supported that 'there may be hope' (category 5) that negative messages were not necessarily fixed and caregiver attitudes could improve with time. This endowed the synthesis with a dynamic dimension, allowing parents to shift from being 'stuck' in a cisgender framework to a 'free' position where they are perceived as seeing gender as a more expansive phenomenon. Parents set off from a place of understanding which predates their child's disclosure and their child may perceive movement through hearing intermediary messages or directly to 'we're ok, you're ok'. As the perceived message changes the child has more hope that all will be ok as 'viscosity' (i.e. stuckness) reduces. Finally, five second order themes demonstrated that 'it's not always about gender' (category 6), i.e. that trans youth were concerned about the 'regular stuff' and that the important perceptions of caregiver attitude do not all revolve around gender identity.

Combined, these categories describe a line of argument that tells us that parental position, as perceived by young people, can change from 'not ok' to 'ok' and this is represented in the 'Viscosity Model of Youth Perception of Caregiver Messages' (Figure 2). Positions on the model are not fixed with any start point possible and movement from left to right perceived as increasingly supportive with increasing sense of being able to achieve transition with caregiver support. What follows is a narrative presentation of these categories with supporting data. In addition to this

Appendix 1.2 tells the story of the development of the synthesis from first order description taken directly from the articles, through second order themes to third order keywords, themes and finally categories.

Category 1: Message: We're OK – You're not OK

The message received is that we have a binary understanding of gender, you are 'wrong' and we will not support you. This 'wrongness' message takes five principal forms reflecting caregiver investment in cisgenderism; 'your gender identity is not real', 'we will put obstacles in your way', 'we will fix you', 'we will abuse you' and 'we will reject you'.

Your gender identity is not real

Trans youth reported that their parents demonstrated disbelief in their identities in ways ranging from describing their identity as a phase to be ignored, refusing to use their chosen name or appropriate pronouns, to clear statement of dismissal such as "boys cannot be girls and vice-versa" (Riley, Clemson, Sitharthan, & Diamond, 2013, p. 251). One participant reported his disappointment that his mother deliberately ignores his identity; "I hang out with my mom once a week and she purposely uses the wrong pronouns and the wrong name. It's very upsetting that they don't even try" (Singh, Meng, & Hansen, 2014, p. 214). Another participant said that his parents cited his appearance as a toddler as evidence that he could not be a boy:

> They sat me down in our living room and my dad got a picture of me as a toddler in a tutu, and he said, "Does this look like a boy to you?" And I was like "Ooh, not the reaction I was hoping for." (Johnson et al., 2020, pp. 160-161)

One participant suggested that parental attitudes might also originate in social norms other than cisgenderism; “I think a lot of the disbelief comes from this culture that says do not believe our children. We should believe our children and listen to them” (Singh et al., 2014, p. 213).

Children living in foster care or homeless shelter accommodation encountered similar attitudes and behaviours from some foster carers and staff which they sometimes put down to “chronic incompetence” (Mountz, Capous-Desyllas, & Pourciau, 2018, p. 112) but also to staff creating “non-affirming environments” in collusion with other service users (Mountz et al., 2018, p. 110). This was exacerbated by ‘relentless’ questions about their identity, and resulted in trans youth feeling devalued and unaccepted:

> …I want people to acknowledge me as… like as I feel I present myself, not having to say it, you know? It’s like, it’s like common sense basically you know. If you see someone present – if they walk like a duck – they a duck, you know? (Shelton, 2015, p. 14)

We will put obstacles in your way

Lack of acceptance could also manifest via ways of restricting activity ranging from refusal to help to active prevention (Riley, Clemson, et al., 2013). Young people reported that sometimes parents would refuse to buy them the things they needed to self-express their gender, e.g. clothes, prosthetics etc. There were also attempts to

cut them off from external support such as restricting access to friends, trans community and mobile phone use. One non-binary participant reported being almost entirely cut-off, reinforced by having their phone taken away and internet use restricted:

> (Parent said) “This is a problem, you are not allowed to talk to (trans friend) any more” and “Nope, can’t talk to your (trans) cousin anymore.” And then I was not allowed to discuss my gender with anybody except my parents or my counsellor. (Johnson et al., 2020, p. 161)

Treatment restriction included preventing young people from accessing medical treatment by refusing to pay for it, withholding legal permission (Johnson et al., 2020) or threatening the young person with expulsion if they did not comply with parental wishes (Kuper, Wright, & Mustanski, 2018).

Participants also reported having to suppress their identity or lead a double life because their gender identity was not acceptable to caregivers. Several participants described a period of denial, some of which was influenced by parents. One participant dared not explore their identity, partly for fear of their mother’s reaction; “My mom, she criticize people like, uh they look disgusting…” (Kuper et al., 2018, p. 447). For some, this meant presenting authentically away from home but suppressing identity at home. This presented difficulties for one participant who had lived independently before financial constraints meant returning to live with parents (Kuper et al., 2018). Another participant, who was diagnosed with Asperger’s

syndrome, used coping skills learned via his condition to avoid difficult family conversations; "I stray away from conversation that would bring up any indicator of the fact that I am not what I seem to be to them", (Singh et al., 2014, p. 213).

In homelessness settings systemic barriers were frequently reported usually around shelters being setup to deal with cisgender people only e.g. single sex dorms, gendered paperwork, lack of training for staff, inability to deal with trans needs and an inflexibility which meant change was felt to be unlikely (Shelton, 2015). All of this led to a feeling of marginalisation even if it was acknowledged that generally the effect was unintentional and led people to seek out shelter programmes designed specifically with the needs of trans people in mind (Shelton, 2015).

> All they gotta worry about is school… I worry about… having special centers where to go to feel secure, and to be with people like me… Like I think there's more of a… weight on my back. (Shelton, 2015, p. 12)

We will fix you

Some caregivers resorted to various forms of 'gender policing' or attempts at 'cure'. Two participants discussed being forced to attend an all-boys boarding school after revealing their identity to parents, several others were taken to see professionals for 'help'; "[I was] forced to go to a therapist who was determined to make a man out of me" (Riley, Clemson, et al., 2013, p. 251), and "my parents took me to an ex-gay clinic, which is like, a clinic where they try to make gay people straight" (Singh et al., 2014, p. 215).

We will abuse you

Verbal, and sometimes physical abuse were a feature of some people's lives at home and also in homeless shelters – which represented a double dose of rejection. Verbal and psychological abuse from parents took the form of transphobic comments and also other forms of ridicule. One participant described how his mother had 'made fun' of his dysphoria at a time when he felt very low in mood and would have appreciated some support. Another was insistent on using female terms outside the house to refer to his trans-male son which effectively 'outs' him and puts him at potential risk; "He says. 'daughter'. He says 'she', he tries to correct them when they say 'he'… I'm just like. 'You are going to put me in more danger'" (Johnson et al., 2020, p. 116). Fear of abuse kept one participant silent; "I thought if I told (my parents) they might put me away in a mental institution" (Riley, Sitharthan, Clemson, & Diamond, 2013, p. 648).

Abuse at home led some participants to run away from home; "I was being bullied at school. Then I had to go home and be, um, mentally tortured and physically tortured" (Mountz et al., 2018, p. 115). However, the situation in foster care and homeless centres was often little better with some participants describing how they had been discriminated against and badly treated, had threats from staff and felt 'in danger'. One participant described how the likelihood of being mistreated limited his choice of homeless shelters that he could safely use; "They gonna single me out… out of everybody. I don't want to be in that predicament" (Shelton, 2015, p. 13). Homeless centres which claimed to cater specifically for lesbian, gay, bisexual and trans (LGBT) youth were rarely experienced as offering the respite one might expect.

In fact some young people were 'harassed' by cisgender LGB service users with one participant remarking that; "Trans stuff is still very new to some people… so you just encounter ignorance, you know, about the transgender stuff" (Shelton, 2015, p. 15). Regardless, some people definitely felt safer having escaped their parents' home. Participants described a life of unpredictability and violence at home where they were beaten for expressing themselves. One third of participants in one article described homelessness as lifesaving; "Honestly I don't think I would be alive today if I wasn't… if I wasn't homeless" (Shelton, 2016, p. 284).

We will reject you

Some caregivers' behaviours were outright rejecting. This included both parents and foster carers who were seen as old fashioned, bigoted, closed minded - often rooted in strong religious beliefs; "My folks were brought up with the closed mentality of gays go to hell… Nothing can and ever will change their beliefs" (Riley, Clemson, et al., 2013, p. 251). Some young people were thrown out by their parents who could not accept them, and one young person told of how a potential foster placement had fallen through because of the foster parents being "traditional Christians" (Mountz et al., 2018, p. 111). More surprising was the rejection experienced by trans youth from lesbian, gay and bisexual (LGB) affirmative caregivers. One participant's mother embraced their sexual orientation but not their non-binary identity; "A lot of people are pro-LGBT, but they do not accept trans people… That's her. She doesn't see the 'T' in LGBT" (Johnson et al., 2020, p. 164).

In the homelessness studies (Shelton, 2015, 2016; Shelton & Bond, 2017; Shelton, Wagaman, Small, & Abramovich, 2018) two-thirds of the 27 participants said

they had been kicked out of their homes because they were trans and eight of the nine others said gender had been a contributing factor (Shelton & Bond, 2017). One participant described being kicked out by her mother in case she 'turned' her brothers; "She was like, 'I don't want no faggots around my other boys. You're the oldest, you're gonna be… you're a bad example" (Shelton & Bond, 2017, p. 287).

Category 2: Message: We're not OK – You're not OK

The message received here was that parental attitudes to gender diversity might be looser, but serious reservations meant that assistance might not be forthcoming. This centred on parental fears of loss with their child becoming "unrecognisable" (Johnson et al., 2020, p. 164). In terms of irreversible medical procedures, caregivers feared having to take responsibility should their child subsequently regret their decision, and so refused to consent to treatment. This was experienced as unsupportive but also as evidence of a lack of trust; "I waited a year after I came out, to make 100% sure that I wanted to transition medically. At this point I really would have appreciated it if they had just let me do it immediately" (Johnson et al., 2020, p. 164).

For some this mixed message came from one parent only, particularly where parents were separated. This caused family discord and it might be left to the court to resolve this which had the same net effect, temporarily at least, on actual treatment (Riggs, Bartholomaeus, & Sansfaçon, 2019). This did mean that at least one parent was sending out a 'you're ok' message, but it was also reported by Johnson et al. (2020) that where parents sent out mixed messages it was the negative one that was most significantly received by the child.

Category 3: Message: We're not OK – You're OK

The message received was that caregivers were committed to being supportive despite their own misgivings. This included not understanding trans identities or what was involved in supporting their child, but making the commitment to support them nevertheless. On disclosing their identity one participant described their parent's reaction and the relief it brought them "…of course they had questions, but before they even asked anything, they just said that they were supportive and that they didn't understand, but that they would try to" (Johnson et al., 2020, p. 162). Another parent was more reserved in giving immediate support but certainly gave reason for optimism; "At first she (mother) was like 'well I don't really understand this, but I'll work on understanding this and then I will support you' and that was really great" (Katz-Wise et al., 2017, p. 14). In particular parents were concerned about safety and side effects of medical treatments, but expressed a willingness to learn and to help with navigating the system. Trans youth received this not just as supportive but sometimes as key to their receiving the treatment they needed; "Without my parents, I do not even know if I would've been able to have the surgery at that moment in time" (Johnson et al., 2020, p. 163).

Category 4: Message: We're OK – You're OK

This message was a signal to the young person that their caregiver(s) were comfortable with challenging the binary gender system, and supportive of their child in doing so. This manifested as four specific messages contained in the following themes; 'we accept and value you', 'we will support and help you', and 'we will protect you and advocate for you', describe increasing levels of support from

caregivers, whilst 'alternative caregivers' examines how other sources of support can replicate the caregiver role.

We accept and value you

This theme revolved around affirmation of gender identity and the experience of being believed and supported without judgement. An important aspect of affirmation was use of the young person's chosen name and gendered pronouns and that this was generally consistent. Although mistakes were sometimes made these were much less impactful where it was believed that a genuine effort was being made, although it was also expressed that getting it right should not be that difficult. That children should be believed "including when the child might voice changes in their understanding of themselves" (Riggs et al., 2019, p. 7) was a clear message not only of the importance of having faith in a child's view of their own gender – but also that it is ok for that view to evolve. Being treated gender appropriately brought comfort, however it was noted in two studies how much trans youth appreciated it when, beyond gender, parents continued to treat them the same. One participant described how their parents had never questioned their gender non-conformance and so when they disclosed their identity there was little to change; "they always knew I liked dolls, so they were just like, ok. It's not really that different from before" (Katz-Wise et al., 2017, p. 16). Another participant expressed how her parents' pride in her identity strengthened her identity, and that this felt like an extension of their own pride in their minority ethnic heritage (Singh, 2013). Sadly there was only one (ultimately) positive experience of foster care expressed across all themes, where a young trans woman said that from over 30 placements there was only one where she

felt safe as a trans person and “cared for as a human being rather than as a source of income” (Mountz et al., 2018, p. 110).

We will support and help you

This theme represents a step further in proactively engaging with supportive activity. Accessing self-education resources to better understand about being trans was experienced as sincerely wanting to be helpful. Offering emotional support around experiences of invalidation, discrimination and dysphoria was valued, in particular when parents understood the increase in dysphoria when barriers to treatment were experienced, and support was offered to reduce the impact on mental health; “My parents definitely picked up on stuff and my mom would let me take mental health days when it was really bad. You know, when I just didn’t want anyone to look at me…” (Johnson et al., 2020, p. 163). Families were described as “supportive sites” (Singh et al., 2014, p. 211) when it was possible to move beyond acceptance and have open conversations about gender identity and fluidity and to receive practical guidance; “My mom actually was the one that helped me find my male name, which is the name she would have given me if I was born male…” (Schimmel-Bristow et al., 2018, p. 277). Finally, there was practical help with things like getting to medical appointments, accessing support groups and financial assistance to buy appropriate clothes and other things which affirmed gender. This was critical to many young people who were financially dependent upon their parents and was particularly appreciated by one participant whose mother was on a tight budget herself:

> She's very frugal with some things, so she will be able to give me money so I can buy makeup. I'm able to buy clothing. So I can buy perfume. So I can buy wigs and stuff like that. So I'm able to feel better transitioning. Like, you know, just make my self-esteem be up there, instead of down here, (Johnson et al., 2020, p. 163).

We will protect you and advocate for you

This theme takes support a step further and describes experiences of caregivers offering to stand with trans youth, against the outside world where necessary. Parents were reported as helping with extended family and out in the community; "It's everybody you deal with from the dentist to the baker to being misgendered in the supermarket, so that kind of support by having that one person to reinforce that to everybody around is one of the biggest things" (Riggs et al., 2019, p. 8). Several participants described parents as advocating for them with school, including one instance where a mother told the school that she was not letting her child attend that particular school because of their non-affirmative stance. Access to healthcare was an area where advocacy was especially important due to the complexities of the system, with long waiting times and, in some cases, the need for court approval for treatment. Here there was a sense of a joint struggle against the system where parental advocacy was instrumental in securing help; "It would've been a lot more annoying and exhausting if that was a thing I would've had to do, and I probably wouldn't have honestly done it…" (Riggs et al., 2019, p. 10). One participant described the importance of his mother's support describing her as a "cis ally in the

best kind of way" (Ref1, p.163), whilst another emphasised the critical role that caregiver advocacy can play in a young person's struggle as being life-saving; "Because if they didn't support me, I most likely wouldn't be here…" (Riggs et al., 2019, p. 8).

Alternative caregivers

This theme comes out of the literature based on institutional caregiving for homeless youth. Whilst there were instances of appreciation for individual staff members, homeless centres were not seen positively on the whole. However, some participants who were supported in LGBT affirmative programmes did find these to be affirmative and also to offer opportunities to learn and to stand up for themselves; "I could honestly say I got educated here. And I got empowered here. It liberated me. It feels good." (Shelton, 2016, p. 286). LGBT affirmative programs also offered youth a chance to understand their own identities and connect to community, which offered hope for the future and an understanding of possible ways forward. Finally these environments enabled trans youth to connect with others from their communities and to form 'surrogate' families which became the supportive caregivers that they had not previously experienced; "for the first time I was being told, you know, that you know, this is okay, you know, and you know, like you can still do anything you want to do" (Shelton, 2016, p. 285).

Category 5: There may be hope

This category supports the idea that the unsupportive position is not necessarily permanent, and there was a message that over the course of time many caregivers became more supportive of their trans children (Johnson et al., 2020). One

participant described how support came following their mother finding out more about gender diversity; “At first she wasn’t really [supportive]… she started doing research about it… then she started helping me” (Schimmel-Bristow et al., 2018, p. 277). Children also saw that they might have contributed to the difficulties in some cases; “I can’t remember because it was so long ago, but I assume not, I was probably in the mindset of no one understands me, oh, I’m so sad, blah blah blah, a typical teenager mindset”, (Riggs et al., 2019, p. 12). That said positive outcomes cannot be expected in all cases though, and certainly expectations are often low. One participant who had ended up in the care system observed that their strained family dynamics meant that “the possibility of post-care reunification was less likely” (Mountz et al., 2018, p. 111).

Category 6: OK, or not OK, it’s not always about gender

This final message brings together some received messages which illustrate that trans youth face a variety of other challenges and positives which may not be solely gender related. For example, some people were supported but still ended up homeless for other reasons (Shelton & Bond, 2017). Some people didn’t get along well in some of the homeless shelters, but it was not clear how much that had to do with gender because the organisation concerned had a bad attitude to homeless people in general (Shelton et al., 2018). One participant was not accepted by her family, not because of gender but judgement of her sex work (Singh et al., 2014). Conversely, one participant found family acceptance of gender linked to their pride about their minority ethnic status (Singh, 2013).

Discussion

The overwhelming majority of the evidence pointed towards caregivers being perceived as unsupportive by trans youth. This is reflected by 43 second order themes sitting under the received message that 'we (the caregivers) are ok, but you (the youth) are not OK'. This is set against 18 second order themes, of a 'we're ok, you're ok' position and five second order themes around intermediary positions of 'we're not ok, you're not ok' and 'we're not ok, you're ok'. Some parents were shown to give a mixture of positive messages, or an intermediary message of 'we're not ok, you're not ok' or we're not ok, you're ok'. However the negative balance of received message was reinforced by the observation by Johnson et al. (2020) that where there are a mixture of positive and negative messages present, trans youth are likely to perceive caregivers as unsupportive (Johnson et al., 2020). Mathews and MacLeod (2005) found immediate negative attention bias in the presence of anxiety and on processing of information with low mood in the general population. One particular finding, that some LGB parents are not supportive seems surprising at first given that those parents know only too well the effect of having to suppress identity. However this might be understood in terms of cisgenderism and the pressure on LGB parents to raise a 'normative' child in order to avoid accusation of influencing their child's identity (Malpas, 2011). It seems important to note at this point that quantity here, and following, is measured in terms of depth i.e. the range of responses resulting in the same message but, although these were not counted, the impression reading the articles was that numerical quantity was approximately equal to depth of findings.

The evidence for the intermediary messages was relatively sparse which might cast doubt on their inclusion. Indeed it might be said that they are simply aspects of the other two messages as the first is still about being unsupportive and the other about being supportive despite reservations. However these messages do differ from their clearer and more robust neighbours and offer positions which demonstrate movement – as backed up by the evidence that over time unsupportive parents can move towards being more supportive. Without these two positions the change in mood is quite extreme so they offer tentative steps in the direction of being supportive. That the transition from stuck to free can be a gradual process is a key tenet of the model which reflects the evidence presented by Johnson et al. (2020) and Schimmel-Bristow et al. (2018). That parents can change with the right support is a key message expounded by Lev (2019) and Ehrensaft (2019) and offers hope that sceptical or condemning parents can come round with time. Importantly, these two themes also show a change in emphasis of parental attitude where less supportive messages are based to an increasing degree on fear of the consequences of transition – social and physical health focussed. This might indicate that as attachment to a gender binary loosens other fears emerge, or it might indicate that those fears are simply less obvious to young people when anti-trans expression is front and centre.

The finding that not all received messages are grounded in the young person's gender identity is important to note. It is a common assumption by health professionals that a trans person's issues are intrinsically associated with their gender identity. Mental health professionals can discount client goals by making this assumption (Hunt, 2014), and in giving evidence to a public enquiry one respondent

made reference to attending their GP with a cold and coming away with a diagnosis of 'trans cold' (*Women and Equalities Committee: Transgender equality*, 2016, p. 38). Robinson (2018) reports LGBT youth experience the 'we're not ok, you're not ok' message with abuse and neglect, but particularly in tandem with poverty rather than rejection necessarily based on concern about gender (or sexual) identity.

Implications for Practice

Considering the largely negative perceived message in light of the adverse mental health profile of trans youth (e.g. Grossman & D' Augelli, 2007) and the ameliorating effect of caregiver support (e.g. Durwood et al., 2017) some kind of family intervention and/or support, as advocated by Lev (2004) and Parker, Hirsch, Philbin, and Parker (2018), would most likely be beneficial to the wellbeing of trans youth. What form such an intervention would take is a matter for further investigation but it is considered likely that communication would be a key element, especially given that these findings reflect perceived messages – and these perceptions may be flawed. This further justified using the language of Berne's (1962) 'life positions' from Transactional Analysis (TA) to encapsulate the four messages as perceived by trans youth. Berne (1962) demonstrates that two individual positions (ok or not ok) yield four possible life positions as described in the first four categories. This is reductive in that there can surely be intermediary positions (somewhat ok) and things caregivers were ok about and other things they were not ok with. However, the labels were only intended to characterise the received messages, and as a perception the duality seems to work, especially given that young people were shown to tend towards perceiving caregivers as 'not ok' unless presented with a fundamentally 'ok' message.

Further, TA, in its most basic form, offers a useful framework to explain communication problems based on ‘ego states’ of ‘parent, adult, or child’ (Berne, 1961) where most useful communication is seen when both parties communicate assertively from the ‘adult’ state (see Figure 3). TA has been utilised to help improve communication in various scenarios including nursing (Kenward, 2013), clinical leadership (Thiagarajan & McKimm, 2019) and, pertinently, couples therapy (Dixit & Ramachandran, 2019), and so might offer a useful element to any intervention.

A serious limitation to any intervention is how to engage those who are actually very negative, and it was disturbing to read the levels of abuse and hatred that some trans youth suffer at the hands of their caregivers. There is no easy answer to this, except to hope that public perception and wider education softens such attitudes over time. However it must also be noted that (i) a sizeable proportion of participants were older people reflecting on their experiences which might not reflect a modern context; (ii) therapist experience points to most parents wanting to do the best by their child even if they do not know the best way to achieve this (Lev, 2019); and (iii) experiences of trans youth in foster care or the homeless system are inevitably set against a background of rejection or loss. Counter to that, however, therapists will tend to see parents who are seeking help and a disproportionate number of trans youth find themselves homeless or at risk of homelessness (Durso & Gates, 2012). In particular findings around reparative therapy which aims to ‘change’ gender (and/or sexual) identity, are perhaps not as disturbing as they might be. This is because chiefly these came from the aforementioned older participants who are reflecting on their childhood. Reparative therapy is increasingly classed as unethical with e.g. most

major UK psychotherapeutic organisations signing up to the Memorandum of understanding on conversion therapy (MoU2, 2019). However this is not the case everywhere and there is not universal agreement that gender identity should be included alongside sexual identity.

Institutional care received more criticism than praise, often including shelters which purported to cater for LGBT service users. Generally this was attributable to systemic cisgenderism. This is a problem of training and the need for reconsideration of fundamental practices and organisation of homeless shelters in order to best serve the needs of all youth regardless of gender identity. Pyne (2011) highlighted the situation for homeless trans women in Toronto subject to inclusion criteria in order to be accommodated appropriately. This included a requirement to have had surgery and be taking female hormones. 'Sustained advocacy' (Pyne, 2011, p. 133) led to improvements. Ferguson and Maccio (2015) discuss 'promising' programs in the USA – some of which offer an integrated service for LGBT people and others who tailor services to sub-groups including trans people. While all these programs are described in a positive light the experiences described in the synthesis make it likely that some integrated services will fall short for trans people.

Limitations

This review did not separate narratives of binary from non-binary people, which can differ. Therefore results does not account that e.g. non-binary people are less likely to pursue hormone treatment (Clark, Veale, Townsend, Frohard-Dourlent, & Saewyc, 2018) even though medical intervention was a particular point of conflict. Perhaps all we can say is that if a young person doesn't seek medical intervention

they are less likely to run into parental opposition. Additionally (Riley, Clemson, et al., 2013) included participants aged from 18 to 66, reporting inseparably on childhood experiences from different eras, some of which may no longer be relevant. These points warrant further investigation.

A problem which typifies literature reviews on trans experience is the dearth of dedicated studies and relative abundance of studies amalgamating LGBT experiences making it difficult or impossible to partial out trans experiences. There is an assumption that experiences are comparable – but the evidence of this review would suggest not and the decision to reject LGBT papers was justified. Unfortunately then, many trans experiences from LGBT focussed papers did not inform this article.

Finally, it is noted that, as with all qualitative research, the resulting synthesis is 'in the eye of the beholder' and another researcher might have delivered a different interpretation (Noblit & Hare, 1988, p. 80). This is inevitable given individual differences in attitude and experience of researchers which also affects the type of evidence sought and how that evidence is filtered and weighted. In assessing the rigour of the evidence the CASP tool was employed along with the 'relevance' score to make up for some of CASP's shortcomings. In conducting the metasynthesis care was taken to avoid the criticism Thorne (2017) makes about researchers actually amalgamating just the most popular themes by endeavouring to ensure that all relevant themes were included in the line of argument. Inevitably metasynthesis involves invisible cognitive process but as far as possible this process has been made transparent in Appendix 1.2: Article Translation. Perhaps the greatest limitation to

the trustworthiness of the metasynthesis is that unavoidably this was the work of a single researcher which precluded data triangulation.

Conclusion

Four messages were identified illustrating trans youth perception of caregivers as holding views on a continuum between a wholly negative and wholly positive standpoint on gender diversity. Overwhelmingly the perception tended towards the negative, even with mixed messages, but there was also hope more positive with time. Results suggested the value of better communication and a review of homeless and foster care to engender a more welcoming and fit for purpose service for those experiencing rejection from parents.

References

Beck, A. T., Rush, J. A., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*: Guilford Press.

Berne, E. (1961). *Transactional Analysis in Psychotherapy*. New York: Grove Press.

Berne, E. (1962). Classification of positions. *Transactional Analysis Bulletin, 1*(3), 23. Retrieved from https://calisphere.org/item/78b49942-aca7-4c30-83f6-eda7a5857d50/

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta ethnography to synthesise qualitative research: a worked example. *J Health Serv Res Policy, 7*(4), 209-215. doi:10.1258/135581902320432732

Clark, B. A., Veale, J. F., Townsend, M., Frohard-Dourlent, H., & Saewyc, E. (2018). Non-binary youth: Access to gender-affirming primary health care. *The international journal of transgenderism, 19*(2), 158-169. doi:10.1080/15532739.2017.1394954

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: The SPIDER tool for qualitative evidence synthesis. *Qualitative Health Research, 22*(10), 1435-1443. doi:10.1177/1049732312452938

Diamond, M. (2000). IV. Sex and gender: Same or different? *Feminism & Psychology, 10*(1), 46-54. doi:10.1177/0959353500010001007

Dixit, V., & Ramachandran, K. (2019). Transactional analysis: A marital therapy. *Indian journal of health and wellbeing, 10*(10), 362-367.

Duggleby, W., Holtslander, L., Kylma, J., Duncan, V., Hammond, C., & Williams, A. (2010). Metasynthesis of the hope experience of family caregivers of persons with chronic illness. *Qualitative Health Research, 20*(2), 148-158. doi:10.1177/1049732309358329

Durso, L. E., & Gates, G. J. (2012). Serving our youth: Findings from a national survey of services providers working with lesbian, gay, bisexual and transgender youth who are homeless or at risk of becoming homeless.

Durwood, L., McLaughlin, K. A., & Olson, K. R. (2017). Mental health and self-worth in socially transitioned transgender youth. *Journal of the American Academy of Child & Adolescent Psychiatry, 56*(2), 116-123.e112. doi:10.1016/j.jaac.2016.10.016

Ehrensaft, D. (2017). Gender nonconforming youth: current perspectives. *Adolescent Health, Medicine and Therapeutics, 8*, 57. doi:10.2147/AHMT.S110859

Ehrensaft, D. (2019). It takes a creative parent. In A. I. Lev & A. R. Gottlieb (Eds.), *Families in transition: Parenting gender diverse children, adolescents and young adults* (pp. 40-59). New York: Harrington Park Press.

Ferguson, K. M., & Maccio, E. M. (2015). Promising programs for lesbian, gay, bisexual, transgender, and queer/questioning runaway and homeless youth. *Journal of Social Service Research, 41*(5), 659-683. doi:10.1080/01488376.2015.1058879

Finding qualitative research articles. (2020). Retrieved from https://guides.lib.uw.edu/hsl/qualres/cin

Gender Identity Law, (2012).

Gender Identity, Gender Expression and Sex Characteristics Act, (2015).

Gender Recognition Act. (2004). Retrieved from https://www.legislation.gov.uk/ukpga/2004/7/contents
GIDS. (2016). Gender Identity Development Service statistics. Retrieved from https://tavistockandportman.nhs.uk/documents/408/gids-service-statistics.pdf
GIDS. (2020). Referrals to GIDS, financial years 2015-16 to 2019-20. Retrieved from https://gids.nhs.uk/number-referrals
Griffiths, D. A. (2018). Diagnosing sex: Intersex surgery and 'sex change' in Britain 1930–1955. *Sexualities, 21*(3), 476-495. doi:10.1177/1363460717740339
Grossman, A. H., & D' Augelli, A. R. (2007). Transgender youth and life – threatening behaviors. *Suicide and Life – Threatening Behavior, 37*(5), 527-537. doi:10.1521/suli.2007.37.5.527
Hunt, J. (2014). An initial study of transgender people's experiences of seeking and receiving counselling or psychotherapy in the UK. *Counselling & Psychotherapy Research, 14*(4), 288-296. doi:10.1080/14733145.2013.838597
Husserl, E. (1960). *Cartesian meditations : an introduction to phenomenology*: M. Nijhoff.
Joel, D., Tarrasch, R., Berman, Z., Mukamel, M., & Ziv, E. (2013). Queering gender: studying gender identity in 'normative' individuals. *Psychology and sexuality, 5*(4), 291-321. doi:10.1080/19419899.2013.830640
Johnson, K. C., LeBlanc, A. J., Sterzing, P. R., Deardorff, J., Antin, T., & Bockting, W. O. (2020). Trans adolescents' perceptions and experiences of their parents' supportive and rejecting behaviors. *Journal of Counseling Psychology, 67*(2), 156-170. doi:10.1037/cou0000419
Katz-Wise, S. L., Budge, S. L., Fugate, E., Flanagan, K., Touloumtzis, C., Rood, B., . . . Leibowitz, S. (2017). Transactional pathways of transgender identity development in transgender and gender-nonconforming youth and caregiver perspectives from the Trans Youth Family Study. *International Journal of Transgenderism, 18*(3), 243-263. doi:10.1080/15532739.2017.1304312
Kenward, L. (2013). Teaching communication via awareness of Berne's personal ego states. *Nurse Educ Today, 33*(10), 1096-1098. doi:10.1016/j.nedt.2013.03.008
Klein, K., Holtby, A., Cook, K., & Travers, R. (2015). Complicating the coming out narrative: Becoming oneself in a heterosexist and cissexist world. *Journal of Homosexuality, 62*(3), 297-326. doi:10.1080/00918369.2014.970829
Kuper, L. E., Wright, L., & Mustanski, B. (2018). Gender identity development among transgender and gender nonconforming emerging adults: An intersectional approach. *International Journal of Transgenderism, 19*(4), 436-455. doi:10.1080/15532739.2018.1443869
Lee, J. G. L., Ylioja, T., & Lackey, M. (2016). Identifying lesbian, gay, bisexual, and transgender search terminology: A systematic review of health systematic reviews. *PLoS ONE, 11*(5). doi:10.1371/journal.pone.0156210
Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. Binghamton, NY: Haworth Clinical Practice Press.
Lev, A. I. (2019). Introduction. In A. I. Lev & A. R. Gottlieb (Eds.), *Families in transition: Parenting gender diverse children, adolescents and young adults* (pp. 10-36). New York: Harrington Park Press.

Malpas, J. (2011). Between pink and blue: A multi – dimensional family approach to gender nonconforming children and their families. *Family Process, 50*(4), 453-470. doi:10.1111/j.1545-5300.2011.01371.x

Mathews, A., & MacLeod, C. (2005). Cognitive vulnerability to emotional disorders. *Annu Rev Clin Psychol, 1*(1), 167-195. doi:10.1146/annurev.clinpsy.1.102803.143916

McDermott, E., Hughes, E., & Rawlings, V. (2016). *Queer Futures: Understanding lesbian, gay, bisexual and trans (LGBT) adolescents' suicide, self-harm and help-seeking behaviour*. Retrieved from http://www.queerfutures.co.uk/wp-content/uploads/2016/06/Queer-Futures-Final-Report.pdf

Mountz, S., Capous-Desyllas, M., & Pourciau, E. (2018). 'Because we're fighting to be ourselves:' Voices from former foster youth who are transgender and gender expansive. *Child Welfare, 96*(1), 103-125. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=130544599&site=ehost-live&authtype=ip,shib&user=s1523151

Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography : synthesizing qualitative studies*: Sage.

Parker, C. M., Hirsch, J. S., Philbin, M. M., & Parker, R. G. (2018). The urgent need for research and interventions to address family-based stigma and discrimination against lesbian, gay, bisexual, transgender, and queer youth. *Journal of Adolescent Health, 63*(4), 383-393. doi:10.1016/j.jadohealth.2018.05.018

Pyne, J. (2011). Unsuitable bodies: Trans people and cisnormativity in shelter services. *Canadian Social Work Review, 28*(1), 129-137.

Reed, B. W. D., Cohen-Kettenis, P. T., Reed, T., & Spack, N. (2008). Medical care for gender variant young people: Dealing with the practical problems. *Sexologies, 17*(4), 258-264. doi:10.1016/j.sexol.2008.08.004

Riggs, D. W., Bartholomaeus, C., & Sansfaçon, A. P. (2019). 'if they didn't support me, I most likely wouldn't be here': Transgender young people and their parents negotiating medical treatment in australia. *International Journal of Transgenderism*. doi:10.1080/15532739.2019.1692751

Riley, E. A., Clemson, L., Sitharthan, G., & Diamond, M. (2013). Surviving a gender-variant childhood: the views of transgender adults on the needs of gender-variant children and their parents. *Journal of Sex & Marital Therapy, 39*(3), 241-263. doi:10.1080/0092623X.2011.628439

Riley, E. A., Sitharthan, G., Clemson, L., & Diamond, M. (2013). Recognising the needs of gender-variant children and their parents. *Sex Education, 13*(6), 644-659. doi:10.1080/14681811.2013.796287

Robinson, B. A. (2018). Conditional families and lesbian, gay, bisexual, transgender, and queer youth homelessness: Gender, sexuality, family instability, and rejection. *Journal of Marriage and Family, 80*(2), 383-396. doi:10.1111/jomf.12466

Schimmel-Bristow, A., Haley, S. G., Crouch, J. M., Evans, Y. N., Ahrens, K. R., McCarty, C. A., & Inwards-Breland, D. J. (2018). Youth and caregiver experiences of gender identity transition: A qualitative study. *Psychology of*

Sexual Orientation and Gender Diversity, 5(2), 273-281. doi:10.1037/sgd0000269

Serano, J. (2020). Julia's trans, gender, sexuality, & activism glossary! Retrieved from http://www.juliaserano.com/terminology.html

Shelton, J. (2015). Transgender youth homelessness: Understanding programmatic barriers through the lens of cisgenderism. *Children & Youth Services Review, 59*, 10-18. doi:10.1016/j.childyouth.2015.10.006

Shelton, J. (2016). Reframing risk for transgender and gender-expansive young people experiencing homelessness. *Journal of Gay & Lesbian Social Services, 28*(4), 277-291. doi:10.1080/10538720.2016.1221786

Shelton, J., & Bond, L. (2017). 'It just never worked out': How transgender and gender expansive youth understand their pathways into homelessness. *Families in Society: Journal of Contemporary Social Services, 98*(4), 284-291. doi:10.1606/1044-3894.2017.98.33

Shelton, J., Wagaman, M. A., Small, L., & Abramovich, A. (2018). I'm more driven now: Resilience and resistance among transgender and gender expansive youth and young adults experiencing homelessness. *International Journal of Transgenderism, 19*(2), 144-157. doi:10.1080/15532739.2017.1374226

Silverman, D. (2013). *Doing qualitative research* (4th ed.). Los Angeles: Sage.

Simons, L., Schrager, S. M., Clark, L. F., Belzer, M., & Olson, J. (2013). Parental support and mental health among transgender adolescents. *J Adolesc Health, 53*(6), 791-793. doi:10.1016/j.jadohealth.2013.07.019

Singh, A. A. (2013). Transgender youth of color and resilience: Negotiating oppression and finding support. *Sex Roles: A Journal of Research, 68*(11-12), 690-702. doi:10.1007/s11199-012-0149-z

Singh, A. A., Meng, S. E., & Hansen, A. W. (2014). "I am my own gender": Resilience strategies of trans youth. *Journal of Counseling & Development, 92*(2), 208-218. doi:10.1002/j.1556-6676.2014.00150.x

Stonewall. (2017). *School report: The experiences of lesbian, gay, bi and trans young people in Britain's schools in 2017*. Retrieved from https://www.stonewall.org.uk/system/files/the_school_report_2017.pdf

Testa, R. J., Michaels, M. S., Bliss, W., Rogers, M. L., Balsam, K. F., & Joiner, T. (2017). Suicidal ideation in transgender people: Gender minority stress and interpersonal theory factors. *Journal of Abnormal Psychology, 126*(1), 125-136. doi:10.1037/abn0000234

Thiagarajan, P., & McKimm, J. (2019). Mapping transactional analysis to clinical leadership models. *Br J Hosp Med (Lond), 80*(10), 600-604. doi:10.12968/hmed.2019.80.10.600

Thorne, S. (2017). Metasynthetic Madness: What Kind of Monster Have We Created? *Qual Health Res, 27*(1), 3-12. doi:10.1177/1049732316679370

Wilson, B. D. M., Cooper, K., Kastanis, A., & Nezhad, S. (2014). Sexual and gender minority youth in foster care: Assessing disproportionality and disparities in Los Angeles.

Women and Equalities Committee: Transgender equality. (2016). House of Commons Retrieved from

https://publications.parliament.uk/pa/cm201516/cmselect/cmwomeq/390/390.pdf

Tables

Table 1: *Noblit and Hare's seven phase metasynthesis (meta-ethnography) procedure*.

Phase	Actions
1	**Getting Started**: Identification of a research question.
2	**Deciding what is relevant to the initial interest**: Establishing inclusion and exclusion criteria for articles, conducting a literature search and arriving at a set of suitable articles to review.
3	**Reading the studies**: extracting second order (article author) interpretations, and first order (participant) descriptions from each article. this review.
4	**Determining how the studies are related**: Compiling a list of keywords and phrases as a basis for third order (reviewer) interpretations
5	**Translating the studies into one another**: Formation of themes and categories based on how the third order interpretations fit together.
6	**Synthesising translations**: expressing themes and evidence to support them from data extracted from the articles
7	**Expressing the synthesis**: presenting the synthesis in a way which will be of practical use to the target audience. This may be diagrammatic if appropriate.

Table 2: SPIDER Search Terms

Spider Element	Search Term
S – Sample	“cross dress*” OR “cross sex” OR crossgender OR F2M OR “female-to-male” OR R “gender change” OR “gender dysphoria” OR “gender identity” OR “gender minorit*” OR “gender queer” OR genderqueer OR genderqueer OR intersex OR M2F OR “male-to-female” OR “non-binary” OR “trans female” OR “trans feminin*” OR “trans male” OR transman OR “trans man” OR “trans masculin*” OR “trans men” OR “trans people” OR “trans person” OR transwoman OR “trans woman” OR “trans women” OR “trans-sexuality” OR transexual* OR transgender* OR transsexual* OR transvest* OR “gender questioning” OR “ gender non-conforming” OR TGNC OR “gender divers*”
PI – Phenomenon of Interest	famil* OR child* OR youth OR young OR adolescen* OR parent* OR mother* OR father* OR caregiver OR “care giver*” OR sibling* OR kin OR relation* OR relative* OR home* OR house* **Plus, for checking for existing reviews** AND (“literature review” OR “systematic review” OR metasynthesis OR “meta synthesis” OR meta-ethnography OR “meta analysis” OR review)
D- Design	interview* OR "focus group*" OR "case stud*” OR “content analysis” OR “discourse analysis” OR “action research” OR ethnog* OR “ethnological research” OR “grounded theory” OR “thematic analysis” OR narrative* OR phenomenolog*
E – Evaluation	experienc* OR view* OR opinion* OR percept* OR belie* OR feel* OR know* OR understand* OR “life story”
R – Research Type	qualitative OR "mixed method"

Search string was as follows: [S AND PI] AND [(D OR E) AND R]

With S, PI, D & E searched on ‘title and abstract’ and R searched on ‘all text’

Table 3: Study Details

Study No.	Author(s)	Year	Country	Participants (Youth only)	Ethnicity	Recruitment Setting	Research Question/Aims	Data Collection Method	Analysis
1	Johnson, LeBlanc, Sterzing, Deardorff, Antin & Bockting.	2020	USA: New York & San Francisco	N=24 16-20 years old 1 Female 1 Male 4 Trans female 8 Trans Male 8 Non-Binary 2 Agender	9 White 5 Black 4 Latinx 3 Asian 2 Mixed Race 1 Middle East	50% through a trans identiy project 50% through clinics and non-profit organisations	To describe youth accounts of parental behaviours towards trans youth and youth perception of the consequences of those actions	Two in depth interviews with each participant including visual, participant-driven methods	Thematic analysis
2	Katz-Wise, Budge, Fugate, Flanagan, Touloumtzis, Rood, Perez-Brumer & Leibowitz.	2017	USA: Midwest Northeast South	N=16 7-18 years old 9 Trans boy 5 Trans girl 1 Gender fluid boy 1 Girlish boy	14 White 2 Multiracial	LGBTQ community organisations and support networks for families of trans youth	To integrate trans and gender non-conforming youth and caregiver perspectives on trans identity developmental pathways	Semi-structured interviews with separate protocols for youth and caregivers	Thematic analysis
3	Kuper, Wright & Mustanski.	2018	USA Midwest	N=20 19-22 years old 4 Transmale 7 Transfemale 1 Stud (half/half) 4 Female 2 Male 1 Gender Fluid 1 Androgynous	10 African American 5 White 2 Multiracial 1 Belizean 1 Biracial 1 Hispanic	Community - using flyers in LGBT youth centres, neighbourhoods, email avertisement and incentivised peer recruitment	To investigate similarities and differences in the gender related experiences of trans and gender non-conforming 'emerging adults'.	Semi-structured interviews with focus on 5 areas including family and other relationships	Constructivist grounded theory

Study No.	Author(s)	Year	Country	Participants (Youth only)	Ethnicity	Recruitment Setting	Research Question/Aims	Data Collection Method	Analysis
4	Mountz, Capous-Desyllas & Pourciau.	2018	USA Los Angeles	N=7 18-26 years old 2 Transmale 2 Transfemale 1 Gender fluid 1 Demi/tri-gender 1 Intersex	2 Black 1 Black & Asian 1 Black, Native & Asian 1 Latino 1 Latino & White 1 Native	Community - targetted and snowball sampling via flyers, social media and social service organisations	To examine factors contributing to resilience of trans youth in the child welfare system, with attention paid to the fact that most are youth of colour	In depth interviews of 1-3 hours	Thematic analysis using a consensual qualitative research approach
5	Riggs, Bartholomaeus & Sansfacon.	2019	Australia: Victoria & S.Australia	N=10 Average age 14.3 5 Male 4 Female 1 Non-Binary	Not reported	Through a group run by parents of gender diverse children	To investigate how trans youth and parents experience gender services and how this was shaped by institutional factors and parent views	Interviews conducted as child-parent dyad	Thematic analysis

Study No.	Author(s)	Year	Country	Participants (Youth only)	Ethnicity	Recruitment Setting	Research Question/Aims	Data Collection Method	Analysis
6	Riley, Clemson, Sitharthan & Diamond.	2013 *	50 USA 30 Australia 8 Canada 7 UK 2 France 2 Japan 2 S. Africa 1 Mexico 1 Norway 7 No Reply	N=110 10 aged 18-25 39 aged 26-45 57 aged 46-65 4 aged 66+ 18 Transgender 20 Transman 33 Transwoman 22 Female 5 Male 1 Two-spirit 1 Masc. Genderqueer 1 Androgyne 3 No Label	Not reported	Advertisement in various media and via academic listing related to gender, followed by snowball sampling	Inquiry into the childhood experiences of trans adults to explore met and unmet needs of themselves and their parents	Internet Survey of trans adults asking about childhood experiences. Included closed (demographic) and open (experiential) questions.	Grounded Theory using thematic and content analysis
7	Riley, Sitharthan, Clemson & Diamond.	2013 *	Australia & Worldwide but not specified - see note* below	N=110 Age range and identities not specified - see note* below	Not reported	Advertisement in various media and via academic listing related to gender, followed by snowball sampling	To identify the needs of gender variant children (aged 12 or under) and their parents to evidence better programmes, training and policies to support them.	Internet Surveys of parents of trans youth, professionals and trans adults (asking about childhood experiences). Included closed (demographic) and open (experiential) questions.	Grounded Theory using thematic and content analysis

Study No.	Author(s)	Year	Country	Participants (Youth only)	Ethnicity	Recruitment Setting	Research Question/Aims	Data Collection Method	Analysis
8	Schimmel-Bristow, Haley, Crouch, Evans, Ahrens, McCarty & Inwards-Breland.	2018	USA Seattle	N=15 14-22 years old 3 Trans-feminine 7 Trans-masculine 2 Genderqueer 1 Gender fluid 1 Non-binary 1 Androgynous	10 White 1 Hispanic 1 Native American 3 Multiracial	Health clinic for trans youth and a local support group's listserv.	To get a first hand perspective of how trans youth and their families experience transition.	one to one interviews and focus groups	Deductive thematic analysis
9	Shelton	2015 **	USA New York	N=27 18-25 years old All identified as trans or gender non-conforming but 'labels' not reported. Pronouns reported as: 14 She/Her 8 He/Him 1 Ze/They 4 Don't care	10 Black 9 Mixed Race 4 Hispanic 4 White	Purposive sampling via LGBT youth centres and homelessness centres	To understand the experiences of trans youth accessing shelter for homeless use and how cisgenderism created barriers in this situation	Semi-Structured Interview	Phenomenological Analysis

Study No.	Author(s)	Year	Country	Participants (Youth only)	Ethnicity	Recruitment Setting	Research Question/Aims	Data Collection Method	Analysis
10	Shelton	2016 **	USA New York	N=27 18-25 years old 10 Transfemale 3 Transmale 5 Woman 2 Man 5 Multiple labels 1 Don't care 1 Boy/girl	10 Black 9 Mixed Race 4 Hispanic 4 White	Purposive sampling via LGBT youth centres and homelessness centres	To understand trans youth experiences of homelessness in terms of risk, but also beyond risk to see how homelessness can build resilience and sometimes reduce risk	Semi-structured interview	Phenomenological Analysis
11	Shelton & Bond	2017 **	USA New York	N=27 Most aged 21-25 All participants trans or gender expansive	10 Black 9 Mixed Race 8 Other**	Purposive sampling via LGBT youth centres and homelessness centres	To better understand how gender identity and homelessness have meaning for trans youth in terms of their journey into homelessness.	Semi-structured interview	Phenomenological Analysis
12	Shelton, Wagaman, Small & Abramovich.	2018 **	USA New York	N=27 18-25 years old 10 Transfemale 3 Transmale 5 Woman 2 Man 5 Multiple labels 1 Don't care 1 Boy/girl	10 Black 9 Mixed Race 4 Hispanic 4 White	Purposive sampling via LGBT youth centres and homelessness centres	How do trans youth experiencing homelessness demonstrate resilience in the midst of oppressive structures?	Semi-structured interview	Phenomenological Analysis

Study No.	Author(s)	Year	Country	Participants (Youth only)	Ethnicity	Recruitment Setting	Research Question/Aims	Data Collection Method	Analysis
13	Singh	2013	USA Southeast	N=13 15-24 year old 5 Transman 5 Transwoman 2 Genderqueer 1 Gender fluid	4 African American 2 Black 2 Chicana 2 Pacific Island 2 Mutiracial 1 Latino	Organisations serving transgender youth of colour	What are the resilience strategies transgender youth of colour (use) as they negotiate intersections of transprejudice and racism?	Semi-structured interview	Phenomenolo gical Analysis
14	Singh, Meng & Hansen	2014	USA 10 Southeast 3 Midwest 1 Northeast 1 Northwest 4 Unreported	N=19 15-25 years old 11 Transman 2 Female to male 3 Male 2 Genderqueer 1 Male to female	13 White 3 Mutiracial 2 African American 1 Pacific Island	Via trans focussed listservs, facebook and twitter	To examine supports and challenges to trans youth development of resilience	Semi-structured interview	Phenomenolo gical Analysis

Table 4: *CASP Quality approval of studies*

Study #	First Author	Year	CASP Screening		CASP Scoring**									Additional papers in ref. list: used (read)	Relevance 1= low 2= medium 3= high
			Q1.	Q2.	Q3.	Q4.	Q5.	Q6.	Q7.	Q8.	Q9.	Q10.	Score (8-24)		
1	Johnson	2020	Y	Y	3	3	3	3	1	3	3	3	22	1(2)*	3
2	Katz-Wise	2017	Y	Y	2	3	3	3	2	3	3	2	21	1(2)*	1
3	Kuper	2018	Y	Y	2	3	3	3	1	3	3	3	21	0	1
4	Mountz	2018	Y	Y	3	3	3	2	1	1	3	3	19	0	2
5	Riggs	2019	Y	Y	2	3	3	1	3	2	2	2	18	0	2
6	Riley, Clemson et al.	2013	Y	Y	3	3	2	1	2	3	3	3	20	0	3
7	Riley, Sitharthan et al.	2013	Y	Y	3	2	2	1	1	3	3	3	18	0	3
8	Schimmel-Bristow	2018	Y	Y	2	2	3	2	1	2	2	2	16	0(1)	1
9	Shelton	2015	Y	Y	3	3	3	2	2	3	3	3	22	0(1)	3
10	Shelton	2016	Y	Y	3	3	3	2	1	3	3	3	21	0(1)	3
11	Shelton	2017	Y	Y	3	3	2	1	1	3	2	2	17	0	2
12	Shelton	2018	Y	Y	3	3	3	1	1	3	3	3	20	0(1)	3
13	Singh	2013	Y	Y	3	3	3	3	2	3	3	3	23	0(2)	2
14	Singh	2014	Y	Y	3	2	3	3	1	3	3	3	21	0	2

* Both additional papers were the same - so actually only one new paper was added - Singh (2014) which referenced no additional suitable papers itself.

** QUESTIONS – Scored; 1 = weak, 2 = moderate, 3 = strong. (Duggleby et al., 2010)

1. Was there a clear statement of the research aims? (Y/N)
2. Is qualitative methodology appropriate? (Y/N)
3. Was the research design appropriate to address the aims of the research?
4. Was the recruitment strategy appropriate to the aims of the research?
5. Was data collected in a way that addressed the research issue?
6. Has the relationship between the researcher and participants been adequately considered?
7. Have ethical issues been taken into consideration?
8. Was the data analysis sufficiently rigorous?
9. Is there a clear statement of findings?
10. How valuable is the research?

Figures

Figure 1: Filtering Studies

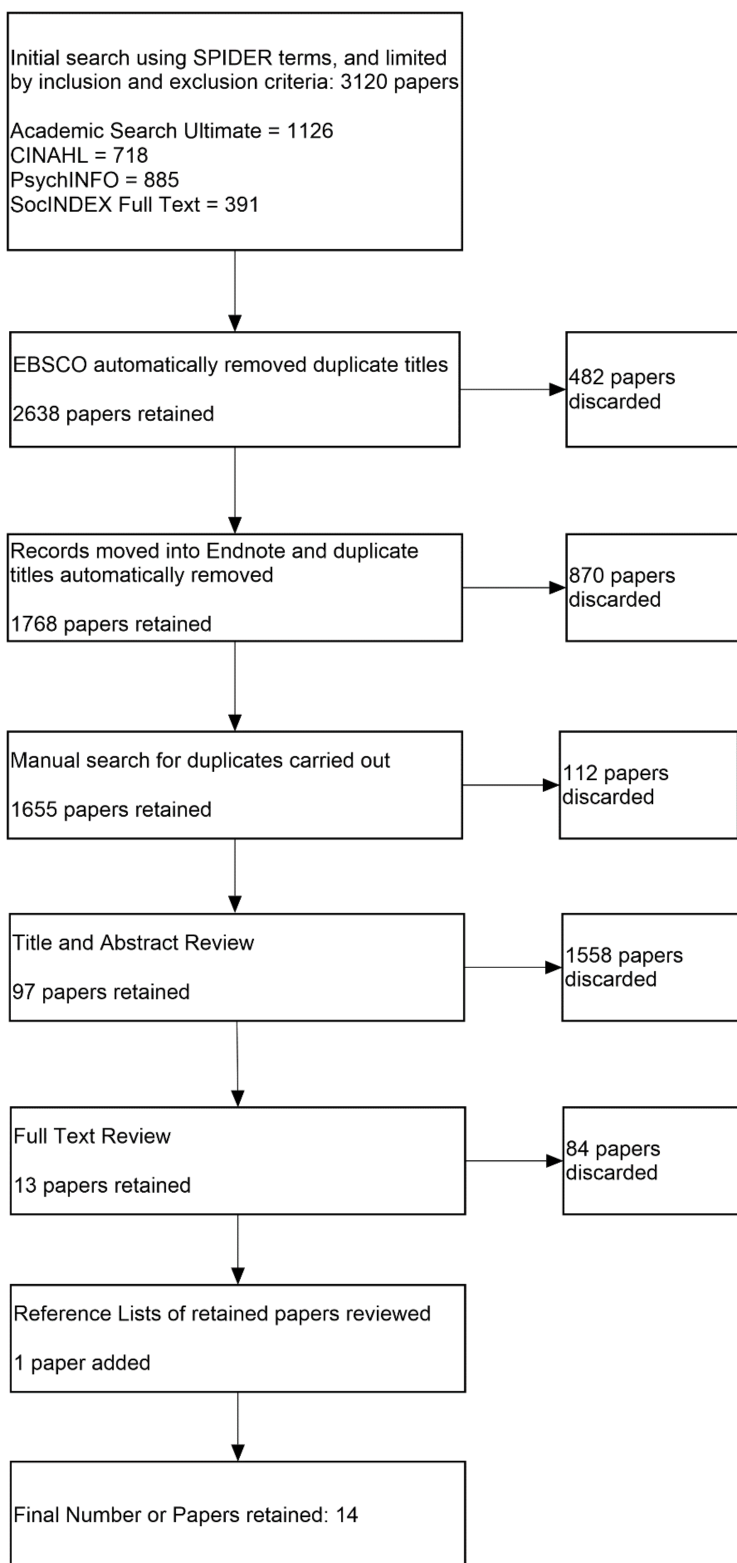


Figure 2: Viscosity Model of Youth Perception of Caregiver Messages

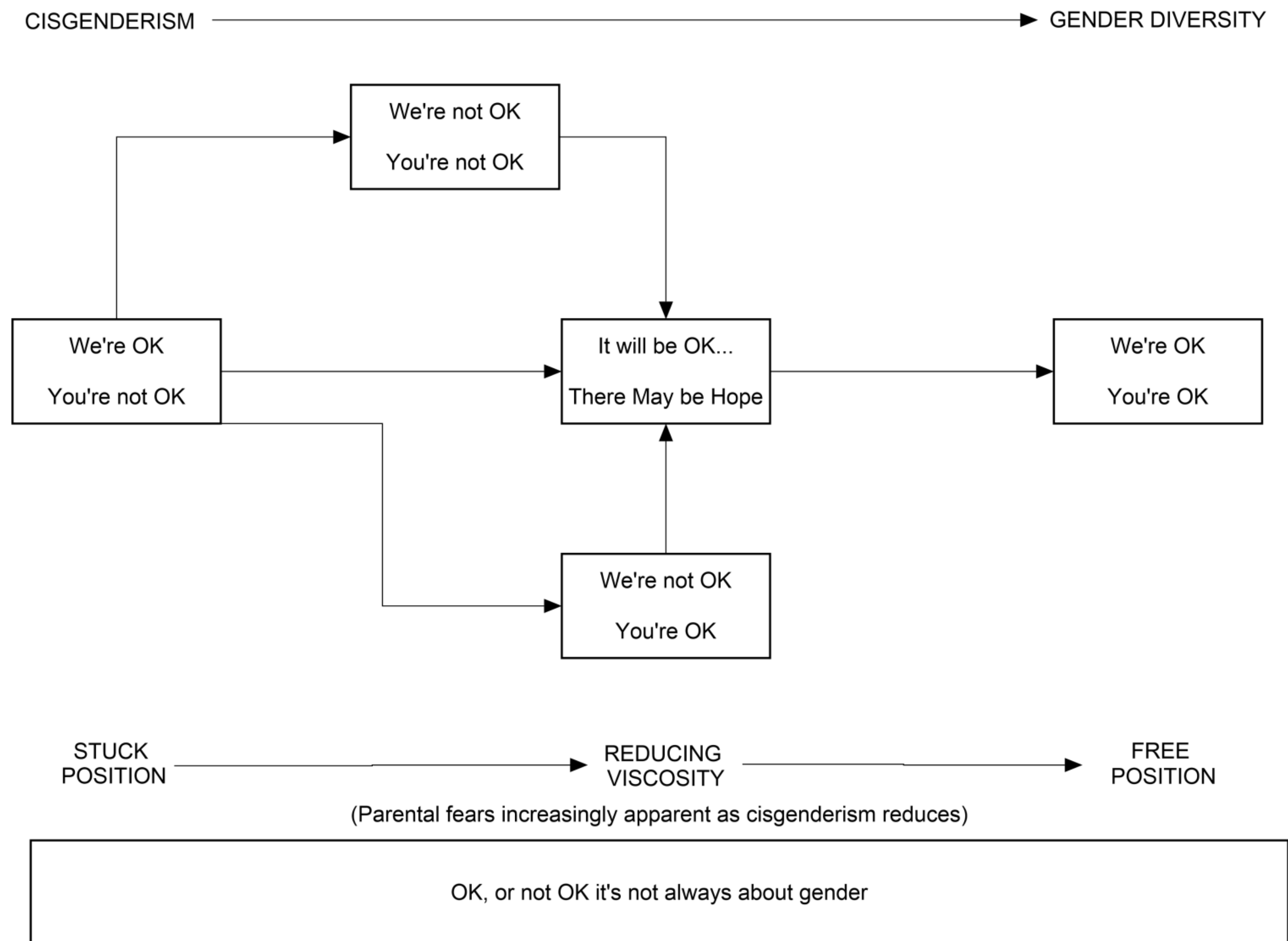
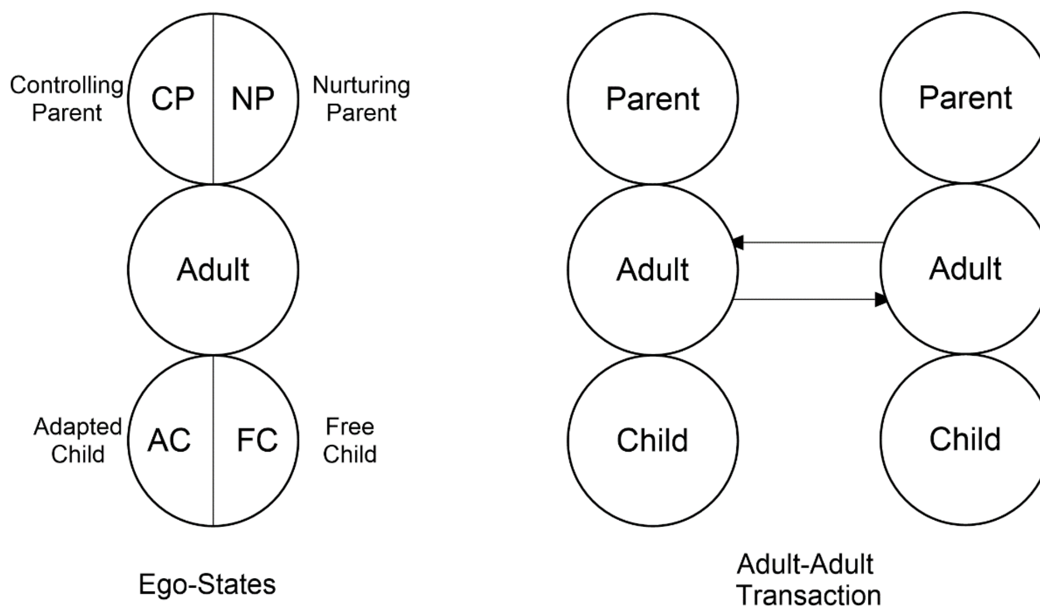


Figure 3: Parent-Adult-Child (PAC) Model



Appendices

Appendix 1.1: Journal Submission Guidelines

N.B.: These guidelines serve for both the literature review and the research article.

Journal of GLBT Family Studies: Instructions for authors

Thank you for choosing to submit your paper to us. These instructions will ensure we have everything required so your paper can move through peer review, production and publication smoothly. Please take the time to read and follow them as closely as possible, as doing so will ensure your paper matches the journal's requirements.

For general guidance on every stage of the publication process, please visit our Author Services website.

For editing support, including translation and language polishing, explore our Editing Services website

This journal uses ScholarOne Manuscripts (previously Manuscript Central) to peer review manuscript submissions. Please read the guide for ScholarOne authors before making a submission. Complete guidelines for preparing and submitting your manuscript to this journal are provided below.

About the Journal

Journal of GLBT Family Studies is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

Please note that this journal only publishes manuscripts in English.

Journal of GLBT Family Studies accepts the following types of article: original articles.

Peer Review and Ethics

Taylor & Francis is committed to peer-review integrity and upholding the highest standards of review. Once your paper has been assessed for suitability by the editor, it will then be peer reviewed by independent, anonymous expert referees. Find out more about what to expect during peer review and read our guidance on publishing ethics.

Preparing Your Paper

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as

appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

Word Limits

Please include a word count for your paper. There are no word limits for papers in this journal.

Style Guidelines

Please refer to these quick style guidelines when preparing your paper, rather than any published articles or a sample copy.

Please use American spelling style consistently throughout your manuscript.

Please note that long quotations should be indented without quotation marks.

Formatting and Templates

Papers may be submitted in Word or LaTeX formats. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting template(s).

Word templates are available for this journal. Please save the template to your hard drive, ready for use.

If you are not able to use the template via the links (or if you have any other template queries) please contact us here.

References

Please use this reference guide when preparing your paper.

Taylor & Francis Editing Services

To help you improve your manuscript and prepare it for submission, Taylor & Francis provides a range of editing services. Choose from options such as English Language Editing, which will ensure that your article is free of spelling and grammar errors, Translation, and Artwork Preparation. For more information, including pricing, visit this website.

Checklist: What to Include

1. Author details. All authors of a manuscript should include their full name and affiliation on the cover page of the manuscript. Where available, please also include ORCiDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes

to affiliation can be made after your paper is accepted. Read more on authorship.

2. Should contain an unstructured abstract of 200 words.
3. You can opt to include a video abstract with your article. Find out how these can help your work reach a wider audience, and what to think about when filming.
4. Between 3 and 6 keywords. Read making your article more discoverable, including information on choosing a title and search engine optimization.
5. Funding details. Please supply all details required by your funding and grant-awarding bodies as follows:

   For single agency grants

   This work was supported by the [Funding Agency] under Grant [number xxxx].

   For multiple agency grants

   This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].
6. Disclosure statement. This is to acknowledge any financial interest or benefit that has arisen from the direct applications of your research. Further guidance on what is a conflict of interest and how to disclose it.
7. Data availability statement. If there is a data set associated with the paper, please provide information about where the data supporting the results or analyses presented in the paper can be found. Where

applicable, this should include the hyperlink, DOI or other persistent identifier associated with the data set(s). Templates are also available to support authors.

8. Data deposition. If you choose to share or make the data underlying the study open, please deposit your data in a recognized data repository prior to or at the time of submission. You will be asked to provide the DOI, pre-reserved DOI, or other persistent identifier for the data set.
9. Supplemental online material. Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. We publish supplemental material online via Figshare. Find out more about supplemental material and how to submit it with your article.
10. Figures. Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour, at the correct size). Figures should be supplied in one of our preferred file formats: EPS, PS, JPEG, TIFF, or Microsoft Word (DOC or DOCX) files are acceptable for figures that have been drawn in Word. For information relating to other file types, please consult our Submission of electronic artwork document.
11. Tables. Tables should present new information rather than duplicating what is in the text. Readers should be able to interpret the table without reference to the text. Please supply editable files.

12. Equations. If you are submitting your manuscript as a Word document, please ensure that equations are editable. More information about mathematical symbols and equations.
13. Units. Please use SI units (non-italicized).

Using Third-Party Material in your Paper

You must obtain the necessary permission to reuse third-party material in your article. The use of short extracts of text and some other types of material is usually permitted, on a limited basis, for the purposes of criticism and review without securing formal permission. If you wish to include any material in your paper for which you do not hold copyright, and which is not covered by this informal agreement, you will need to obtain written permission from the copyright owner prior to submission. More information on requesting permission to reproduce work(s) under copyright.

Submitting Your Paper

This journal uses Routledge's Submission Portal to manage the submission process. The Submission Portal allows you to see your submissions across Routledge's journal portfolio in one place. To submit your manuscript please click here.

If you are submitting in LaTeX, please convert the files to PDF beforehand (you will also need to upload your LaTeX source files with the PDF).

Please note that Journal of GLBT Family Studies uses Crossref™ to screen papers for unoriginal material. By submitting your paper to Journal of GLBT Family Studies you are agreeing to originality checks during the peer-review and production processes.

On acceptance, we recommend that you keep a copy of your Accepted Manuscript. Find out more about sharing your work.

Data Sharing Policy

This journal applies the Taylor & Francis Basic Data Sharing Policy. Authors are encouraged to share or make open the data supporting the results or analyses presented in their paper where this does not violate the protection of human subjects or other valid privacy or security concerns.

Authors are encouraged to deposit the dataset(s) in a recognized data repository that can mint a persistent digital identifier, preferably a digital object identifier (DOI) and recognizes a long-term preservation plan. If you are uncertain about where to deposit your data, please see this information regarding repositories.

Authors are further encouraged to cite any data sets referenced in the article and provide a Data Availability Statement.

At the point of submission, you will be asked if there is a data set associated with the paper. If you reply yes, you will be asked to provide the DOI, pre-registered DOI, hyperlink, or other persistent identifier associated with the data set(s). If you have selected to provide a pre-registered DOI, please be prepared to share the reviewer URL associated with your data deposit, upon request by reviewers.

Where one or multiple data sets are associated with a manuscript, these are not formally peer reviewed as a part of the journal submission process. It is the author's responsibility to ensure the soundness of data. Any errors in the data rest solely with the producers of the data set(s).

Publication Charges

There are no submission fees, publication fees or page charges for this journal.

Colour figures will be reproduced in colour in your online article free of charge. If it is necessary for the figures to be reproduced in colour in the print version, a charge will apply.

Charges for colour figures in print are £300 per figure ($400 US Dollars; $500 Australian Dollars; €350). For more than 4 colour figures, figures 5 and above will be charged at £50 per figure ($75 US Dollars; $100 Australian Dollars; €65). Depending on your location, these charges may be subject to local taxes.

Copyright Options

Copyright allows you to protect your original material, and stop others from using your work without your permission. Taylor & Francis offers a number of different license and reuse options, including Creative Commons licenses when publishing open access. Read more on publishing agreements.

Complying with Funding Agencies

We will deposit all National Institutes of Health or Wellcome Trust-funded papers into PubMedCentral on behalf of authors, meeting the requirements of their respective open access policies. If this applies to you, please tell our production team when you receive your article proofs, so we can do this for you. Check funders' open access policy mandates here. Find out more about sharing your work.

Open Access

This journal gives authors the option to publish open access via our Open Select publishing program, making it free to access online immediately on publication. Many funders mandate publishing your research open access; you can check open access funder policies and mandates here.

Taylor & Francis Open Select gives you, your institution or funder the option of paying an article publishing charge (APC) to make an article open access. Please contact openaccess@tandf.co.uk if you would like to find out more, or go to our Author Services website.

For more information on license options, embargo periods and APCs for this journal please go here.

My Authored Works

On publication, you will be able to view, download and check your article's metrics (downloads, citations and Altmetric data) via My Authored Works on Taylor & Francis Online. This is where you can access every article you have published with us, as well as your free eprints link, so you can quickly and easily share your work with friends and colleagues.

We are committed to promoting and increasing the visibility of your article. Here are some tips and ideas on how you can work with us to promote your research.

Article Reprints

You will be sent a link to order article reprints via your account in our production system. For enquiries about reprints, please contact the Taylor & Francis Author Services team at reprints@tandf.co.uk. You can also order print copies of the journal issue in which your article appears.

Queries

Should you have any queries, please visit our Author Services website or contact us here.

Appendix 1.2: Article Translation

Third Order Categories: The received message	Third Order Themes	Third Order Keywords/ Phrases	Second Order Themes	First order Description	Studies
1. We're ok - You're not ok Re-enforcing gender norms	Your gender identity is not real	Dismissed, not believing, gender norms, microaggression	**Non-Affirmation**	Dismissed, not believing, not acknowledging or respecting name/pronoun	1
		LGB…T?	**Accepting some identities but not others**	Embracing sexuality but not gender, Accepting gender but being homophobic	1
		Ignorance Gender Norms Microaggresion Not getting it	**Lack of Worker and Caregiver Competency**	chronic incompetence, misgendering, denying identity, 'forgetting' or refusing pronouns/name, forcing normed clothing, workers creating non-affirming environment jointly with other youth, not getting it.	4
		Gender Norms Not Getting it Prejudice	**(NEED) For Parents to Transcend their Cultural Heritage, Familial Influences and Religion to Develop Acceptance of Gender Variance in their Children**	boys cannot be girls and vice-versa, homophobic and transphobic culture of which they were a product, old-fashioned, bigoted, close-minded, would never have understood,	6

Third Order Categories: The received message	Third Order Themes	Third Order Keywords/ Phrases	Second Order Themes	First order Description	Studies
		Dysphoria, Gender Norms	**Physical Presentation**	often not acknowledged as true gender, waiting for surgery to look right, own sense of gender devalued,	9
		Gender Norms	**Feeling Misunderstood**	No box for you, judgement and discrimination, relentless questions, verbal harassment, wondering what people are thinking	9
		Not Believing Prevented Cured Agency	**Experiences of Adultism**	Children seen as extension of parents, belief that trans is a phase, can be treated using conversion therapy, can just be ignored, culture of disbelieving children	14
		Microaggression Distress	**Emotional and social isolation**	I hang out with my mom once a week and she purposely uses the wrong pronouns and the wrong name. It's very upsetting that they don't even try.	14
	We will put obstacles in your way	Prevention Sanction Isolation Cure?	**Activity Restriction**	Taking away phone/internet access, cutting off from (trans) social networks	1

Third Order Categories: The received message	Third Order Themes	Third Order Keywords/ Phrases	Second Order Themes	First order Description	Studies
		Prevention Sanction	**Instrumental Support Restriction**	Refusing to help buy gender appropriate clothing or trans apparel (e.g. binders), Threatening to cut off financial support/remove from college/make homeless if go ahead with medical procedures	1
		Prevention Sanction Gender norms	**Blocking Access to Gender Affirming Medical Care**	Withholding legal permission for procedures or hormones	1
		Gender norms enforced, self-suppression, gender norms challenged	**Gender Presentation**	Being forced to wear inappropriate clothing, having to lead a double life - go elsewhere to be 'self'	3
		Fear Gender norms enforced Self-Suppression Avoiding conflict	**Exploration**	Fear of parents reaction limiting gender exploration, denial based on relationship with parents inhibiting transition	3
		Instability Lack of Choice Self-Suppression	**Integration**	financial instability meaning need to return home and supress identiy due to unsupportive parents	3
		Systemic barriers	**Increased placement disruption**	discriminatory policies	4

Third Order Categories: The received message	Third Order Themes	Third Order Keywords/ Phrases	Second Order Themes	First order Description	Studies
		Ignored Dismissed Systemic Barriers	**Barriers to Accessing Gender-Affirming Medical Care**	Not even acknowledging request for help, told to keep quiet, systemic barriers even where workers supportive.	4
		Distress Parental Discord	**Parents as Barriers or Facilitators**	Distress of waiting for a decision when one parent refuses consent (most commonly men, in couples who had separated)	5
		Prevention	**(NEED) To be protected - Not Bullied, Harassed, Blamed, Shamed or Attacked**	not being allowed to do what I want to do, being who people expected me to be	6
		Systemic Barriers	**The Pivotal Role of Programs**	Barriers in programs due to cisgenderist policies such as policies designed to encourage independence which were inflexible in the face of trans youth issues	9
		Systemic Barriers Good Intentions Gender Norms	**Unique needs of transgender and gender expansive young people**	Systemic barriers designed to promote independence without the support to meet the rules… seeking out centres where competent care is available, most centres not designed with trans needs in mind.	9

Third Order Categories: The received message	Third Order Themes	Third Order Keywords/ Phrases	Second Order Themes	First order Description	Studies
		Prevented	**Physical Presentation**	lack of support to deal with trans issues e.g. facial hair, affirmation would have made a huge difference.	9
		LGB…T?	**Feeling Misunderstood**	Even 'LGBT Friendly' services not catering for needs of trans people, cisgender setup	9
		systemic barriers	**Feeling Misunderstood**	cisgender setup - even in lgbt organisations	9
		Systemic Barriers Good Intentions Gender Norms	**Employment Related Needs** **AND** **Identification and Employment**	Rules intended to help youth to help themselves (requirement to have job or be enrolled in school to qualify for a bed) are a barrier to trans youth - employers who won’t employ trans people, not having clothing etc to pass, trans people feeling unsafe at school. Further to which, lack of access to correctly gendered documentation and rigid approach by centres who could allow time to sort this out	9

Third Order Categories: The received message	Third Order Themes	Third Order Keywords/ Phrases	Second Order Themes	First order Description	Studies
	We will fix you	Evicted, cure	**(NEED) For Parents to Love and Value the Child and Provide Space for Them to Talk about Their Feelings**	Forced to leave home, sent to an all boys school in order to effect a cure	6
		Gender Norms Cure	**To be Heard**	I did not think I could tell anyone, When I did tell I got a clear message I was doing wrong, boarding school to cure me. Being put in a mental institution if I told anyone.	7
		Mental Health Impact Self-Suppression Gender Norms	**Reframing of Mental Health Challenges**	Addressing mental health by being normal, Autistic trans youth - I try to pass as normal for the family, staying away from conversation which indicates I'm not what I seem,	14
		Cure Microaggression Gender Norms	**Gender Policing**	My parents took me to an 'ex gay' clinic, not helpful, pathologising mother not using name, hard to predict when gender policing will occur.	14
	We will abuse you	Not getting it, ridicule, tough love, not caring	**Empathic Failure**	Being ridiculed and not having distress/dysphoria recognised	1

Third Order Categories: The received message	Third Order Themes	Third Order Keywords/ Phrases	Second Order Themes	First order Description	Studies
		Prejudice, danger, cure	**Harassment**	transphobic comments and deliberate public assertion of birth sex	1
		Abuse, escape, rejection	**Increased Placement Disruption**	physical and emotional abuse (at home). couldn't take not being myself, post-care reunification less likely	4
		Ridicule Fear Still Affected	**(NEED) To be protected - Not Bullied, Harassed, Blamed, Shamed or Attacked**	being ridiculed, teased beaten & bullied by parents - still affected by this to this day	6
		Gender Norms Cure	**Fear of Abuse**	I did not think I could tell anyone, When I did tell I got a clear message I was doing wrong, boarding school to cure me. Being put in a mental institution if I told anyone.	7

Third Order Categories: The received message	Third Order Themes	Third Order Keywords/ Phrases	Second Order Themes	First order Description	Studies
		Gender Norms Fear Danger Not Believing Systemic Barriers LGB…T?	**Safety**	physical and emotional safety, real and perceived safety a barrier to wanting to access particular centres, pathologising questions. Threats from other youth, perceived threat from staff, anxiety, alienation and sense of danger, invalidating and alienating documents, communicating disbelief in gender identity LGBT - issues also in LGBT specific centres, bad remarks by staff, cisgenderism, assumptions of gender expression,	9

Third Order Categories: The received message	Third Order Themes	Third Order Keywords/ Phrases	Second Order Themes	First order Description	Studies
		Risk Gender Norms Danger Instability Prevented Mental Health Impact Escape Life Saving	**Home as a Site of Risk**	Life prior to housing instability - similar attributes to homelessness - instability, danger, risk. Connected to gender ID Name calling, insult, safer in shelter program than homes, home was risky, more risky. Stopped from expressing ID at home, but also mistreated in group homes. result: Violence and instability at home, beaten for being self, unpredictable, loving then rejecting. Would have taken own life if never left home said 1/3. Unsupportive home life profound impact. Homelessness saved lives.	10
	We will reject you	LGB…T? culture clash	**LGB but not T**	LGB parent happy to accept sexual but not gender identity, this is an American thing, not an African thing…	1
		Rejection, instability, systemic barriers, distress @ self-suppression, loss (of parents)	**Increased placement disruption based on assigned sex**	Rejection from birth family and from foster homes where placements are based on assigned sex at birth	4

Third Order Categories: The received message	Third Order Themes	Third Order Keywords/ Phrases	Second Order Themes	First order Description	Studies
		Culture Clash, limited options, couldn't take not being myself, post-care reunification less likely	**Increased Placement Disruption based on religious belief**	Not welcome at home or at foster placements because of foster parent's religious beliefs	4
		Instability Escape Disrupted Life	**Distinct Barriers to Housing, Education and Employment**	Homelessness, foster care relationship breakdown, having to leave there and then, negative experiences in foster care, mentally and physically tortured, running away disrupted education due to numerous placement moves	4
		Culture Clash Loss (of Parents)	**(NEED) For Parents to Transcend their Cultural Heritage, Familial Influences and Religion to Develop Acceptance of Gender Variance in their Children**	Gays go to hell, homophobic and transphobic culture of which they were a product, old-fashioned, bigoted, close-minded, would never have understood, still will not speak to me, religion as a barrier, imposition of a strict barrier, gender isn't a religious moral imperative.	6

Third Order Categories: The received message	Third Order Themes	Third Order Keywords/ Phrases	Second Order Themes	First order Description	Studies
		Fear Self-Suppression Gender Norms Evicted Cure Danger	**(NEED) For Parents to Love and Value the Child and Provide Space for Them to Talk about Their Feelings**	Forced to leave home, sent to an all boys school in order to effect a cure	6
		Gender Norms Instability Rejection	**Contribution of Gender Identity**	18 said Gender Identity was reason they perceived as to why they were made homeless 7 Said Gender Identity was a contributing factor 2 Said it was unrelated	11
		Gender Norms Not getting it Rejection	**Getting Kicked out (of home)**	A bad influence, 'turning' the other boys in the family Gender treatment, flipped, not in my home Locks changed, a note, don’t care where you go, your lifestyle is sick	11

Third Order Categories: The received message	Third Order Themes	Third Order Keywords/ Phrases	Second Order Themes	First order Description	Studies
		Rejection Gender Norms Comfort being Self Systemic Barriers Let Down Evicted	**Surviving in the System**	Rejection for one person came within the care system, with frequent expulsion because of her gender expression - you can't dress like a girl, that's too tight - so got my own clothes but they chucked me out. In another place I wore a skirt for school - you got to dress like a boy, i refused, they threw me out. The happiest times of my life I've been homeless - not having to answer to anybody. Let down by systemic barriers - received rejection not care. Cisgenderism.	11
2. We're not OK - You're not OK Letting go of gender norms is still too difficult to allow us to fully support you	Our fears that you are doing the wrong thing are holding us back from supporting you.	Support, but... Parental fears Loss (of Child) Empathy for parents BUT... Feeling untrusted	**Emotional support but restriction of medical intervention**	Understood as... Fears about adverse consequences, child regret, leading to blaming parents, becoming a different person - unrecognisable to parents. Children empathising with fears but feeling frustrated, feeling discouraged by lack of trust	1

Third Order Categories: The received message	Third Order Themes	Third Order Keywords/ Phrases	Second Order Themes	First order Description	Studies
	We disagree between ourselves about supporting your decisions, so you don't get supported	Distress Parental Discord	**Parents as Barriers or Facilitators**	Distress of waiting for a decision when one parent refuses consent (most commonly men, in couples who had separated)	5
3. We're not OK - You're OK Letting go of gender norms is difficult but not enough to stop us supporting you	We have concerns but we want to support you	Helped... Despite Concerns Child needs over own fears	**Assistance in Obtaining Gender Affirming Medical Care**	Often despite concerns... openess to learning, help to navigate the system, attending appointments with them	1
		Supported Effort	**Family Adjustment/Impact**	Supportive, not understanding but willing to try to learn, in shock.	2
		Helped (despite concerns) Parental Fears Loss (of child)	**Gender Transition and Reactions to Coming out from Family**	Positive but troubled about medical treatment - accepting but resistant (to hormones and stuff), also youth said parent expressed mourning - loss of kid - I have a new kid now	8

Third Order Categories: The received message	Third Order Themes	Third Order Keywords/ Phrases	Second Order Themes	First order Description	Studies
4. We're OK - You're OK Embracing New Norms	We accept and value you	Acceptance Affirmed Believed Loved Effort/Helped Honesty	**Identity Affirmation**	Acceptance, curiosity, non-judgemental, communicated support and intent to understand, using name and pronouns, buying appropriate clothes, being open about making honest mistakes	1
		Knowing me Business as usual (in a good way)	**Support**	Knowing who I was, identifying as trans didn't change anything	2
		Comfort being self	**Gender Expression**	Feeling comfortable when family treat them gender appropriately	3
		Valued	**Increased Placement Disruption**	Good Foster Home: only one experience, human rather than source of income	4
		Believed	**Children Know Who they are**	The importance of believing children (about their gender), Believing and being ok with change of child's understanding of self	5

Third Order Categories: The received message	Third Order Themes	Third Order Keywords/ Phrases	Second Order Themes	First order Description	Studies
		Business as usual (In a good way) Affirming Not Difficult	**Children value continuity of parental treatment**	Continuing to be treated the same - like a normal human being, changing the pronouns but not acting differently, changing pronouns shouldn't be that difficult or challenging	5
		Pride Acceptance	**Evolving, simultaneous Self-Defiinition of Racial/Ethnic and Gender Identities**	Influenced by family sense of pride in their ethnicity, which became stronger as her family accepted her gender identity	13
	We will support and help you	Effort/Helped Education Easier/relief	**Self-Education**	Parents willing to find out what they need to know - sincere interest to help	1
		effort/Helped Easier/relief	**Emotional Support**	support with dysphoria, discrimination and invalidation. Help to overcome barriers to help, taking time off school when feeling low	1
		Helped	**Instrumental Support**	help to buy appropriate clothes and trans apparel, help to get to support groups or medical appointments	1

Third Order Categories: The received message	Third Order Themes	Third Order Keywords/ Phrases	Second Order Themes	First order Description	Studies
		Support Helped	**Gender Transition and Reactions to Coming out from Family**	Positive support and guidance - including help to find a name.	8
		Comfort Being Self Gender Stability	**Ability to Self-Define and Theorize one's own Gender**	Family as 'supportive site', place to have conversations about defining gender, in a fluid way as well	14
	We will protect and you advocate for you	Advocacy Helped Protection	**Advocacy**	Educating extended family, checking out restaurants, pressuring school over policy, being outspoken - a cis ally	1
		Supported Protected Life Saving	**Families are important Advocates for Children**	Fighting for me about treatment and at school. Without their support I most likely wouldn't be here, importance of extended family too	5
		Shared Stress	**The Impact of the Court System**	Higher level 'caregivers' putting a strain on parents and children	5
		Shared Stress	**The Impact of Service Wait Times**	Again uncertainty putting a strain on both	5

Third Order Categories: The received message	Third Order Themes	Third Order Keywords/ Phrases	Second Order Themes	First order Description	Studies
	Alternative Caregivers	Community Access Support Acceptance	**Community Belonging**	Development of 'surrogate' families aka 'gay families', gave belonging and validation. Helpful in lots of ways, first time I was told you are ok, not constantly tearing me down. Gay father supportive and helped access to information and services	10
		Community Access Comfort being Self Education	**Access to Information**	Being supported in an LGBTQ shelter program gave access to information and understanding about self which wasn't previously available. Understanding of unacceptability at homes had made feel isolated at home and not understanding of who they were or what they could do about it. LGBT affirming service helped 'get educated and empowered - liberated me.	10
5. In time it may be OK	There May be Hope	Time as a healer	**LONGITUDINAL TRAJECTORY**	Behaviours tend to improve over time.	1

Third Order Categories: The received message	Third Order Themes	Third Order Keywords/ Phrases	Second Order Themes	First order Description	Studies
		Not getting it Empathy for Parents Moving forward	**Parent Journeys to Understanding**	Not feeling parents understood - but putting that into context of having a teenager mindset, Rolling of eyes mum says reasonably painless process - did made it harder than needed - a journey to understanding	5
		Fear Time is a Healer Education	**Gender Transition and Reactions to Coming out from Family**	Mixed reaction or change over time, supportive after educating self, Fear due to knowing dad's stance on LGBT	8
6. OK, or not OK, it's not always about gender	Homeless but supported	Moving Forward	**Searching for opportunity**	Some people were supported at home but left in search of opportunity but ended up homeless as a result.	11
	It's not always about gender…	Instability	**Continued instability**	Moving around between institutions and/or family, for a variety of reasons around perceived safety, ability to follow rules, length of stay restrictions and age - but it is not clear how much, or if, gender identity was a factor in the examples…	11

Third Order Categories: The received message	Third Order Themes	Third Order Keywords/ Phrases	Second Order Themes	First order Description	Studies
	Bad attitude towards all service users	Systemic Barriers Prejudice Gender Norms	**Societal Messages**	Whilst not so with staff one person talked about how the organisations helping the homeless perpetuated a less than message about ALL homeless youth on their website. This was in addition to negative message about their gender identity from birth family	12
	Family pride fosters pride in the person	Pride Acceptance	**Evolving, simultaneous Self-Definition of Racial/Ethnic and Gender Identities**	Influenced by family sense of pride in their ethnicity, which became stronger as her family accepted her gender identity	13
	Alternative sources of shame	Supportive Culture Clash	**Limited access to financial resources**	Family supportive of being trans - but not of prostituting herself to support herself	14

Chapter 2: Research Paper

The Trans Family Dynamics Model: A picture of parent-child interaction pre and post childhood disclosure of transgender identity

Debbie Helen Wood

Doctorate in Clinical Psychology

Division of Health Research: Lancaster University

Target Journal: *Journal of GLBT Family Studies*

Main Text word count: 7959 of 8000 words

References, Tables, Figures and Appendices word count = 6003

Abstract

Existing models of trans youth development are oriented to child OR parent perspective alone. Given that parental affirmation has been shown as protective against detrimental minority stress effects, but that identity disclosure is often conflict laden, a new model was conceptualised to investigate the dynamic between youth and parents when a trans identity is disclosed by the young person. Taking a constructivist grounded theory approach, six trans young people and eleven parents participated in a focus group and individual interviews. A two stage model with five elements resulted. Stage one involved young people forming conclusions about identity and contemplating parental reaction to possible disclosure, with parents noticing clues which they may, or may not, have acted upon to aid disclosure. Stage two involved a dynamic interaction where, broadly, the young person makes their disclosure, parents react and the young person reacts to that reaction. A combination of parental cisgenderism and concern for child safety and youth expectations were contributory to the dynamic. The resulting model is discussed relative to existing stage models, limitations highlighted and next steps considered, with the ultimate aim being to inform intervention(s) to smooth the dynamic.

Keywords: *trans*, non-binary, genderqueer, family, youth, grounded theory*

The last twenty years have witnessed an exponential increase in people expressing a gender identity beyond cisgender[1] norms, identifying as transgender (trans[2]), transsexual, non-binary, genderqueer, genderfluid, agender and gender non-conforming, amongst others (Richards & Barker, 2013; Serano, 2020). This is reflected in increased demand for gender identity services, described as a 'tsunami' in the USA (Ehrensaft, 2017). In the UK, the Gender Identity Development Service (GIDS) has seen referrals increase 28 fold in a decade from 97 in 2009/10 (GIDS, 2016) to 2728 in 2019/20 (GIDS, 2020). This period has also seen positive change in how mental health professions view trans people and support them; including reduced pathology of trans identities with e.g. 'gender identity disorder' replaced by 'gender dysphoria'[3] (Lev, 2013) and trans affirmative psychotherapy guidelines emerging e.g. (American Psychological Association, 2015; British Psychological Association, 2012, 2019).

However, challenging societal cisgenderism[4] remains difficult. In a US study, Reisner et al. (2015) found that trans youth were two-three times more likely than cisgender youth to be diagnosed with depression or anxiety and engaged in self-harm and suicidal behaviour. Grossman and D' Augelli (2007) estimated that 25% of US trans youth had attempted suicide and a UK a self-report survey by Stonewall (2017) reported that 48% of trans youth made at least one attempt compared to 13% (girls)

[1] Cisgender describes gender identity aligned to sex assigned at birth conforming to societal norms. From Latin 'cis'; 'on one side of', ergo 'non-trans'.

[2] Henceforth 'trans' is used as an umbrella for all non-cisgender identities.

[3] Gender dysphoria is the experience of incongruence between gender identity and the physical, sexed, body.

[4] Cisgenderism is the mechanism maintaining the assumption that trans identities are invalid. See also Serano (2020)

and 5% (boys) of cisgender youth. This mental health profile finds explanation in minority stress theory (Brooks, 1981; Meyer, 1995, 2003) as applied to gender minorities (Hendricks & Testa, 2012; Tan, Treharne, Ellis, Schmidt, & Veale, 2019), which describes three categories of problematic experience. External factors are interpersonal; including discrimination, abuse and rejection from family, and microaggressions; ongoing 'minor' disaffirming behaviours such as habitually using incorrect pronouns (Chang & Chung, 2015). Internal factors are twofold; expectation of discrimination by others and self-directed, socially driven, internalised transphobia (Hendricks & Testa, 2012). The necessity to disclose trans identity (aka 'coming out') or be assumed cisgender has possible consequences which bring expectation of discrimination into focus, including; losing intimacy, security and stability with significant others (Lev, 2004), rejection and disappointing family (McDermott, Hughes, & Rawlings, 2016), and links to suicidality for gender and sexual minority youth (McDermott et al., 2016). Lack of autonomy means youth transition cannot be realised without co-operation from parents or caregivers (Coolhart & Shipman, 2017) who might react with shock or hostility (Lev, 2004) or attempt to ignore it because it is unacceptable or distressing to them (Reed, Cohen-Kettenis, Reed, & Spack, 2008). Significantly Testa et al. (2017) found non-affirmation predicted delayed/non-disclosure which predicted suicidal ideation via thwarted belongingness and perceived burdensomeness. Conversely, parental support protects against poor mental health (Simons, Schrager, Clark, Belzer, & Olson, 2013) and supported social transition can reduce self-injurious behaviours to general population levels (Durwood, McLaughlin, & Olson, 2017; Hidalgo et al., 2013). This highlights the importance of understanding

the family dynamic, particularly between trans youth and parents, to management of mental health difficulties predicted by gender minority status.

Interventions do exist which take an affirmative stance to gender diversity and tend to include psycho-education for parents followed by individual or joint working towards supporting the child's gender expression. Systemic approaches inform the Trans-Formative Therapeutic Model for working with parents (Raj, 2008), the 'multi-dimensional family approach' (Malpas, 2011) and the 'family attunement' approach (Coolhart & Shipman, 2017) while Austin and Craig (2015b) present a cognitive-behavioural approach. Only the latter has been evaluated (Austin, Craig, & D'Souza, 2018) as far as known, but all have been developed from extensive experience and are based on existing models of trans experience. This includes Lev's (2004) models of transgender emergence and adult family emergence, Devor's (2004) 14 stage model of transsexual identity formation and Rosenfeld & Emerson's (1998) Staged Treatment Model (as cited in Raj, 2008) focussed on family loss and grief. However, Johnson et al. (2020) highlighted the importance of hearing both voices to understanding the interaction. These models concentrate on individual trans people or, separately, on family rather than the parent-child dynamic, so there may be important evidence which these interventions do not consider. The aforementioned tsunami of referrals places high demand on a small number of trained individuals and Parker et al. (2018) highlight the need for research and interventions to support sexual and gender minority youth which can be implemented at all levels, including non-specialist and community services.

However, the first step towards evidence based intervention is to begin the process of understanding intra-familial dynamics. Initial disclosure of identity has been shown to be a potential conflict point laden with negative expectation and so this study will investigate the process leading up to initial disclosure of a trans identity, the disclosure itself and the immediate aftermath - from parent and child perspective, by asking the question:

"What can young people and their parents tell us about the evolving dynamic between them when a young person discloses a trans identity?"

Method

Design

Qualitative methods allow researchers to connect with their participants' world view (Corbin & Strauss, 2015). Grounded theory was specifically adopted as a vehicle for interpreting qualitative data and transforming it into theory grounded in those data (Glaser & Strauss, 1967) via iterative data collection and evaluation (Walsh et al., 2015). Ideally iteration continues until theoretical saturation – i.e. collecting further data adds nothing new to theory (Charmaz, 2014), albeit in practice 'theoretical sufficiency', i.e. having enough data to construct plausible theory, is more realistic (Dey, 1999, as cited in Charmaz, 2014).

Epistemology

In contrast to Glaser and Strauss' original positivist grounded theory (Walsh et al., 2015), Charmaz (2014, 2017) presents a constructivist version explicitly acknowledging context dependence of findings and researcher influence, mandating reflexivity to minimize effect on ensuing theory. This version of grounded theory is less concerned with discovering universal truths than with developing theory on the understanding that it represents the version of events related by a usually small sample, in a social context, as seen through the researcher's lens (Charmaz, 2014; O'Connor, Carpenter, & Coughlan, 2018). It is therefore expected and accepted that the dynamic observed will be influenced by social constraints, and resulting theory influenced by the researcher's frame of reference.

Author Connection to the Topic

The author identifies as a genderqueer trans person, knows trans people socially, and previously accessed UK NHS adult gender services. They experienced childhood gender dysphoria and, in adulthood, disclosed their identity to family. They work psychotherapeutically with trans people, deliver gender diversity training and chair an LGBT charity. They hold a constructivist view of gender as largely performative and rooted in social norms (Butler, 2006), which colors expectations of parents, trans people and wider society, and that trans people are simply expressing themselves authentically – within or without a binary framework (Bornstein, 1994; Butler, 2006). To maintain research quality (Meyrick, 2006) the author's research diary includes reflections on potential bias (See extract: Appendix 2.1).

Ethical Considerations

Considering the high risk demographic (Testa et al., 2017) participants were encouraged to self-care via time out or terminating interview as necessary. Post interview, participants were facilitated to discuss strong emotions and telephone numbers for appropriate support were provided. The procedure was designed in consultation with a group of Trans youth and parents from a dedicated support group were consulted on the procedure, and input included support for project goals and using focus groups initially plus endorsement of the interview schedule.

Ethical Approval was granted by Lancaster University Faculty of Health & Medicine Research Ethics Committee. (Chapter 4).

Participants

Participants were trans youth and parents of trans youth. Trans participants met two additional inclusion criteria. Firstly they must have disclosed identity to family whilst legally a minor, i.e. under 18 in the UK, and thus experienced family dynamics with limited agency. Secondly they were aged between 16 and 32. The lower limit was guided by United Nations definition of youth; aged 15 to 24 ("Youth," n.d.) and NSPCC research guidelines (NSPCC, 2012) where 16 is the minimum age for participation without parental consent or Gillick competence. The upper limit kept experiences pertinent to modern context. The Gender Recognition Act (*Gender Recognition Act*, 2004) legally recognized binary trans identities[5], contributed to increased disclosure in the UK, and people aged 17 in 2004 would be 32 when recruitment took place. This range facilitated contributions from people currently within the family dynamic and those now removed with time to reflect. Parental inclusion was contingent on their child having disclosed whilst legally a minor. Only fluent English speakers were eligible.

Participants were recruited via local groups working with trans people and their families, and social media outlets using a press release and a poster. A (UK) national trans youth charity also publicized the research to parents. Interested parties contacted the author directly and were sent participant information, a demographics form to return by post or email, and a consent form (Chapter 4). Forty expressions of interest yielded 27 people joining a participant pool on the understanding that they

may not be selected. This allowed a degree of theoretical sampling by matching demographic information to unfolding research need. Seventeen participants were interviewed, six trans youth aged 18-24 (mean = 21), eleven parents; three male aged 46-64 (mean = 56) and eight female aged 39-65 (mean = 54) including three heterosexual couples. Two 'sets' of parents and child gave a degree of triangulation - albeit relevance for qualitative approaches is debatable (Yardley, 2000). Relationships and demographics are detailed in Table 1 and Table 2.

Data Collection and Analysis

Data were collected in phases aligned to unfolding theory. Phase one employed focus groups and phase two one-to-one interviews conducted in stages as analysis established new foci. Mixed use of focus groups and interviews endows a large initial dataset, and has precedence (e.g. Jenney, Mishna, Alaggia, & Scott, 2014; McDermott et al., 2008; Sinclair et al., 2018). Two focus groups were assembled, one consisting of trans people and one of parents. Consideration was given to interviewing complete families to allow sight of the dynamic interaction under investigation, but this was rejected on grounds that it could inhibit, particularly youth, responses (Yee & Andrews, 2006). Five parents and four trans people agreed to participate, but one parent and three trans people were subsequently unavailable. The parents' group proceeded with four participants (Martha, Joey, Rebecca and John)[6] lasting approximately 90 minutes. The remaining trans person (James) was interviewed one-

---

[5] i.e. people who change from male to female or vice versa aka 'transsexual'.
[6] See Table 1 for participant demographics – pseudonyms used throughout

to-one as re-arranging the focus group was unviable. Thirteen one-to-one interviews were conducted in seven stages, lasting between 40 and 60 minutes. The author facilitated focus group and conducted all interviews. The focus group was audio and video recorded to aid participant identification. Six interviews were conducted face-to-face and audio recorded; seven were video recorded over online platform – to reduce travel and partly resulting from Covid-19.

A semi-structured question schedule guided interviews, focusing on short and long term sequelae of disclosure (Chapter 4). This article focusses on data around disclosure and immediate aftermath. Interview(s) were transcribed verbatim, analyzed and the schedule updated to reflect emerging interest. Transcripts were anonymized including pseudonyms chosen by participants. Initial coding broadly adhered to Charmaz (2014) using gerunds to code for actions e.g. 'Making it Easier' and 'Doing it Badly', but also experiential codes, e.g. 'Just Knowing' and categorical codes e.g. 'Parental Roles'. Coding was not strictly 'line by line' but aligned to 'relevant text' (Saldaña, 2016, p. 18) from single utterances to full paragraphs. Refocused coding identified codes relevant to the narrative, organizing them into 'core categories' - analogous to themes and building blocks of inductive theory development (Charmaz, 2014). There was overlap between initial and refocused coding as the story unfolded, permissible given Charmaz's 'malleable' approach (Kenny & Fourie, 2015). Although avenues of investigation remained, theoretical sufficiency was considered satisfied after speaking to 17 participants as robust theory had emerged from the data.

Results

The data suggested a trans family dynamics model (TFDM) involving stages of; (1) contemplation and (2) disclosure and reaction (see Figure 1). Stages (3) parental disclosure and (4) ‘next steps’ are beyond the scope of this article, and discussed in Chapter 3.

Stage 1: Contemplation

Youth Contemplation

Prior to disclosure, trans youth were forming identities, contemplating others reactions and considering how to tell parents. Two questions arose; ‘who am I?’ and ‘how will my parents react?’, where ‘how’ emerged following reflection on ‘being’ the resulting ‘who’.

Who am I?

Trans youth discussed self-discovery, gender experimentation, and exploration of sexual identity; “… James, he said ‘I’ve tried to be a lesbian and I’m not.’” (Martha). Self-understanding was sometimes hampered by lacking language. Robbie said he was ‘boyish’ around nine, knew something was wrong by 14, but couldn’t name it until 16-17. For Lexi societal attitudes made her discount being trans:

> Because people usually give us some sort of like kind of like, like a joke. So it was like I just used to think oh that’s not a real thing… then I found out it was and I was like gobsmacked.

Most trans youth confided in friends and siblings initially finding reassurance, but not James; “I grew up with it (being LGBT) being normal, so when I went to school and found out it wasn’t normal I think that’s maybe, that’s when I kind of struggled with stuff.”

‘Knowing’ allowed progression, but exploration often continued; e.g. Thomas described initially settling on ‘gender neutral’, but evolving to ‘trans male’.

How will my Parents React?

Contemplating parental reaction shapes initial dynamic because youth expectation shapes disclosure. The weathervane was parental attitude to LGBT people, sometimes informed by sexual identity disclosure. Robbie’s father had experimented with sexuality in his youth; “when I first came out... as gay, he was really supportive of me then. So, I thought he’d be supportive of me through this as well”.

For some, sexual identity disclosure was a test. Thomas expected support but; “there was still that little inkling of doubt… what if it’s OK for other people but not for me.” Jack did not receive the reassurance sought; “(what) held me back from telling my parents is the way they reacted about me being bisexual”. This caused Jack to arrange alternative accommodation should he be kicked out. Eddie wondered if Ade coming out as pansexual was exploratory; “Looking back I’ve said to him was you looking into it then? He says yeah I was testing you. So, he knew a year before he even broached it with me or friends”.

There were varying degrees of concern about disclosing but all trans participants trusted, or hoped, parents would be supportive. This demonstrates strength of feeling, especially as Emily remarked; “I think… every LGBT person, has some tiny form of doubt in their head when they come out to someone new”.

Parental Contemplation

Parents meanwhile were picking up clues from child behaviours, interpreting and sometimes acting upon these to facilitate assisted disclosure.

Parents noticed preference for cross-gender behaviours and appearance, often from an early age. Joey said that Lexi preferred girls’ toys and female friends from around 18 months. Rebecca recalled not understanding why Danny did not want to wear a dress at her wedding. Robbie’s father disapproved of his cross-gender behaviour:

> I used to always go for like the boys’ toys... I used to like climbing trees, I was part of the football club and everything… when I got older I cut my hair short when I was fifteen which was another thing my dad made comments on saying that he didn’t like it and that I looked too boyish… but I quite liked that. (Robbie).

Two parents described ‘just knowing’ their children’s gender. Boo insisted on girls’ clothes and toys from an early age, but as Belle said; “they’re five, so it wasn’t, you know, they didn’t know about being transgender”. Joanne became concerned

about Andrew “At nursery he told people his name was Andrew. Everyone had to call him Andrew”. Parents wanted to help but not make decisions for their children;

> I could feel that things were changing… so I sort of helped her to find the words and, you know, not leading, it’s really tricky when they’re little, you don’t want to lead them… So I asked her, I said what do you want me to say when people say are you a boy or a girl, and so she said I want you to say I’m a girl and that was the moment I definitely knew. (Belle)

Similarly Robin employed closed questions to facilitate 12 year old Ted in expressing needs:

> So we had this conversation that started with me saying erm you know that time when somebody mistook you for a boy and I corrected them. Do you want me to stop doing that? So it was a way of giving him a kind of yes/no kind of answer to a question and then we kind of went on from there.

Finally, some parents noticed clues ‘holding them in mind’ without making connections which helped to ‘make sense of it all’ when their child eventually disclosed their identity.

Stage 2: Disclosure and Reaction

The family dynamic truly begins when the young person discloses their gender identity to parents, parents react to this disclosure and the young person reacts to their reaction. This is rarely so linear, but the endpoint influences 'parental disclosure' and 'next steps' stages - beyond the described model.

Youth Disclosure

Trans youth disclosed gender identity in various ways, and accompanying factors made this easier or harder. Participants usually told extended family, if at all, following disclosure to parents and often parents made this disclosure for them as indicated by the broken line on Figure 4.

The most straightforward approach, albeit nerve-wracking, was a conversation; James told his mother that he felt he was 'in the wrong body' and unsure what to do about it. Robbie described taking an opportunity "Well when I first told him, er I was quite nervous but he was erm, I think he was working on something so I sat down next to him and I told him". Jack planned his approach but nerves derailed him:

> I had planned that I was going to tell her in the car on the way home from school… so I had a whole hour to tell her how I felt. And then I was panicking so much that I only told her in the last two minutes...

Some were less direct. Rebecca and John got a letter from Danny; "we got the letter… a lovely long letter saying erm I've been born into a body that I don't feel comfortable with erm and I'm a boy". More dramatically, Joey received the news

second-hand after Lexi posted on social media telling friends, but not family. Thomas also told parents via text message. This indirect approach was experienced as easier by the young person, but not always by parents.

Making it Easier or Harder

James made life easier by choosing a similar name to his deadname[7]. Conversely Jack, following lack of parental acknowledgement, shaved his head to make it impossible to ignore ("it was jarring") but did not win them over. Eddie described how societal ignorance of non-binary identity means Mike has to disclose every time they meet somebody new. Emily said her mother could 'read her like a book' and gave her permission to disclose via reassurance. Robin said that Ted had delayed disclosing until he needed practical assistance. Finally, it is notable that with two exceptions disclosure was made to mothers before fathers, and sometimes mothers were relied upon to tell fathers, suggesting it was perceived as easier to tell mothers.

Telling Extended Family

Trans youth discussed difficulty disclosing to extended family and often abdicated responsibility to parents. In particular, grandparents were often seen as 'old school' and unlikely to be supportive. Jack considered delaying treatment until they "pop their clogs" convinced that they were homophobic and it would not go well. Thomas just wasn't taking the chance "I don't want to put myself in a position where

---

[7] Deadname is commonly used by trans people to describe the name given by their parents, not aligned to their gender identity, which they no longer use and generally do not wish other people to use.

I’m just going to go there and be invalidated every time.” Conversely, James was not sure why his late maternal grandmother was not told as he thought she would have been accepting.

Parental Reaction

Two initial reactions: ‘underestimated or dismissed’ and ‘this will be difficult’ distilled into either; ‘We are not OK with this’ or ‘We are OK with this’. These could be partial reactions with some parents accepting some aspects of a disclosure and not others. Five types of initial adjustments moderated ongoing reaction as shown in Figure 5 and described with examples following.

We are not OK with this:

Robbie’s dad dismissed his identity because he did not conform to masculine stereotypes despite Robbie saying that his dad did not conform either:

> …when he saw that I was actually serious he… started saying you’re not trans, you don’t…his words exactly, you look like a drag king. You look like you’re trying too hard. You don’t go into the pub to watch football. You’re sensitive so you don’t…when you’re upset you cry whereas men would just kick each other in the shin and tell each other to get over it.

Eddie described how, despite accepting pansexuality and gender fluidity, trans was a step too far and she rejected Ade’s male name and identity for a year. She was terrified of him taking medication and wanting to ‘chop apart’ his body. Most parents

had this fear even where accepting. Eddie eventually relented when she realised Ade was steadfast and is now a trans advocate.

Absent biological fathers were reported to struggle with their child's disclosure. Rebecca described Danny's biological father as generally discriminatory and that Danny feels uncomfortable when he has to visit. Similarly Andrew's father, "he can't cope with the whole er…but he doesn't see Andrew. He'll probably ring about once a year and that's it. Erm he hasn't actually said he's got a problem with it. Erm but he'll still call him Andrea when he rings" (Joanne).

We are OK with this

John and Rebecca discussed how 'being ok' was part of loving unconditionally and protecting Danny from others, including dropping unsupportive friends. John spoke of his own childhood difficulties and the importance of providing a supportive environment for Danny. Rebecca was clear that not understanding would not stand in the way of supporting her son "This is about how I can be there and support you, because this really, although we are affected in some way by this we don't really one hundred per cent know what that feels like…".

Most parents who participated were generally accepting of their child's disclosure, but not without reservations. Most believed to some degree that it was a phase that they might grow out of. Supportive parents harboured doubts about 'doing the right thing' especially when helping young children to make potentially life-changing decisions. Amelia described her initial reaction "Erm it probably took me and my partner a year to take them seriously, which is probably not one of my proudest moments".

Underestimated or Dismissed

Several parents described underestimating their child's strength of feeling or the effect of not having identity acknowledged. Amelia was shocked on hearing from another parent that Toni had been talking about suicide. Thomas' mother believed his limited disclosure meant he wasn't serious. Actually he was concerned how others would react based on her reaction; "so my mother like a few months after I came out she was very much like well, you've got to prove to us that this is real by erm telling everyone". Other parents, like Robbie's and Andrew's fathers, were dismissive based on their cisgender frame of reference or, like Eddie on initial fears for their child.

This will be difficult:

This covered substantive areas which parents, both 'OK' and 'not OK' considered as adding difficulty. Parents feared their child would suffer discrimination which would limit life chances or endanger them, e.g. "the first thing that goes through my mind is he's going to be raped. He's going to get beaten up." (Eddie).

The prospect of medical interventions and other practices such as breast binding were a concern for parents:

> Because there were medical consequences and when he started to talk to me about things, I mean it did worry me but that's, like if he had said he had to have an operation to have his appendix removed that would, you know, it's the same. (Fred)

Parents also worried about the mental health consequences. Stories in the press, both 'gender critical' articles and reports of trans suicide were drivers for concern. There was also a wider understanding of the difficulty of being different and, ironically, the challenges of long waiting times for medical treatment; "You know, it's like not treating a cancer till you've had it a year. You know what I mean? It's not going to do anybody any good. Erm, not physically, but mentally" (Fred).

For Amelia, becoming aware of Toni's suicidal thoughts prompted her to take them seriously:

> … the mother of one of their school friends… said that my child had told their child that they're wanting die by suicide. And it was at that point that I was like OK now we actually have to do something. (Amelia)

Initial Adjustment

Initial reaction was followed by initial adjustment, both positive and negative, in five principal areas. Firstly parents discussed how the disclosure 'made sense of things', linking to 'Parental Contemplation' and clues present which did not prompt consideration of gender identity. Robin remarked that; "Erm so yeah, we just kind of probably went back through our memories of his childhood and went oh, OK, this all makes so much more sense…"

Parents discussed that 'transgender' was new to them and they lacked understanding about why their children were trans or how to react. Finding out was imperative and was another area where mothers seemed to take a lead:

> The day we found out, we didn't have a clue, not the foggiest idea what we could do. It was her mam that was researching things and Googling and she goes all in, her mam, on them things so I don't really have to. I confess. (Mo)

In 'changing address', to a more gender appropriate name and pronouns, there were mixed reactions. Some found it easy; Belle said "it's surprising how quickly we got used to it", but Belle also helped Boo to pick her name which might partly explain this. Older children informed parents of their new name. Most were ok, even if they found this a challenge initially. Fred explained his personal reservations;

> I told him I didn't like the name James. Erm you know, straightforward I don't like it, you know. It wouldn't be the name I would have chosen. If you'd been born birth a boy then we'd have chosen a name. So, you know, and I'm not saying that I'll expect to choose it now, but we've passed that now. If he wants to be called James he can be called James but I don't like the name. (Fred)

Eddie, was more emphatic; "He said my name's Ade. And I said I'm not going to use that. I gave you the birth name, that's your name. So I shut him down completely and didn't accept it" (Eddie). Mo said he was accepting of Lexi, but the one thing that has challenged him is talking about events prior to her transition. He uses her deadname and was unsure whether that was appropriate.

Most parents discussed a sense of loss. This included loss of a gendered child or loss of certain dreams and expectations. For Belle it was relatively easy; "I've never really been attached to what gender my children are" and although worried that being trans complicates life "we just sort of saw her being so much happier, sort of takes that away". Joanne experienced a more profound sense of loss; "I think the hardest thing through all of this erm was you do go through a grief process. And I think I went through it for about 18 months." Eddie found resolution through ceremony:

> I gave my daughter back to the goddess and I did a ceremony like kind of a funeral… it was sad, but she's gone. And then we did a naming ceremony... So, you know, goodbye to her and welcome the son, sort of thing. Erm and that's helped me a lot in I don't feel the loss of a daughter now. (Eddie)

Several parents talked about their children having children. For Danny this was not an option "… he's like no way" (Rebecca). Martha said that James had discussed freezing eggs. Joey talked about Lexi's individual solution; "She's always said she'll have the babies that the straight people don't want".

As previously alluded to, there was also something about gendered parental roles, with male parents generally reported as being less involved emotionally (James), while female parents did the research (Mo), took the lead (Eddie) and adapted more quickly to their child's disclosure (Belle). This is also reflected in earlier description of absent fathers finding acceptance more difficult.

Youth Reaction (to Parental Reaction)

Youth reaction indicates how accepted and supported they feel, affects wellbeing, influences belief about the wisdom of disclosure and shapes future trajectory (see Figure 6).

Experienced as Rejecting and Unsupportive

Robbie's father was dismissive of his gender identity, saying nothing at first; "a few days later he approached me and sat me down and then went through oh you're not trans and blah, blah, blah". He continues to deny Robbie's identity and his name. Emily experienced her father's initial reaction as "a punch in the stomach" when he said "I was being selfish by not considering how he feels", albeit she now understands it was his reaction to the perceived loss of his only son. Lexi found it hard to gauge her parents' reaction and believed that it took them several months to accept her. This contradicted the story told by Joey and Mo, but their account also indicated that communication with Lexi was initially challenging; "She would get really cross about things and things that you'd think well it's not worth getting annoyed about. Questions in particular. If you ask her a question on anything she would blow" (Mo).

Jack said his parents wanted to incessantly talk about his disclosure in an attempt to dissuade him:

> Pretty much like all my parents have ever said, why can't you just be you? Why did you have to find a label? And I'm like I'm not trying to find a label, it's just who I am and that's how I best present.

Following his disclosure Jack's parents appeared to go into denial, continuing to use his deadname and feminine terms of affection, so he adopted a double life where with friends and at school he was Jack, whilst at home nothing changed.

Adapting to a trans person's new name and appropriate pronouns is a significant indicator of support which Jack did not receive. Andrew no longer speaks to his father who always uses his deadname. Thomas received a very mixed message; "Yeah. It's mainly just they say like they are supportive, but then their actions don't necessarily reflect that… Erm like they paid for me to legally change my name and title, but they don't use the name and title". James said his parents are very supportive but his father, particularly, struggles with addressing him appropriately. While he wishes that were different, he understands; "They forget. They're not, you know, they've had twenty-ish years of this, of me being female, so it's hard to kind of…". Sometimes he corrects them and sometimes he cannot be bothered to.

Experienced as Accepting and Supportive

Some trans youth expressed surprise. Thomas was pleased at how accepting his father was of his disclosure "… my dad, he commented on the post being like oh I'm proud of you and if that's how you feel that's how you feel, it's very brave of you to do this and tell everyone". Lexi said it took her a while to get used to acceptance because she had spent so long worrying about it. James' parents supported him to attend a local LGBT youth group, his mother attended appointments at the gender identity clinic, and was there when he wanted to talk. His father was more 'back seat'

which reflects 'parental roles' but showed his support in more 'usual' ways, such as giving advice about choosing 'masculine' clothes.

Joey said they had bought new bedding and redecorated Lexi's room in a more 'girly' style which she had appreciated. When asked a general question about how parents could demonstrate support one suggestion Lexi gave was; "Even if like buying like a mug with your new name on it. You know, like little things like that, I think, can really like change how people feel and make them feel more comfortable".

Most trans participants, and parents, talked about an initial challenge to adjust to new names and pronouns. Emily promoted a need for understanding which paid off for her:

> I gave them some leeway and every time they deadnamed me they would apologise straight away and I was like well I know they're trying. You don't need to apologise every time… After a few months they got it and obviously now they just never use my old name.

Effect on Wellbeing

Whilst there is no inference of generalised cause and effect, and no denying other factors including the reaction of siblings, friends, extended family and wider society, discussions did highlight that parental reaction to disclosure impacted wellbeing. It also affected the future trajectory of the child-parent dyad in terms of moving towards living their gender identity authentically.

The first point is illustrated by James' statement that; "I've always struggled with mental health problems", but "not because of being trans… bullying". Robbie was clear that his mental health issues were a result of his difficult disclosure(s); "since coming out and their reaction I've definitely got anxiety, one hundred per cent." Jack said that telling his parents he was having suicidal thoughts because he was trans only led to further interrogation. Thomas described his mental health as "very bad erm up until about the age of eighteen", but said that it had improved since he moved into his own place. Emily talked about a long history of anxiety which began to improve once her transition began; "Yeah, there's been a massive improvement. Even my mam says like my mam has noticed…she's told me multiple times that since this has all started she's thought I've been a lot happier".

Robin talked about Ted's mental health issues, but was keen to stress that it was not all related to gender identity.

> …he says very clearly my mental health is something that's separate to my gender that they can have an impact on each other but essentially it's a separate thing. Erm which I think is quite helpful to hear and to understand.

More positively, Belle spoke about how Boo has come out of herself since transition which is most notable at school in her interaction with others; "I can see her in the playground… she's just happy you can see her all huddled with her friends and she didn't really have friends that she spoke about that much (before transition)"

(Belle). Finally, Eddie, who had initially opposed Ade's transition said; "I've got a really lovely handsome healthy happier son now".

Discussion

This research aimed to understand the interaction between parents and children around disclosure of trans identity. The resulting Trans Family Dynamic Model (TFDM) begins to map how trans youth contemplate gender identity before moving towards living authentically by telling their parents. In parallel, parents contemplate their child's behavior out with gendered norms, consider how to react (if at all) and, potentially, how to react to the news when it is delivered to them. These two stories are linked dynamically and influenced at points of conflict by cisgenderism, and minority stress. It is not unusual for parents and children to disagree over challenging societal norms. Indeed it is perhaps inevitable for gender identity, if not gender roles, that cisgender parents will have 'foreclosed' their identities based on unchallenged conformity (Marcia, 1966, 1980) and that this influences expectations of their children. Children meanwhile seek 'moratorium', i.e. to establish identity (Erikson, 1968; Marcia, 1966, 1980) in the face of societal cisgenderism and parental foreclosure. Other conflict laden domains involving parental expectation exhibit no significant impact on mental health, e.g. academic achievement (Warikoo, Chin, Zillmer, & Luthar, 2020) which might minimise parental expectation of negative impact. However, gender identity rejection can have detrimental consequences to youth mental health via internal and external minority stressors (Testa et al., 2017). This is demonstrated by e.g. Jack's experience of paternal rejection, and Toni discussing suicide with friends when Amelia conceded that they were not taking them seriously. Of course not all conflict resided in parental behavior, and youth expectation of discrimination was another cause of discord. Lexi acknowledged her negative

expectations made her behavior at home difficult and her supportive parents concurred.

There were other reasons for conflict, and Eddie talked of fears that her trans son would be raped, and several parents expressed reservations about surgery on 'healthy bodies', reflecting the evidence base (e.g. Schimmel-Bristow et al., 2018; Wren, 2002).The latter might be viewed on a continuum between 'reasonable' and 'cisgenderism in action'. Perhaps most striking, particularly from parent narratives, was the relative lack of conflict discussed and high level of support. Perhaps because only supportive parents volunteered to participate, preferred a supportive discourse to avoid judgement or had overcome their cisgenderism in the time elapsed between the disclosure and our conversation.

We will next examine what the TDFM has in common with existing models of trans experience, and what it adds to them. Both the six stage model of 'transgender emergence' (Lev, 2004) and 14 stage model of transsexual identity formation (Devor, 2004) describe trans adult progress from contemplation, through disclosure and identity integration. Akin to TFDM 'Youth Contemplation', Lev's model describes pre-disclosure stages of 'awareness' and 'seeking information/reaching out'. These approximate to 'exploring sexuality', 'finding gendered language' and 'attitudes of others' under the 'who am I?' question. The TFDM adds 'trying gender identities' which Lev includes, but places post disclosure. This discrepancy may be explained by increased internet access granting opportunities to connect, explore and be influenced by online role models (Te'Neil Lloyd, 2002) before disclosure to parents. Devor (2004) breaks Youth Contemplation into eight stages; 'abiding anxiety',

'identity confusion about assigned sex/gender' and 'identity comparison', 'discovery of transsexualism', 'identity confusion about transsexualism', 'identity comparison', 'tolerance of transsexual identity' and 'delay before acceptance of transsexual identity' which encapsulates Youth Contemplation of the 'Who am I?' question. Beyond personal reflection, TFDM explicitly explores the social question 'how will my parents react' using parental attitudes to sexuality as a weathervane to 'test the water' for gender identity disclosure - as conceded by Ade to Eddie and evident in accounts of LGBTQ youth disclosure (Klein, Holtby, Cook, & Travers, 2015). However, known attitudes to LGB identities did not always predict attitude to trans disclosure. Eddie discussed accepting pansexuality but not trans identity and Robbie was shocked by his father's rejection. Johnson et al. (2020) found LGB identified parents were not always trans positive, an experience shared by Robbie, whose father had experimented with sexuality in his youth. His rejection played into internalized transphobia, and affected Robbie in casting doubt on the wisdom of social transition.

At disclosure stage Devor (2004) focuses on acceptance describing disclosure in passing, possibly because; (a) this model focusses on adult transition, and (b) in 2004 it was common practice that trans adults had to divorce to progress transition (*Gender Recognition Act*, 2004; Lev, 2004). By contrast, Lev's 'disclosure to significant others' stage is detailed spanning Youth Contemplation, Disclosure and Reaction. Lev (2004) examines the 'how will my parents react' question through thoughts and feared consequences - loss of intimacy, security and stability - evidenced in TFDM by e.g. Jack making alternative accommodation preparations. Lev does not consider 'testing the water' perhaps reflecting her adult focus, and TFDM

adds detailed discussion of 'how' disclosures are made, how this can be easier or more difficult and hurdles to telling extended family. Lev briefly discusses 'discovery' as opposed to disclosure – which Lexi experienced albeit via a deliberate act. Both models discuss emotions and reactions to expected and actual parental reaction making unique observations. E.g. TFDM discusses Thomas' surprise at his father's pride, while Lev discusses tension between self-expression and keeping others happy (Lev, 2004, p. 249). Remaining stages of Lev's and Devor's models concern individual trajectory post-disclosure, beyond the scope of this article.

Two existing models have relevance to the Parental Reaction stage of TFDM, albeit both relate to family of adult trans people – principally partners – and begin post-disclosure. Lev's (2004) four stage model of 'Family Emergence', stage one, 'discovery and disclosure' discusses shock, betrayal and confusion equating to elements of 'this will be difficult' assuming negative response, a possible function of emphasis on spousal reaction. Stage two, 'turmoil' views parental reaction as conflict laden. All participants accounts included difficulties, but rapid acceptance was sometimes evident e.g. Lexi's parents quickly accepted her and offered support. Stages three 'negotiation' and four 'finding balance' have some relevance to initial parental reaction and ensuing youth reaction, introducing an element of dynamic but, again, are most relevant to trajectory beyond this article. Rosenfeld and Emerson's (1998) five stage model (as cited in Raj, 2008) follows the Kübler-Ross (1969) grief model comprising denial, anger, bargaining, depression and acceptance. While some elements were present in participant narratives, overall experiences were not consistent with this approach. Eddie's story most closely aligned but acceptance came

during stage four of the TFDM – highlighting that TFDM tells an uncompleted story. Participants did discuss loss and grief in terms of gendered expectations for their child, commonly in terms of the Kubler-Ross model (Raj, 2008; Wahlig, 2015) or the Parkes and Weiss 'tasks of grief' (Wren, 2002). This makes sense within a cisgender framework but is a potential hindrance to trans youth in reinforcing their position beyond social norms (Riggs & Bartholomaeus, 2018).

The TFDM adds parental contemplation – that parents might independently consider their child's gender identity. Joanne and Belle both noticed 'cross-gender' behaviour and helped their children express preferred gender presentation. Neither children voiced a disclosure they simply expressed 'knowing' identity via behaviour, and surprise that others did not understand. Equating behaviour to gender identity appears to reinforce cisgender stereotypes, but both parents endeavoured not to lead their child's decision. Both children are settled now, fitting the assertion by Bradley and Zucker (1997) that gender identity is established by four to five and initially expressed stereotypically. Alternatively, parents might 'make sense' of information 'held in mind' but not previously considered significant. This was expressed by Joey and Mo given Lexi's lifelong preference for the stereotypically feminine, and reflects other studies of parental experience (e.g. Malpas, 2011; Wren, 2002). Apparent 'knowing' was less present in teenage transitioners, perhaps indicating that older children repress their 'self-knowledge' as a defense, before reconsidering having developed the ability to better express beliefs about themselves (Diamond, 2000).

Finally, the TFDM highlights the explicitly iterative nature of the parent-child reaction cycle. It is acknowledged that some stages described will be absent in the

experiences of some people. This is alluded to as a weakness of stage models (Klein et al., 2015) acknowledged by both Lev (2004) and Devor (2004). Certainly, no participant experienced every aspect of every stage, nor did they necessarily go through them in order.

Limitations

A significant limitation was the missing voices of parents unaccepting of their child's desire to transition. Only Eddie was initially unaccepting though she gradually shifted position and now volunteers to help others. In particular nobody expressed conflict with religious belief, which can be a common sticking point (Austin & Craig, 2015a; Raj, 2008). Demographically the sample was largely restricted to binary trans people. A broader sample might highlight differences in the dynamic experienced by people who are more challenging of cisgender norms. The all white British demographic was another limitation, the lack of ethnic minority participants perhaps being regional or resulting from intersecting minority stresses or other, cultural inhibiting factors (Koken et al., 2009; Rehman, Jaspal, & Fish, 2020). Regardless, to be most useful, ethnic minorities need to be included, and so ways need to be found to facilitate their participation. It might also have been useful to have more family units. In this article it proved useful to contrast perceptions of the same event with two participating sets of parents and child. Finally, the TFDM does not account for other aspects of the social world such as friends, extended family, school, all highlighted as important (Raj, 2008).

Future Directions

The next step will probably be to develop Stage 3 (Parental Disclosure) and Stage 4 (Next Steps) from existing data, although it would also be useful to address some of the limitations highlighted above. Ultimately the intention is that TFDM informs interventions designed to smooth the dynamic when a child discloses their identity. The existing dataset also contains further insight into cisgenderism than discussed, and expanding this seems useful to intervention building and understanding the trans experience more generally.

Conclusion

Building on existing models which explain the trans experience from the individual perspective of trans people or family, the TDFM represents the first attempt to model interactive family dynamics in addressing youth consideration of known parental attitudes and how disclosure affects parental reaction. Parental contemplation pre-disclosure is addressed, grief reactions examined through a non-cisgender lens, and the contribution of parental cisgenderism, concern for safety and youth expectation are acknowledged. The model needs further work and limitations include the need to access wider demographics. Ultimately the model might inform intervention(s) to improve families’ experiences when children disclose trans identities.

References

American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist, 70*(9), 832-864. doi:10.1037/a0039906

Austin, A., & Craig, S. L. (2015a). Empirically Supported Interventions for Sexual and Gender Minority Youth. *J Evid Inf Soc Work, 12*(6), 567-578. doi:10.1080/15433714.2014.884958

Austin, A., & Craig, S. L. (2015b). Transgender Affirmative Cognitive Behavioral Therapy: Clinical Considerations and Applications. *Professional Psychology: Research & Practice, 46*(1), 21-29. doi:10.1037/a0038642

Austin, A., Craig, S. L., & D'Souza, S. A. (2018). An AFFIRMative Cognitive Behavioral Intervention for Transgender Youth: Preliminary Effectiveness. *Professional psychology, research and practice, 49*(1), 1-8. doi:10.1037/pro0000154

Bornstein, K. (1994). *Gender outlaw : on men, women, and the rest of us*: Routledge.

Bradley, S. J., & Zucker, K. J. (1997). Gender identity disorder: A review of the past 10 years. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*(7), 872-880. doi:10.1097/00004583-199707000-00008

Brill, S. A. (2016). *The transgender teen : a handbook for parents and professionals supporting transgender and non-binary teens*.

British Psychological Association. (2012). *Guidelines and literature review for psychologists working therapeutically with sexual and gender minorities*. Retrieved from https://www.bps.org.uk/sites/beta.bps.org.uk/files/Policy%20-%20Files/Guidelines%20and%20Literature%20Review%20for%20Psychologists%20Working%20Therapeutically%20with%20Sexual%20and%20Gender%20Minority%20Clients%20(2012).pdf

British Psychological Association. (2019). *Guidelines for psychologists working with gender, sexuality and relationship diversity*. Retrieved from https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Guidelines%20for%20psychologists%20working%20with%20gender%2C%20sexuality%20and%20relationship%20diversity.pdf

Brooks, V. R. (1981). *Minority stress and lesbian women*. Lexington MA: Lexington Books.

Butler, J. (2006). *Gender trouble : feminism and the subversion of identity* (Second edition. ed.). New York: Routledge.

Chang, T. K., & Chung, Y. B. (2015). Transgender microaggressions: Complexity of the heterogeneity of transgender identities. *Journal of LGBT Issues in Counseling, 9*(3), 217-234. doi:10.1080/15538605.2015.1068146

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed. ed.).

Charmaz, K. (2017). Constructivist grounded theory. *The Journal of Positive Psychology: Qualitative Positive Psychology. Edited by Kate Hefferon and Arabella Ashfield, 12*(3), 299-300. doi:10.1080/17439760.2016.1262612

Coolhart, D., & Shipman, D. L. (2017). Working toward family attunement: Family therapy with transgender and gender-nonconforming children and adolescents. *Psychiatric Clinics of North America, 40*(1), 113-125. doi:10.1016/j.psc.2016.10.002

Corbin, J. M., & Strauss, A. L. (2015). *Basics of qualitative research techniques and procedures for developing grounded theory* (4th ed.). Los Angeles: Sage.

Devor, A. H. (2004). Witnessing and mirroring: A fourteen stage model of transsexual identity formation. *Journal of Gay & Lesbian Psychotherapy, 8*(1-2), 41-67. doi:10.1300/J236v08n01_05

Diamond, M. (2000). IV. Sex and gender: Same or different? *Feminism & Psychology, 10*(1), 46-54. doi:10.1177/0959353500010001007

Durwood, L., McLaughlin, K. A., & Olson, K. R. (2017). Mental health and self-worth in socially transitioned transgender youth. *Journal of the American Academy of Child & Adolescent Psychiatry, 56*(2), 116-123.e112. doi:10.1016/j.jaac.2016.10.016

Ehrensaft, D. (2017). Gender nonconforming youth: current perspectives. *Adolescent Health, Medicine and Therapeutics, 8*, 57. doi:10.2147/AHMT.S110859

Gender Recognition Act. (2004). Retrieved from https://www.legislation.gov.uk/ukpga/2004/7/contents

GIDS. (2016). Gender Identity Development Service statistics. Retrieved from https://tavistockandportman.nhs.uk/documents/408/gids-service-statistics.pdf

GIDS. (2020). Referrals to GIDS, financial years 2015-16 to 2019-20. Retrieved from https://gids.nhs.uk/number-referrals

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory strategies for qualitative research*. New Brunswick: Aldine Transaction.

Grossman, A. H., & D' Augelli, A. R. (2007). Transgender youth and life – threatening behaviors. *Suicide and Life – Threatening Behavior, 37*(5), 527-537. doi:10.1521/suli.2007.37.5.527

Hendricks, M., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model. *Professional Psychology: Research & Practice, 43*(5), 460-467. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=cin20&AN=108107131&site=ehost-live&authtype=ip,shib&user=s1523151

Hidalgo, M. A., Ehrensaft, D., Tishelman, A. C., Clark, L. F., Garofalo, R., Rosenthal, S. M., . . . Olson, J. (2013). The gender affirmative model: What we know and what we aim to learn. *Human Development, 56*(5), 285-290. doi:10.1159/000355235

Jenney, A., Mishna, F., Alaggia, R., & Scott, K. (2014). Doing the right thing? (Re) Considering risk assessment and safety planning in child protection work with domestic violence cases. *Children and Youth Services Review, 47*(1), 92-101. doi:10.1016/j.childyouth.2014.07.015

Johnson, K. C., LeBlanc, A. J., Sterzing, P. R., Deardorff, J., Antin, T., & Bockting, W. O. (2020). Trans adolescents' perceptions and experiences of their parents' supportive and rejecting behaviors. *Journal of Counseling Psychology, 67*(2), 156-170. doi:10.1037/cou0000419

Kenny, M., & Fourie, R. (2015). Contrasting classic, straussian, and constructivist grounded theory: Methodological and philosophical conflicts. *Qualitative Report, 20*(8), 1270-1289.

Klein, K., Holtby, A., Cook, K., & Travers, R. (2015). Complicating the coming out narrative: Becoming oneself in a heterosexist and cissexist world. *Journal of Homosexuality, 62*(3), 297-326. doi:10.1080/00918369.2014.970829

Koken, J. A., Bimbi, D. S., Parsons, J. T., Koken, J. A., Bimbi, D. S., & Parsons, J. T. (2009). Experiences of familial acceptance-rejection among transwomen of color. *Journal of Family Psychology, 23*(6), 853-860. doi:10.1037/a0017198

Krieger, I. (2017). *Counseling transgender and non-binary youth*. London: Jessica Kingsley.

Kübler-Ross, E. (1969). *On Death and Dying*: Routledge.

Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. Binghamton, NY: Haworth Clinical Practice Press.

Lev, A. I. (2013). Gender dysphoria: Two steps forward, one step back. *Clinical Social Work Journal, 41*(3), 288-296. doi:10.1007/s10615-013-0447-0

Malpas, J. (2011). Between pink and blue: A multi – dimensional family approach to gender nonconforming children and their families. *Family Process, 50*(4), 453-470. doi:10.1111/j.1545-5300.2011.01371.x

McDermott, E., Hughes, E., & Rawlings, V. (2016). *Queer Futures: Understanding lesbian, gay, bisexual and trans (LGBT) adolescents' suicide, self-harm and help-seeking behaviour*. Retrieved from http://www.queerfutures.co.uk/wp-content/uploads/2016/06/Queer-Futures-Final-Report.pdf

McDermott, E., Roen, K., Scourfield, J., McDermott, E., Roen, K., & Scourfield, J. (2008). Avoiding shame: young LGBT people, homophobia and self-destructive behaviours. *Culture, Health & Sexuality, 10*(8), 815-829. doi:10.1080/13691050802380974

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior, 36*(1), 38-56. doi:10.2307/2137286

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674-697. doi:10.1037/0033-2909.129.5.674

Meyrick, J. (2006). What is good qualitative research?: A first step towards a comprehensive approach to judging rigour/ quality. *Journal of Health Psychology, 11(5)*, 799-808. doi:10.1177/1359105306066643

Nealy, E. C. (2017). *Transgender children and youth : cultivating pride and joy with families in transition* (First edition. ed.).

NSPCC. (2012). NSPCC Research Ethics Committee: Guidance for applicants. Retrieved from https://www.nspcc.org.uk/globalassets/documents/evaluation-of-services/research-ethics-committee-guidance-applicants.pdf

O’Connor, A., Carpenter, B., & Coughlan, B. (2018). An Exploration of Key Issues in the Debate Between Classic and Constructivist Grounded Theory. *The grounded theory review, 17*(1). Retrieved from http://groundedtheoryreview.com/2018/12/27/an-exploration-of-key-issues-in-the-debate-between-classic-and-constructivist-grounded-theory/

Parker, C. M., Hirsch, J. S., Philbin, M. M., & Parker, R. G. (2018). The urgent need for research and interventions to address family-based stigma and discrimination against lesbian, gay, bisexual, transgender, and queer youth.

Journal of Adolescent Health, 63(4), 383-393. doi:10.1016/j.jadohealth.2018.05.018

Raj, R. (2008). Transforming couples and families: A trans-formative therapeutic model for working with the loved-ones of gender-divergent youth and trans-identified adults. *Journal of GLBT Family Studies, 4*(2), 133-163. doi:10.1080/15504280802096765

Reed, B. W. D., Cohen-Kettenis, P. T., Reed, T., & Spack, N. (2008). Medical care for gender variant young people: Dealing with the practical problems. *Sexologies, 17*(4), 258-264. doi:10.1016/j.sexol.2008.08.004

Rehman, Z., Jaspal, R., & Fish, J. (2020). Service provider perspectives of minority stress among black, asian and minority ethnic lesbian, gay and bisexual people in the UK. *Journal of Homosexuality*, 1-23. doi:10.1080/00918369.2020.1804256

Reisner, S. L., Vetters, R., Leclerc, M., Zaslow, S., Wolfrum, S., Shumer, D., & Mimiaga, M. J. (2015). Mental health of transgender youth in care at an adolescent urban community health center: A matched retrospective cohort study. *Journal of Adolescent Health, 56*(3), 274-279. doi:10.1016/j.jadohealth.2014.10.264

Richards, C., & Barker, M. (2013). *Sexuality & gender for mental health professionals : a practical guide*. London: Sage.

Riggs, D. W., & Bartholomaeus, C. (2018). Cisgenderism and certitude: Parents of transgender children negotiating educational contexts. *TSQ: Transgender Studies Quarterly, 5*(1), 67-82. doi:10.1215/23289252-4291529

Saldaña, J. (2016). *The coding manual for qualitative researchers* (3rd ed.). London: Sage.

Schimmel-Bristow, A., Haley, S. G., Crouch, J. M., Evans, Y. N., Ahrens, K. R., McCarty, C. A., & Inwards-Breland, D. J. (2018). Youth and caregiver experiences of gender identity transition: A qualitative study. *Psychology of Sexual Orientation and Gender Diversity, 5*(2), 273-281. doi:10.1037/sgd0000269

Serano, J. (2020). Julia's trans, gender, sexuality, & activism glossary! Retrieved from http://www.juliaserano.com/terminology.html

Simons, L., Schrager, S. M., Clark, L. F., Belzer, M., & Olson, J. (2013). Parental support and mental health among transgender adolescents. *J Adolesc Health, 53*(6), 791-793. doi:10.1016/j.jadohealth.2013.07.019

Sinclair, S., Hack, T. F., Raffin-Bouchal, S., McClement, S., Stajduhar, K., Singh, P., . . . Chochinov, H. M. (2018). What are healthcare providers' understandings and experiences of compassion? The healthcare compassion model: A grounded theory study of healthcare providers in Canada. *BMJ open, 8*(3), e019701. doi:10.1136/bmjopen-2017-019701

Stonewall. (2017). *School report: The experiences of lesbian, gay, bi and trans young people in Britain's schools in 2017*. Retrieved from https://www.stonewall.org.uk/system/files/the_school_report_2017.pdf

Tan, K. K. H., Treharne, G. J., Ellis, S. J., Schmidt, J. M., & Veale, J. F. (2019). Gender minority stress: A critical review. *Journal of Homosexuality*. doi:10.1080/00918369.2019.1591789

Te'Neil Lloyd, B. (2002). A Conceptual Framework for Examining Adolescent Identity, Media Influence, and Social Development. *Review of general psychology, 6*(1), 73-91. doi:10.1037/1089-2680.6.1.73

Testa, R. J., Michaels, M. S., Bliss, W., Rogers, M. L., Balsam, K. F., & Joiner, T. (2017). Suicidal ideation in transgender people: Gender minority stress and interpersonal theory factors. *Journal of Abnormal Psychology, 126*(1), 125-136. doi:10.1037/abn0000234

Wahlig, J. L. (2015). Losing the child they thought they had: Therapeutic suggestions for an ambiguous loss perspective with parents of a transgender child. *Journal of GLBT Family Studies, 11*(4), 305-326. doi:10.1080/1550428X.2014.945676

Walsh, I., Holton, J. A., Bailyn, L., Fernandez, W., Levina, N., & Glaser, B. (2015). What grounded theory Is…a critically reflective conversation among scholars. *Organizational Research Methods, 18*(4), 581-599. doi:10.1177/1094428114565028

Warikoo, N., Chin, M., Zillmer, N., & Luthar, S. (2020). The Influence of Parent Expectations and Parent – Child Relationships on Mental Health in Asian American and White American Families. *Sociological forum (Randolph, N.J.), 35*(2), 275-296. doi:10.1111/socf.12583

Wren, B. (2002). 'I can accept my child is transsexual but if I ever see him in a dress I'll hit him': Dilemmas in parenting a transgendered adolescent. *Clinical Child Psychology & Psychiatry, 7*(3), 377. doi:10.1177/1359104502007003035

Yee, W. C., & Andrews, J. (2006). Professional researcher or a 'good guest'? Ethical dilemmas involved in researching children and families in the home setting. *Educational review (Birmingham), 58*(4), 397-413. doi:10.1080/00131910600971859

Youth. (n.d.). Retrieved from https://www.un.org/en/sections/issues-depth/youth-0/

Tables

Table 1: Youth Participant Demographics

Pseudonym	Gender Identity	Age	Ethnicity	Mother* (pseudonym)	Father* (pseudonym)	Brothers	Sisters	Age Disclosed	
								Sexuality	Gender
Robbie	Trans Man	22	White British	x	x	0	1	13	16
Jack	Trans Male	19	White British	x	x	2	0	12	14
Lexi	Female	18	White British	Joey	Mo	0	1	12	14
James	Masc. Non-Binary	25	White British	Martha	Fred	0	0	13	15
Emily	Female	24	White British	x	x	2	0	12	17
Thomas	Trans Male	20	White British	x	x	1	1	14	16

*Where participating in this research, otherwise not named 'x'

Table 2: Parent Participant Demographics

Pseudonym	Gender Identity	Age	Ethnicity	Partner* (pseudonym)	Trans Child (pseudonym)	Child Gender Identity	Child Age	Age Child Disclosed		Cisgender children
								Sexuality	Gender	
Martha	Female	65	White British	Fred	James	Masc. Non-binary	25	13	15	0
Joanne	Female	44	White British	x	Andrew	Trans Boy	11	-	4	2
Joey	Woman	43	White British	Mo	Lexi	Trans Girl	18	12	14	1
Mo	Man	46	White British	Joey	Lexi	Trans Girl	18	12	14	1
Rebecca	Female	49	White British	John	Danny	Trans Male	17	12	13	4
John**	Male	59	White British	Rebecca	Danny	Trans Male	17	12	13	3
Eddie	Female	50	White British	x	Ade	Trans Male	18	13	14	0
					Mike	Non-binary	16	6	16	-
Robin	Woman	50	White British	x	Ted	Trans Boy	16	-	12	1
Belle	Woman	39	White British	x	Boo	Trans Girl	5	-	5	1
Amelia	Female	41	White British	x	Toni	Fem. Non-binary	12	-	7	1
Fred	Man	64	White British	Martha	James	Masc. Non-binary	25	13	15	0

*Where participating in this research, otherwise not named 'x'
**John is married to Rebecca and is Danny's step-father

Figures

Figure 1: Trans Family Dynamics Model (TFDM)

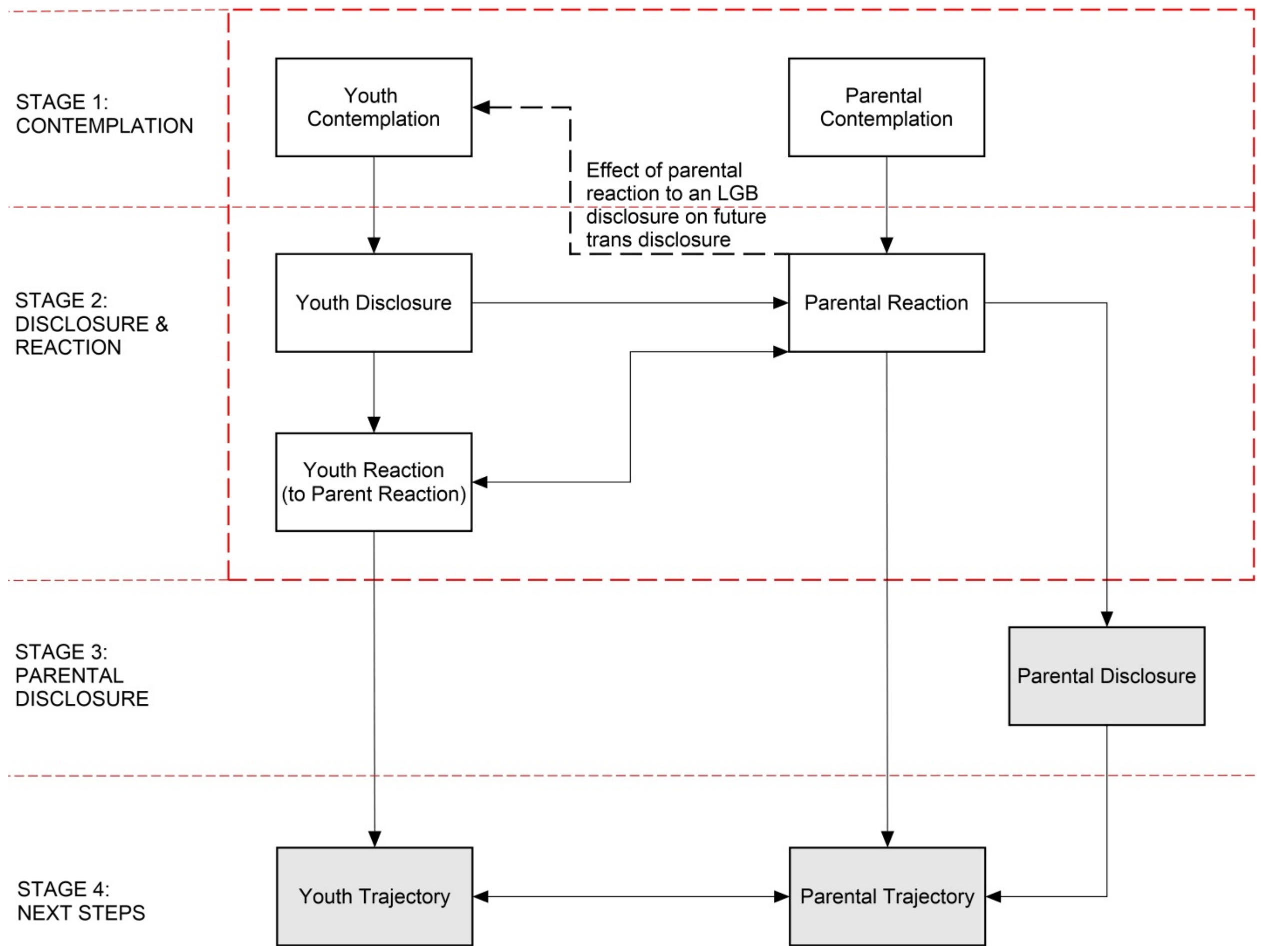


Figure 2: Youth Contemplation

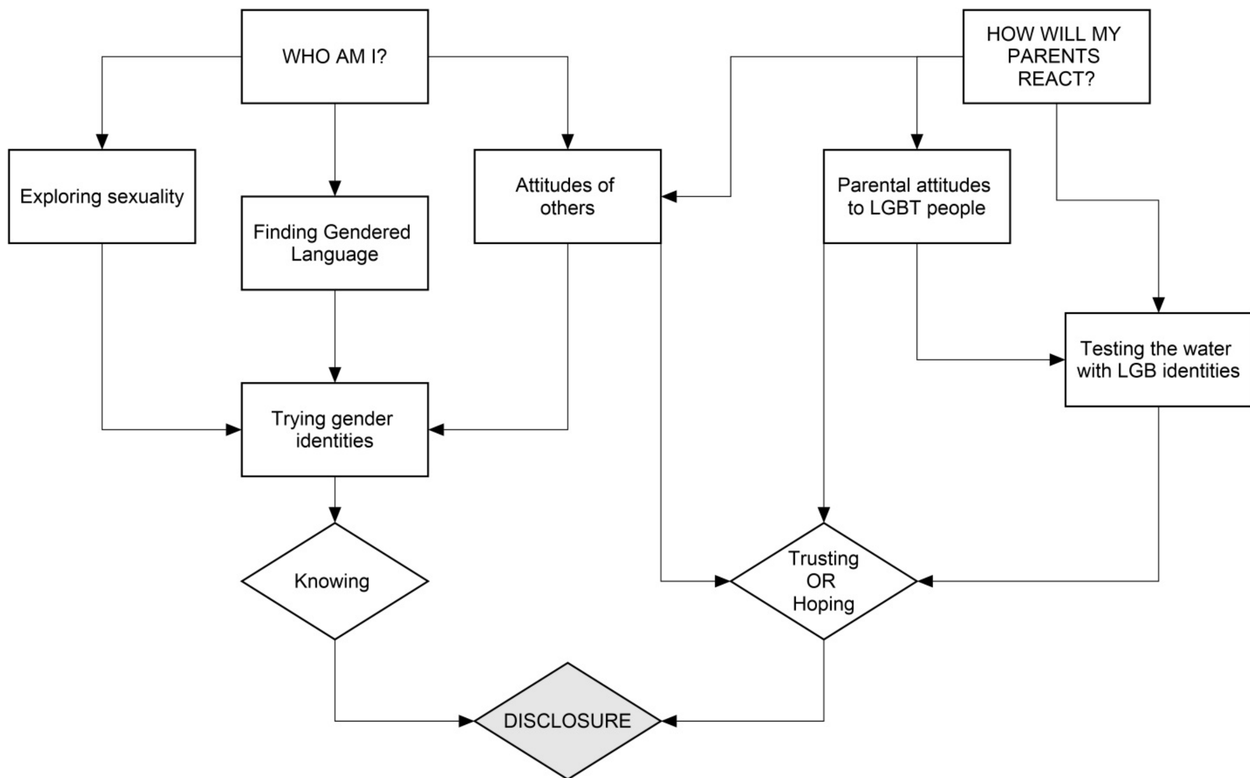


Figure 3: Parental Contemplation

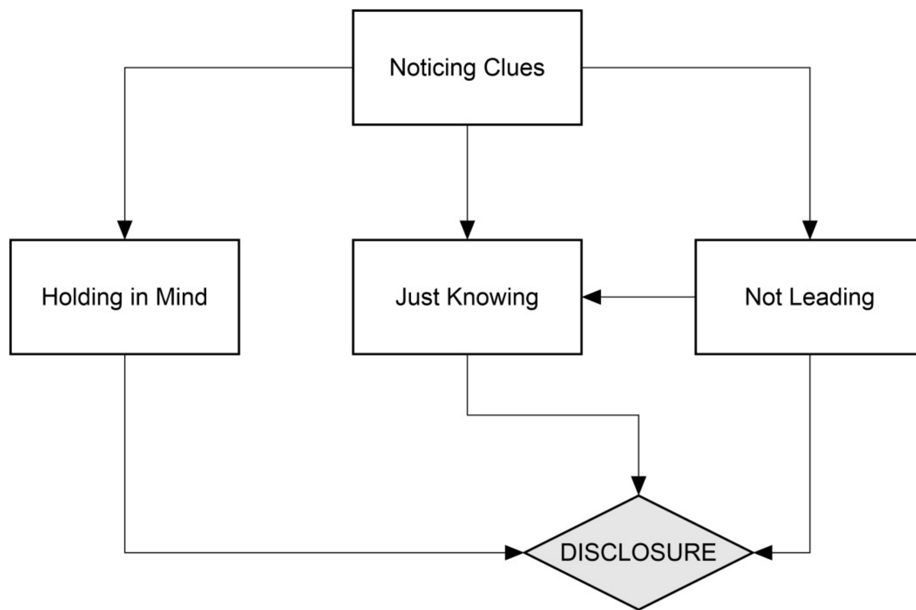


Figure 4: Youth Disclosure

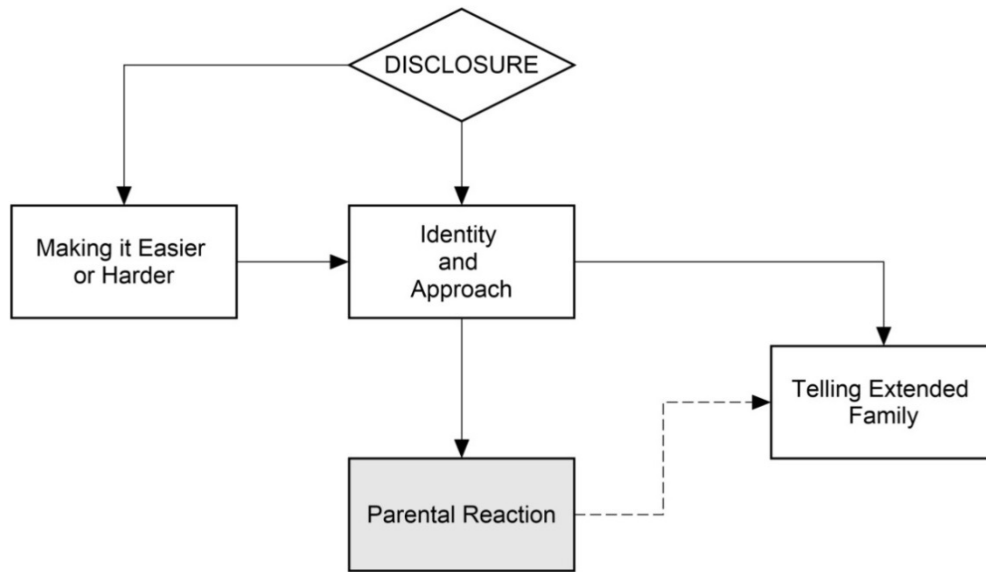


Figure 5: Parental Reaction

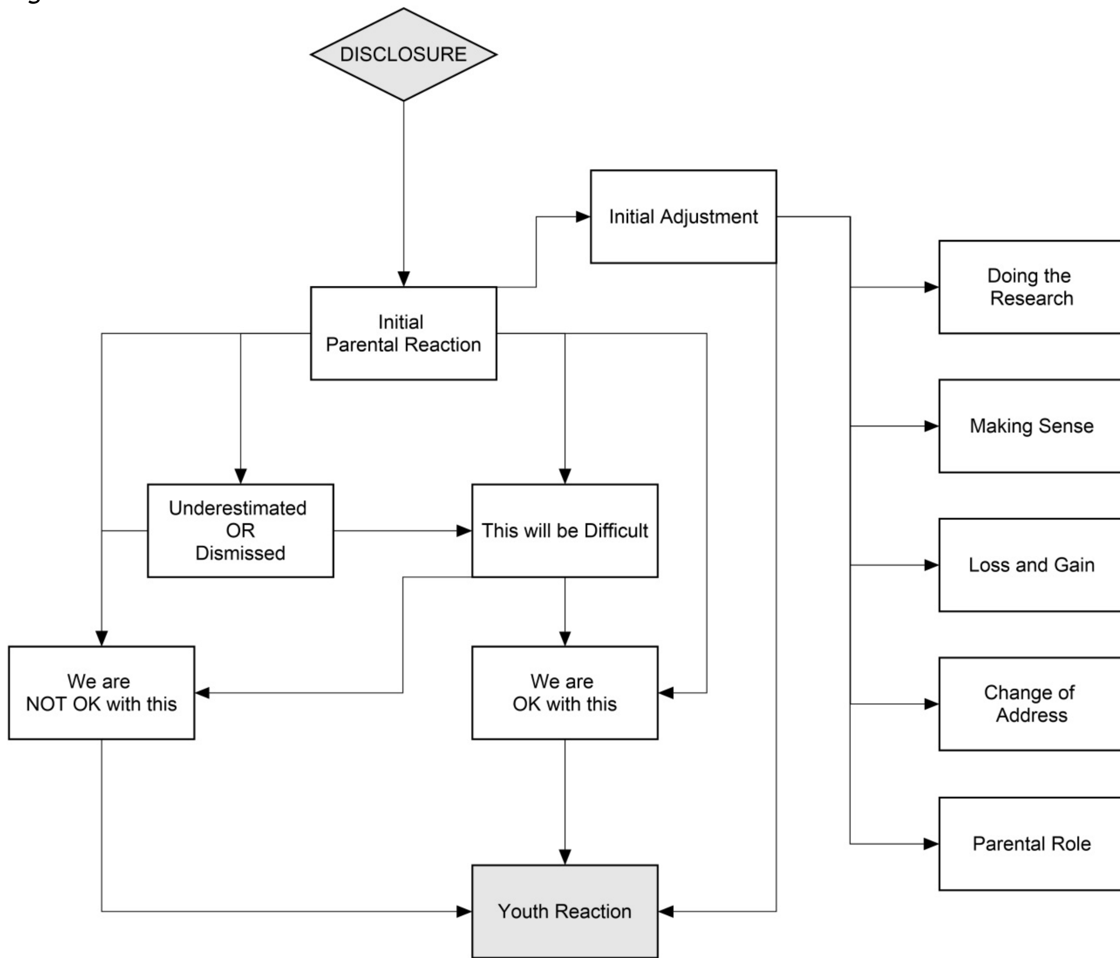
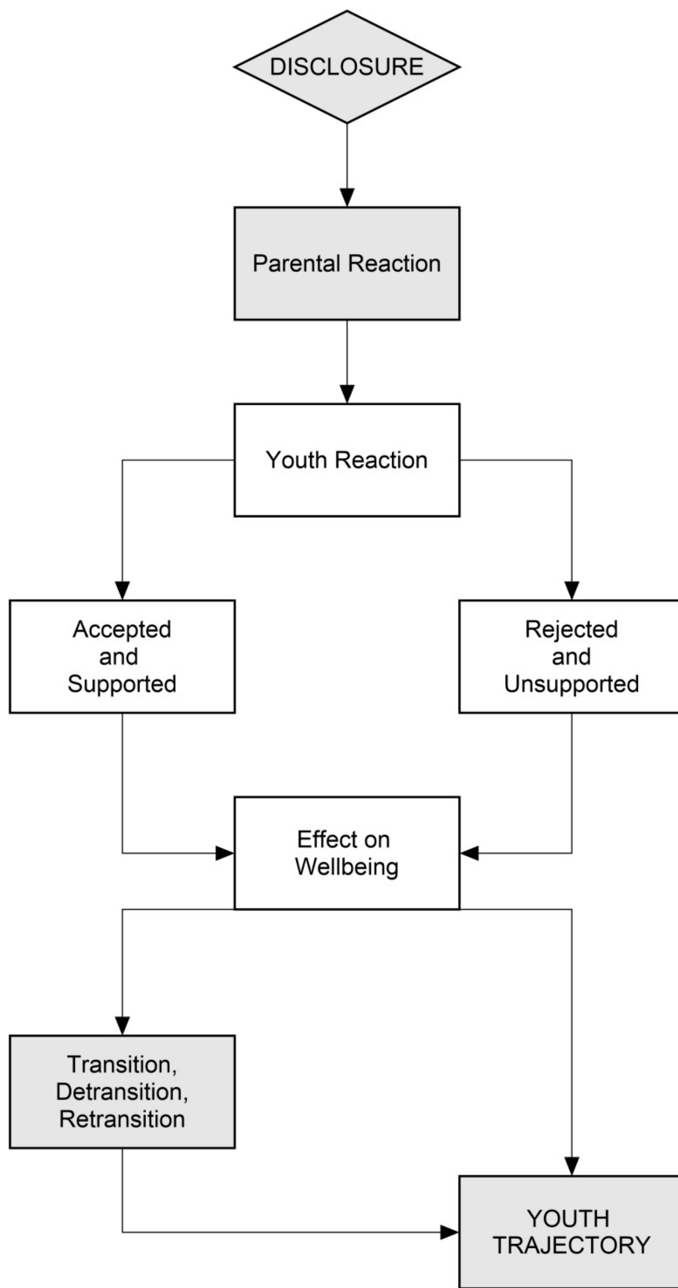


Figure 6: Youth Reaction



Appendices

Appendix 2.1: Research Diary Extracts

The following two extracts demonstrate how the research diary was used to reflect on findings, think about lines of enquiry and also to reflect on own process.

EXTRACT #01

Reflection following interview 01 with James and interview 02 with Lexi – which followed the focus group where I had spoken to both of their mothers.

Disclosing Trans Identity

The evidence so far suggests that disclosing a trans identity is considered difficult even when parents and other important people would be expected to be supportive. There is still uncertainty about how people will react. For some this resulted in risky behaviour for which parents had no explanation – or for which they came up with explanations which were wide of the mark. This is perhaps the first stage of parents 'making sense of it all'.

This may be part of the reason why both trans people I have spoken to reported that they had never conformed to gender norms, even from an early age, but initially came out as gay or bisexual, and this also echoes parental experience. One person said that this seemed like a more acceptable version of being different, but that 'coming out in stages' was also part of coming to an understanding of oneself – trying things out. Sometimes there was a gradual realisation of a trans identity, sometimes a 'lightbulb' moment or event

This adds an element to Lev's (2004) model of trans awareness in terms of awareness, information seeking and disclosure and highlights that at the least the model is missing some important elements. Elements which may, or may not, be particular to people who disclose at an early age. (*Note: following this I interviewed Joanne – see below – an example of theoretical sampling*)

EXTRACT #02

Following interview 03 with Joanne whose son began to transition around five years old:

Joanne's story was heart rending in terms of the battle she fought for Andrew and brought up questions about cisgenderism – that is how typical were her efforts to not lead Andrew into adopting a stereotypical role? She appears to have handled this sensitively but her profession might have a bearing on this. It feels really important especially given the current narrative of about parents encouraging their kids down a trans path to satisfy stereotypes… I need to speak to another parent of a young child – and preferably with a dad present to see if this influences the situation (*Note: I subsequently spoke to Belle*).

Reflecting I think this is really important – and it was heartening to hear her non-leading approach. I hope this proves typical as a counter to the gender critical crowd – and as evidence of responsible loving parenting – but I have to remain aware of my hopes!

Appendix 2.2: Coding: Stage 1: Contemplation

Data Example	Initial Coding	Refocussed Coding	Core Category
STAGE 1: Contemplation			
he was like oh I'm a lesbian now. And I was like right, OK. So then he had a girlfriend and I got attached to her. For a while I just thought I was like a gay male.	I'm gay	Who am I: Exploring Sexuality	Youth Contemplation
I'm not a lesbian mum. Erm it was about six months later he was like I'm not a lesbian.	Not gay (any more)		
I think it was about discovering who I was. I was at that age where I was just trying to figure out who I was… And we're all growing up, you know, at the same time and trying to figure out who we are.	Working it out		
they made this video. They got some funding and they had all different relationships, you know, trans relationships female to female, all the different LGBT+ straight relationship, and it was talking about it	Video	Who am I: Finding Gendered Language	
this person came up to me with like a leaflet with like stuff about being trans on it and it kind of clicked into place that that's what I was, and it felt right	Leaflet		

I mean it wasn't until someone told me that it was a thing that I was just gobsmacked. I was like what. Because I'd always heard about people going on about oh they've had a sex change and I was always like well that's not a real thing.	Gobsmacked	
I was boyish' around nine, knew something was wrong by 14, but couldn't name it until 16-17	Bit by bit	
My view on that is she…she was coming to understand herself. She was confused. It wasn't that she had any reticence in declaring one thing or the other. I think she was confused and she genuinely didn't know what erm where she was in terms of gender.	Coming to understanding	Who am I: Trying Gender Identities
I knew that there was something different about me but I thought it was just like a body dysmorphia and like I thought that the uncomfortableness about my body was to do with that.	Something different	
when I was fifteen and my hair was first short erm that people didn't actually realise if I was a boy or a girl. They didn't actually know and I quite like that. I felt that I was gay but I always thought I was going to end up a drag queen	Gender bending	

he was like oh I played around with a lot of pronouns and like tried to see how it felt when other people recognised me as that. And I was like OK, and then I thought, you know, gender neutral would be a good way to ease myself in almost.	Playing with pronouns	
they basically made me question my gender by sort of posing that A(m) wasn't myself as much as it was an alter ego.	Not for real	Who am I: Attitudes of Others
I think school friends not accepting it and then them going oh well you're too girly, you're not kind of you don't…you're not very masculine, you don't do this,		
Because I was talking to my friends in school in class and in break times and they were like oh yeah well you're probably like this, and then I did a bit more research about it and I was like oh I'm going to cut my hair, I'm going to change the way I dress, things like that.	Support to explore	
what very much puts me off every telling them (grandparents) about me being trans is they got very upset when Elton John had a baby with his husband. Like very upset. Same with Tom Daly and his husband having a baby. Also got very upset.	Parents parents	How will my parents react: Attitudes of Others

when I was fifteen which another thing my dad made comments on saying that he didn't like it and that I looked too boyish with it, but I quite liked that	And we don't care…	
I think it was just a general kind of consensus of how people reacted. I was kind of introduced to LGBT people from the ages of, I don't know, as long as I can remember because we had two friends who were lesbians and then when I was about eleven I went to their civil partnership so.	Parents having LGBT friends	How will my parents react: Parental attitude to LGBT people
before she came out we'd also been to a civil partnership of two lesbians. So she didn't see…we brought her up in a way where she didn't see this as being not normal in any sense of the word at all.	It was normal	
"(what) held me back from telling my parents is the way they reacted about me being bisexual	Not positive	
When I first came out... as gay, he was really supportive of me then. So, I thought he'd be supportive of me through this as well	Reassurance	How will my parents react: Testing the water
Now looking back I've said to him was you looking into then, he says yeah I was testing you. So, he knew a year before he even broached it with me or friends. He knew. He'd been looking at it for some time before then.	Tested	

I think every person, every LGBT person, has some tiny form of doubt in their head when they come out to someone new	You can never be sure (even if they are ok with LGB people)		
I think before he was two erm it was as if I went and put something pink on him or anything that looked slightly girly he just screamed and wouldn't wear it.	Nothing girly!	Noticing Clues	Parental Contemplation
It wasn't a massive shock.	Not shocking		
this is more serious, there's something more going on here, because at the same time he was quite down as well.	Something going on		
when she started nursery at three she was always found in the home corner playing with dolls, in the kitchen playing, lots of stuff like that.	Everything girly!		
So we ended up with this conversation where we said how about we ask you questions about what we think is going on and you can then answer and that might be easier.	Closed questions	Not leading	
I said what do you want me to say when people say are you a boy or a girl, and so she said I want you to say I'm a girl and that was the moment I definitely knew.	How do I respond?		
At nursery he told people his name was T(m). Everyone had to call him T(m).	My name is…	Just knowing	

with her being five, you know people are sort of like oh she's so young can they really know at that age	How can they know?	
she's never wavered on it since September, she's not once said, you know, I don't think I'm a girl actually, she just is who she is.	Never wavered	
when she was about eleven going into secondary she sat down with my mum and said I think I've been born in the wrong body and my mum says OK what do we do. Nothing, I just wanted you to know. So my mum thought about it. She told me and L(F)'s dad	Don't do anything yet	Holding in mind
I mean it was just Ben Ten. It was really he would wear this Ben Ten costume. He would hate wearing dresses. And I used to think I wonder if it's because it's itchy	I wonder why?	

Appendix 2.3: Coded Transcript Extracts

The following are the coded extracts from all transcripts for a single node in NVivo 12

YOUTH CONTEMPLATION – HOW WILL PARENTS REACT?

<Files\\Trans People\\Trans Interview - INT01> - § 5 references coded [3.32% Coverage]

Reference 1 - 0.82% Coverage

Erm and that was I think coming out with that I was worried…I don't…I don't really know what I was worried about because my parents are youth workers so they're the best people to come out to.

R: Yeah.

P1: But I think I was worried about what they might say, might think, I guess. It's one of those things that makes you nervous even though you shouldn't be. Yeah. I think that was…

Reference 2 - 1.08% Coverage

Didn't really have any expectations. Erm I kind of, now I'm thinking about it, I kind of started looking at this when I was doing psychology GSCE and we looked at the case studies of kind of transgendered young people and things like that, and that's when it started. I'm not sure if that's after I'd been to Bradford or before, but that's when I started to kind of properly look into it. Erm and kind of that's where all my research came out of it. So I didn't really have that many expectations per se

Reference 3 - 0.54% Coverage

So I didn't really know anyone. It was through the group that I got to know kind of more trans people and I wouldn't say I ever had an expectation of what it would be like, I just thought I don't know, yeah. I didn't really have an expectation per se.

Reference 4 - 0.26% Coverage

Well, I think I knew it would be harder to date. Erm…

R: Harder to date, did you say?

P1: Harder to date people. Yeah.

Reference 5 - 0.61% Coverage

P1: No. But I kind of expected that, I think, because he's a youth worker and he's dealt with these kinds of things and he's been in the LGBT community what with our gay friends and yeah.

[20:00]

R: Yeah, so it's not new. It's not the sort of new territory for him as it might be for

<Files\\Trans People\\Trans Interview - INT02> - § 1 reference coded [0.64% Coverage]

Reference 1 - 0.64% Coverage

R: So what was it that stopped you from telling your mam?

P1: I just didn't want to tell her.

R: You just didn't want to tell her. Is that because you were worried about how she would react?

P1: Yes.

R: Yeah. How did you expect she might react?

P1: I thought she'd just kick off.

R: You thought she'd kick off.

P1: Which she did.

<Files\\Trans People\\Trans Interview - INT06> - § 2 references coded [1.10% Coverage]

Reference 1 - 0.59% Coverage

P: Erm but I don't know. I mean when I first came out, for instance, as gay, he was really supportive of me then. So I thought he'd be supportive of me through this as well, but he wasn't.

Reference 2 - 0.51% Coverage

And he was…the really funny thing is, was when I first told him he even told me that when he was about my age at the time he dated a guy, for instance, for a while.

<Files\\Trans People\\Trans Interview - INT08> - § 2 references coded [1.06% Coverage]

Reference 1 - 0.58% Coverage

But held me back from telling my parents is the way they reacted about me being bisexual. They were like hmm, well, you need to pick a side, don't really get that. So, it was sort of knowing that they had hesitations around me being LGB let alone T.

Reference 2 - 0.48% Coverage

But I was prepared for the absolute worst case scenario. I was like well, I could be kicked out of the house. It's not unheard of for that to happen to young transgender people, so I want to prepare for that.

<Files\\Trans People\\Trans Interview - INT10> - § 2 references coded [2.68% Coverage]

Reference 1 - 2.26% Coverage

Erm I expected it to go quite well. I knew that there was going to be an adjustment period because obviously they'd known me as this person but their whole, like the whole time I'd been alive, like a whole entire sixteen years.

R: Yeah.

P: Erm so I did expect it to go well because my family aren't exactly shy to LGBT issues.

R: Right.

P: 'Cos I know that my mother used to be quite involved in the scene when she was younger, before she settled down and had her kids.

R: Oh right.

P: And so did my dad too. It was like he used to run **[05:00]** an LGBT pub erm be like before I was born. So I did expect it to go well.

Reference 2 - 0.42% Coverage

but there was still that little inkling of doubt where it was like what if it's OK for other people but not for me.

<Files\\Trans People\\Trans Interview - INT11> - § 2 references coded [1.54% Coverage]

Reference 1 - 1.13% Coverage

I think it would be a bit more of a hurdle than it was coming out as gay.

R: OK.

P: But I didn't think it would be without problems. But I didn't think it would be an issue.

R: OK. So what sort of problems did you anticipate?

P: Erm…I don't know. I just scared myself silly by reading lots of coming out stories.

Reference 2 - 0.42% Coverage

I think every person, every LGBT person, has some tiny form of doubt in their head when they come out to someone new.

Appendix 2.4: Participant Narratives

The model presented offers fragments of stories but it seemed important to contextualize these by offering a short precis of the disclosure stories participants told. This is not intended to be a set of cause and effect narratives because different parents might react very differently to the same youth actions, but more to put what precedes this in context. It is also important to note that only in two instances (Lexi: Joey and Mo, James: Martha and Fred) do we have both sides of the story.

Trans Youth

Robbie's dad never liked him being a tomboy, but was ok with his lesbian identity. Robbie sat him down and told him he was trans. Dad took time out before explaining to Robbie that he wasn't. Robbie felt hurt and rejected but did not pursue transition. Several years later he tried and again and was again rebuffed. Only now having moved out is Robbie able to express his identity, but his father still does not accept this and Robbie continues to repress his feelings in the company of his dad.

Jack originally came out as bisexual but did not expect his parents to be ok about him being trans, and made plans to live elsewhere just in case. Eventually he told his mother and left it to her to tell his dad. This resulted in a tsunami of questions, and a kind of acceptance without really changing the way they referred to him or saw him and so Jack lead a double life where he felt accepted at school but not at home.

Lexi came out as bisexual as a teenager and had always been quite feminine. She came out as trans over social media but her parents, Joey and Mo, found out about this via an acquaintance. Despite this Joey and Mo were supportive, albeit Lexi

felt uncertain of their support for some time. Lexi had a difficult time at school and some other past difficulties which all contributed to tension between her and her parents, mostly this was not about her being trans. Things are much improved now and with temporal distance Lexi sees that Joey and Mo love her and accept her for who she is.

James came out as bi, then lesbian before disclosing a trans identity after attending a pride event with his mother. His parents mixed in diverse circles and were fine with him, albeit dad was worried about the idea of surgery. However James had a negative experience with a clinician at the gender clinic, and an initially supportive girlfriend convinced James that he was not trans. James stopped his transition for a while, but following the breakup of his relationship he re-examined his position and is in the process of re-starting his transition on his own terms.

Emily was quite worried about disclosing her trans identity, but didn't need to because her mother worked it out and made clear that she was ok with it. Dad struggled a bit with it because he was sad about the loss of his son. Emily wrote him a letter and while he was digesting this he witnessed a trans person being abused. This was the turning point and he has been supportive ever since. It took them a little while to adjust to new name and pronouns but Emily was patient. In particular her mother has really helped to push things forward while dad has taken a supportive back seat.

Thomas expected his disclosure to go ok as his parents had connections to the LGBT community. Their initial reaction was accepting and they showed support in helping with the practical issues which arose. However Thomas' parents did not make

the adjustment to his new name and pronouns, and questioned his commitment to the change, which caused him to feel like their support was not wholehearted. Things are easier and slowly improving since Thomas moved into a place of his own.

Parents

Martha and Fred were both open to James' initial disclosure that he was a gay woman, having had a very diverse social circle. They also adapted to his trans disclosure and Martha in particular did her best to help him navigate this. Fred had his concerns about surgery but was supportive in the background. They were not convinced when James renounced his trans identity, believing this was led by his girlfriend – and following the breakup of the relationship gave him time and space to re-assert his trans identity.

Joey and Mo found out about Lexi's disclosure on social media via an acquaintance. This was a surprise rather than a shock as Lexi had always had a preference for feminine toys and behavior, and had come out as gay some time earlier. Both tried to show their support for Lexi but it took her a while to accept their acceptance – and this was complicated by unrelated difficulties at school and in life. Joey has become an advocate for trans people and their families as a result of Lexi's experiences. Mo is equally supportive but happy to take a back seat and just be there when needed.

Rebecca and John had hints that their son was unhappy living as a girl but when they received his feelings in a letter they were left in no doubt of the path he wanted to take. Making that change has meant challenges needed to be faced and they both have fears for the future living in what can be an unkind world. However they have

both been behind him from the start and made it clear to others that they take second place to his welfare.

Joanne did not understand her son's assertion that he was a boy at first but as it became clear that he was unhappy living as a girl she helped him to make the change in appearance and socially – fighting his corner where other's put up resistance. This included standing up against some of her own family where necessary and facing challenges of her own as a result.

Eddie's son, Ade, came out as pansexual initially which Eddie found to be a lovely concept – that it was the person you loved rather than the gender. However she did not accept his later revelation that he was trans, based significantly on her fear of the changes he wanted to make to his body. He stuck to his guns and Eddie came to accept this over time. She is now a fierce advocate for trans young people

Robin and her partner had clues that their child was non-binary which eventually led Robin to facilitate disclosure via a series of open questions. This lead to some challenges with Ted's brother for a while and with the outside world. However it has also resulted in both Robin and her partner re-examining their own relationships with gender. Robin is now an advocate for trans people in the education sector.

Belle understood what her daughter's preferences and behaviors might mean from a very early age and did her very best to facilitate Boo to express her gender preference without leading her down a particular path. Boo made It clear she was a girl with none of the fears or preconceptions older children have. Her transition at school has not been without challenges, principally for Belle, but she has been

rewarded with a child who has come out of her shell and who seems much more at ease with herself.

Amelia and her partner did not take their non-binary child serious at first. It was only when they were told that Toni had been talking about suicide to a friend that they realized that Toni needed support with this. Once this was apparent they found that they had a fight on their hands with the outside world. Other parents and statutory support services both presented challenges which they are still working hard to overcome. This has meant personal sacrifices have had to be made in order to support Toni.

Chapter 3: Critical Appraisal

OF

Examining the caregiver-child dynamic on youth disclosure of trans identity

Debbie Helen Wood

Doctorate in Clinical Psychology

Division of Health Research: Lancaster University

Word count: 3963 of 4000 words

References and Figures word count = 955

Project Summary

This project emerged out of a long held intention to design an intervention, which can be delivered by non-specialist services, to smooth the path of families where there is a young person who has disclosed a trans identity. The author has experience of working in this field in the third sector and a statutory child and adolescent mental health setting, has observed a lack of understanding about trans identities from parents and poor intra-family communication as major contributors to conflict, and is aware that overstretched specialist services means families have to wait a long time for help. What follows is a brief summary of both ensuing articles, followed by reflections initial thoughts about intervention, next steps, examination of methodological issues and final reflections on the thesis project.

The Literature Review

The literature review brought together 14 articles giving voice to trans youth about how parents or other caregivers had reacted to them being trans. The principal finding was four messages which reflected youth perception of caregiver positions on their stance about the young person's identity. These were encapsulated by Eric Berne's 'life positions' from transactional analysis theoryas; 'we're ok – you're not ok', 'we're not ok - you're not ok', 'we're not ok- you're ok' and we're ok – you're ok'(Berne, 1962). The resulting synthesis revealed an overwhelmingly negative received message reflective of perceived cisgenderism, two intermediary messages indicating relaxing of cisgenderism, but also substantial evidence of supportiveness. Importantly, where messages were mixed it was the negative message that was received. However, the supplementary message 'there may be hope' indicated that

with time caregivers may come to a more gender flexible position. Finally, there was also the important finding that caregiver interaction with trans youth does not always revolve around gender and all the above messages might focus on other aspects of the dynamic between caregiver and youth.

The Research Paper

The research paper set out to model the dynamic between parent and youth, when a young person discloses a trans identity by using a constructivist grounded theory approach. Contributions from six trans people and eleven parents resulted in a model which described a process involving: youth contemplation of their identity and likely parental reaction; disclosure; parental noticing pre-disclosure and reaction post-disclosure; then trans youth reaction to parental reaction. The resulting model is dynamic and interactional in contrast to existing models which tend to concentrate on either trans youth OR parents. Data relevant to parental disclosure and next steps as a family were also collected, and will be used for future articles.

A Family Intervention: Considerations

As an intervention designed to be delivered by non-specialist services, this might include people without specific psychotherapy and/or gender identity training. It therefore seems likely that there would be a manual which could prescribe a basic delivery and also act as a guide for skilled therapy practitioners. Since the model is incomplete the following is an indication of what current findings might suggest rather any kind of definitive design. Importantly, this intervention will not be a substitute for specialist gender services and so there will be no involvement with medical intervention beyond disseminating information. However, this introduces an

element of watchful waiting (Ehrensaft, 2017), giving a space for youth and parents to develop their understanding while they await a specialist appointment – should that be wanted.

Fundamentally the model highlights that there are discrete pieces of work to be completed individually with young people and parents, and others which would benefit from working together. This mirrors the approaches of Raj (2008) and Coolhart and Shipman (2017) with the latter specifically recommending initial work separately followed by family therapy. The first part of the model highlights a period of pre-disclosure youth contemplation which is necessarily going to exclude parents. This comprises exploration of sexual and gender identity and thinking about how to make the disclosure to parents. Exploration with trans youth might include aspects of the AFFIRM intervention for trans youth which uses cognitive behavioural techniques to tackle the impact of minority stress (Hendricks & Testa, 2012) by challenging cisgenderism and internalised transphobia (Austin, Craig, & D'Souza, 2018). It is particularly useful that this intervention has also been successfully evaluated and applied to sexual identity as the model describes a process whereby sexuality is often explored and sometimes disclosed prior to gender identity. Thoughts about making the disclosure, identified in the model, included considering the impact of known parental attitudes to sexual and gender diversity. None of the participants discussed trying to access professional help at this stage, relying on friends and the internet for information gathering and support so intervention would rely on 'reaching' young people at this stage. Regards intervention, this suggests the possibility of a group intervention perhaps with an element of staff or peer coaching to think about how the

disclosure can be made easier rather than harder – which was a conundrum revealed in the grounded theory. Participant stories included suggestions, such as letter writing which might be included in discussion. Thinking practically it will be important to consider the risk of a bad reaction from parents with contingency planning, especially since trans youth face a disproportionate risk of youth homelessness (Robinson, 2018). A further complication is the possible need for parental consent to access treatment. In the UK children under 16 would need to demonstrate 'Gillick Competence' (Griffith, 2016) in order to do so without parental consent, and this requirement will vary by country.

Parents might present for help pre disclosure if they suspect that their child might be trans either because of observed clues or finding out through third parties – both of which were situations described by participants. The data suggests it is more likely that parents will seek help post-disclosure as they come to terms with their child's revelation. Either way the model revealed difficulties in adjusting despite all parents being very supportive at interview, on average four years post disclosure. All the current interventions discussed in chapter 2 (Austin & Craig, 2015; Coolhart & Shipman, 2017; Malpas, 2011; Raj, 2008) included an element of psycho-education for parents which would help with expressed need to do their own research and concern about 'making sense'. To quote Coolhart and Shipman (2017, p. 114) "the initial goal of family therapy is to help families understand, accept and learn to advocate for the TGNC (trans) child". It is important for parents to be able to express opinions, fears and emotions freely, even where this might be uncomfortable to hear. For this reason the process should begin without the child, at least until the parents are able to

discuss the issues without damaging the child's sense of self (Coolhart & Shipman, 2017). Interventions might include discussion, especially for younger children around 'am I doing the right thing?' (Malpas, 2011), discussion of minority stress to highlight issues which might be faced (Hendricks & Testa, 2012) and discussion around pronouns, health and concerns about treatment (Coolhart & Shipman, 2017). Parental roles were identified in the model and can be problematic especially where fathers have less involvement or are less affirmative (Malpas, 2011; Wren, 2002), and loss and grief are important subjects which are discussed most extensively by Raj (2008) with reference to Kübler-Ross (1969) five stage grief model. Information gained from the youth reaction part of the model might also be used educationally to demonstrate the positive effect of feeling accepted and the negative effect of rejection. This would be psychoeducational and might employ statistics (e.g. Stonewall, 2017) and factors identified as pertaining to self-harm and suicide (Testa et al., 2017). Powerfully, it might also include testimony from this and other research, in written or video form, around the difficulties of disclosure and the consequences of perceived rejection and non-disclosure. Finally, as well as professional input, peer experiences can also be useful for parents and groups are therefore a consideration and may be more appealing to less supportive parents who might view professionals as gender affirmative and/or coercive. Hopefully, to quote Malpas, "Gradually, parents realize that acceptance *is* protection" (Malpas, 2011, p. 468).

The family intervention which could follow the above would be around forging a joint understanding, and working out the next steps. The elements to employ are beyond the scope of this research because the data on that part of the process

remains unanalysed, albeit a brief discussion is included below. However, a fundamental element of any family intervention is communication. Family therapists are well versed in facilitating this, but this intervention is intended for use by less qualified staff. The use of transactional analysis using the Parent-Adult-Child model was briefly explored in chapter 1 as a way to encourage good communication which is relatively simple and which has been explored for use by non-psychological health professionals e.g. nurses (Kenward, 2013). Other techniques might be needed to help either side explore how their own biases are affecting the received messages. For example, the Cognitive-Behavioural technique of 'decentring' helps clients to take a step back and examine how automatic thoughts can drive misinterpretation of the messages received from other people (Westbrook, Kennerley, & Kirk, 2011). Also from Chapter 1, the message that 'there may be hope' has support (Ehrensaft, 2019; Lev, 2019) and is a potential selling point for youth and parents alike. The message that it is 'not all about gender' is a cautionary one for practitioners in terms of focus and relationship building, but is also helpful in normalising some aspects of the dynamic.

Next Steps

Expanding the Model

Considerations of time and available word count meant that in order to construct a model which did justice to the data, Chapter 2 concentrated on the process of trans youth identity disclosure from contemplation (stage 1) to disclosure and reaction (stage 2). However this leaves the model incomplete as Figure 1 illustrates two further stages. Stage 3, parental disclosure describes the process by

which parents decide to disclose that they are 'the parent of a trans child' (or not) to others including extended family, friends and institutions such as school. This experience can include despair, shame and fear of others' reactions (Moser, 2019) and might parallel the experience of young people in making their own disclosure, though perhaps with less intensity. The evidence collected suggests that parental disclosure was difficult for some, but it might be that parents who have their own issues with their young person's gender identity are more likely to find their own disclosure difficult. This warrants further investigation. How others react will have a direct bearing on the next steps which parents are willing, or able, to take in pursuit of their child's desire to live authentically. Stage 4, next steps, describes what happens next in terms of youth trajectory – a combination of desired and actual outcomes, parental trajectory and the interplay between the two. This has not yet been well developed although the data have been collected. This is an important part of the model, and any subsequent intervention, because families might seek help at any point in their journey.

Grounded Theory - Methodological Concerns

Recruitment

A major challenge was retention of trans youth participants who were recruited and held in a pool. Even people who had seemed keen became unavailable for a variety of reasons which led to two problems. Firstly, one focus group ended up with a single participant, albeit some prospectives did participate in a one-to-one interview later – suggesting the group format might have been off-putting. This suggests asking about participant preference for one-to-one or group setting rather

than just allocating. In fact, there was an assumption that a group setting would have been preferred on the basis of being able to meet others in a similar situation – which did not transpire even for all parents. Secondly, for a grounded theory study, having a pool of participants is helpful in allowing selection based on evolving need to ask particular questions of particular people as the project progresses. One possible explanation for withdrawal was that more time allowed more rumination of how being interviewed might be; another that it is simply a 'youth phenomenon' to be variously available and unavailable.

The biggest challenge is probably to recruit parents who are unsupportive of their child's transition. Shaghaghi, Bhopal, and Sheikh (2011) discuss sampling techniques with 'hard to reach' groups emphasising the importance of understanding the characteristics of your target population. This might be about motivation, how to make involvement seem worthwhile. It might also be about barriers. In this case, parents who do not support their child's transition may well see the researcher, as a trans person, as biased and with an agenda. Somebody cisgender might seem more neutral and less threatening of their worldview. Indeed, it might also be important for the research to consider how biased they might be in relation to this population.

Reliability, Validity and Generalisability

Traditional notions of reliability, validity and generalisability are rooted in a positivist, quantitative, paradigm and so they are contested and reframed in qualitative circles and not always easy to separate (Golafshani, 2003). In a quantitative sense, broadly, validity is a judgement on whether a piece of research measures what it set out to measure while reliability is 'consistency' - that results

would be reproducible using the same method with the same, or similar, sample (Golafshani, 2003).

Validity is reframed qualitatively as credibility and rests with whether or not the method was appropriate and executed correctly (Leung, 2015). One way to ascertain this is reflexivity – to lay bare the researcher bias and mitigation to allow the reader to judge bias in reporting (Hall & Callery, 2001). This chapter reports on reflexivity below in an attempt to satisfy this criterion. Cohen and Crabtree (2008) also talk about procedural validity or, was this piece of research actually constructivist grounded theory? This might be judged based on the written method, or tables such as in Appendix 2.2 which illustrates the process by which data became theory. More specifically for this project 'theoretical sampling' and data saturation/theoretical sufficiency were critically examined. The first links to the recruitment issue discussed above and the conclusion is 'not optimally' – if the participant pool had worked as hoped for. However, the research diary demonstrated that participants were chosen, as far as possible, to answer specific questions arising as well as to give more detail on more general questions and so a degree of theoretical sampling was evident.

From the beginning it was recognized that one of the constraints of this research, that it must be completed in just over a year, meant that data saturation might not be attained, and so the aim would be to at least meet theoretical sufficiency. Aldiabat and Le Navenec (2018) assert that knowing when you have achieved saturation involves researcher 'subjectivity, wisdom and intuition'. Perhaps a little more usefully Hennink, Kaiser, and Marconi (2017) suggest that code

saturation which they described as ‘having heard it all’ generally occurs at nine interviews whereas meaning saturation ‘having understood it all’ occurs between 16 and 24 interviews. Of course this is subjective but by their estimation this research, at thirteen interviews (albeit with 17 participants) could claim to have identified the pertinent issues but not to have achieved a complete understanding of the mechanisms behind them. This indicates that theoretical sufficiency was probably achieved. However, to further complicate matters it is arguable that this project examined two phenomena if we separate youth and parental experience. Additionally, there is a question remaining as to whether data saturation can ever be achieved without question, but that is a research question in itself!

Reliability, or trustworthiness in qualitative terms (Golafshani, 2003), is generally tested using triangulation (Cohen & Crabtree, 2008; Silverman, 2013) which can involve using different data sources or holding post-hoc meetings with participants to check for agreement on meaning (Cohen & Crabtree, 2008), or inter-rater reliability analysis using a statistical test such as Cohen’s Kappa (Foreshaw, 2007). However, “the concept of reliability is misleading in qualitative research”(Stenbacka, 2001), although another argument is that in qualitative research reliability equals ‘quality’ (Golafshani, 2003) which might take us back to reflexivity and procedural validity.

Finally, generalisability, or ‘external validity’ is about whether findings are applicable to wider populations (Cohen & Crabtree, 2008) which, in this case, might include trans people from different locations or different ethnic backgrounds or unsupportive parents as discussed above. Constructivist grounded theory does not

aim for generalisability as a strength of the method is to produce theory firmly rooted in time and situation Charmaz (2014). That said it seems legitimate to hypothesise that family dynamics centred on social norms, fears for offspring and effects of minority stress would tend to differ only in respect to localised norms governing gender. As ever replication of this study in different situations would be needed to confirm this.

Reflexivity

It is an expectation of constructivist grounded theory that researcher bias will influence resulting theory (Charmaz, 2014), which I acknowledge having briefly mentioned my personal attachment to the thesis subject in previous chapters. This includes lived experience of the process of self-understanding in childhood followed by a protracted period of 'non-disclosure' and internalised transphobia driven denial. In adulthood I re-explored gender identity and disclosed to my remaining parent – my father – followed by further re-exploration of the whole concept of gender identity. I have been hugely influenced by Kate Bornstein's artful deconstruction of gender (Bornstein, 1994) in understanding myself as a non-binary (genderqueer) person, and by Butler (2006b) in seeing gender as contestable and largely constructed for the purpose of social control. I do acknowledge a possible biological element to gender identity which might, e.g. be driven hormonally (Diamond, 2000) or by sexually dimorphic brain structures (Ku et al., 2013). However, the cultural (Butler, 2006a; Kessler & McKenna, 2006) and temporal (Kessler & McKenna, 2006) situatedness of gender expression suggest to me that embodied gender dysphoria may, for some, be

driven by a need to comply with cisgender norms, via surgical modification of the body, in order to find both societal and self-acceptance against a backdrop of minority stress. That said I also believe that the interplay of biological and social factors which contribute to gender identity will be unique for each individual, and I accept that my personal belief - that if the concept of gender disappeared physical dysphoria might disappear with it – may be wrong and is unfalsifiable in our deeply gendered societies. However, despite my (unfalsifiable) personal theory of gender dysphoria I support an affirmative stance towards personal gender identity and choice of age appropriate treatment. Therapy is client centred (Rogers, 1951) and collaborative (Beck, Rush, Shaw, & Emery, 1979) and evidence for positive psychological outcome lies with affirmation (Durwood, McLaughlin, & Olson, 2017; Ehrensaft, 2017; Hidalgo et al., 2013). The job of clinicians is, I believe, to improve psychological outcome for people living in the world, not to advance theoretical agenda.

Returning to research, I believe I need to ask myself how my perspective has shaped findings, and in particular to my (potentially biased) view that cisgenderism tends to be the root of any negative family dynamic. Reflecting on the results of the literature review helped me to see that actually there is a strong element of concern for the child (even where misguided) in acknowledging the danger of flouting cisgender norms, and also in terms of fears about engaging with irreversible medical intervention. This reminded me of the words of Arlene Lev (2014) - that however badly concerns are expressed most parents are doing their best to protect their child.

I have often not acknowledged this internally – and I tried to carry this reflection beyond the literature review and into the research.

The data around parental contemplation and 'just knowing' caused me some discomfort based on parents, with good intentions, imposing cisgender stereotypes. This guided questioning and found parents holding similar fears endeavouring not to lead their children. Given the cisgender cues surrounding us this is difficult, even when children seem very clear, as it is impossible to determine whether they are responding to social cues they are not consciously aware of (Butler, 2006a). My reflection was that this was probably the least harmful approach given that gender affirmative parenting is protective to mental health (Durwood et al., 2017), that Boo was demonstrably happier and Andrew had persisted with his gender expression for seven years despite experiencing minority stressors. Not all parents are wedded to their child's gender expression (Riggs & Bartholomaeus, 2018) and I believe that Joanne and Belle would support a change of mind – albeit society may not be so generous.

Given the timing of this research it is important to acknowledge the influence which Covid-19 on participants, the process and myself. Firstly, interviews were moved to online platform following lockdown. This impact was apparently minimal as I had been expecting to employ this medium with distant participants to save travel. One participant had to cancel their interview because of increased caring responsibilities. A substitute was available, although one never knows what data were lost. However a complication with consent highlighted an unexpected problem. I needed to contact the university ethics committee to check whether recorded verbal

consent was admissible which incidentally highlighted that I had been conducting interviews online. The ethics submission did not specify meeting face-to-face and so I had assumed that there was no requirement to submit an amendment. The ethics committee disagreed and I was informed that this was beyond the approval granted. This placed a substantial part of my data in jeopardy. On review of documentation I was able to see why they had come to this conclusion. A process ensued whereby I provided information to verify that the research had been carried out ethically. The ethics committee accepted that the move to online interviews had been carried out in good faith, ethically conducted and that the researcher had learned from the process. The data were sanctioned allowing me to honour the time of my participants and complete this thesis. My personal learning was the value of containing my emotional reaction to the news, reflecting on my judgement, staying professional and, above all, if in any doubt submit an amendment.

More generally this has been an unusual and sometimes stressful time which has affected different people in different ways. I do not know how this affected my participants; we did not discuss this in any depth. For me, working from home, it afforded me more research hours but robbed me of some of the things which take away the stress of working long hours.

Final Reflections – My Learning

This was my second attempt at a systematic review using a metasynthesis approach and, I believe was more systematic than the first! Perhaps the biggest learning has been around data quality, use of the CASP and identifying what is important, that articles need, first and foremost, to contribute to the research

question. Grounded theory was a new and positive experience. However, in future I will be more organized about recording my reflections in one place and in order. The topic is close to my heart and much of what I found was confirmatory, although I hope reflexivity avoided that being self-fulfilling. A few things were reframed, not least the possible parallel between youth disclosure and subsequent parental disclosure partially emerging from Stage 3. Not so much learning as an observation is my great admiration for my participants who honored me with their stories, all of which were difficult in places at least. I think the biggest thing I will take away is a greater level of compassion for parents who struggle to be supportive of their trans child. My own emotional response has sometimes clouded the understanding that generally parents are trying to do their best for their children, and I found Eddie's story to be a very powerful illustration of this.

References

Aldiabat, K. M., & Le Navenec, C.-L. (2018). Data saturation: The mysterious step in grounded theory methodology. *Qualitative Report, 23*(1), 245.

Ashley, F. (2020). A critical commentary on ‘rapid-onset gender dysphoria’. *The Sociological review (Keele), 68*(4), 779-799. doi:10.1177/0038026120934693

Austin, A., & Craig, S. L. (2015). Transgender Affirmative Cognitive Behavioral Therapy: Clinical Considerations and Applications. *Professional Psychology: Research & Practice, 46*(1), 21-29. doi:10.1037/a0038642

Austin, A., Craig, S. L., & D'Souza, S. A. (2018). An AFFIRMative Cognitive Behavioral Intervention for Transgender Youth: Preliminary Effectiveness. *Professional psychology, research and practice, 49*(1), 1-8. doi:10.1037/pro0000154

Beck, A. T., Rush, J. A., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guildford Press.

Berne, E. (1962). Classification of positions. *Transactional Analysis Bulletin, 1*(3), 23. Retrieved from https://calisphere.org/item/78b49942-aca7-4c30-83f6-eda7a5857d50/

Bornstein, K. (1994). *Gender outlaw : on men, women, and the rest of us*: Routledge.

Butler, J. (2006a). Doing Justice to Someone: Sex reassignment and allegories of transexuality. In S. Stryker & S. Whittle (Eds.), *The transgender studies reader* (pp. 183 - 193). New York: Routledge.

Butler, J. (2006b). *Gender trouble : feminism and the subversion of identity* (Second edition. ed.). New York: Routledge.

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed. ed.).

Cohen, D. J., & Crabtree, B. F. (2008). Evaluative criteria for qualitative research in health care: controversies and recommendations. *Ann Fam Med, 6*(4), 331-339. doi:10.1370/afm.818

Coolhart, D., & Shipman, D. L. (2017). Working toward family attunement: Family therapy with transgender and gender-nonconforming children and adolescents. *Psychiatric Clinics of North America, 40*(1), 113-125. doi:10.1016/j.psc.2016.10.002

Diamond, M. (2000). IV. Sex and gender: Same or different? *Feminism & Psychology, 10*(1), 46-54. doi:10.1177/0959353500010001007

Durwood, L., McLaughlin, K. A., & Olson, K. R. (2017). Mental health and self-worth in socially transitioned transgender youth. *Journal of the American Academy of Child & Adolescent Psychiatry, 56*(2), 116-123.e112. doi:10.1016/j.jaac.2016.10.016

Ehrensaft, D. (2017). Gender nonconforming youth: current perspectives. *Adolescent Health, Medicine and Therapeutics, 8*, 57. doi:10.2147/AHMT.S110859

Foreshaw, M. (2007). *Easy statistics in psychology: A BPS guide*. Oxford: Blackwell.

Golafshani, N. (2003). Understanding Reliability and Validity in Qualitative Research. *Qualitative Report*. doi:10.46743/2160-3715/2003.1870

Griffith, R. (2016). What is Gillick competence? *Hum Vaccin Immunother, 12*(1), 244-247. doi:10.1080/21645515.2015.1091548

Hall, W. A., & Callery, P. (2001). Enhancing the Rigor of Grounded Theory: Incorporating Reflexivity and Relationality. *Qual Health Res, 11*(2), 257-272. doi:10.1177/104973201129119082

Hendricks, M., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model. *Professional Psychology: Research & Practice, 43*(5), 460-467. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=cin20&AN=108107131&site=ehost-live&authtype=ip,shib&user=s1523151

Hennink, M. M., Kaiser, B. N., & Marconi, V. C. (2017). Code saturation versus meaning saturation: How many interviews are enough? *Qual Health Res, 27*(4), 591-608. doi:10.1177/1049732316665344

Hidalgo, M. A., Ehrensaft, D., Tishelman, A. C., Clark, L. F., Garofalo, R., Rosenthal, S. M., . . . Olson, J. (2013). The gender affirmative model: What we know and what we aim to learn. *Human Development, 56*(5), 285-290. doi:10.1159/000355235

Hutchinson, A., Midgen, M., & Spiliadis, A. (2019). In support of research into rapid-onset gender dysphoria. *Arch Sex Behav, 49*(1), 79-80. doi:10.1007/s10508-019-01517-9

Kenward, L. (2013). Teaching communication via awareness of Berne's personal ego states. *Nurse Educ Today, 33*(10), 1096-1098. doi:10.1016/j.nedt.2013.03.008

Kessler, S. J., & McKenna, W. (2006). Toward a theory of gender. In S. Stryker & S. Whittle (Eds.), *The transgender studies reader* (pp. 165 - 192). New York: Routledge.

Ku, H.-L., Lin, C.-S., Chao, H.-T., Tu, P.-C., Li, C.-T., Cheng, C.-M., . . . Hsieh, J.-C. (2013). Brain signature characterizing the body-brain-mind axis of transsexuals. *PLoS ONE, 8*(7), e70808-e70808. doi:10.1371/journal.pone.0070808

Kübler-Ross, E. (1969). *On Death and Dying*: Routledge.

Leung, L. (2015). Validity, reliability, and generalizability in qualitative research. *J Family Med Prim Care, 4*(3), 324-327. doi:10.4103/2249-4863.161306

Littman, L. (2018). Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports. *PLoS ONE, 13*(8), 1-41. doi:10.1371/journal.pone.0202330

Malpas, J. (2011). Between pink and blue: A multi – dimensional family approach to gender nonconforming children and their families. *Family Process, 50*(4), 453-470. doi:10.1111/j.1545-5300.2011.01371.x

Moser, E. (2019). My own transition. In A. I. Lev & A. R. Gottlieb (Eds.), *Families in transition: Parenting gender diverse children, adolescents and young adults* (pp. 220-229). New York: Harrington Park Press.

Raj, R. (2008). Transforming couples and families: A trans-formative therapeutic model for working with the loved-ones of gender-divergent youth and trans-identified adults. *Journal of GLBT Family Studies, 4*(2), 133-163. doi:10.1080/15504280802096765

Restar, A. J. (2019). Methodological critique of Littman’s (2018) parental-respondents accounts of “rapid-onset gender dysphoria”. *Arch Sex Behav, 49*(1), 61-66. doi:10.1007/s10508-019-1453-2

Riggs, D. W., & Bartholomaeus, C. (2018). Cisgenderism and certitude: Parents of transgender children negotiating educational contexts. *TSQ: Transgender Studies Quarterly, 5*(1), 67-82. doi:10.1215/23289252-4291529

Robinson, B. A. (2018). Conditional families and lesbian, gay, bisexual, transgender, and queer youth homelessness: Gender, sexuality, family instability, and rejection. *Journal of Marriage and Family, 80*(2), 383-396. doi:10.1111/jomf.12466

Rogers, C. R. (1951). *Client-centred therapy*. London: Constable.

Shaghaghi, A., Bhopal, R. S., & Sheikh, A. (2011). Approaches to recruiting 'hard-to-reach' populations into re-search: A review of the literature. *Health Promot Perspect, 1*(2), 86-94. doi:10.5681/hpp.2011.009

Silverman, D. (2013). *Doing qualitative research* (4th ed.). Los Angeles: Sage.

Stenbacka, C. (2001). Qualitative research requires quality concepts of its own. *Management decision, 39*(7), 551-556. doi:10.1108/EUM0000000005801

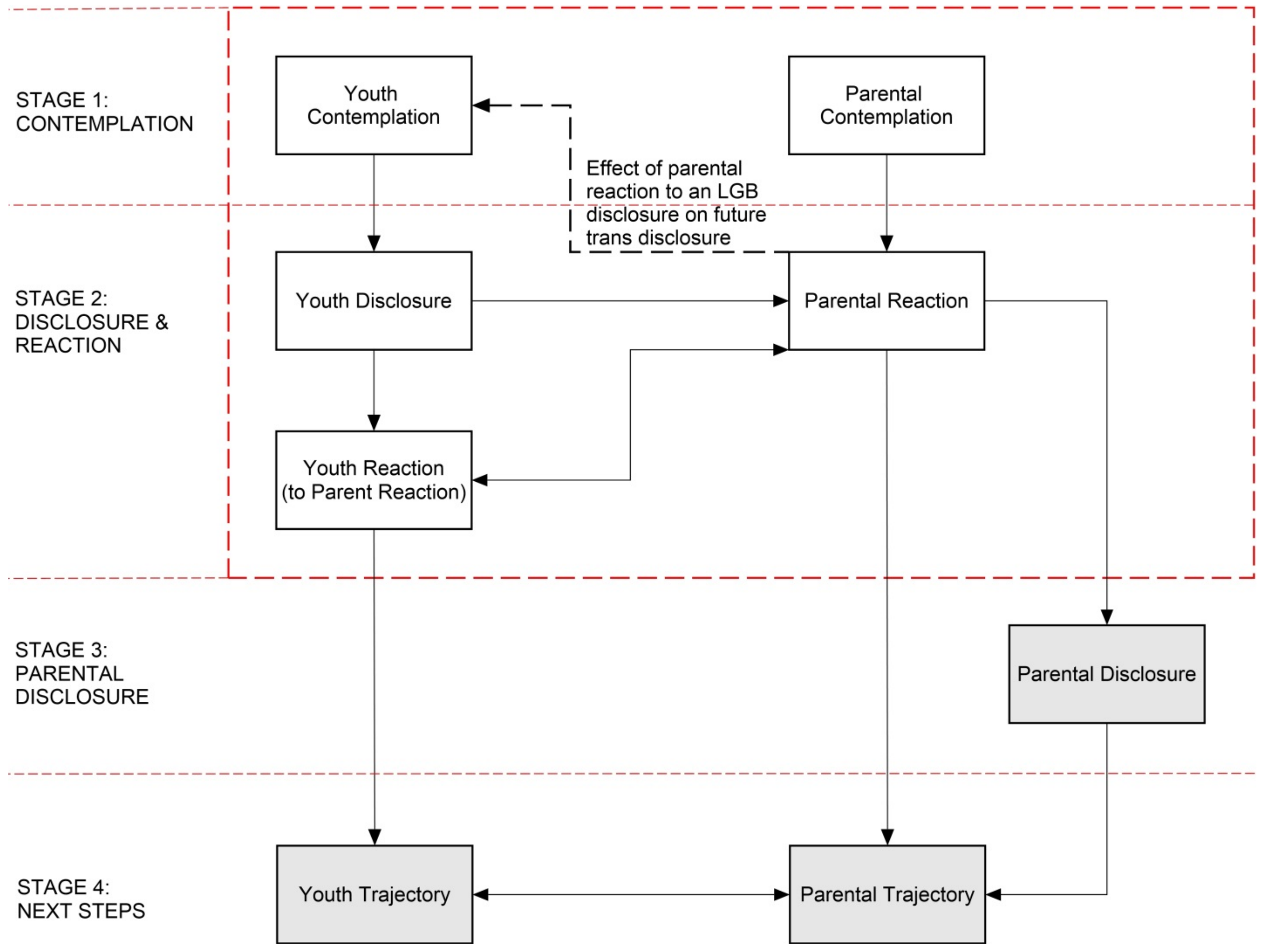
Stonewall. (2017). *School report: The experiences of lesbian, gay, bi and trans young people in Britain's schools in 2017*. Retrieved from https://www.stonewall.org.uk/system/files/the_school_report_2017.pdf

Testa, R. J., Michaels, M. S., Bliss, W., Rogers, M. L., Balsam, K. F., & Joiner, T. (2017). Suicidal ideation in transgender people: Gender minority stress and interpersonal theory factors. *Journal of Abnormal Psychology, 126*(1), 125-136. doi:10.1037/abn0000234

Wren, B. (2002). 'I can accept my child is transsexual but if I ever see him in a dress I'll hit him': Dilemmas in parenting a transgendered adolescent. *Clinical Child Psychology & Psychiatry, 7*(3), 377. doi:10.1177/1359104502007003035

Figures

Figure 1: Trans Family Dynamics Model (TFDM)



Chapter 4: Ethics Proposal

Ethics Application for Research Paper:

The Trans Family Dynamics Model: A picture of parent-child interaction pre and post childhood disclosure of trans gender identity

Debbie Helen Wood

Doctorate in Clinical Psychology

Division of Health Research: Lancaster University

Main text word count: 4749 of 6000 words, comprising:

Introduction = 93 words, IRAS Form Answers = 4656 words

Appendices word count: 11319 words, comprising:

FHMREC Letter = 215 words, Supporting Documentation & Materials = 11104 words

Introduction

The ethics application for this project was made via an IRAS form because the original intention was to interview clinicians in addition to trans youth and their parents, and this would have required an HRA application. Ultimately it was decided that the youth-parent dyad should be the focus of the research and so the HRA application was discontinued. The IRAS form (below) was therefore accepted by FHM Ethics in lieu of the standard FHMREC form.

Appendices following will include the approval letter from FHMREC and all supporting documentation and materials submitted to FHMREC.

IRAS (FHMREC) Form

Full Set of Project Data IRAS Version 5.13

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
Understanding family dynamics affecting mental health of trans youth

1. Is your project research?

(x) Yes ( ) No

DRAFT

2. Select one category from the list below:

( ) Clinical trial of an investigational medicinal product
( ) Clinical investigation or other study of a medical device
( ) Combined trial of an investigational medicinal product and an investigational medical device
( ) Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
( ) Basic science study involving procedures with human participants
( ) Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
(x) Study involving qualitative methods only
( ) Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
( ) Study limited to working with data (specific project only)
( ) Research tissue bank
( ) Research database

If your work does not fit any of these categories, select the option below:

( ) Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	( ) Yes	(x) No
b) Will you be taking new human tissue samples (or other human biological samples)?	( ) Yes	(x) No
c) Will you be using existing human tissue samples (or other human biological samples)?	( ) Yes	(x) No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

[x] England
[ ] Scotland

- [ ] Wales
- [ ] Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

- (●) England
- ( ) Scotland
- ( ) Wales
- ( ) Northern Ireland
- ( ) This study does not involve the NHS

4. Which applications do you require?

- [x] IRAS Form
- [ ] Confidentiality Advisory Group (CAG)
- [ ] Her Majesty's Prison and Probation Service (HMPPS)

Most research projects require review by a REC within the UK Health Departments' Research Ethics Service. Is your study exempt from REC review?

(●) Yes ( ) No

4b. Please confirm the reason(s) why the project does not require review by a REC within the UK Health Departments Research Ethics Service:

- [ ] Projects limited to the use of samples/data samples provided by a Research Tissue Bank (RTB) with generic ethical approval from a REC, in accordance with the conditions of approval.
- [ ] Projects limited to the use of data provided by a Research Database with generic ethical approval from a REC, in accordance with the conditions of approval.
- [ ] Research limited to use of previously collected, non-identifiable information
- [ ] Research limited to use of previously collected, non-identifiable tissue samples within terms of donor consent
- [ ] Research limited to use of acellular material
- [ ] Research limited to use of the premises or facilities of care organisations (no involvement of patients/service users as participants)
- [x] Research limited to involvement of staff as participants (no involvement of patients/service users as participants)

5. Will any research sites in this study be NHS organisations?

( ) Yes (●) No

6. Do you plan to include any participants who are children?

( ) Yes (●) No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

( ) Yes (●) No

DRAFT

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ◉ No

9. Is the study or any part of it being undertaken as an educational project?

◉ Yes ○ No

Please describe briefly the involvement of the student(s):
The doctoral student will be the Chief Investigator

Please note that in this application the student is purposefully listed as the chief investigator in this study. This is because the student is an experienced care practitioners undertaking doctoral-level study while employed by a health care provider, and in such circumstances the UK Policy Framework for Health and Social Care explicitly permits students to take the chief investigator role (p17 of the Framework contains this specific provision).

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

◉ Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ◉ No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ◉ No

DRAFT

Full Set of Project Data IRAS Version 5.13

Integrated Research Application System
Application Form for Research involving qualitative methods only

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
Understanding family dynamics affecting mental health of trans youth

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Understanding the role of family dynamics in affecting the mental health and wellbeing of transgender youth

A2-1. Educational projects

Name and contact details of student(s):

Student 1

	Title	Forename/Initials	Surname
	Ms	Debbie	Wood

Address

Post Code

E-mail d.wood6@lancaster.ac.uk

Telephone 07969679934

Fax

Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:
Doctorate in Clinical Psychology

Name of educational establishment:
Lancaster University

Name and contact details of academic supervisor(s):

Academic supervisor 1

	Title	Forename/Initials	Surname
	Dr	Suzanne	Hodge

Address Clinical Psychology, Div. Of Health Research

DRAFT

Lancaster University
Lancaster
Post Code LA1 4YG
E-mail s.hodge@lancaster.ac.uk
Telephone 01524 592712
Fax

Academic supervisor 2

Title	Forename/Initials	Surname
Professor	Bill	Selwood

Address Clinical Psychology, Div. Of Health Research
Lancaster University
Lancaster
Post Code LA1 4YG
E-mail b.sellwood@lancaster.ac.uk
Telephone 01524 593998
Fax

Academic supervisor 3

Title	Forename/Initials	Surname
Dr	Igi	Moon

Address
Post Code
E-mail igi.moon@roehampton.ac.uk
Telephone
Fax

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	Academic supervisor(s)
Student 1 Ms Debbie Wood	☑ Dr Suzanne Hodge ☑ Professor Bill Selwood ☑ Dr Igi Moon

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

- (●) Student
- ( ) Academic supervisor
- ( ) Other

DRAFT

A3-1. Chief Investigator:

	Title	Forename/Initials	Surname
	Ms	Debbie	Wood
Post	Trainee Clinical Psychologist		
Qualifications	BEng (Hons) Mechanical Engineering BSc (Hons) Psychology MSc Psychological Research Methods PgDip Advanced Practice of Cognitive Behavioural Therapy		
ORCID ID	0000 0002 2269 7959		
Employer	Lancaster University / Lancashire Care NHS Foundation Trust		
Work Address			
Post Code			
Work E-mail	d.wood6@lancaster.ac.uk		
* Personal E-mail	debbie.wood@redwoodpsychology.com		
Work Telephone	07969679934		
* Personal Telephone/Mobile			
Fax			

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and HRA/R&D reviewers that is sent to the CI.

	Title	Forename/Initials	Surname
		Becky	Gordon
Address	Deputy Head of Research Services Lancaster University		
Post Code	LA1 4YW		
E-mail	sponsorship@lancaster.ac.uk		
Telephone	01524592981		
Fax			

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):	
Sponsor's/protocol number:	
Protocol Version:	1.1
Protocol Date:	03/08/2019
Funder's reference number (enter the reference number or state not applicable):	
Project website:	

Additional reference number(s):

DRAFT

Ref.Number Description	Reference Number

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

◯ Yes ◉ No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments' Research Ethics Service, this summary will be published on the Health Research Authority (HRA) website following the ethical review. Please refer to the question specific guidance for this question.*

The last ten years has seen a huge surge in the number of people being open about their transgender (trans) identity and this has put a tremendous strain on the NHS services designed to help both adults and children. This means that waiting times can be up to two years before someone gets to see a clinician . This is very difficult for people who have opened up and might feel vulnerable as a result, especially as trans people have been shown to suffer higher rates of low mood, self-harm and suicidal behaviours than the general population. Research tells us that the reasons behind this revolve around suffering prejudice from other people and feeling rejected and 'wrong' as a result. Research also shows that trans people who have supportive families, who allow them to express themselves, exhibit significantly reduced distress and mental health problems. For most families the news that their child is transgender comes as a surprise and brings unexpected challenges. All families are unique in their beliefs and dynamics, and consequently family support for trans children varies widely. This highlights an identified need to develop a family intervention with the purpose of helping families to deal with the challenges they face in order to foster acceptance and understanding of their trans child. This research is part of a doctoral thesis project which aims to lay the foundations for such an intervention. By talking to trans people, their families and the professionals who work with them the intention is to build a theoretical understanding of the way family dynamics affect the mental health and wellbeing of trans youth.

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, R&D office or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

Informed Consent - participants will be provided with an information sheet which they will be asked to read. Before their data collection begins they will be given the opportunity to ask questions and then asked to sign a consent form.

Confidentiality - All personally identifiable information will stored in encrypted electronic format or under lock and key, and will be removed from transcripts to before analysis to maintain participant anonymity. As part of the consent form all focus group participants will be asked to agree not to disclose what other people have said in the group setting.

Data Withdrawal - Participants can request to withdraw from the study at any time. However, once their data has been analysed it becomes increasingly difficult to disentangle their data. Therefore participants will be advised that if they request data withdrawal before analysis takes place, which is likely to be within 2-4 weeks, then their data will be withdrawn. After analysis withdrawal of data cannot be guaranteed.

Participant Distress - There is a risk that participants, particularly transgender people and their families, could find that the interviews are experienced as highly emotional. It will be made clear in the participant information, and on the day, that participants may take a break from the interview, or withdraw at any point. At debrief there will be an opportunity to briefly discuss how the participant feels and to signpost them accordingly. The debrief sheet, which they take away also contains information about who they might contact in the event of ongoing emotional disturbance.

Limitations - Travel costs may be prohibitive for some participants, especially when trying to bring people together from different locations for a focus group. There is a small budget which can be used to pay for travel costs up to a maximum of £20.00. So that less affluent participants are not excluded from this research location will be considered when recruiting to focus groups. Unfortunately, there are no resources for translators or other people with communication difficulties so these groups are
excluded from this research. These are acknowledged limitations of this research.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply:*

- ☐ Case series/ case note review
- ☐ Case control
- ☐ Cohort observation
- ☐ Controlled trial without randomisation
- ☐ Cross-sectional study
- ☐ Database analysis
- ☐ Epidemiology
- ☐ Feasibility/ pilot study
- ☐ Laboratory study
- ☐ Metanalysis
- ☑ Qualitative research
- ☑ Questionnaire, interview or observation study
- ☐ Randomised controlled trial
- ☐ Other (please specify)

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

The project aims to understand the family dynamic which develops around finding out that a child from the family is transgender. This research aims to investigate how this develops in ways which are positive or negative for the wellbeing of the transgender child in the family, without forgetting how other family members are affected, and how this also affects the transgender child. This will be achieved by capturing the experiences and viewpoints of children and family as well as people who work with them. A longer term aim is to use the results of this research to inform the development of a family intervention which aims to foster a dynamic which is beneficial for all, but primarily to be positive for the mental health and wellbeing of the transgender child.

Research Question:
What are the core processes which influence family dynamics affecting the mental health and wellbeing of transgender youth in a UK setting?

In lay language:
How does the whole family react when a child reveals that they are transgender, and what effect does that reaction have on the trans child's mental health?

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

None

DRAFT

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

One result of the recent surge in the number of transgender adults and children being open about their identities has been a strain on NHS and third sector services seeking to support them. This is a problem because transgender people are a vulnerable group who experience higher rates of low mood, self-harm and suicidal behaviours than the general population (McNeil et al., 2012; Stonewall, 2018). Research indicates that this is because transgender people are subject to 'minority stress' which is a set of problems people experience when they are part of a minority group because they are treated differently by others, sometimes including their own families. This can lead to social pressure, feeling of not 'fitting in' and negative self image (Testa et al., 2017). This is a particular problem for children who are less able to make decisions for themselves or to go and live with other people.

Research also shows that supportive families, allowing for self-expression, can significantly reduce distress and mental health problems (Durwood, McLaughlin & Olsen, 2017). The news that a child is transgender brings unexpected challenges to most families, and widely varying beliefs and dynamics mean family support for transgender children varies widely. In 2004 Arlene Lev called for clinicians to develop family interventions for working with families, and in 2018 this call was repeated by Caroline Parker and colleagues. This identifies a need to develop a family intervention to help families to deal with challenges and to foster acceptance and understanding of their transgender child. This research is part of a project to lay theoretical foundations for an intervention which might be delivered by CAMHS or third sector professionals.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

The design of this project is to use a 'constructivist grounded theory' approach collecting data from a mixture of focus groups and one-to-one interviews.

Constructivist grounded theory is a method primarily designed for the development of theory which is 'grounded' in data collected from participants. This involves collecting an initial data set and analysing it for themes (core categories) which go together to begin to explain the phenomenon of interest to the research. The resulting theory is examined for gaps or anomalies. Further, focussed, data collection is then carried out to account for these and strengthen the resulting theory. The approach is iterative and it is acceptable within the method to carry out as many stages of data collection as are required to reach data saturation (where nothing new emerges from subsequent data) or theoretical sufficiency where the resulting theory is considered to be 'good enough'. In all cases participants are purposively 'theoretically' sampled against inclusion criteria to best meet the needs of the research question.

Prospective participants will be recruited from a variety of non-NHS sources including third sector organisations (e.g. [redacted]). A poster will be provided for organisations to distribute and participants will be asked to contact the CI directly if they wish to be involved. These organisations will not be asked to recruit, just to signpost via their normal channels including social media. People who contact will be sent a covering letter, participant information, anonymised demographics form and a copy of the consent form. They will be asked to return the demographic form if they wish to participate. From the information provided a decision will be made as to whether they meet inclusion, or exclusion, criteria and they will be informed that they have been placed on a list of possible participants, or not, and thanked for their interest in the project. Participants for all phases will be selected from the pool of suitable candidates who will be informed when needed and asked if they still wish to participate. There may be more than one round of recruitment dependent upon need.

On arrival for interview participants will be asked to sign two copies of the consent form. One will be retained by the interviewer and the other by the participant. The consent form includes an option to be supplied with a precis of the analysis of their interview and to feedback on the analysis. Following the interview a debrief form will be supplied. This has contact information for suitable organisations in case of post interview distress. It also re-iterates that feedback would be valued post-analysis and explains that a subsequent interview may be requested for the next phase of data collection.

Phase one of data collection will involve interviews carried out with two focus groups of up to eight people. One group will be made up of transgender people in the age range 16-32*, the other of family members. The focus groups will last up to one and a half hours. They will be audio and video recorded (the latter for participant identification where audio is unclear). They will take place at a location TBA dependent upon the location of participants. This will probably be a suitable, private room, in a staffed building run by an NHS, community or third sector organisation.

Phase two of data collection will comprise one-to-one interviews with people chosen to examine particular areas of the developing theory. These might come from any of the following populations:

1. Trans youth aged 16-32 some of whom have received support and may be in treatment with specialist gender services, and some who have not received any support.
2. The families, and particularly the parents, of trans youth.
3. Clinicians involved in the care of trans youth.
4. Policy makers involved with trans healthcare.
5. Other people with involvement in trans healthcare.

People who fit criteria 3-5 may be recruited via NHS sites but again via signposting keeping site involvement to a minimum.

Interviews will be scheduled to last approximately one hour and will take place at a location TBA dependent upon the location of participant. This will probably be a suitable, private room, in a staffed building run by an NHS, community or third sector organisation. It may also be the participant's home or the CI's home - in which case employers lone worker policy will be employed.

All interviews will be semi-structured. An interview guide has been produced to highlight important areas of interest but this is not intended to be prescriptive.

* The United Nations define youth as being between the age of 15 and 24 whilst acknowledging that member states vary and that context has a bearing on this definition, see https://www.un.org/esa/socdev/documents/youth/fact-sheets/youth-d efinition.pdf (United Nations, no date). For the purpose of this study it was decided to raise the limit to 16 to avoid having to assess Gillick competence and to raise the upper limit to include people who were 'youth' when the 2004 Gender Recognition Act came into force. The age range will allow for contributions from people who are still in the family dynamic through to people who were but may now be removed from it and have had some time to reflect on the experience. Including younger children was considered but given the changing family dynamic in transitioning from childhood to youth, and limited time and resources available, it was decided to concentrate on the 16+ age range. Further research with younger children would then be considered as a separate project which would feed into the overall aim to design an intervention for families. In particular it was considered that containing a focus group with widely differing ages might present ethical dilemmas around potential language use and subjects discussed.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

- [x] Design of the research
- [ ] Management of the research
- [ ] Undertaking the research
- [x] Analysis of results
- [x] Dissemination of findings
- [ ] None of the above

Give details of involvement, or if none please justify the absence of involvement.
I attended a local trans family group and discussed what I was doing with them and how I plan to do it. I also publicised and explained my research on their facebook page to give people who weren't at the meeting a chance to comment. The reaction was positive, with some expressions of interest. We discussed whether or not whole family focus groups were a good idea and the unanimous consensus was that this format could inhibit honest answers and might be heated. The preference was for a group of trans young people and then a group of family members.

In my protocol and debrief document I describe how I will offer participants an opportunity to review my findings and feedback to me once the stage of the project that they are involved with is complete.

At my meeting with families I also discussed the possibility of people involved with the research and/or the group making a video to highlight important findings. There was definite interest in this.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A15. What is the sample group or cohort to be studied in this research?

DRAFT

Select all that apply:

- [ ] Blood
- [ ] Cancer
- [ ] Cardiovascular
- [ ] Congenital Disorders
- [ ] Dementias and Neurodegenerative Diseases
- [ ] Diabetes
- [ ] Ear
- [ ] Eye
- [ ] Generic Health Relevance
- [ ] Infection
- [ ] Inflammatory and Immune System
- [ ] Injuries and Accidents
- [x] Mental Health
- [ ] Metabolic and Endocrine
- [ ] Musculoskeletal
- [ ] Neurological
- [ ] Oral and Gastrointestinal
- [ ] Paediatrics
- [ ] Renal and Urogenital
- [ ] Reproductive Health and Childbirth
- [ ] Respiratory
- [ ] Skin
- [ ] Stroke

Gender:	Male and female participants
Lower age limit: 16	Years
Upper age limit: 32	Years

DRAFT

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

Participants must be:
1. A transgender person between the ages of 16 and 32 who was open to their family about their transgender identity before their 18th birthday. OR
2. A family member of a transgender person who was open to their family about their transgender identity before their 18th birthday. OR
3. A professional person working in the field of child and adolescent healthcare involving work with or about transgender youth.

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

Participants will be excluded if:
1. They are non-English speakers. This is because there are insufficient resources to pay for translation. This is recognised as a limitation of the research.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Asking questions & consent seeking	1	N/A	10 mins	Researcher/CI Interviews would take place at a location TBA based on convenience for the participant(s).This might be an NHS, community or 3rd Sector office or the participants or researchers home, with appropriate safeguarding measures in place.
Focus Group	0-1	N/A	1.5 hours	Researcher/CI. Interviews would take place at a location TBA based on convenience for the participants. This might be an NHS, community or 3rd Sector office
One-to-one interview. NB Column 1 is max, 1 will be typical.	0-3	N/A	1 hour	Researcher/CI. Interviews would take place at a location TBA based on convenience for the participant. This might be an NHS, community or 3rd Sector office or the participants or researchers home, with appropriate safeguarding measures in place.
Debrief	1	N/A	10 mins	Researcher/CI. This will take place following the focus group or interview

A21. How long do you expect each participant to be in the study in total?

In total the maximum expected length of the focus group interviews will be two hours including consent signing and debrief. One to one interviews will be a approximately one and a half hours. Participants may be asked if they would complete subsequent interview(s) although there is no commitment to do so. In total the maximum time that any one participant would expect to be involved with the research is six months. This is the anticipated time between first data collection and final data analysis.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

There is a possibility that some participants may view the interviews as therapy. If this happens as a by-product of the interview and is positive then this is fine but it will be made clear in the participant information that this is not the purpose of the interview.

There is also a risk that participants, particularly transgender people and their families, could find that the interviews are experienced as highly emotional. It will be made clear in the participant information, and on the day, that participants may take a break from the interview, or withdraw at any point. At debrief there will be an opportunity to discuss how the participant feels and to signpost them accordingly to organisations detailed on the debrief sheet. The debrief sheet will include contact information for transgender support organisations (Mermaids, LGBT Consortium and Mindline Trans+) as well as the Samaritans who offer 24 hour emotional support. There will also be advice to contact GP or NHS crisis services if a participant feels at risk.

Participants may need to travel and incur costs. There is a small budget to cover this eventuality and refund, or partial refund, will be negotiated in line with university rules at the time.

DRAFT

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

(•) Yes ( ) No

If Yes, please give details of procedures in place to deal with these issues:

There is a possibility that participants, particularly transgender people and their families, could find that the interviews are experienced as highly emotional. It will be made clear in the participant information, and on the day, that participants may take a break from the interview, or withdraw at any point. At debrief there will be an opportunity to briefly discuss how the participant feels and to signpost them accordingly. The debrief sheet, which they take away also contains information about who they might contact in the event of ongoing emotional disturbance.

A24. What is the potential for benefit to research participants?

The main benefit will be to be involved with something which makes things easier for others in a similar situation in the future. However it may also be beneficial to be able to talk about experiences which they may have been unable to talk about in the past. For people involved with the focus groups there is also the added bonus of potentially making social contacts with people who have had some similar experiences.

A26. What are the potential risks for the researchers themselves? *(if any)*

The researcher may be conducting interviews in places where there is nobody else around. In this case the employer lone working policy will be adhered too. This involves a buddy system whereby another person is aware that the researcher will be lone working, where and between what times. If the researcher does not contact their buddy within an agreed time frame then the buddy would attempt to ring the researcher. If this fails then they would contact the police. If the address is sensitive (i.e. confidential client information) then the buddy would be supplied with this information in a sealed envelope - only to be opened if required, and to be returned to the researcher un-opened if not required.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used? *For example, identification may involve a disease register, computerised search of social care or GP records, or review of medical records. Indicate whether this will be done by the direct care team or by researchers acting under arrangements with the responsible care organisation(s).*

Participants will be self-selecting. Various third sector and community organisations have agreed to distribute information about the research via their usual channels. Potential recruitment centres will be sent an information sheet and a poster to advertise over their normal channels. There will be no requirement to target individuals or screen participants. Potential participants will have researcher details and will contact the researcher independently. They will then be asked to fill in and return a demographics form and will be screened by the researcher against inclusion/exclusion criteria.From that point on the researcher will further screen potential participants for suitability to take part in the various phases of the research, from the available pool and based on the information on the demographics form.

The demographics form includes a question about ethnicity. This is to allow the researcher the opportunity to make the sample as ethnically representative of the UK as possible, or at least to be aware of this factor.

For clinicians and people who work with transgender people there is the additional option of NHS sites assisting with recruitment. However this will still amount to signposting keeping NHS staff involvement to a minimum.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

(•) Yes ( ) No

Please give details below:

DRAFT

Only insofar as the information supplied by participants on the demographic form sent out by the researcher. There will be no access requested for medical or other records held by other organisations.

A27-3. Describe what measures will be taken to ensure there is no breach of any duty of confidentiality owed to patients, service users or any other person in the process of identifying potential participants. *Indicate what steps have been or will be taken to inform patients and service users of the potential use of their records for this purpose. Describe the arrangements to ensure that the wishes of patients and service users regarding access to their records are respected. Please consult the guidance notes on this topic.*

The demographics form has a unique identifier rather than the participants name. Once received by the researcher this will be stored in a locked filing cabinet - either on paper or electronically on an encrypted USB stick.

A27-4. Will researchers or individuals other than the direct care team have access to identifiable personal information of any potential participants?

○ Yes ◉ No

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

◉ Yes ○ No

If Yes, please give details of how and where publicity will be conducted, and enclose copy of all advertising material (with version numbers and dates).

Yes. Trans people and family members will be alerted to the research via a poster and information sheet advertised via a number of third sector and community organisations using their normal methods of communicating with their service users.

A29. How and by whom will potential participants first be approached?

Trans people and their families will not be individually targeted. The information will be placed where they can see it and it will be up to them to contact the researcher. The approach will be from the researcher following initial contact from the prospective participant.
Healthcare professionals may be contacted either by their employer or by the researcher. It will be made clear that any participation is on a voluntary basis and that there will be no penalty for non-participation.

A30-1. Will you obtain informed consent from or on behalf of research participants?

◉ Yes ○ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

Participants will be over the age of 16 and will be asked to read the participant information sheet, preferably before attending for interview. Before the interview the researcher will give participants an opportunity to ask questions and, if they still wish to continue participants will be asked to sign a consent form.

If you are not obtaining consent, please explain why not.

N/A

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

DRAFT

(•) Yes ( ) No

A31. How long will you allow potential participants to decide whether or not to take part?

Prospective participants will be sent information and consent forms to read and complete in their own time. I will request on the accompanying letter that participants reply within a two week time frame but not doing so will not make them ineligible.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?*(e.g. translation, use of interpreters)*

Unfortunately there will be no provision for special communication needs or for people who do not speak English due to a lack of resources. It is recognised that this is a limitation of this research.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

( ) The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.

( ) The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.

( ) The participant would continue to be included in the study.

( ) Not applicable – informed consent will not be sought from any participants in this research.

(•) Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

N/A

DRAFT

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?*(Tick as appropriate)*

- [ ] Access to medical records by those outside the direct healthcare team
- [ ] Access to social care records by those outside the direct social care team
- [x] Electronic transfer by magnetic or optical media, email or computer networks
- [ ] Sharing of personal data with other organisations
- [ ] Export of personal data outside the EEA
- [x] Use of personal addresses, postcodes, faxes, emails or telephone numbers
- [x] Publication of direct quotations from respondents
- [ ] Publication of data that might allow identification of individuals
- [ ] Use of audio/visual recording devices
- [x] Storage of personal data on any of the following:

- [x] Manual files (includes paper or film)
- [ ] NHS computers
- [ ] Social Care Service computers
- [ ] Home or other personal computers
- [x] University computers
- [ ] Private company computers
- [ ] Laptop computers

Further details:
Data will be held on the researcher's password protected drive and BOX folder on the university secure server which is accessible from their home and/or in a locked filing cabinet in the researcher's home, to which only they have a key. Information at the researcher's home will be kept on an encrypted USB stick or on paper. Paper records will be kept to a minimum and transferred to electronic storage as quickly as practical.

Participant demographic forms and the register of participants will be electronic, or converted to electronic format as quickly as possible. In either case they will be stored in the researcher's locked cabinet and nobody else will have access to these.

There will almost certainly be identifiable data on the interview recordings. These will need to be transported between interview sites and the CI's home in unencrypted format. Once there they will be transferred to encrypted USB stick and/or the CI's encrypted Lancaster University network folder.

A professional transcriber may be employed. If so the transcriber will be sent a link to access directly from this folder and will sign an agreement to store recordings securely and delete recordings and transcripts once they have completed their work.

Transcripts will be e-mailed to the researcher as password protected MS Word files. These will then be decrypted and saved to an encrypted USB stick and/ or the researcher's secure university folder. The researcher will edit transcripts to remove personally identifiable material.

A37. Please describe the physical security arrangements for storage of personal data during the study?

Data will be held on the researcher's password protected drive and BOX folder on the university secure server which is accessible from their home and/or in a locked filing cabinet in the researcher's home, to which only they have a key. Information at the researcher's home will be kept on an encrypted USB stick or on paper. Paper records will be kept to a minimum and transferred to electronic storage as quickly as practical.

A38. How will you ensure the confidentiality of personal data?*Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

Participants will be informed that their data will be treated as confidential in that they will not be identified in the write up or to third parties outside of the research team. Direct quotations will be taken from edited transcripts only and if necessary other contextual information will be removed or changed in a way that makes the information confidential but without losing it's relevance. Participant names will not be used in anything which is published, but will be replaced with a pseudonym or a reference number.

There is a caveat however in that if a participant discloses risk to themselves or others then it may be necessary to disclose this to an appropriate party - depending upon the disclosure. If at all possible this would be discussed with the participant first. Finally, it will be a condition of taking part in the focus groups that participants agree to treat anything anybody else says as confidential. All of these points are included on the consent form and participants are required to sign and initial these points to confirm understanding and agreement.

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

There will be no access to external or NHS records as part of this research. Participants will provide a small amount of personal information as part of the opt-in process. This will be stored securely by the researcher and nobody else will

DRAFT

have access.

Storage and use of data after the end of the study

A41. Where will the data generated by the study be analysed and by whom?

The data will be analysed by the researcher at their home. A small amount of data may be analysed by one of the supervisors as triangulation. This would be via a shared folder on the university secure drive or BOX and carried out in a private place, at their home or office.

A42. Who will have control of and act as the custodian for the data generated by the study?

	Title	Forename/Initials	Surname
	Dr	Suzanne	Hodge
Post	Lecturer		
Qualifications	PhD, MSc, BA		
Work Address	Clinical Psychology, Div. of Health Research		
	Lancaster University		
	Lancaster		
Post Code	LA1 4YG		
Work Email	s.hodge@lancaster.ac.uk		
Work Telephone	01524592712		
Fax			

DRAFT

A43. How long will personal data be stored or accessed after the study has ended?

- (•) Less than 3 months
- ( ) 3 – 6 months
- ( ) 6 – 12 months
- ( ) 12 months – 3 years
- ( ) Over 3 years

A44. For how long will you store research data generated by the study?

Years: 10
Months: 0

A45. Please give details of the long term arrangements for storage of research data after the study has ended. *Say where data will be stored, who will have access and the arrangements to ensure security.*

Anonymised transcripts will be held by the university in accordance with their policy. This data will be transferred electronically using a secure method that is supported by the University to a password-protected file space on the university server. After ten years this data will be deleted. It wil be noted on participant information and consent that the data may be re-analysed within this timeframe for the purposes of further research into this field.

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives

for taking part in this research?

(•) Yes ( ) No

If Yes, please give details. For monetary payments, indicate how much and on what basis this has been determined.
Participants may be reimbursed, or partially reimbursed for travelling expenses up to a maximum of £20.00

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

( ) Yes (•) No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

( ) Yes (•) No

DRAFT

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

( ) Yes (•) No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50-1. Will the research be registered on a public database?

( ) Yes (•) No

Please give details, or justify if not registering the research.
No relevant database has been identified

Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? *Tick as appropriate:*

- [x] Peer reviewed scientific journals
- [ ] Internal report
- [x] Conference presentation
- [ ] Publication on website
- [ ] Other publication
- [ ] Submission to regulatory authorities
- [ ] Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators

☐ No plans to report or disseminate the results

☑ Other (please specify)

This research will be presented to my peers and staff as part of my doctorate in clinical psychology. Ultimately the plan is to use the results to inform the design of a family intervention for trans youth.

A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?

All personally identified data will have been removed before any form of write up or publication.

A53. Will you inform participants of the results?

◉ Yes ○ No

Please give details of how you will inform participants or justify if not doing so.
The debrief form explains that analysis of the participants part of the research is available on request and that feedback from participants would be welcomed and utilised.

DRAFT

5. Scientific and Statistical Review

A54-1. How has the scientific quality of the research been assessed? *Tick as appropriate:*

☐ Independent external review

☐ Review within a company

☐ Review within a multi−centre research group

☑ Review within the Chief Investigator's institution or host organisation

☑ Review within the research team

☑ Review by educational supervisor

☐ Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
This project will have been reviewed by Lancaster University Faculty of Health & Medicine REC.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size:	28
Total international sample size (including UK):	28
Total in European Economic Area:	0

Further details:
The initial plan is to interview up to eight transgender people aged 16-32 in a focus group and up to eight family members in a focus group. Subsequent one-to-one interviews will be with up to another 12 individuals who might come from any of the three identified populations of interest:

1. Trans youth some of whom have received support and may be in treatment with specialist gender services, and some who have not received any support.
2. The families, and particularly the parents, of trans youth.
3. Clinicians involved in the care of trans youth.
4. Policy makers involved with trans healthcare.

5. Other people with involvement in trans healthcare.

All of these groups have been identified on the basis that they might have some insight into family dynamics involving a transgender child.

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

Ideally there would be no upper limit on the sample. However, with approximately 6 months to have all interviews completed, transcribed and analysed it was considered that this number was the maximum that would be achievable.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

The data will be analysed using constructivist grounded theory to identify core themes which will inform the development of a theory of family dynamics affecting the mental health and wellbeing of transgender youth.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co-applicants, protocol co-authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

Title Forename/Initials Surname

Post
Qualifications
Employer
Work Address

Post Code
Telephone
Fax
Mobile
Work Email

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status:
- ○ NHS or HSC care organisation
- ◉ Academic
- ○ Pharmaceutical industry
- ○ Medical device industry
- ○ Local Authority
- ○ Other social care provider (including voluntary sector or private organisation)

Commercial status: Non-Commercial

DRAFT

◯ Other

If Other, please specify:

Contact person

Name of organisation	Lancaster Univeristy
Given name	Becky
Family name	Gordon
Address	Lancaster University
Town/city	Lancaster
Post code	LA1 4YW
Country	UNITED KINGDOM
Telephone	01524592981
Fax	
E-mail	sponsorship@lancaster.ac.uk

A65. Has external funding for the research been secured?

Please tick at least one check box.

☐ Funding secured from one or more funders

☐ External funding application to one or more funders in progress

☑ No application for external funding will be made

What type of research project is this?

◉ Standalone project

◯ Project that is part of a programme grant

◯ Project that is part of a Centre grant

◯ Project that is part of a fellowship/ personal award/ research training award

◯ Other

Other – please state:

A66. Has responsibility for any specific research activities or procedures been delegated to a subcontractor (other than a co-sponsor listed in A64-1) ? *Please give details of subcontractors if applicable.*

◉ Yes ◯ No

Name: Jaqueline Dobor: JD Transcription

Type of organisation:
◯ NHS ◯ Academic ◉ Commercial ◯ Other

Please give further details of sub-contractor and main areas of delegated responsibility: Transcription of recordings

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

○ Yes ◉ No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A69-1. How long do you expect the study to last in the UK?

Planned start date: 01/08/2019
Planned end date: 01/08/2020
Total duration:
Years: 1 Months: 0 Days: 1

A71-1. Is this study?

◉ Single centre
○ Multicentre

A71-2. Where will the research take place? *(Tick as appropriate)*

- [x] England
- [ ] Scotland
- [ ] Wales
- [ ] Northern Ireland
- [ ] Other countries in European Economic Area

Total UK sites in study

Does this trial involve countries outside the EU?
○ Yes ◉ No

A72. Which organisations in the UK will host the research? *Please indicate the type of organisation by ticking the box and give approximate numbers if known:*

- [ ] NHS organisations in England
- [ ] NHS organisations in Wales
- [ ] NHS organisations in Scotland
- [ ] HSC organisations in Northern Ireland
- [ ] GP practices in England
- [ ] GP practices in Wales
- [ ] GP practices in Scotland
- [ ] GP practices in Northern Ireland
- [ ] Joint health and social care agencies (eg community mental health teams)
- [ ] Local authorities
- [ ] Phase 1 trial units

DRAFT

- ☐ Prison establishments
- ☐ Probation areas
- ☐ Independent (private or voluntary sector) organisations
- ☑ Educational establishments 1
- ☐ Independent research units
- ☐ Other (give details)

Total UK sites in study: 1

A73-1. Will potential participants be identified through any organisations other than the research sites listed above?

◉ Yes ○ No

A73-2. If yes, will any of these organisations be NHS organisations?

◉ Yes ○ No

If yes, details should be given in Part C.

A73-3. Approximately how much time will these organisations expect to spend on screening records and/or provision of information to potential participants, and how will the costs of these activities be funded?

There will be no time screening records as I am only wanting to recruit staff from these sites. I will be supplying a poster and an information sheet to be e-mailed out to teams. After that it will be up to staff to contact me directly. The time needed will be minimal and sites I have spoken to have not mentioned needing payment. for this.

A74. What arrangements are in place for monitoring and auditing the conduct of the research?

Regular supervision. There are three supervisors with various expertise in research generally, grounded theory particularly, the research subject and the wider picture of intervention design and implementation.

Please note that in this application the student is purposefully listed as the chief investigator in this study. This is because the student is an experienced care practitioner undertaking doctoral-level study while employed by a health care provider, and in such circumstances the UK Policy Framework for Health and Social Care explicitly permits students to take the chief investigator role (p17 of the Framework contains this specific provision).

A76. Insurance/ indemnity to meet potential legal liabilities

Note: in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

- ☐ NHS indemnity scheme will apply (NHS sponsors only)
- ☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

- [ ] NHS indemnity scheme will apply (protocol authors with NHS contracts only)
- [x] Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

- [ ] NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)
- [x] Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Lancaster University legal liability cover will apply

Please enclose a copy of relevant documents.

A78. Could the research lead to the development of a new product/process or the generation of intellectual property?

○ Yes ○ No ◉ Not sure

PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For further information please refer to guidance.*

Investigator identifier	Research site	Investigator Name
IN1	◉ NHS/HSC Site ○ Non-NHS/HSC Site	

DRAFT

Country ENGLAND

Participant Identification Centres

PIC Type	Centre	Individual(s)
◉ NHS (England) ◯ NHS (outside England) ◯ Non-NHS		E-mail:

IN2

◉ NHS/HSC Site
◯ Non-NHS/HSC Site

Forename
Middle name
Family name
Email
Qualification (MD...)
Country

Participant Identification Centres

PIC Type	Centre	Individual(s)
◉ NHS (England) ◯ NHS (outside England) ◯ Non-NHS		E-mail:

DRAFT

Appendices: Supporting Documentation

Appendix 4.1: FHMREC Approval Letter

Applicant: Debbie Wood
Supervisor: Suzanne Hodge and Bill Sellwood
Department: Health Research
FHMREC Reference: FHMREC18116

13 August 2019

Dear Debbie

Re: Understanding the role of family dynamics in affecting the mental health and wellbeing of transgender youth

Thank you for submitting your research ethics application for the above project for review by the Faculty of Health and Medicine Research Ethics Committee (FHMREC). The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 593987
Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

R.E. Case

Becky Case
Research Ethics Officer, Secretary to FHMREC.

Appendix 4.2: Research Protocol

Research Protocol

TITLE: Understanding the role of family dynamics in affecting the mental health and wellbeing of transgender youth

Chief Investigator/ Clinical Psychology Trainee: Debbie Helen Wood
Tel: 07969 679934
Email: d.wood6@lancaster.ac.uk

Research Supervisor: Dr Suzanne Hodge
Address: Clinical Psychology, Div. Of Health Research, Lancaster University, Lancaster, LA1 4YG
Tel: 01524 592712
Email: s.hodge@lancaster.ac.uk

Research Supervisor: Professor Bill Selwood
Address: Clinical Psychology, Div. Of Health Research, Lancaster University, Lancaster, LA1 4YG
Tel: 01524 593998
Email: b.sellwood@lancaster.ac.uk

Field Supervisor: Dr Igi Moon
Email: igi.moon@roehampton.ac.uk

Lay Summary

The last ten years has seen a huge surge in the number of people being open about their transgender (trans) identity and this has put a tremendous strain on the NHS services designed to help both adults and children. This means that waiting times can be up to two years before someone gets to see a clinician. This is very difficult for people who have opened up and might feel vulnerable as a result, especially as trans people have been shown to suffer higher rates of low mood, self-harm and suicidal behaviours than the general population. Research indicates that this is because transgender people are subject to minority stress leading to social pressure and negative self-image. Research also shows that supportive families, allowing for self-expression, can significantly reduce distress and mental health problems. For most families the news that their child is transgender comes as a surprise and brings unexpected challenges. All families are unique in their beliefs and dynamics, and consequently family support for trans children varies widely. This highlights an identified need to develop a family intervention with the purpose of helping families to deal with the challenges they face in order to foster acceptance and understanding of their trans child. This research is part of a doctoral thesis project which aims to lay the foundations for such an intervention. By talking to trans people, their families and the professionals who work with them the intention is to build a theoretical understanding of the way family dynamics affect the mental health and wellbeing of trans youth.

Introduction

The last ten years have seen a huge surge in the number of people openly expressing a transgender (trans), questioning or non-binary gender identity[1] and this is reflected in the number of people being referred to specialist gender services for adults and children alike. Figures obtained in 2016 by the Guardian newspaper via a freedom of information request show that in the last decade UK adult gender services have seen referrals increase between three fold and twenty-eight fold at Leeds and Nottingham Gender Identity Clinics respectively (Lyons, 2016). Meanwhile, the Gender Identity Development Service (GIDS) for children and adolescents has seen referral rates increase by approximately 50% per year between 2009-15 followed by a 100% increase in 2016 from 697 to 1419 (Tavistock & Portman NHS Foundation Trust, 2016). This slowed to approximately 42% in 2017 and 25% in 2018, but represents a total of 2519 referrals for 2018 (GIDS, 2018). Overall this represents a thirty fold increase in referrals in ten years. This has placed services under strain with long waiting times the result. For adults the wait between referral and first appointment varies between seventeen months (Leeds & York Partnership NHS Foundation Trust, 2019) and over two and a half years (Nottinghamshire Healthcare NHS Foundation Trust, no date). For children it currently takes 14-18 months to be seen following referral (GIDS, 2019). Not all trans people seek treatment from specialist gender services (Richards & Barker, 2013) but even just finding support for associated mental health difficulties can be a challenge because clinicians are not generally trained to work with some of the specific challenges trans people present with (Parker, Hirsch, Morgan & Parker, 2018).

This bottleneck means that already vulnerable people who are dealing with high levels of distress are being kept waiting for help at the point where they have opened up to others about their gender identity thus increasing their vulnerability. Transgender people across the lifespan suffer higher rates of depression and anxiety, and exhibit significantly increased rates of self-harm and suicidal behaviour compared to the general population (McNeil et al., 2012; Stonewall, 2018). Suicidal behaviour has been shown to be linked to discrimination, rejection, victimisation and non-affirmation by others and internalised transphobia, negative expectations and fear of disclosure from self (Testa et al., 2017). Conversely, an environment where children are supported to express their transgender identity has been shown to ameliorate these feelings. Research has found that children who are supported to socially transition, that is to present in the gender which feels right without medical intervention, exhibit reduced distress and self-injurious behaviours aligned to general population averages (Durwood, McLaughlin & Olsen, 2017). However, the support needed from parents to facilitate social transition, or even help seeking of any form, is not always forthcoming and this can be e.g. because parents think cross-gender behaviour is wrong or unacceptable or because they find it distressing and attempt to ignore it (Reed, Cohen-Kettenis, Reed & Spack, 2008).

For those who seek support little is available. NHS Child and Adolescent Mental Health Services (CAMHS) support children questioning gender (East London NHS Foundation Trust, no date) but eligibility criteria mean that approximately 50% of all CAMHS referrals are not accepted (Care Quality Commission, 2018). CAMHS clinicians are also not gender identity specialists and transgender youth face unique, under-researched issues, including family-based stigma and discrimination which

[1] Henceforth I will use the term 'trans' as an umbrella term for all people whose gender identity lies out with the social norm or man/boy or woman/girl. For a fuller explanation of gender diversity and a glossary of common gender identity related terms please see Appendix I: Gender Identity.

require identification and focussed interventions (Parker et al., 2018). Third sector organisations offer additional limited support but generally lack specialisation. Absence of a supportive environment is damaging for children and adults alike, but children are more reliant on parental support. Fifteen years ago Lev (2004) called for the development of a trans specific family intervention, and only last year Parker et al. (2018) made a similar plea for research to address family based stigma and discrimination against lesbian, gay, bisexual, transgender and queer (LGBTQ) youth. This suggests that there is need for research to develop an intervention to facilitate a supportive family environment for transgender youth. The Chief Investigator identifies as non-binary, works with trans people in the third sector and has spent time on placement with a CAMHS service. Her experiences suggest that something which could be delivered by CAMHS or third sector services might bridge the wait for GIDS, or be the intervention in its own right for people who need help but not physical intervention. This is something she would hope to develop and ultimately pilot, write up as a treatment manual, deliver training on and disseminate.

The Chief Investigator is currently a student on the Doctorate in Clinical Psychology at Lancaster University and will use her doctoral thesis to undertake research which lays the foundations for such an intervention in line with the stages suggested for the development of complex interventions by the Medical Research Council (Craig et al., 2006). This involves identifying the evidence base, identifying/developing theory and modelling process and outcomes. The thesis aim is to achieve this by:

1. Carrying out a literature review to ascertain the current evidence for factors which might be important in the development of such an intervention.
2. Conducting a piece of research to better understand how family dynamics might affect the mental health and wellbeing of transgender youth in a UK setting.
3. Writing a review article setting out where the research has taken me and the next steps which this suggests.

The rest of this protocol sets out how item 2, the research arm of this strategy, will be achieved beginning with the formulation of the research question as follows:

What can transgender people, their families and the people who work with them tell us about how family dynamics might affect the mental health and wellbeing of transgender youth in a UK setting?

Method

Design

The research design is qualitative using a mixture of focus groups and one-to-one semi-structured interviews to collect data. Since the purpose of the project is theory development this data will be analysed using an inductive, constructivist, version of grounded theory (Charmaz, 2014). This would involve using the rich qualitative data to iteratively develop a theory of the changes required in the family dynamic. Grounded theory is flexible because it allows for a variety of data collection methods to be used and it is conducted in stages. At the end of each stage resulting theory is examined and more data sought to fill the gaps in theory which become apparent. This gives advantage over more static methodology such as interpretative phenomenological analysis (IPA) or straightforward thematic analysis. IPA has merits in terms of the experiential nature of the subject matter and

certainly thematic analysis could be one of the tools employed in data analysis but neither possesses the iterative element needed to rigorously develop theory.

Participants

The sample will be UK based youth who identify as transgender (trans) or non-binary, their families or others involved with their care. To be eligible to participate a trans person must meet two inclusion criteria. Firstly they must have disclosed their trans identity to family whilst legally a minor, i.e. under 18 in the UK. This is deemed essential in order to have experienced family dynamics at a point where the participant had limited control over their own destiny. Secondly they must be aged between 16 and 32 years. The lower limit is based on the United Nations definition of youth as being between 15 and 24 years old (United Nations, no date). A lower limit of 16 was chosen over 15 based on NSPCC research guidelines (NSPCC, 2012) which define 16 as the lowest age where a child can participate in research without parental consent or the need to demonstrate Gillick competence. Younger children were not considered as the family dynamic is likely to be different as the transition from childhood to youth occurs and further research with ages 12-15 could be the subject of complimentary research towards the ultimate goal of family intervention development. The upper limit is based on keeping experiences pertinent to a modern context. The Gender Recognition Act (UK Government, 2004) legitimised transition between binary genders making it safer to be open about a trans identity. This was an important factor in the increase in people disclosing a trans identity. People who were 17 in 2004 would be 32 now. The age range will allow for contributions from people who are still in the family dynamic through to people who were but may now be removed from it and have had some time to reflect on the experience. The inclusion criteria for family members is that their trans family member must have disclosed their trans identity to family whilst legally a minor, i.e. under 18 in the UK. Finally, due to limited resources only people who are fluent English speakers would be eligible to participate. In summary:

Participants will be principally drawn from the following populations:

- Trans people aged 16-32 who disclosed while minors, some of whom have received support and may be in treatment with specialist gender services, and some who have not received any support.
- The families, and particularly the parents, of trans youth who disclosed while minors.

In addition the following populations may also be drawn upon:

- Clinicians involved in the care of trans youth.
- Policy makers involved with trans youth healthcare.
- Other people with involvement in trans youth healthcare.

Procedure

Contact has been made with a variety of organisations to ask permission to include them as prospective recruitment sites or to advertise the research to other potential participants. NHS Sites contacted are local CAMHS services and GIDS for the recruitment of clinicians and people who work with trans youth. Non-NHS organisations contacted to publicise the research to trans youth and families include a trans family support group, a group which hosts social events for trans adults and several youth organisations which are inclusive of LGBT people. Once ethical clearance has been achieved these sites and other organisations will re-contacted and provided with material to advertise the research. Participants will be able to contact the Chief Investigator directly, either by

telephone or e-mail and will be sent a participant information sheet along with a demographics form to complete and return by post or email and a consent form which will be completed at the point of participation (See Appendix II: Materials). The information on the demographics form will be used to assemble focus groups geographically for logistical reasons and for 'theoretical sampling' of participants in later phases of the research. This method is a core element of grounded theory allowing recruitment from the population which is most likely to answer the research question(s) (Charmaz, 2014).

Data Collection and Analysis Initial Phase: Focus Groups

Recruitment will initially be for two or three focus groups with a maximum of eight participants in each. One will consist of trans youth aged 16-32, the other of family members – principally parents. Participants will have contacted the Chief Investigator directly having seen information publicised by non-NHS organisations who have agreed to signpost their service users. They will be chosen to meet inclusion criteria and to minimise travel and contacted by letter or email and asked to attend a venue for one of the focus groups. On arrival participants will be asked to sign the consent form which includes an item requiring that participants respect the confidentiality of their fellow participants outside the group.

Focus groups will be scheduled to last one to one and a half hours. The Chief Investigator will facilitate the discussion and if possible may have a colleague to assist. A semi-structured interview guide will be used to inform, but not dictate, questions. Focus groups will be audio recorded with additional video recording to aid identification of speakers. Following the focus group there will be a debrief sheet for each participant which will include local and national contact information for support in case participants require some emotional support following the focus group. Participants will also be asked if they wish to see a summary of initial findings and whether they might be prepared to feedback on this. Focus group interviews will then be transcribed and analysed for core categories following the guidelines of Charmaz (2014). Core categories are analogous to themes and are the building blocks of inductive theory development. The resulting analysis will be summarised and sent out to willing focus group members for feedback, in order to add some triangulation into the process.

Data Collection and Analysis Subsequent Phase: Individual Interviews

Unlike standard thematic analysis, grounded theory is an iterative process which allows for further data collection and re-evaluation where it is believed that a category which is not well supported by the existing data might benefit by asking different questions and/or different people. Using individual interviews for phase two onwards will be employed because this allows for focus on specific topics. It is anticipated that at least one round of individual interviews will be necessary and that these will include at least one interview with a clinician working in the field. Unlike trans and family member participants, clinicians may be recruited from NHS sites. Ultimately participants for individual interview will be theoretically sampled to explore emerging core categories in detail. Participants may by people already recruited but not yet interviewed, people asked for additional interview following focus group involvement, new recruits or, most likely, some combination. Recruitment and debrief procedure will be the same as for the focus groups, interviews will be scheduled to last one hour and will be audio recorded only. The interview guide may be adjusted for new lines of inquiry. Feedback will again be sought following analysis. This process of analysis, coding and resampling will ideally be continued until the categories are saturated – which is to say that collecting further data is unlikely to add anything new. Although this iterative process could go on

indefinitely the constraints of this research, that it must be completed in just over a year, mean that saturation might not be reached so the aim would be to at least meet theoretical sufficiency.

Practical Issues

Data Storage

For the life of the thesis project the Chief Investigator would store sensitive electronic material, such as recordings and transcriptions, on their secure university drive, and hard copies in their locked filing cabinet at home. Following project completion anonymised data would be retained by Lancaster University for ten years in line with Doctorate in Clinical Psychology Programme policy. During this time, this data may be re-analysed and used for subsequent research into this field.

Transcription

Recording of the focus groups and individual interviews will be transcribed verbatim either by the Chief Investigator or by a professional transcriber. The transcriber will be asked to sign a confidentiality agreement which will include a clause requiring that copies of recordings and transcripts will not be retained. All costs incurred for transcription will be met by the Chief Investigator.

Ethical Concerns

Emotional Distress

This research is with a potentially vulnerable group of young people some of whom are waiting a long time for treatment and who are subject to more risk than the general population. Involvement in this research might trigger their unmet needs. However, on the other hand it might serve to be therapeutic as a chance to talk about issues and to feel like part of the solution. It will therefore be necessary to have some support in place in case it is needed. Should there be any issue at the time of interview I will make it clear that we can stop the discussion at any point or have a time out. I can also be on hand for debrief afterwards. Beyond that I will ensure that the debrief sheet has some numbers for support and advice lines including Samaritans – which is a 24/7 service offering emotional support as well as an opportunity to talk about suicidal feelings.

Focus Group Demographic

Travel costs may be prohibitive for some participants, especially when trying to bring people together from different locations for a focus group. There is a small budget which can be used to pay for travel costs up to a maximum of £20.00. So that less affluent participants are not excluded from this research location will be considered when recruiting to focus groups. Unfortunately, there are no resources for translators or other people with communication difficulties so these groups are excluded from this research. These are acknowledged limitations of this research.

Timescale

Ethics Submission Prep	May – June 2019
Submit IRAS Form	Mid July 2019
University Ethical Approval	10th July 2019
NHS Ethics HRA Application	Hopefully by August/September 2019
Data Collection in stages	August 2019 – December 2019
Data Analysis	Ongoing from collection
Write-up and draft reads	February 2020 – May 2020
Thesis Hand-In	15th May 2020
Viva	June/July 2020

References

Care Quality Commission (2018). *Are we Listening? Review of children and young people's mental health services*. Retrieved from: https://www.cqc.org.uk/sites/default/files/20180308b_arewelistening_report.pdf

Charmaz, K. (2014). *Constructing grounded theory*. Sage.

Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I. & Petticrew, M. (2006). *Developing and evaluating complex interventions* [PDF file]. Medical Research Council. Retrieved from https://mrc.ukri.org/documents/pdf/complex-interventions-guidance/

Durwood, L., McLaughlin, K.A., & Olsen, K.R. (2017). Mental health and self-worth in socially transitioned transgender youth. *Journal of the American Academy of Child & Adolescent Psychiatry,* 56(2), 116-123.

East London NHS Foundation Trust. (no date). *Transgender Issues*. Retrieved from https://camhs.elft.nhs.uk/Conditions/Transgender-Issues

GIDS (2019). *Our waiting times and our therapeutic approach*. Retrieved from http://gids.nhs.uk/news-events/2018-07-13/our-waiting-times-and-our-therapeutic-approach

GIDS (2018). *GIDS referrals increase in 2017/18*. Retrieved from http://gids.nhs.uk/news-events/2018-05-16/gids-referrals-increase-201718

Larcher, V. & Hutchinson, A. (2009). How should paediatricians assess Gillick competence? *Archive of Disease in Childhood*, 95, 307-311.

Leeds & York Partnership NHS Foundation Trust. (2019). *Gender Identity Service: Waiting times explained*. Retrieved from https://www.leedsandyorkpft.nhs.uk/our-services/services-list/gender-identity-service/

Lev, A.I. (2004). *Transgender emergence: Therapeutic guidelines doe working with gender-variant people and their families*. New York: Haworth.

Lyons, K. (2016). *Gender identity clinic services under strain as referral rates soar*. Retrieved from https://www.theguardian.com/society/2016/jul/10/transgender-clinic-waiting-times-patient-numbers-soar-gender-identity-services

McNeil, J. et al., (2012) *Trans Mental Health Survey 2012*, Edinburgh: Scottish Transgender Alliance. Retrieved from https://www.scottishtrans.org/trans_mh_study/

NSPCC. (2012). *NSPCC research ethics committee: Guidance for applicants*. Retrieved from https://learning.nspcc.org.uk/media/1504/research-ethics-committee-guidance-applicants.pdf

Parker, M.C., Hirsch, J.S., Morgan, M.P. & Parker, R.G. (2018). The urgent need for research and interventions to address family-based stigma and discrimination against lesbian, gay, bisexual, transgender and queer youth. *Journal of Adolescent Health*. 63, 383-393.

Reed, B.W.D, Cohen-Kettenis, P.T, Reed, T & Spack, N. (2008). *Medical care for gender variant young people: Dealing with the practical problems* [PDF file]. Gender Identity Research & Education Society. Retrieved from https://www.gires.org.uk/wp-content/uploads/2014/09/sexologies-print.pdf

Richards, C, & Barker, M. (2013). *Sexuality & Gender for mental health professionals: A practical guide*. London: Sage.

Sinclair, S., Hack, T.F., Raffin-Bouchal, S., McClement, S., Stajduhar, K., Singh, P., Hagen, N.A., Sinnarajah, A. & Chochinov, H.M. (2018). What are healthcare providers' understandings and experiences of compassion? The healthcare compassion model: A grounded theory study of healthcare providers in Canada. *BMJ Open*. DOI: 10.1136/bmjopen-2017-019701

Stonewall (2017). *School Report (2017)*. Retrieved from https://www.stonewall.org.uk/school-report-2017

Sykes, J.B. (1977). *The Concise Oxford Dictionary* (6th Ed.), London: Book Club Associates.

Tavistock & Portman NHS Foundation Trust. (2016). *Meeting demand for our Gender Identity Development Service*. Retrieved from: https://tavistockandportman.nhs.uk/about-us/news/stories/meeting-demand-our-gender-identity-development-service/

Testa, R., Michaels, M.S., Bliss, W., Rogers, M.L., Balsam, K. & Joiner, T. (2014). Suicidal Ideation in Transgender People: Gender Minority Stress and Interpersonal Theory Factors. *Journal of Abnormal Psychology*, 126 (1).

The Nottinghamshire Centre for Transgender Health. (no date). *Appointments*. Retrieved from https://www.nottinghamshirehealthcare.nhs.uk/appointments-transgender-health

UK Government (2004). *Gender Recognition Act 2004*. Retrieved from http://www.legislation.gov.uk/ukpga/2004/7/contents

United Nations (No Date). Definition of Youth..Retrieved from: https://www.un.org/esa/socdev/documents/youth/fact-sheets/youth-definition.pdf

Appendix I: Gender Identity

For the majority of the population gender identity is a felt sense which broadly aligns the biological sex assigned to them at birth with 'gendered' roles, interests and outward expression. That is to say that females generally identify as girls/women and males as boys/men. In discussing this aligned position it is becoming common to use the term 'cisgender' – which means gender on one side[2] of a female/male binary. Conversely, transgender (trans) is an umbrella term for somebody whose gender identity defies social norms by not being so simply aligned with the binary. Although there are a plethora of terms for ways in which individuals identify their gender (see glossary below for definitions of some of the more popular terms), broadly there are binary trans people – who identify as the gender 'opposite' to their biological sex, and non-binary trans people – who identify 'between' traditional genders, or who do not identify with either man or woman. Contemporary estimates suggest binary trans people make up approximately 1-1.5% of the population and non-binary trans people make up between 2-3% of the population.

It is also worth mentioning 'trans' people who do not identify as trans and intersex people who may, or may not identify as trans. Some binary trans people transition, or desire to transition, but do not identify as trans, or cease identifying as trans once their transition is perceived by them to be complete. That is to say they identify as a man or a woman without reference to being trans. For the purposes of this research they fit the criteria for being binary trans in terms of their experiences – but I completely respect their right not to identify as such. Intersex people or, medically, people with a disorder/difference of sexual development (DSD) are people who fall outside the medical definition of male or female by virtue of having ambiguous genitals, chromosomal anomalies or both. Traditionally intersex people were medically assigned to the most suitable sex as determined by a doctor when they were children in order to 'normalise' them. This practice is rare in the UK now – but there is a legacy of people who were not satisfied with their assignment or who wish to have been allowed to remain 'in-between'. Some people have re-assigned their gender and some of these identify as trans while others do not. For the purpose of this research all of these people qualify as trans on the basis of their lived experiences, but it is important to respect their decision not to identify as such.

Glossary of Terminology and Commonly used Trans Identities

Thanks to Karen Pollock from Bi-Pride UK for allowing me to reproduce their glossary of terms as part of this glossary.

Androgenous – having an appearance that does not fit with strictly 'male' or 'female'

AFAB and AMAB: Acronyms meaning "assigned female/male at birth" (also designated female/male at birth or female/male assigned at birth). This refers to the biological sex determined at birth and written on a person's birth certificate.

Agender: (or A-Gender) the state of not having a gender, or not identifying with gender

Cisgender/cis: term for someone whose gender identity aligns with their sex assigned at birth

[2] From the Latin prefix 'cis' meaning 'on one side of' (Sykes, 1977).

Cissexism: Systemic prejudice in the favour of cisgender people

Cross-Dresser – a none medical term with similar meaning to transvestite (see below).

Deadnaming: Calling someone by their birth name after they have changed their name

Gender Dysphoria: Anxiety and/or discomfort regarding a mismatch between one's gender identity and sex assigned at birth

Gender Fluid: A term for someone who 'plays' with gender; adopting either of the binary, or a non-binary presentation, as the mood takes them.

Gender Identity: A person's innate sense of their own gender, whether male, female or something else

Genderqueer: term for someone who identifies as neither male nor female (see also non-binary)

Heteronormative / Heteronormativity: These terms refer to the assumption that heterosexuality is the norm,

Intersex – medically someone born with a difference of sexual development (DSD). This refers to a range of conditions including ambiguous genitals and chromosomal anomalies. Approximately 1% of the population are born with an intersex condition and traditionally surgeries have been carried out to 'correct' genitals to bring the person back into alignment with the gender binary.

Non-Binary (Also Nonbinary): Modern term for someone who identifies as neither male nor female, used as an adjective (e.g. Jesse is a nonbinary person)

Questioning: A term for someone who is in the process of finding the gender identity which works for them. This might end up being a trans term, cisgender, or something else.

Transgender/Trans: an umbrella term which covers many gender identities of those who do not identify or exclusively identify with their sex assigned at birth.

Transman (Transboy): A man (boy) who has a trans history – that is they were assigned female at birth.

Transmisogyny: Originally coined by the author Julia Serano, this term designates the intersections of transphobia and misogyny and how they are often experienced as a form of oppression by trans women

Transphobia: Systemic violence against trans people, associated with attitudes such as fear, discomfort, distrust, or disdain

Transition: A person's process of developing and assuming a gender expression to match their gender identity

Transsexual: Medical term, adopted as an identity, to denote a person who has transitioned to live as the gender opposite to that associated with their sex assigned at birth, with or without medical intervention.

Transvestite: Medical term to denote a person who presents as the gender opposite to their sex assigned at birth but does not live that role full time.

Transwoman (Transgirl): A woman (girl) who has a trans history – that is they were assigned male at birth.

Research Protocol

Appendix II: Materials

The following is a list of the documents for this project:

- Covering letter for prospective participants.
- Participant information sheets which give more details of the research and explains what would be expected and also participant rights, including the right to withdraw from the study and how that is affected by the progress of the research. There is a separate information sheet for transgender participants, their families and for professionals.
- Consent form, a copy of which will be retained by the researcher and another by each participant.
- Demographics form to capture essential information about participants which will inform this research.
- Semi-Structured Interview Guide – detailing likely topic areas and some specific exemplar questions.
- Debrief sheet for trans youth and family members which contains an invitation to review and feedback on findings, and information about what to do following an emotional reaction to the topic.
- Poster: produced for sites to display and/or distribute to potential participants.
- Sub-contractor Confidentiality Agreement
- Chief Investigator CV

Appendix 4.3: Participant Letter

Participant Letter

Debbie Wood
Trainee Clinical Psychologist
Furness College
Lancaster University
Lancaster
LA1 4YT
d.wood6@lancaster.ac.uk
Tel No TBC

Dear Potential Participant,

Thank you for getting in touch, I have sent you some more information about my research so that you can decide whether or not you want to participate. I've also sent a consent form for you to have a look at and a demographics form. If you decide you wish to participate please send the completed demographics form to me either by e-mail or in the pre-paid envelope depending on how you opted to be contacted originally. I will use this information to judge whether, and at what stage, I would like to interview you. I will contact you to let you know my decision as soon as possible, and to arrange a date and location for interview.

If we do arrange an interview, please bring the consent form with you to sign on the day.

You can take the time you need to decide whether or not to participate, but I would be very grateful if you were able to get back to me within two weeks. If you wish to ask any questions please feel free to get in touch.

Thank you for expressing an interest in my research.

Yours Sincerely

Debbie Wood

Appendix 4.4: Consent Form

Consent Form

TITLE: Understanding the role of family dynamics in affecting the mental health and wellbeing of transgender youth

Please initial the boxes to indicate 'Yes'

1. I have read and understood the participant information sheet. I have had a chance to ask questions and, if I asked questions, I am happy with the answers given. ☐
2. I understand that I do not have to take part in this research and even if I do, I can withdraw my data within limits described below. ☐
3. I understand that once the data has been analysed my own contribution will be made anonymous and it may not be possible to withdraw my data. ☐
4. I understand my interview or focus group will be audio or video recorded and my words typed on a transcript afterwards. ☐
5. I understand that my words will be treated as confidential, but if I discuss risk to myself or others the researcher may need to talk to someone or take action. ☐
6. If I am taking part in a focus group I agree to treat the words of other participants as confidential. ☐
7. I understand that data may be shared, confidentially, with research supervisors and people involved in ensuring that this research is to a certain standard ☐
8. I consent to my anonymised transcript being stored by Lancaster University for ten years after the research is completed, and potentially used in subsequent research. Access to the data would be under the control of Lancaster University and would be given to bona fide researchers based on the merit of their request. ☐
9. I understand that some direct quotes from me may be published in reports, other publications, training materials etc., but that I will not be identified in these. ☐
10. I consent to take part in the above research ☐

PARTICIPANT: Print name

Date: Signature

RESEARCHER: Print name

Date: Signature

Consent Form: Debbie Helen Wood Version 0.3 Date: 04/08/19

Appendix 4.5: Participant Information – Transgender People

Participant Information – Transgender People

TITLE: Understanding the role of family dynamics in affecting the mental health and wellbeing of transgender youth

What is the research about?

This research is being carried out to try to work out what happens for families when one of their children tells the family that they are transgender. The plan is to use this information to build up a picture of how families can work together to better understand and support one another. The hope is that, armed with this information, people who work with families can help them in a way that makes life easier for the whole family and which will improve the wellbeing of the transgender young person.

Who can take part?

In order to take part you must be either:

- A transgender person aged between 16 and 32 who disclosed their identity to their family before they were 18 years old.
- The member of a family where a transgender person disclosed their identity to your family before they were 18 years old.
- A professional who works with, or for transgender youth.

What will I be asked to do if I decide to take part?

If you would like to take part then please fill in the demographics form and send it to me by email, or post in the stamped addressed envelope provided. I would then contact you to invite you to take part in a small focus group discussion or a one-to one interview with myself. The discussion would be about your experiences as a transgender young person who told their family they were transgender before their 18th birthday..

Group discussions would last about one and a half hours, individual interviews will take about an hour. I would record the interviews using an audio recorder, whilst for focus groups I would also video record the session to help me identify individual speakers. The interview will take place at a convenient, safe location which will depend on who agrees to participate and where they live or can travel too. If you need to travel any distance reimbursement may be available up to a maximum of £20.00. After the interview or focus group is completed I may re-contact you to ask you if you would mind being interviewed again, but this is optional and may not be required.

You would also be given the opportunity to read the analysis of your data and to comment on my findings, which I would take into consideration when writing up my results.

Do I have to take part?

No. Your participation is entirely voluntary. If you decide you want to take part you will be asked to fill in a form with some information about yourself and to sign a consent form but you can still change your mind at any time up until the point where the data has been analysed. At this point your data will have been changed to be anonymous and it might not be possible to remove it. Typically this will be between 2 to 4 weeks after your interview. If you decide not to participate you may keep this sheet. If you decide not to take part in this research there will be no negative consequences. If you found out about this via a service you attend they will not be told whether or not you choose to participate.

What will you do with the information I give you?

The results will be written up into my thesis as part of my doctorate in clinical psychology, and it is my intention that they will also be submitted for publication to a journal. Results will also be presented to people on my course and at conferences. It is my hope that training manuals for professionals and workbooks for transgender families would also be a result of this work. Your information would be kept anonymous in any writing etc. that comes out of this research.

What about confidentiality? Who will have access to my data?

The information you provide will only be accessed by people who have a need to do so. The recording(s) will be transferred onto a secure drive and then deleted from the recorder. The recording will only be seen/heard by me, my supervisor and possibly someone else who will transcribe this into a written document. The person who carries this out will have signed an agreement to keep anything they hear confidential and once they have finished their job they will no longer have access to the recording. My supervisor may listen to the recording. Nobody else will have access to your data until it has been transcribed and all information which might link it to you removed/changed. I will use a different name, or number, to refer to you and I will remove, or change, any obvious details which might identify you. The recordings will be deleted at the end of the study. The transcripts will be encrypted and password protected so only my supervisors, or myself, can view them. At the end of the study the transcripts will be kept securely by the university for 10 years and then permanently deleted. During this time the transcripts may be re-analysed as part of further research into this field or in order to check my findings. Lancaster University will be responsible for deciding who can access the data.

I might quote you directly in the written report, but under a different name or a number and with identifying information altered. There are some limits to confidentiality: if you said something that made me think you, or someone else, is at significant risk of harm then I will have to tell someone, like your GP, or a parent or other responsible person. Where possible I will discuss this with you first.

Lancaster University will be the data controller for any personal information collected as part of this study. Under the GDPR you have certain rights when personal data is collected about you. You have the right to access any personal data held about you, to object to the processing of your personal information, to rectify personal data if it is inaccurate, the right to have data about you erased and, depending on the circumstances, the right to data portability. Please be aware that many of these rights are not absolute and only apply in certain circumstances. If you would like to know more about your rights in relation to your personal data, please speak to me.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

Are there any risks?

There is always a risk that talking about your experiences may be upsetting to some degree. If you become upset during the group or individual interview you will be able to stop or leave for as long as you need to, and I will be on hand to discuss things afterwards. If you find that you are still upset, or become upset, later then I will be providing some guidance on places you might contact for support after the interviews.

Will there be a benefit for me?

There are no direct benefits although the greatest benefit will hopefully be to young transgender people who follow you. It is important to stress that the interviews are not therapy and the discussion will be guided by the interviewer in order to gather as much information as possible. You may still find it therapeutic however to have had a chance to talk about your experiences and this would be a positive coincidence.

What if I want to talk to someone before I decide to participate?

If you have any problems or any questions you want to ask, please feel free to contact me using details supplied below and I will do my best to address any concerns you may have:

Debbie Helen Wood, Trainee Clinical Psychologist
Clinical Psychology, Furness College, Lancaster University, Lancaster, LA1 4YG
Tel: TBA
Email: d.wood6@lancaster.ac.uk

What if I have a complaint?

If you want to make a complaint about any aspect of this research and do not wish to contact the researcher please contact:
My Supervisor:
Professor Bill Selwood
Clinical Psychology, Div. Of Health Research, Lancaster University, Lancaster, LA1 4YG
Tel: 01524 593998
Email: b.sellwood@lancaster.ac.uk

Or the Research Director:
Dr Ian Smith,
Clinical Psychology, Div. Of Health Research, Lancaster University, Lancaster, LA1 4YG
Tel: 01524 592282
Email: i.smith@lancaster.ac.uk

Thank you for reading

Appendix 4.6: Participant Information – Family Members

Participant Information – Family Members

TITLE: Understanding the role of family dynamics in affecting the mental health and wellbeing of transgender youth

What is the research about?

This research is being carried out to try to work out what happens for families when one of their children tells the family that they are transgender. The plan is to use this information to build up a picture of how families can work together to better understand and support one another. The hope is that, armed with this information, people who work with families can help them in a way that makes life easier for the whole family and which will improve the wellbeing of the transgender young person.

Who can take part?

In order to take part you must be either:

- A transgender person aged between 16 and 32 who disclosed their identity to their family before they were 18 years old.
- The member of a family where a transgender person disclosed their identity to your family before they were 18 years old.
- A professional who works with, or for transgender youth.

What will I be asked to do if I decide to take part?

If you would like to take part then please fill in the demographics form and send it to me by email, or post in the stamped addressed envelope provided. I would then contact you to invite you to take part in a small focus group discussion or a one-to one interview with myself. The discussion would be about your experiences as the member of a family where a young transgender person told the family they were transgender before their 18th birthday..

Group discussions would last about one and a half hours, individual interviews will take about an hour. I would record the interviews using an audio recorder, whilst for focus groups I would also video record the session to help me identify individual speakers. The interview will take place at a convenient, safe location which will depend on who agrees to participate and where they live or can travel too. If you need to travel any distance reimbursement may be available up to a maximum of £20.00. After the interview or focus group is completed I may re-contact you to ask you if you would mind being interviewed again, but this is optional and may not be required.

You would also be given the opportunity to read the analysis of your data and to comment on my findings, which I would take into consideration when writing up my results.

Do I have to take part?

No. Your participation is entirely voluntary. If you decide you want to take part you will be asked to fill in a form with some information about yourself and to sign a consent form but you can still change your mind at any time up until the point where the data has been analysed. At this point your data will have been changed to be anonymous and it might not be possible to remove it. Typically this will be between 2 to 4 weeks after your interview. If you decide not to participate you may keep this sheet. If you decide not to take part in this research there will be no negative consequences. If you found out about this via a service you attend they will not be told whether or not you choose to participate.

What will you do with the information I give you?

The results will be written up into my thesis as part of my doctorate in clinical psychology, and it is my intention that they will also be submitted for publication to a journal. Results will also be presented to people on my course and at conferences. It is my hope that training manuals for professionals and workbooks for transgender families would also be a result of this work. Your information would be kept anonymous in any writing etc. that comes out of this research.

What about confidentiality? Who will have access to my data?

The information you provide will only be accessed by people who have a need to do so. The recording(s) will be transferred onto a secure drive and then deleted from the recorder. The recording will only be seen/heard by me, my supervisor and possibly someone else who will transcribe this into a written document. The person who carries this out will have signed an agreement to keep anything they hear confidential and once they have finished their job they will no longer have access to the recording. My supervisor may listen to the recording. Nobody else will have access to your data until it has been transcribed and all information which might link it to you removed/changed. I will use a different name, or number, to refer to you and I will remove, or change, any obvious details which might identify you. The recordings will be deleted at the end of the study. The transcripts will be encrypted and password protected so only my supervisors, or myself, can view them. At the end of the study the transcripts will be kept securely by the university for 10 years and then permanently deleted. During this time the transcripts may be re-analysed as part of further research into this field or in order to check my findings. Lancaster University will be responsible for deciding who can access the data.

I might quote you directly in the written report, but under a different name or a number and with identifying information altered. There are some limits to confidentiality: if you said something that made me think you, or someone else, is at significant risk of harm then I will have to tell someone, like your GP, or another responsible person. Where possible I will discuss this with you first.

Lancaster University will be the data controller for any personal information collected as part of this study. Under the GDPR you have certain rights when personal data is collected about you. You have the right to access any personal data held about you, to object to the processing of your personal information, to rectify personal data if it is inaccurate, the right to have data about you erased and, depending on the circumstances, the right to data portability. Please be aware that many of these rights are not absolute and only apply in certain circumstances. If you would like to know more about your rights in relation to your personal data, please speak to me.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

Are there any risks?

There is always a risk that talking about your experiences may be upsetting to some degree. If you become upset during the group or individual interview you will be able to stop or leave for as long as you need to, and I will be on hand to discuss things afterwards. If you find that you are still upset, or become upset, later then I will be providing some guidance on places you might contact for support after the interviews.

Will there be a benefit for me?

There are no direct benefits although the greatest benefit will hopefully be to young transgender people and their families in the future. It is important to stress that the interviews are not therapy and the discussion will be guided by the interviewer in order to gather as much information as possible. You may still find it therapeutic however to have had a chance to talk about your experiences and this would be a positive coincidence.

What if I want to talk to someone before I decide to participate?

If you have any problems or any questions you want to ask, please feel free to contact me using details supplied below and I will do my best to address any concerns you may have:

Debbie Helen Wood, Trainee Clinical Psychologist
Clinical Psychology, Furness College, Lancaster University, Lancaster, LA1 4YG
Tel: TBA
Email: d.wood6@lancaster.ac.uk

What if I have a complaint?

If you want to make a complaint about any aspect of this research and do not wish to contact the researcher please contact:
My Supervisor:
Professor Bill Selwood
Clinical Psychology, Div. Of Health Research, Lancaster University, Lancaster, LA1 4YG
Tel: 01524 593998
Email: b.sellwood@lancaster.ac.uk

Or the Research Director:
Dr Ian Smith,
Clinical Psychology, Div. Of Health Research, Lancaster University, Lancaster, LA1 4YG
Tel: 01524 592282
Email: i.smith@lancaster.ac.uk

Thank you for reading

Appendix 4.7: Participant Information - Professionals

Participant Information – Professional

TITLE: Understanding the role of family dynamics in affecting the mental health and wellbeing of transgender youth

What is the research about?

This research is being carried out to try to work out what happens for families when one of their children tells the family that they are transgender. The plan is to use this information to build up a picture of how families can work together to better understand and support one another. The hope is that, armed with this information, people who work with families can help them in a way that makes life easier for the whole family and which will improve the wellbeing of the transgender young person.

Who can take part?

In order to take part you must be either:

- A transgender person aged between 16 and 32 who disclosed their identity to their family before they were 18 years old.
- The member of a family where a transgender person disclosed their identity to your family before they were 18 years old.
- A professional who works with, or for transgender youth.

What will I be asked to do if I decide to take part?

If you would like to take part then please fill in the demographics form and send it to me by email, or post in the stamped addressed envelope provided. I would then contact you to invite you to take part in a one-to one interview with myself. The discussion would be about your experiences as someone who works with young transgender people and/or their families.

The interview would be recorded using an audio recorder, would take about an hour and would take place at a convenient, safe location. I would most likely travel to you, but if you need to travel any distance reimbursement may be available up to a maximum of £20.00. After the interview is completed I may re-contact you to ask you if you would mind being interviewed again, but this is optional and may not be required.

You would also be given the opportunity to read the analysis of your data and to comment on my findings, which I would take into consideration when writing up my results.

Do I have to take part?

No. Your participation is entirely voluntary. If you decide you want to take part you will be asked to fill in a form with some information about yourself and to sign a consent form but you can still change your mind at any time up until the point where the data has been analysed. At this point your data will have been changed to be anonymous and it might not be possible to remove it. Typically this will be between 2 to 4 weeks after your interview. If you decide not to participate you may keep this sheet. If you decide not to take part in this research there will be no negative consequences. If you found out about this via a service you work for they will not be told whether or not you choose to participate.

What will you do with the information I give you?

The results will be written up into my thesis as part of my doctorate in clinical psychology, and it is my intention that they will also be submitted for publication to a journal. Results will also be presented to people on my course and at conferences. It is my hope that training manuals for

professionals and workbooks for transgender families would also be a result of this work. Your information would be kept anonymous in any writing etc. that comes out of this research.

What about confidentiality? Who will have access to my data?

The information you provide will only be accessed by people who have a need to do so. The recording(s) will be transferred onto a secure drive and then deleted from the recorder. The recording will only be seen/heard by me, my supervisor and possibly someone else who will transcribe this into a written document. The person who carries this out will have signed an agreement to keep anything they hear confidential and once they have finished their job they will no longer have access to the recording. My supervisor may listen to the recording. Nobody else will have access to your data until it has been transcribed and all information which might link it to you removed/changed. I will use a different name, or number, to refer to you and I will remove, or change, any obvious details which might identify you. The recordings will be deleted at the end of the study. The transcripts will be encrypted and password protected so only my supervisors, or myself, can view them. At the end of the study the transcripts will be kept securely by the university for 10 years and then permanently deleted. During this time the transcripts may be re-analysed as part of further research into this field or in order to check my findings. Lancaster University will be responsible for deciding who can access the data.

I might quote you directly in the written report, but under a different name or a number and with identifying information altered. There are some limits to confidentiality: if you said something that made me think you, or someone else, is at significant risk of harm then I will have to tell someone, like your manager or other responsible person. Where possible I will discuss this with you first.

Lancaster University will be the data controller for any personal information collected as part of this study. Under the GDPR you have certain rights when personal data is collected about you. You have the right to access any personal data held about you, to object to the processing of your personal information, to rectify personal data if it is inaccurate, the right to have data about you erased and, depending on the circumstances, the right to data portability. Please be aware that many of these rights are not absolute and only apply in certain circumstances. If you would like to know more about your rights in relation to your personal data, please speak to me.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

Are there any risks?

There is always a risk that talking about your experiences may be upsetting to some degree. If you become upset during the interview you will be able to stop altogether or for as long as you need to, and I will be on hand to discuss things afterwards. If you find that you are still upset, or become upset, later then I would advise that you speak to your manager, supervisor, or another member of your team.

Will there be a benefit for me?

There may eventually be a benefit as this research aims to ultimately inform the way professionals work with young transgender people and their families. As a result the greatest benefit will hopefully be to young transgender people and their families in the future.

What if I want to talk to someone before I decide to participate?

If you have any problems or any questions you want to ask, please feel free to contact me using details supplied below and I will do my best to address any concerns you may have:

Debbie Helen Wood, Trainee Clinical Psychologist
Clinical Psychology, Furness College, Lancaster University, Lancaster, LA1 4YG
Tel: TBA
Email: d.wood6@lancaster.ac.uk

What if I have a complaint?

If you want to make a complaint about any aspect of this research and do not wish to contact the researcher please contact:
My Supervisor:
Professor Bill Selwood
Clinical Psychology, Div. Of Health Research, Lancaster University, Lancaster, LA1 4YG
Tel: 01524 593998
Email: b.sellwood@lancaster.ac.uk

Or the Research Director:
Dr Ian Smith,
Clinical Psychology, Div. Of Health Research, Lancaster University, Lancaster, LA1 4YG
Tel: 01524 592282
Email: i.smith@lancaster.ac.uk

Thank you for reading

Appendix 4.8: Demographics Form

Demographics Form

TITLE: Understanding the role of family dynamics in affecting the mental health and wellbeing of transgender youth

Participant Identifier: ____________

Date of birth	
First Line of home postcode e.g. 'CA2'	
Gender Identity This might be man/boy or woman/girl or it may be something else such as transgender man or woman, non-binary or something else entirely. If you want to add explanation please use the space or continue onto reverse of this form.	
Does your gender identity align with the sex on your birth certificate? Please circle appropriate response or write in the space below	Yes / No / Prefer not Say
How would you describe your ethnicity? This might include your nationality and e.g. whether you would describe yourself as white, black, Asian, mixed race etc.	

Question for transgender youth and family members only

Have you, or your family member, accessed support around gender identity issues?	YES NO
If YES can you tell us a little about the type of support accessed?	
Please tell us a little about the important people you live with. Please tick or write a number for the following people who are in your life and use the space provided to tell us about anyone we've missed. If required please continue onto reverse of this form.	Parents: Mother Father Stepmother Stepfather Grandparents: Grandfather Grandmother Children/Siblings: Boys Girls Trans-boys Trans-girls Non-binary Other Identity (please specify) Other people: (please specify)

Continued Overleaf

Question for clinicians and people who work with or for transgender people only

Where do you work?(tick all that apply)	Public Sector	NHS	Private Sector
Can you tell us a little about the work you do with/for transgender people?			

Please use this additional space to expand on any of your answers.

Appendix 4.9 Interview Guide

Interview Guide

TITLE: Understanding the role of family dynamics in affecting the mental health and wellbeing of transgender youth

This schedule is intended as a guide only for the interviews. This is in line with grounded theory methodology. For example, other questions may be asked within the interview if more detail or additional clarification is required, or if a participant brings up a topic that is relevant to the research question. As the interview progresses it may be necessary to alter the wording or order of questions. Additionally, due to the method of analysis the second set of interviews may follow a different schedule, based on themes that develop from the initial set of interviews. This is a semi-structured, dynamic interview and this is only a guide.

Possible questions for transgender people

COMING OUT

What, if anything, held you back from telling others about your trans identity?

When did you tell them? Or did they find out another way?

How were things when you first told them?

How did other people react – family, extended family, colleagues, friends etc?

Was it as good/bad as you expected?

MOVING ON

Did anything good come out of this?

Did anything bad come out of this?

How did things progress over time?

How accepting were people of your being trans?

SNAKES AND LADDERS

What changes did you make?

How supported were you?

Were there things you were prevented from doing by someone else, or yourself?

WELLBEING

Are you happier for telling people?

How would you describe your mental health?

How important are your family in your wellbeing?

Winding down question – something positive? Hopes for the future?

Possible Questions for family

Framework – Kubler Ross

Finding out your child is trans has been likened to the process of grief. It doesn't need to be like this but it seems wortwhile to hold in mind Kubler-Ross' 5 stage model during the interview/focus group

Denial – Anger – Bargaining – Depression - Acceptance

FINDING OUT

When did your child/sibling first tell you about their gender identity?

Or did you find out another way?

Was it a surprise? Were there clues? If so, what?

How were things when you were first told?

ADJUSTMENT

What were your greatest fears?

Was there a sense of loss, or gain?

What did transgender mean to you when you were first told – or to other family members?

What does it mean now?

How are things now?

REACTION OF OTHERS

How did other people react – family, extended family, colleagues, friends etc?

How are their relationships with family members, before and now? How has this affected you?

SNAKES AND LADDERS

What made it difficult or easy?

What made it better or worse?

WELLBEING

Do you think they are happy?

How would you describe their mental health?

How do you see their future?

Winding Down – something positive? Hopes for the future?

Possible questions for people working with young trans people

EXPERIENCE
How many trans people have you worked with? Over how long? With whom?

UNDERSTANDING OF TRANS
Briefly, how do you understand transgender people?

What factors do you think affect transgender people's mental health and wellbeing?

THOUGHTS AROUND FAMILY DYNAMICS
Have you worked directly with other family members? If so, who?

What struck you about the family dynamic? Positive, negative, neutral?

What differences in dynamics with age of young person, age of parents?

How did this change over time, if at all?

What about other members – siblings, grandparents, extended family, friends, neighbours?

BEYOND FAMILY
Effect of environment? Attitudes of others close by?

OUTCOMES
Were there specific factors about the family which seemed to affect supportiveness?

Were there specific factors about the child which seemed to affect supportiveness?

Most positive thing, most negative thing?

Appendix 4.10: Debrief Sheet

Debrief Sheet

TITLE: Understanding the role of family dynamics in affecting the mental health and wellbeing of transgender youth

Thank you for taking part in the above research. Hopefully this will help us have a better understanding of how families work when they, perhaps unexpectedly, find that one of their family members sees their gender a little differently from everyone else. I will be using the information you, and others, have supplied to develop some theory. It is my hope that I can use this to help others have a better understanding so that they can help families who might be struggling to be supportive of their transgender young people.

If you would like summary of my findings and a chance to feedback your thoughts about my conclusions then please let me know by contacting me using the details below and letting me know your preferred contact method. Email works quickest and easiest for me but I'm aware that this doesn't suit everyone. Your feedback would be welcomed and may influence the final write up of this research.

Debbie Wood
Trainee Clinical Psychologist
Furness College
Lancaster University
Lancaster
LA1 4YT
d.wood6@lancaster.ac.uk
Tel: TBA

If you feel distressed after talking about your experiences I would encourage you contact people your normally find supportive. If this is not possible or appropriate, I also include details of organisations who advertise that they support people who are trans or who are in crisis.

MERMAIDS UK offer information and support to gender diverse young people, and their families.
Phone: 0808 801 0400 available Monday – Friday 09:00 – 21:00, or email info@mermaidsuk.org.uk

LGBT CONSORTIUM have a national Trans 24 Hour Helpline On 08443 583204 or 07527 524034
They can also be contacted via: nationaltrans24helpline@gmail.com

MINDLINE TRANS + runs Monday & Friday 8pm – 12pm on 0300 330 5468

If your distress is serious enough that it is making you think about hurting yourself, and you want someone to talk to about this you can call:

SAMARITANS on 116 123. This is a free call and the lines are open 24 hours a day, 7 days a week. They offer a non-judgmental listening and emotional support. You can also email Samaritans on jo@samaritans.org

If you actually feel at risk you should contact your GP or Care Co-ordinator if you have one, or your local NHS crisis support service.

Appendix 4.11: Confidentiality Agreement

Confidentiality Agreement

Debbie Wood
Trainee Clinical Psychologist
Furness College
Lancaster University
Lancaster
LA1 4YT
d.wood6@lancaster.ac.uk
Tel: TBA

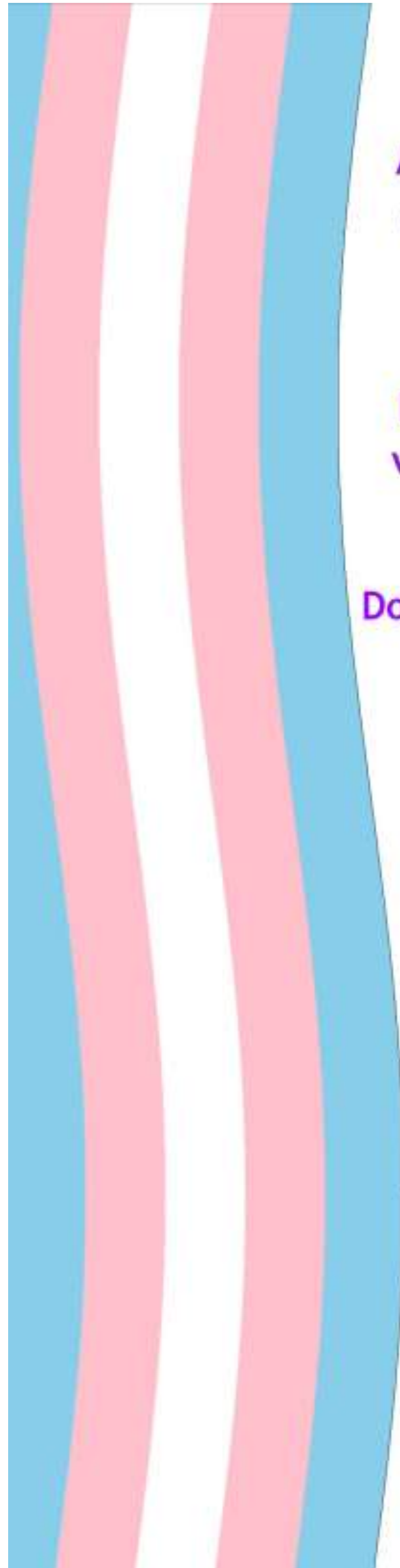
I the undersigned in agreeing to transcribe the recordings provided to me by Debbie Wood do agree;

1. Not to disclose any details or information contained within the recordings, or to give copies of these recordings, to any third party.
2. Not to keep copies of these recording or any resulting transcripts beyond that which is necessary to complete the transcriptions.
3. To comply with any other instructions received from Debbie Wood with respect to the contents or retention of these recordings or the resulting transcripts.
4. To supply finished transcripts as password protected Microsoft Word Files, and to send the password(s) in a separate email to the transcript.

Print Name: Signed

Company Name: Date:

Appendix 4.12: Publicity Poster



Are You…

A transgender or non-binary person aged 16-32, who came out to their family before they were 18?

Or

Is one of your family a trans person who came out before they were 18?

Or

Do you work with young transgender people and/or their families?

If so, I would really like to talk to you about your experiences

I am carrying out some research to help build a picture of how families can best work together to understand and support their transgender children.

I plan to use my findings to improve support for transgender people and their families.

If you think you could help, please contact me:

Email: d.wood6@lancaster.ac.uk
Or write: Debbie Wood
Trainee Clinical Psychologist
Furness College
Lancaster University
Lancaster LA1 4YT

Health & Medicine | Lancaster University