# The Experience of Waiting for Gender-affirming Care in England: emotions, temporality and coping

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## Abstract

Waiting times for initial appointment for gender-affirming healthcare services in England can be seven years (NHS, 2023a). Months pass between follow-up appointments and subsequent care, falling well outside NHS standards. This thesis examines the emotional and temporal consequences of this protracted waiting, and coping mechanisms used by patients to approach and manage this time. In order to investigate these issues, the study adopted a mixed qualitative methodology of semi-structured interviews, diaries, and ethnography with 26 trans identified people living in England. The analysis of the data revealed that waiting for gender-affirming care is a depressing, anxious time for many who experience distortions of time perception that are detrimental to their emotional and social wellbeing. The many coping strategies showed some well-thought-out methods of managing lengthy waiting experiences. Active strategies to progress through transition, or at least give the illusion of it, appear in the form of supplementary gender-affirming clothes, obtained hormones, or social affirmation. More private and solitary strategies of emotional release also offer relief from the difficult waiting experience. The majority of participants also use trans social media as an information source and found comfort from others in knowing that their experience is shared. The findings of thesis contribute to studies of waiting time in healthcare, queer temporality literature, minority coping theory, and community social media use. Also importantly, this study sheds light on how trans people function - together and alone – in the context of the difficulties of waiting for gender-affirming care. It shows community is an invaluable source of care in the absence of timely medically sanctioned treatment. This thesis recommends an informed consent approach to trans healthcare be implemented in England and further afield, with hormone replacement therapy available from primary care, removing the burden of waiting from the trans community.

## Table of Contents

## Chapter 1. Introduction

Waiting times for gender-affirming care in England across the eight adult gender identity clinics (GIC) all exceed 18 weeks, with some trans people waiting six years for an initial assessment (NHS 2023b; NHS, 2023d), and longer still, for treatment. London's GIC alone has over 11,000 individuals on their waiting list, with a waiting time of about four years (NHS, 2023a). A recent high court case revealed that the reason for these lengthy waiting times across clinics is due to a lack of staff, which is not the fault of the NHS (Guardian, 2023). However, this means that trans people are expected to wait an inordinate amount of time to receive gender-affirming care, which is detrimental to their well-being. During the waiting period, many turn towards the trans community for support.

With increased trans visibility and world-wide online communication available, it is easier than ever to locate a physical or online transgender community. This social access results in an extensive amount of anecdotal literature on endocrinological and surgical reassignment results, as well as the accounts of being a patient at each of the Gender Identity Clinics (GICs), produced by trans people themselves. What emerges from the experiences shared in these spaces is that gender healthcare in the UK is desperately slow, with a 13-30+ month waiting time from the point of GP's referral to the initial appointment at a GIC (Genderagenda, 2017).

These lengthy waiting times in England are due to a limited number of physicians wanting to specialise in the area of gender care, in combination with increased numbers of people attempting to access the service (Davis et al, 2013). The long waiting times cause substantial emotional stress to transgender people who suffer emotionally (Heyes, 2016). Wylie, Hainsworth and Ryles (2007, p 93) reported 81%

of people were either “dissatisfied or very dissatisfied with the time they had been on the waiting list”. Transgender people find these times excessively long and suffer from a low measure of well-being as a consequence (Heyes, 2016). This negative experience is at the centre of this thesis which investigates its contexts and consequences.

A very small number of doctors are approved to diagnose gender dysphoria in the UK (UK Trans Info, 2014). Under the conditions of the World Professional Association of Transgender Health (2022) a diagnosis is necessary to begin monitored hormone replacement therapy. Each medical stage of the transition requires approval from specialists, and this is only obtained within appointments, which are scheduled many months apart (NHS, 2023a). The lengthy waiting times, therefore, are not exclusive to initial access to the GICs in terms of first appointment; they are also a part of the process to obtain the different medical interventions, signatures of approval, and consequential surgeries, once an individual reaches those stages of their transition. External to the GICs, other healthcare for transgender people remains poor. Studies, within and outside of England, show there is a distinct lack of GPs, nurses, and endocrinologists knowledgeable on transgender medicine, whose expertise is vital to the safe monitoring of a medical transition (Bauer et al, 2009; Hobster & McLusckey, 2020; Sanchez et al, 2009). Having a limited number of these crucial professionals can lengthen the time it takes to access and maintain gender-affirming care.

In the intermediate time, engaging with the transgender community for support, friendship, validation, or an online platform for safe expression and as a resource of information can be lifesaving for those waiting (Levitt & Ippolito, 2014). There are numerous online spaces of transgender people who access them from all over the world, creating community spaces in which to share knowledge and experiences with others. These spaces allow transgender people to explore their gender identity with others in similar circumstances. Identifying with a transgender community is beneficial to well-being by creating a feeling of proximity to others, even if there is a large geographical distance between communicators (Barr et al, 2016).

The medical field has claimed authority over transgender identities since the addition of psychiatric diagnoses for gender variances in the Diagnostic Statistical Manual III (DSM) in 1980 (Johnson, 2015). Two diagnoses were added to the DSM III: Transsexualism and Gender Identity Disorder of Childhood, for adults and children respectively. In the DSM IV 1994's publication, Transsexualism was superseded by Gender Identity Disorder of Adolescence and Adulthood. Interestingly, in this edition, the sexuality of transgender women was described as capable of being hetero/homo/bi/a/sexual; however, transgender men were described as predominantly heterosexually inclined. It was considered a rare phenomenon to encounter a gay transgender man. However, this is more likely due to transmasculine individuals hiding their sexuality from fear of homophobia and of not being allowed to transition if they do not fit the medical stereotype. In 2015, the DSM V brought forward Gender Dysphoria and, with it, some changes to the categorisation of the condition. Zucker (2015) noted 10 significant changes between the 4th and 5th editions, with the most noteworthy being: the de-categorisation of this condition from Sexual Dysfunctions and Paraphilic Disorders; the fact it was no longer necessary for one to be of a specific sexual orientation; more stringent criteria around the diagnosis of children; the inclusion of intersex people as individuals who may obtain this diagnosis; and a reduction of the time the condition persists for necessary for a diagnosis.

The removal of gender dysphoria from the Sexual Dysfunctions and Paraphilic Disorders section into one of its own is a recognition from the medial field of the natural variation of gender expressions within humans of the same gender. This was a move encouraged by transgender activists, who argued that the transgender experience is not a mental disorder, though Zucker and others argued otherwise (Zucker, 2015). Zucker has a controversial reputation for trans healthcare with a history of suspected conversion practices on very young children in his early career. He remains a prominent voice in global trans healthcare, with trans academics and activists opposing his participation in trans health conferences (Pearce, 2017). The removal of the criterion which required individuals to have a specific sexual orientation was certainly necessary and was not only a sign of progress for the transgender community, but for the LGB+ communities as well. With the old standard in place, same-sex attraction continued to be pathologised in the medical field, which was detrimental to transgender non-heterosexual individuals’ access to treatment. The increased stringency over childhood diagnoses is explained by Zucker as intending to “likely sharpen the distinction between a diagnosis of GD and normative variation” (2015, pg. 34). While practitioners may find making a diagnosis harder, the official recognition of the fact that “gender nonconformity is not in itself a mental disorder” (American Psychiatric Association, 2013, pg. 1) is a positive step towards the acknowledgement of varied gender expression in children, and, ultimately, adults as well.

Despite changes to gender-affirming care in recent history, trans people continue to have difficult experiences in accessing care. It is estimated that over 25,000 people are currently waiting for an initial appointment for gender-affirming care across the eight English GICs (The Guardian, 2023). The combination of the limited number of clinics and specialists, as well as increasing numbers of trans people attempting to access gender-affirming care, has resulted in the patients being provided a service unable to meet their needs in a timely manner. As mentioned above, a recent court case has shown the NHS does not accept fault or liability for this, citing a shortage of staffing as the main issue (The Guardian, 2023). Therefore, the only ones bearing the consequences of this institutional problem are those in the trans community themselves; the burden of waiting falls onto them. The emotional impact that this lengthy waiting has on trans people is the focus of this thesis' investigation.

## 1.1 Current Gender-Affirming Care Context

At present, those seeking to medically transition in England may use the NHS gender identity services or one of few private gender-affirming practices. These practices utilise the World Professional Association for Transgender Health (2022) guidelines in the delivery of gender-affirming care, which use diagnostic criteria for gender dysphoria from the DSM-5 and ICD-11. While some NHS clinics allow for self-referral, the usual practice is to begin one's medical transition journey after being referred by a GP. This referral is followed by extensive waiting in the average region of three to six years depending on the clinic, as detailed previously, until the first appointment. Private clinics operate similarly, under the same standards of care as the NHS but with an initial wait of months, rather than years, for the first appointment and briefer time between follow up appointments. In some NHS clinics, an appointment with a psychologist is provided in the interim of waiting for a clinical assessment. However, this is not universal across clinics, information about it is not freely advertised on their websites and, most importantly, it is not a diagnostic appointment.

Individuals desiring hormone replacement therapy (HRT, full terminology list in Appendix 6) can be prescribed to following one diagnostic appointment, though a team is expected to care for them including a nurse, psychologist, and endocrinologist who may assess the patient before their diagnosis (World Professional Association for Transgender Health, 2022). It has been normal across NHS clinics for two diagnostic appointments to be performed until quite recently. While this is no longer required, it may still be used in certain instances to confirm a diagnosis. Waiting times between diagnostic appointments and for follow-up appointments are not advertised on most GIC websites but appear to range from 3 to 18 months apart varying by clinic.

Gender-affirming surgery referrals may be offered after at least 6 months of HRT in the instance of its use; HRT is not a prerequisite for gender-affirming surgery if it is not desired or causes the patient harm (World Professional Association for Transgender Health, 2022). Individual surgeons may have their own requirements for eligibility based on, for example, weight. NHS waiting times for gender-affirming surgeries vary by chosen surgeon, of which there are few, and can extend into many years.

While this process appears straight-forward, it is fraught with many obstacles and unexpected delays, as this thesis demonstrates. It also rests against a backdrop of political and social unease for trans people. While trans people wait longer than most for healthcare, they also subject to the demands of social life in the process and are expected to maintain their livelihoods while transitioning. Media and political attention have increased around trans identities and bodies in the last decade, drawing focus onto the provision of trans healthcare over the last decade, with the few voices seeking to limit access to it having greater influence over the lives of transgender people than they do themselves. At the time of the interviews, the Gender Recognition Act 2004 went into consultation, giving many the hope of more autonomy over gender identity. However, the result of the consultation did not grant this autonomy, continuing to gatekeep legal gender recognition behind a diagnosis, obtainable only after many years of waiting. Additionally, creeping regulations in the sport and education sectors are seeing trans people excluded from participation and being outed against their will. The portrayal of these events in the news is usually negative, vilifying trans people and suggesting their inclusion will cause moral corruption to the masses, beginning with children. Interestingly, much of the current anti-trans rhetoric is focused on the idea that children are in need of protection from the allegedly nefarious effects of simply existing around trans people. Trans people suffer the same accusations of child abuse as those spewed against gay men by the likes of Anita Bryant. In fact, the modern opponents of the social inclusion of transgender individuals seem to be using the same set of talking points as many figures of the anti-gay movements of the past, claiming that being around trans people can actually ‘turn’ a child trans (Rosky, 2012). Moral outrage is created and used to limit trans peoples’ autonomy politically, and subsequently, medically. Existing while trans in such socially contradictory times is a contextual burden for all trans people, which is simultaneously exacerbated by and actively exacerbating the suffering caused by years of waiting for gender-affirming healthcare.

## 1.2 Thesis Aims and Background

The aim of my thesis is to investigate how trans people emotionally experience waiting for gender-affirming care. I also investigate how trans people cope with the waiting times and how social media is used during the waiting time. Specifically, the research questions of this thesis are as follows:

- How does waiting for gender-affirming care feel?
- How do transgender people cope with the waiting time?
- How is trans social media used during the lengthy medical transition and the waiting it involves? How do digital documentations of transitional progress influence transition across waiting time?

Given the length of time it takes to medically transition in the NHS, it is important to understand the emotional effect of the process of waiting on transgender people, particularly at points when a medical transition is delayed beyond their control. All stages of waiting throughout the transitioning process are reflected in this thesis, from waiting for a GP referral to the end of medically transitioning.

At the core of my thesis is the temporality of the transgender experience of waiting for gender-affirming healthcare and the progression of one’s medical transition. Trans and queer temporalities, i.e. experiences of time, show varied descriptions of the passing and movement of time (Horak, 2014; Carter, 2013; Pearce, 2018). However, most queer and trans temporality theories do not consider waiting for gender-affirming care. My thesis contributes to the limited research on emotions of trans people waiting for care and trans temporality research, with the aim of informing better healthcare practices in the future.

In regard to the coping strategies of trans people, my thesis shows the necessary, sometimes costly and risky, methods of managing the emotional and temporal effects of waiting. These strategies are presented along existing trans coping literature, emphasising the importance of reliance on the self and intercommunity care in the absence of formal medical care.

This thesis is finally concerned with how online social media spaces devoted to trans people are used while waiting for gender-affirming care. Further, an examination of digital documentations of transitions is presented, as those represent a large part of the content consumed and created by trans people on social media sites, such as YouTube and Tumblr. The interviewees' understanding of what community connectivity means to them is also investigated, adding to and elaborating on previous definitions of community connectivity.

## 1.2 Thesis Structure

This thesis is structured as follows:

Chapter 2 reviews literature pertaining to the three research questions. Emotional experiences of trans people under various conditions are examined first to form an understanding of their general emotional state under stressful circumstances relating to their gender identity. Temporality literature is then reviewed to present how trans people experience the passing of time during different periods of their lives. This literature demonstrates the fluctuating sense of passing of time under different conditions. The chapter then proceeds to review how trans people tend to cope with stressors that arise from their trans status, such as discrimination and gender-related stress. These studies highlight the importance of community support and validation. Finally, the chapter reviews literature on social media used by trans people and community connectedness online.

Chapter 3 presents the methodological approach adopted in this research and details the data collection and methods of analysis employed. I discuss the benefits of the three data collection methods I utilised in light of the post-modern feminist approach of this thesis. I also discuss how participants were recruited and the difficulties experienced during the recruitment process. I finally reflect on the research process reflexively, as a trans researcher.

Chapter 4 is the first of the four analysis chapters. Its focus is on the emotional experiences of my participants, which are presented in a chronological order of the individuals' medical transition. They reveal that severe emotional suffering accompanies the waiting time at every stage of the medical process; the emotional states described by the interviewees matched, in many cases, with diagnostic criteria of moderate to severe anxiety and depression. Negative emotional states and experiences persist through transitioning, particularly when additional barriers to healthcare are regularly imposed by GICs.

Chapter 5 analyses the temporal experiences of waiting for gender-affirming care. I review how the motion of time feels to individuals, forming comparisons to other theories of queer temporality. I also present the similarities and differences of gender-related waiting temporalities compared to other waiting experiences of the individuals. Waiting for gender-affirming care feels slower in comparison with objective time. Some of the interviewees felt out of touch with time altogether due to their powerlessness to influence their transition's progress.

Chapter 6 examines the coping strategies the interviewees used to manage the emotional and temporal effects of waiting. Against a backdrop of trans and queer coping literature, many beneficial strategies are examined, and I explore how these strategies help manage waiting for gender-affirming care. Community immersion allows trans people to mentally invest in trans culture and enjoy other trans peoples' company, art, and participate in other social events. These acts help separate waiting from their trans identity, allowing them to celebrate their transness as a source of joy and togetherness. Information about transitioning is also found in community spaces, filling the gap left by medical services. Several methods of addressing gender dysphoria are discussed. Finally, I present the actions and distractions that served to reorient the interviewees' sense of time and manage emotional experiences. Chapter 6 provides an in depth understanding of the multiple ways in which trans people manage waiting for gender-affirming care.

Chapter 7 interrogates trans social media use by the interviewees during the waiting process. I firstly present how the interviewees interact with trans social media, including how community immersion provides them the opportunity to: learn about transitioning, including the waiting times; share experiences of waiting; find empathy from other trans people; and create long-term bonds of friendship. I then focus on digital documentations of transition, i.e. the videos, blogs, and other media created by trans people to show their medical or social changes during transition. I examine the ways in which the interviewees interacted with this kind of content, as well as the reasons for which some of them had, or had not, created their own digital documentations. Chapter 7 ends with an analysis of the meaning of community connectedness to the interviewees in comparison with previous literature that measures community connectedness.

I conclude my thesis with a summary of its novel contributions and recommendations for those medical practitioners responsible for caring for trans people. I also reflect on the research’s methodological design reflexively, as a trans researcher. My recommended solution to the problem of lengthy waiting times is a change of healthcare practice in the case of gender-affirming care to an informed consent approach, with hormone replacement therapy available at the level of the GP, and greater involvement from local level clinicians to facilitate medical transitioning.

## Chapter 2. Literature Review

This chapter reviews several research areas which have been consulted to assist the answering of the three research questions of this thesis. This chapter will present five areas of sociological literature from which the analysis presented is drawn to situate this research. In answering the research questions, I engaged with literature from different areas of sociology and psychology in order to account for the ranging experience of waiting for gender-affirming care and the social context in which it happens.

Firstly, I will review literature and theories pertaining to sociological theories of emotions, which I will then narrow down to research that looks at trans people's emotional reactions to difficulties they encounter in social life and healthcare specifically. These studies will provide a foundation for an understanding of the emotional circumstances of trans people in preparation for the analysis of how waiting for gender-affirming care is experienced emotionally in Chapter 4. While this waiting time can be emotionally tumultuous, it can also disturb one's perception of time, a phenomenon which is explored separately in Chapter 5.

Literature examining theories of the perception of the movement of time, or temporality, will follow. Studies on trans and queer temporalities offer insight into the ways in which trans people's experience of time differs from cisgender and heterosexual people. They present the trans experience of the flow of time as variably non-linear in multiple social arenas; thus, they provide a basis for an investigation of the temporality of waiting for gender-affirming care. The application of emotional and temporalities theories to the analysis of waiting for gender-affirming care will answer the first research question of "How does waiting for gender-affirming care feel?"

The first research question anticipates difficult emotional and temporal experiences for trans people waiting for gender-affirming care. Therefore, I will review coping literature relevant to the trans experience to address the second research question: “How do trans people cope with the process of waiting for gender-affirming care?” Coping strategies, discussed in the research below, are used within the trans community to manage social difficulties experienced during waiting.

Social media and online resources contribute to a great deal of the trans community’s knowledge about being trans and transitioning. They are an integral resource to many, especially when physical distance is prohibitive of meeting others, and allow exploration of gender, as discussed in the literature presented below. These studies will underpin Chapter 7’s investigation of trans social media’s use during waiting for gender-affirming care.

Finally, I will review the meaning and purpose of community connectivity in reference to mental health. The community has many online spaces to discuss their experiences with other trans people in similar positions with similar lifestyles and interests. In these spaces, they will undoubtably form bonds as they share their experiences and find a sense of belonging. The interaction of community connection, and the very nature of it, particularly when considered in reference to waiting for gender-affirming care, is of implied interest within this thesis’ research questions.

## 2.1 Sociological Explorations of Emotions

Bericat’s (2016) review of forty years of work on the sociology of emotion finds that emotions are an experienced physiological change of state in the body and mind in response to something within the self or in the environment. Bericat (2016) argues that all social situations, from politics to TV shows, are emotionally charged and analysing emotions across different contexts helps to inform on important social phenomena. Many theorists have contributed to the study of emotion, proposing understandings of why emotions occur across various contexts. I will review some whose work is especially useful in my analysis in this section.

Hochschild (1983) theorises that emotional displays are clues as to the true state of one's mind. She also builds on Freud's understanding of anxiety and proposes that anxious sensations come as warnings in hazardous situations. According to Hochschild (1983), different emotions come from appraising different situations, from work and social life, reflecting power structures and to signal an individual to behave in a certain way depending on the context. Individuals learn from new experiences and carry that knowledge into similar future emotional circumstances to help manage difficult emotional reactions appropriately and effectively.

Other theorists explain how emotions can also be shared across social groups facing a common emotive event based on how events are appraised. For example, Yzerbyt, Dumont, Wigboldus and Gordijn (2003) show how shared emotions can present across group members when individuals face a violation to their in-group. They found that the critical emotion, in this case, anger, presented increasingly alongside higher-level in-group identification as their most significant result. Where group membership was not salient to individuals, emotional reactions were recorded with less intensity. However, their findings show that emotions and reactions to an event can be shared across an in-group. Their research compliments appraisal theorists' understanding of emotional reactions and suggests better intergroup relations in multicultural spaces may be formed by sharing experiences with different groups (Yzerbyt et al, 2003). The in-group categorisation was made salient to participants to draw their attention to their group and its other members. Other groups who openly and actively participate in a cultural identity group, such as the trans community, may have broader emotion sharing capacities due to having shared experiences with existing emotional impacts which are related to their identity.

Stryker (2004) alternatively proposes identity theory to include understandings of emotional responses. Stryker argues that emotions are expressed in relation to the (in)validation of an individual’s identity in a social setting. Multiple identities exist within an individual to be used within different social roles, with some identities being more important than others depending on the situation and interlocutors. For example, assuming the identity of a parent is useful with raising children at home, but a professional identity is required in the workplace instead when engaging with colleagues and superiors. Emotions are explained as the product of the difference between an expectation versus the reality of a social interaction and the level of validation of the self from that interaction (Stryker, 2004). To follow from the previous examples, being confirmed as a good parent or professional by others will give rise to positive emotions, and the opposite effect can be expected if one is disaffirmed. Stryker (2004) extends identity theory’s emotional theorisation across social groups, as do theorists of intergroup emotions, whose work will be reviewed next. I apply this theory to the trans community in the analysis of this research to understand how trans people are emotionally affected by, essentially, waiting for the validation of their identity through gender-affirming care.

Von Scheve and Ismer (2013) propose that individual and group emotions are linked and influence each other through several processes. Combining three distinct social research areas, they devised a model to account for emotions arising in groups from face-to-face encounters, culture and shared knowledge, and identification with a social group. They propose that the foundations of collective emotions in groups or collectives are elicited through memories created by group discourse, which grow to exist as attitudes of the group. Membership of a group demands emotions to be expressed in accordance with its norms and values; certain events require explicit behaviours, including the display, or containment, of emotions. Performing emotions in group-accepted ways conveys the emotion around the group, whilst validating it as an appropriate response to an event in the past or present. In this way, sentiments surrounding waiting for gender-affirming care may move around the trans community, validating individuals' emotional responses to it.

These theories of emotion can be applied to trans people's experiences to understand their emotional reactions in the context of their lives. They help account for trans people's emotional experiences as a result of subordination within the healthcare system as a marginalised group. However, theory specific to trans people's emotions is required for a more accurate analysis, as broad theories tend to assume cisgender experiences as the norm. The following section reviews trans and queer literature on emotional outcomes of trans people in healthcare, giving a closer understanding of trans emotional experiences.

## 2.2 Trans Experiences of Healthcare

Van der Miesen et al. (2020) reviewed the paused state of gender-affirming healthcare in the Netherlands due to COVID-19, highlighting the existing and exacerbated difficulties experienced by the trans community in health and social contexts. They discuss access to care, where two thirds of trans patients wait more than 18 months to begin taking hormones, as a ‘serious issue’, acknowledging waiting (averaging much less than UK waiting times for the same treatment) as a crucial problem. The consequences of this problem for the trans community are presented: in the short-term, delayed care may lead some to seek hormones from unsanctioned sources; the long-term effect of waiting in trans people is a propensity for emotional based mental health conditions, such as anxiety, depression, and suicidality (Van der Miesen et al., 2020). Van der Miesen et al. (2020) are concerned that the emotional effects of waiting for or being delayed gender-affirming care is not of research interest to healthcare professionals, and that future research and socio-political movements for trans people may be deferred due to COVID-19 taking precedence in health and politics. Their concern is recognised in this research, as the emotional experience of waiting for gender-affirming care is the primary target of investigation.

Waiting is known to be problematic, even without the influence of COVID-19. Rickett, Johnson, Ingle, and Reynolds (2020) conducted an online survey to capture the experiences of support received from various health services by parents and carers and their gender diverse primary school aged children. Waiting was one of the four common themes of their analysis, noting its enormous emotional cost. Lost time during childhood and adolescence is replaced with stress experienced by both gender diverse children and their parents as they live through the uncertainty of waiting. Conversely, care in the form of hormone-blockers offered a welcome pause, during which children could reflect on their identity without the stress of continued pubescent development. Rickett et al’s (2020) other participants said they and their children felt knowledgeless about the process of care through the waiting periods to accessing care. Only 16% of Rickett et al’s (2020) participants agreed that their GP understood their and their children’s needs, and just under a quarter felt their GP had given them good support. Official information about care practices and guidelines was difficult for their participants to find while they waited for care, leaving them feeling isolated and leading them to seek help from other parents of gender diverse children and charities in the meantime (Ricket et al., 2020). Their research demonstrates the general lack and want of formal accessible healthcare resources across parents, carers, and their gender diverse children and the need to turn to the voluntary care of other individuals with similar experiences and non-profit organisations for emotional support.

Pearce (2016) finds adult trans people mistrust their primary healthcare providers with good reasons. A feature of GPs that is off-putting to trans people making first contact with them is their limited or absent knowledge of gender-affirming care practices. GPs, in some cases, seem unsure of how to provide gender-related, as well as general, care to trans patients. There is a serious case of the “trans broken arm” in healthcare settings, which has remained prevalent as a community topic over time and space, where GPs cannot see beyond the trans identity to provide relevant care (ibid). As discussed by Pearce (2016), stories of GPs obsessing over a patient’s trans identity when it is irrelevant to their problem contribute to a wide-spread fearful anticipation of mistreatment or outright refusal of treatment by healthcare providers in trans communities. Trans people, therefore, have many fears about reaching out for medical support unrelated to their transition, as there is an expectation of a bad outcome, supported by personal and community experience.

Another constant circulating worry amongst the trans community is the anticipation of not being seen as ‘trans enough’ at the Gender Identity Clinic. ‘Trans enough’ here refers to the notion that the clinician has the final say over whether one’s gender dysphoria symptoms are sufficient for them to access a medical transition. Pearce (2016) finds this anxious feeling is paired with stress over up-coming clinical assessments, which are seen to be a ‘test’ by gender clinicians. She finds trans people become stressed in anticipation of what they may be asked, such as how much of their childhood will be delved into, how their relationships with their parents and people around them will be assessed, and whether their time frames of social transition are sufficiently justified to warrant accessing medical transition at that time. Trans people feel that there should be specific answers to the impending personal questions to fulfil criteria to satisfy the clinician that they are indeed trans enough to qualify for a medical transition (Pearce, 2016). Preparation in the form of physical documents, such as a deed poll and identity documents in a new name, serves to ease these fears, as this evidence serves to prove that an individual is living in an acquired gender, which is necessary to pursue a medical transition. Having these documents in place, and having navigated the healthcare service in advance of entry into it via the online community, does give rise to hopefulness towards the future; thus, anticipatory time is not always associated with negative emotions.

Vermeir, Jackson and Marshall (2018) conducted in-depth interviews with eight Canadian trans people on their perceptions or experiences of barriers to emergency and primary care. Healthcare providers including doctors, nurses and techs lacked the cultural competence to provide appropriate care, explained by little to no training and social stigma. In specific medical screening areas, such as gynaecology and radiology, their interviewees experienced inappropriate requests and reactions from healthcare providers, as well as social treatment in waiting areas differing from that exhibited towards cisgender patients. Other interviewees had better experiences of being given the option of a different waiting space for their privacy, which was a welcome offering- when done discretely. They recommend many improvements across healthcare systems to ease trans patients' experiences of healthcare. Most easily, healthcare providers are recommended to record their trans patients name and pronouns to ensure their provider addresses them correctly. Healthcare providers should also be willing to increase their knowledge of trans healthcare through existing healthcare resources, rather than utilising their patients' knowledge of gender in healthcare, as greater knowledge improves care and perceptions of trans people (Vermeir et al., 2018). This, in turn, should make trans people less reluctant to seek healthcare and allow them to take better care of their overall health.

Newman, Smith, Duck-Chong, Vivienne, Davis and Robinson (2021) reviewed the changing and difficult healthcare environment for trans people in Australia and more globally. Recognising the contentions over trans healthcare caused by legal cases, Newman et al (2021) emphasise that there is a great anxiety for all those waiting for gender-affirming care. Various forms of social capital are required on the part of the patient, and they observe that physicians appear ill-equipped to provide the required care, even non-transition related, and inappropriately curious.

The trans experience, Newman et al. (2021) argue, is inextricably linked with waiting. This applies not only to the literal, lengthy waiting times which are a barrier to accessing gender-affirming care, but also to the wider social experience of transness. Trans healthcare, as a field, is still waiting for legitimisation in the medical field, further delayed by the discourse being dominated by critics attacking trans people and their healthcare providers (Newman et al., 2021). Similarly, the trans community is still waiting to be seen and respected both in the media, and, perhaps more importantly, within the legislative system. These forced delays are therefore a part of transness, reinforcing the continued discrediting and threats that trans people experience over their healthcare and social needs (Newman et al., 2021), whilst also taking away the possibility of legally taking ownership over one's own gender identity.

Ker et al. (2020) argue that many barriers to trans health are underpinned by a cisgender interpretation of gender. This means that cisgender is viewed as a normal way to be, and so, the urgency of trans healthcare is reduced and side-lined. This effect is felt throughout the trans community in the forms of lengthy waiting and a tedious, still highly binarised, diagnosis process. Using discourse analysis from their interviews, Ker et al. (2020) review a pilot trans healthcare clinic in New Zealand. It operated with an informed consent model, with general practitioners providing hormone replacement therapy and other healthcare singularly for trans people. The trans users of this facility noted the significant differences in their experiences of pathologisation and waiting time for gender-affirming care between this clinic and the standard hospital; the hospital was an experience of unbalanced power structures, bureaucratic waiting, while the clinic was comfortable, with an attitude of anti-pathologisation, familiar- one user described time there as a luxury. Clinicians attempted to distance themselves from medical discourses in interviews, leaning away from the assessment practice of trans healthcare and towards a more counselling role (Ker et al., 2020). Conceptually, this pilot clinic described is a far reach from the English gender-affirming healthcare practice, and the following analysis will show a radically divergent experience in trans individuals as a product of this difference.

In summary, this section has provided an understanding of how trans people emotionally anticipate and respond to being in the process of gender-affirming care and wider medical care. These studies show that lengthy waiting for gender-affirming care is a global issue which produces anxiety and depression in many. Healthcare systems separate from gender-affirming care highlight cultural incompetencies and inappropriate behaviour towards trans people across the medical field. These studies also show how trans people are currently treated within healthcare settings; they feel fearful in approaching healthcare providers due to over-interest or misunderstanding about their transness by practitioners. In this study I utilise these findings as points of comparison, contrasting experiences to form an understanding of the emotions that are brought up as a result of unfair treatment of trans people within healthcare settings. However, in order to fully understand the impact that waiting for gender-affirming care has on an individual, I must also examine the influence it has on their perception of time itself. To facilitate such an analysis, I review theories of trans and queer time in the following section.

### 2.3 Temporality: The Flow of Trans Time

While waiting to attend a GIC, trans people find themselves experiencing different temporalities, as explored in detail in this study. Temporality refers to the “social patterning of experiences and understandings of time” (Amin, 2014, p.219). Through the study of trans and queer temporalities it is possible to form a greater understanding of gender variance within nonprogressive temporalities to disrupt normative understandings of trans experiences as medically linear, a notion that invalidates manyof them (Amin, 2014). Trans and queer temporalities show an ever-changing sense of the flow of time. The following theories examine the multiple ways in which time deviates and flows contrary to linear from trans and queer perspectives. The first few of these temporal theories flow without structured direction, offering perspectives of time that leave the notion of forward moving time. The following theories flow linearly with queer lives, with the temporalities attached and attributed to specific queer experiences. Queer time and trans time hold different meanings across the following theories, some seeming contradictory, however that is the nature of the trans existence. Across their differences, they aptly cover many aspects of the lived trans experience.

Halberstam describes queer time as “a term for those specific models of temporality that emerge within postmodernism once one leaves the temporal frames of bourgeois reproduction and family, longevity, risk/safety, and inheritance”. (2005, pg. 13). Queer time is anachronic and asynchronous to heterosexual time in that it is non-linear with an anti-futurity quality and is not moving toward traditional heterosexual goals (Halberstam, 2005; McCallum and Tuhkanen, 2011). On straight time, Muñoz (2009, pg. 22). comments that “The only futurity promised is that of reproductive majoritarian heterosexuality, the spectacle of the state refurbishing its ranks through overt and subsidised acts of reproduction”. Heteronormativity demands that time be linear and relative to reproductive time; thus, those who deviate away from this experience may find themselves in a temporality distinct from those around them, experiencing time queerly and non-linearly. Queer time is viewed as an experience of asynchrony (Dinshaw et al., 2007). For Munoz (2009) queer time is the stepping away from prescribed futurity of straight time to utilize the past, present and future to create a utopian time and space. Halberstam (2005) similarly presents queer time as a potential time away from the heteronormative life experience. These theories appear as presenting unlimited potential of time to queers and particularly they appear as opportunities to escape the confines of straight time and heteronormative activities. However, not all opportunities to escape straight time offer such multiple avenues of exploration and creation. The following theories emphasize the temporal displacement endured by trans people as they attempt to align themselves in time.  Carter (2013) gives an alternative, relevant, and realistic experience of transitional time as multi-occupational. Carter interprets a dance performed by Sean Dorsey, which was choreographed to depict Lou Sullivan’s life as a gay trans man, noting simultaneous occupations of time as Lou transitioned from female to male. The choreography emphasises the past being let go of, and the future of a new life being embraced during transition. Transitional time, Carter (2013) argues, is both queer and straight, as it is non-linear, yet refolded back for Lou in his refigured sexuality. The interaction of trans identity with Lou Sullivan’s gay identity is a prominent point in the dance (Carter, 2013). The choreographer, Dorsey, showed Lou’s acceptance into the gay community as if there had always been a space for him in which he fit perfectly, thanks to a clever manipulation of the Dance of the Cygnets, beginning the dance with three, as opposed to four, dancers for him to join later. This demonstration is an overwhelmingly positive representation of community acceptance during a tumultuous time in an individual’s life.

Pearce (2016) considers trans time to be a time of anticipation. She draws on the waiting experience of trans people to show that waiting for healthcare is a distinct trans temporality. For those who medically transition in the UK, nervous anticipation is rife, as little is known about the full extent of the wait ahead. Pearce (2016) reads Bradley and Myerscough’s (2015) Transitional Demands, which presents waiting for transition, and, therefore, anticipation, as a distinct trans temporality and as a form of queer time. Living in a time of anticipation links the current lived experience of awaiting healthcare to a vision of a better future- the present is compressed and liminal; the future contains positive possibilities. Pearce (2016) identifies waiting, mistrust, being trans enough, and hope as key components of considering anticipation as a trans temporality. Waiting is an essential component of trans experience for those who await medical care. The futurity of the pre-transitional state leaves the current time completely anticipatory in advance of the first appointment to a GIC. This is most comparable to Carter's (2013) temporality theory as a non-linear experience of multiple occupations of time, as an old identity is left behind and a new one is strived for simultaneously. Non-linearity is experienced through not knowing exactly when the appointment will take place; typically, no clear time frame is given from the point of referral. During this wait, an individual's old identity has been rejected by them, but a new one, whose existence would be granted along with one's access to gender-affirming care, has not presented itself yet, thus leaving them in a state of timeless limbo. Both temporalities are reminiscent of queer time; however, not all trans temporalities are viewed as queer.

Anticipation continues to manifest even if all the required evidence has been collected in advance of entry into the GIC service. With everything in place, Pearce (2016) notes that hope is a prevalent aspect of this waiting temporality. One of her participants described himself as 'bricking it' and also excited in his anticipation of starting treatment at his GIC. Hope gives an end sight, whereas mistrust, another important element of Pearce's (2016) research, shows possible barriers. It promises the end of the limbo with the beginning of hormone time (Horak, 2014), and so, a return to linear time from a time of uncertainty (Carter, 2013). Anticipation gives the connotation that there will be an end to the current wait which should result in what is being waited for; this end is so desired by trans people that hope stands out clearly as a component of transitional temporalities. Post-transition community members encourage others who are early in their transitions to look forward to the future, with positive accounts of how their lives are more comfortable after transitioning. This helps maintain the community’s spirits around gender-affirming healthcare, as well as allowing those still awaiting it to interact with others further along in the process for whom it has been successful, and who can confirm that their transition was worth the wait.

Horak (2014) describes what she calls hormone time as beginning at the start of hormone replacement therapy and continuing as linear from that time. Specifically, when discussing trans YouTube creators’ videos across many format styles, Horak (2014) demonstrates that hormone time is mapped by creators as a progressive affirmation of themselves across a single, or multiple, videos. Creators use various temporal forms of presenting their transition as a forward movement, often indicating the initiation of hormones and directing viewers’ attention to specific aspects of hormonal changes on the face and body. These can appear as a photo montage of different images of an individual in chronological order, where years, or even decades, can be shown in a few minutes, or as a series of similar images, such as of just the face, over several months to a few years of time at a much faster pace, in a temporal compression, to show the extremely slow changes that hormones produce, imperceivable to the human eye. The talking head nature of some of these videos, where the creator’s head and upper torso are often in view, creates a closeness with the viewer as they address the camera, as if it were a trans peer, in conversation and physically change over time, contributes to their high views and many followers (Horak, 2014). These digital representations of transitions are well-received by the trans community, making their value to those waiting for gender-affirming care an interesting topic of analysis in this research.

There is insufficient research interest in the aspect of waiting in the process of gender-affirming care, as research trends towards treatment outcomes. Research conducted by gender clinicians excuses the existence of the excessive waiting times due to limited funding and few specialist clinicians. However, these excuses only highlight the lack of medical and political interest in trans lives and diminish the experience of that waiting, making it appear as a bureaucratic issue rather than an every-day lived experience that is damaging to trans people. Every person seeking gender-affirming care must experience a lengthy waiting period which extends into many years. The waiting can shape the experience of time for the individuals that experience it, frequently late teenagers and those in their early twenties as in this research, around not having the healthcare they need to live their lives fully. At this important early stage of life focus that should be spent on navigating the adult social world is instead drained navigating the consequences of not being able to obtain the healthcare needed to present the self as recognisable, within and to others. How this situation affects trans people requires more research attention and investigation, both in regards to its temporal and emotional effects.

This section has reviewed literature on trans temporalities, showing that time’s pace can be experienced in different ways in various circumstances across transitioning. Each theory presents a different understanding of the experience of time, accounting for variances to that experience across circumstances. I will use these theories to elaborate on the multifaceted formation of the temporality that is waiting for gender-affirming care. Since, as outlined in this and previous sections, these temporal experiences can present serious emotional consequences for an individual, it is necessary to consider how those in the trans community manage the difficulties of the shift in their temporalities. The following section reviews literature on coping strategies used by trans and queer people in order to provide a foundation for an analysis of those strategies used by my interviewees.

### 2.4 Coping Strategies used by Trans and Queer People

Coping strategies are tools used to manage difficult circumstances. Freese, Ott, Rood, Reisner and Pantalone (2018) used an online survey to gather data from trans and gender non-conforming individuals to examine the relationship between their coping strategies and their mental health. Their participants self-reported psychological scales of coping in relation to gender related stress, depression, anxiety and stress, and a measure of suicidality, before and after the start of transition. These scores were analysed with factor and cluster analysis, resulting in three distinct coping profiles being observed in participants. Some coping strategies were omitted from the analysis due to their low factor loading including “I have been turning to work or other activities to take my mind of things” and “I’ve been making fun of the situation” (pp139). Due to the statistical nature of their analysis, these omissions were necessary; however, a closer analysis of these smaller variables may have yielded an interesting discussion. The three coping profiles reflected use of both functional and dysfunctional coping tendencies. 134 participants fell into high-functional/low-dysfunctional profile (HFLD), favouring coping strategies based in self-reliance and social support and avoiding self-blame and substance abuse. 104 avoided using any strategies (LFLD) and 78 used all the strategies (HFHD). Freese et al.’s (2018) results suggest that trans and gender non-conforming individuals tend towards functional coping strategies, but that higher levels of depression and suicidality appear associated with dysfunctional coping strategies, which, in turn, impedes the well-being gained from functional strategies. They advise future research to investigate substance abuse to understand its specific use as a coping strategy in the trans population.

Bry, Mustanski, Garofalo and Burns' (2018) research focused on individuals who were psychologically resilient to depression and anxiety, despite having experienced stigma from their families. They conducted semi-structured interviews with ten trans women and sexual minority males to discover their coping strategies in relation to their experiences of gender, sexuality, and life-related stressors. Several assets and resources were described by the participants which helped them tackle discriminatory experiences or discount and devalue their impact. Most of their participants devalued societal acceptance, which appeared to minimise the effects of discrimination encountered outside of the home. This, along with other measures, such as normalising gender and sexual variability and being conscious of others' opinions versus fact, assisted their participants in maintaining their high self-esteems and resilience. The authors also found social and religious support was a key variable in self-acceptance as the individual was affirmed by others and their understandings of holy texts, again contributing to resilience. Bry et al. (2018) suggest that minority stress may be treated in clinics by helping individuals obtain problem-solving skills and helping them seek supportive, affirming social spaces.

Gorman, Shipherd, Collins, Gunn, Rubin, Rood and Pantalone (2022) conducted semi-structured qualitative interviews with thirty trans and gender diverse people to assess their coping strategies of gender-related stress. They discussed strategic avoidance as a common multi-use coping mechanism which can be used to conceal a trans identity in social situations which may invite discrimination or harm, as well as avoiding specific spaces and places which may invite the same. While Gorman et al. (2022) recognise that avoidance is usually viewed as problematic as a coping strategy, they argue that this does not appear applicable to the trans and gender diverse community, considering the extremely high trauma rate across its population. Avoidance, therefore, serves as a protective measure used by the trans community, a finding echoed by Bogert, Dale, Daffin, Patel, Klein, Mayer and Pantalone (2018) in their study of coping measures used by HIV-positive Black queer men in cases of discrimination. Bogert et al. (2018) found strategic avoidance of people or places was used as an intervention by their participations, along with problem solving behaviours and humour. This suggests certain types of strategic avoidance may be valuable to other communities, as well as the trans community, to prevent entering potentially discriminatory spaces.

Similar to Bry et al. (2018), Gorman et al's (2022) study showed a rejection of the value of others' stigmatising judgement as beneficial to individuals. Gorman et al's (2022) research also suggested that trans and gender diverse people cope with gender-related stress by helping other people in the community, and that there were benefits from having integrated their gender identity into their sense of self. Validating social support was a major factor in their participants' ability to cope with and be resilient to gender-related stress, and they emphasised the need for continued research into how trans and gender diverse people experience support from in- and outside of the community (Gorman et al., 2022).

Matsuno and Israel (2018) devised the Trans Resilience Intervention Model to demonstrate how group and individual resilience factors mediate the mental health of trans people experiencing different stressors. They identified group resilience factors to be made up of family and social support, having and being a role model in the community, and participating in community activities and activism. Group factors bolster individual factors of resilience comprising of hope, self-definition and worth, self-acceptance and identity pride, and transition (Matsuno & Israel, 2018). Resilience factors mediate the effects of distal (external) stressors, such as gender-related discrimination and rejections, and proximal (internal) stressors, such as expectations of rejection and internalised transphobia (Testa, Peta, Balsam and Bockting 2015). The application of the combination of resilience factors by trans people can mediate mental health outcomes in terms of depression, anxiety, substance use, and suicidality (Matsuno and Israel, 2018). They suggest that future research should focus on specific stressors and their accompanying resilience factors of the trans community.

Puckett, Matsuno, Dyar, Mstanski and Newcomb (2019) sought to separate social support into support from friends and support from family, as they have commonly been conflated in research. Their findings revealed four distinct classes of support from the separate sources of friend support, family support, and community connectedness through pair analysis in high and/or low measure combinations. The group with high levels across all sources of support had the lowest depression and anxiety scores, compared with the group with low support from all sources, with twice as much reported depression and three times as much reported anxiety (Puckett et al., 2019). They also found that community connectedness did not mediate depression or anxiety, reasoning that the vulnerable position of being openly trans with other trans people can invite discrimination, as well as providing positive experiences. Therefore, it may be interesting to discover what modes of community participation specifically aid or harm trans people in stressful situations.

Bogart, Dale, Christian¸ Daffin, Mayer and Pantalone (2017) recorded how Black sexual minority men with HIV cope with discrimination using several coping measures, one being the Africultural Coping Inventory, which is better suited to represent and capture Black and African experiences. This scale's measures include psychological and physical strategic avoidance and seeking community advice. Strategic avoidance is viewed as a positive coping strategy in Bogart et al's (2017) analysis, as the factors of avoidance target potential sources of discrimination, such as a specific location, as opposed to other avoidance measures used, for example, denial. Avoidance coping strategies appear to come in many forms to helpfully remove an individual from, or avoiding encountering, marginalisation (Mizock & Mueser, 2014). It will be interesting to analyse these avoidant forms of coping strategies in terms of their perceived benefits or harms in the context of waiting for gender-affirming care.

The studies discussed in this section have presented many coping strategies that are used by trans and queer people as protections or precautions in difficult situations. These studies form a basis of comparison from which this thesis analyses the coping strategies used while waiting for gender-affirming care. They emphasise a range of behaviours and activities that people engage in to manage their experiences. The analysis of coping strategies in this thesis reflects the wide range of measures used by others in this section. However, studies that delve into coping strategies specifically associated with the use of social media have purposefully been omitted in this section; the importance of social media as a strategy of stress-management in trans individuals has been deemed great enough to require a separate analysis. The following section, therefore, reviews research related to social media use by trans people.

## 2.5 Social Media use by the Trans Community

This section of the literature review will provide an understanding as to how and why trans and LGB+ people use online social media platforms, and the meaning these may have int the individuals' lives. Over the last two decades the world has seen such a rise in internet use that many could not contemplate life without it. The internet has broken down the borders and barriers of communication, nationally and internationally, by providing platforms of communication and information sharing, such as social media sites. While not entirely defined, as it remains in constant evolution, conceptually, social media is an enterable virtual space where those seeking understanding of themselves, or others, may go to do so. It is also a space from which meaning is not only derived, but in which that meaning is created; as those who share many commonalities come together, they obtain the ability to voice their experiences and create labels for themselves that make them recognisable to others in their community. This creates a community under a shared identity which can, hypothetically, be as wide as the internet can reach. This has played a key role in the building and maintenance of LGBT+ communities around the world (Friedman, 2007; De Koster, 2010; Singh, 2012).

Sexual minorities make use of the internet in a range of ways. Friedman (2007) examined historical writings and social media platforms and conducted interviews with members of feminist organisations to discover how lesbians have used social media as a platform to make social change. This use of social media by lesbians in individual Latin American countries as the primary platform on which to organise politically was necessitated by the number of physical spaces available to them being dramatically reduced. Friedman (2007, p.796) also demonstrates how online platforms are “crucial” in many cases, as they protect members of the community from offline discrimination in a “virtual life”. They allowed for previously unheard experiences to be far reaching, and for calls for solidarity and action or proud expressions of identity that would be otherwise silenced offline (Friedman, 2007). She discussed how online spaces became a refuge for many lesbians as physical space has been gradually eroded away from them and discrimination in the offline world remains ever present. Similarly, De Koster (2010) found some Dutch orthodox Protestant homosexual men found refuge online from spaces that could otherwise be hostile.

De Koster (2010) contemplates the meaning of community in the context of internet use. Considering several perspectives, he deduces that a community is present if the people using it view it as one, and if the spirit of community is felt. It is, therefore, possible to belong to more than one community, as in the case being discussed, with the studied group of men belonging to two communities: orthodox Protestant and homosexual. De Koster (2010) finds two broad types of Internet user in this group: one that seeks practical support, and one that seeks emotional support. Each of these uses the available platform differently and views the nature and purpose of the platform to be different. Those seeking practical support welcome views from the heterosexual population and find “no common bonds” between themselves and other users, whereas ones seeking practical support describe the forum as a “little city” and, later, as a “community” (De Koster, 2010, p. 568). The practical users utilise the forum to integrate their dual identities to understand how to manage being homosexual in their church network and do not mind their communications possibly being seen by others. The emotional support users are more inclined to be secretive about their conversations online. It stands to reason that a community exists in the minds of the users if the users find sufficient characteristics in common with each other. Those seeking emotional support online participate in offline social meetings with the same members, some in secret, as they were married. This community membership functions as a second virtual and physical world to one participant, in parallel to his life with his wife, seemingly as a refuge (De Koster, 2010).

These last two examples have shown how a community identity may or may not be formed online. In each case, it is important to note that the online and offline worlds are relevant to each other, as the causes for utilising these platforms are, most often, a lack of support and knowledge, or a want for a space in which to politically organise. In the case of trans people, there are even more reasons to use social media, such as to test an identity, as well as for practical and emotional help (Marciano, 2014; Singh, 2012).

The online and offline worlds may meet for some, but this is not always true, as Marciano (2014) finds in his online analysis of two trans focused spaces of Israeli trans users. Marciano (2014) seeks to understand how trans users navigate offline barriers and their identity between online and offline worlds. By now, it is rather established that queer peoples' use of the internet reduces their social isolation. The level of social isolation that a trans person may feel, like in the case of a person of a sexual minority, is dependent on the social and legal acceptance of their identity. While legal acceptance may be possible, the social climate may create an inhospitable environment for people to be overtly trans. On the other hand, the internet, as an unpoliced, unmoderated space, provides the opportunity for a safe display of gender identity.

While empowerment as an LGBT identified person is positive, balancing this social identity with other identities from other social groups is necessary to some, for whom social media continues to be helpful, as Singh (2012) finds in thirteen trans youth of colour. These youths describe the internet as being crucial to their dual identity solidification as both being trans and a person of colour. In being able to access spaces where they could meet other trans people of colour, they are able to negotiate their own identities by viewing how others perceive their own in positive ways. This empowerment goes further, as these youths find that they now are equipped with the necessary knowledge and tools to manage and deal with both transphobia and racism, as they can develop this resilient skill online and incorporate it into their offline lives when needed.

Finding others with shared identity and experiences gives Internet users a sense of empowerment. Mehra, Merkel and Bishop (2004) examine how fifty-seven US LGBT students meaningfully incorporated their social media use into their lives. In analysing the content of the mailing list and through informal discussions, Mehra et al. (2004) find that, like with the sexual minority cases, this was a good platform from which to form a base to springboard into the offline world. As well as being a platform for socialisation, the mailing list advertises and encourages political participation, and social support and queer history is available in the form of offline social events in addition to the online space. Each of these opportunities elicits empowerment within these LGBT individuals.

Cannon, Speedlin, Avera, Robertson, Ingram and Prado (2017) conduct five semi-structured interviewed with five trans individuals to discover how they use social media. They find two dominant themes in their analysis: social media is used as a resource; social media is used to help understand the self and build authenticity. As a resource it provides their participants with information about medically transitioning and assistance with their gender presentation. Their other participants highlight how important and helpful it is as a space, for experiencing acceptance as trans, and making other trans friends. However, many experienced online bullying and noted behaviours, seemingly avoidant ones, such as disconnection from others, to preserve their well-being. Online spaces are crucial to gaining information and experience life as trans with other trans people safely, however, measures have to be taken by many to protect themselves from harm.

Cipolletta, Votadoro and Faccio (2017) consider how trans people articulate themselves and build relationships online in Italian forums. Through an analysis of forum conversations and interviews with sixteen online forum users these authors find a core category of online help (Cipolletta, Votadoro & Faccio, 2017). Trans users seek help in the form of advice from peers and professionals, as well as social acceptance and relationships with other trans people. The forums provide these as support, solidarity, and a space in which to socialise. Users find the conversations mediated by professionals to be useful, as they also act as security and moderators. However, they require more from other moderators to protect them from people who enter the space with hostile intentions. Overall, higher levels of network support are experienced by these users compared to that in, for example, HIV and eating disorder communities. The relative isolation of trans people is considered to be the reason for this disparity in comparison to the other groups (Cipolletta, Votadoro &

Faccio, 2017). An emotional support network, coupled with the opportunity to give or receive support or advice to and from others, appears to be exceedingly useful for trans people, particularly to those remotely or rurally located. Sherman, Clark, Robinson, Noorani and Poteat (2020) conduct a systematic review of twenty research articles analysing trans community connection to health and wellbeing. They define trans community connectedness to be twofold: emotional connection and an observable connection. These manifest as feelings of belonging and social or online activities with other trans people. They find more trans community connectedness enhances mental health, offers more connection to care, creates a sense of openness to exploration of sexuality and gender identity, and grants individuals knowledge about their medical transitions. Their work finds that trans women in particular are less likely to engage with sexual healthcare providers as a product of trans community connectedness. They note that that future research should focus on health benefits from the same connectedness.

Pflum, Testa, Balsam, Goldblum and Bognar (2015) analyse specific data from 865 trans people who participated in a US based Trans Health Survey. They find that general social support and trans community connectedness could protect trans women from anxiety and depression. General support is a protective factor for trans men, but trans community connectedness is not; the authors suggest that any social support is suitable for trans men, but trans women prefer to seek trans support spaces. Their study used Testa et al’s (2015) Gender Minority Stress and Resilience measure, which proposes that resilience is a combination of community connectedness and pride. Community connectedness is a measure of affiliation and belongingness to the trans community, while pride is measured in positive thoughts towards and willingness to celebrate the trans identity. Together, resilience factors mediate the negative effects of proximal and distal stressors (Testa et al., 2015). However, Testa et al’s measure does not evaluate resilience in any form of active coping strategies on the part of the individual, with most of it being based on feelings or thoughts held within an individual. It does not show how trans people practically cope with difficulties specific to trans lives; rather, it focuses on how connected they feel to their community.

The studies reviewed in this section show the current understanding of what trans people use social media for, as well as what is meant by trans community connectedness, and how that serves trans people to protect them from mental illnesses. Depending on the social climate towards trans identities, the literature examined here shows social media spaces are used to create or manage an identity, as an end of isolation, a refuge, as a source of empowerment in queer and other identities, and a place from which to obtain social support and advice. The advice trans people seek from others with similar experiences in this research seems to often relate to their medical care. It is, therefore, conceivable that trans people in England would use social media to discuss and seek support from each other in the context of waiting for gender-affirming care, which will be examined further in Chapter 7.

## Conclusion

This chapter has reviewed several different sets of literature to build a contextual understanding of how trans people experience the situations surrounding the three questions of this thesis. The first section reviews research which shows how the general population react to difficult experiences, and how trans people, specifically, experience and emotionally react to interacting with healthcare services. The second section reviews several theories of trans and queer temporalities that present trans time as experienced differently to linear time. Thirdly, coping strategies are examined, showing many tactics are necessary for trans people to manage their difficult experiences. Finally, social media and community connectivity literature show good well-being in trans people as a product of community connections and support.

These studies and theories will underpin my analysis of the data gathered in this research in the following analysis chapters. Many similar reactions and experiences to those that this literature review has encompassed are reflected in the following analyses chapters in response to the experience of waiting for gender-affirming care.

The next chapter will present the methodological design used to recruit individuals, gather data, and perform the analysis of this thesis. It also includes the theoretical framework of the thesis.

## Chapter 3. Methodological Design

This chapter explains the methodological approach taken in this thesis. It provides an overview of the research design and the details of its application, changes to the design during the data collection, my approach to the analysis, the ethical considerations and reflections. This research stems from my personal interest in the pace of gender-affirming care in England and its effects on trans people. Most of the incredibly long time spent attempting to access gender-affirming care is spent waiting; therefore, it is a well discussed topic within the trans community- and yet, it is still a neglected research area. It is presently unclear for researchers how trans people cope specifically with waiting for gender-affirming care. To address this gap while centring the individuals' experiences, I conducted twenty-five interviews over five months from July 2018 to December 2018, utilised diaries, and altered the methodology from a second interview to ethnography, which spanned five months from February 2019 to June 2019. During the research process it became clear that trans community interaction is central to managing the waiting experience. This community-based aspect of coping with waiting for gender-affirming care was better investigated utilising an ethnography, rather than conducting further interviews.

I employed a postmodern feminist approach to my research method choices, as it seeks to analyse gender inequalities in society, following the understanding that genders exist as socially constructed pluralities as opposed to biologically determined binaries (Monro, 2000). Utilising feminist methodology ensures the subject's experience is represented within their socio-political context and allows me to recognise the influence of my status as a trans researcher. Postmodern feminism acknowledges the differences of experiences between individuals who share some aspects of their identities, e.g. a black woman’s experience is not the same as a white woman’s (Stanley & Wise, 2013). Feminist intersectionality requires acknowledgement of different locations in relation to identity, power and difference (Crenshaw, 2017). Truths of experience are, therefore, considered to be individual and context driven. Employing this postmodern feminist perspective has been crucial to how I have interpreted the data throughout the analysis. This approach meets with the aims of this thesis, which are to investigate trans experiences within the context of waiting for gender-affirming care. It has allowed an interrogation into the practice of gender-affirming care and its effect on trans people without viewing medically sanctioned practice as having a naturally greater social value than other methods of performing and changing one’s gender. The following description of my data collection will highlight feminist contributions to the critical epistemology and the methodology of this thesis.

## 3.1 Research design

The original plan for this research was to conduct a first round of semi-structured interviews, and then leave interviewees with a diary until a second round of interviews was conducted with the same individuals 3 months later. This final stage was later altered to an ethnography within my local trans community to focus on the actions its members take when faced with waiting in as intimate detail as possible.

I engaged my local trans community to help formulate my interview questions. This is similar to the practice of McNeil, Bailey, Ellis, Morton, and Regan (2012), who sought advice from transgender people in order to ensure those in the community were highly involved in their research. I held a small group meeting in which my proposed research questions were discussed. Alterations were made to the length and clarity of questions during that meeting with the help of the attendees. I also addressed my concerns of the overly personal nature of the research topic generally, and of the proposed questions. The attendees assured me that, while some questions may be difficult or emotional for some to answer, the difficulty and emotions will represent the reality of the experience of waiting for gender-affirming care. It was agreed that potential interviewees would see the questions before agreeing to an interview and that they would be able to remove questions before they were asked for the purpose of data collection.

Semi-structured interviews were chosen as the primary form of data collection, as they allow interviewers and interviewees to explore different areas brought forth by the questions and, more generally, the research area (Britten, 1995). These interviews give more freedom to the interviewee and allows them to take control of the direction of conversation by deviating from the questions; this, in turn, expands the possibilities of the research and the analysis process. Feminists favour this form of interview because it offers a closer balance of power between interviewer and interviewee, minimising further oppression arising from their circumstances (Westmarland, 2001). The experience of waiting for gender-affirming care is a personal, emotional, and particularly subjective experience singular to trans people. The study of this experience, therefore, requires the use of different subjective analysis methods, such as the one described here, as well as those discussed further in this chapter.

Diaries were chosen as the second data collection due to their personal, subjective nature and consistency with a feminist approach (Biber, Hesse-Biber & Leavy, 2006). Emotional and temporal experiences recorded in this descriptive format are subjective to each individual, and precise to the time of the experience, which would otherwise be impossible to capture (Hyers, 2018). Moreover, diaries are a useful tool via which individuals can construct accounts of their experiences of illness and healthcare, allowing for new, unique ways of discussing those topics (Elg, Witell, Poksinska, Engström, Mi Dahlgaard-Park and Kammerlind, 2011). Diary methodology is a flexible technique for both researchers and participants to collect time-sensitive, personal thoughts on specific topics. They may involve answering daily, close-ended questions or give users more freedom to respond to specific contextual events in their own words (Biber, Hesse-Biber, & Leavy, 2006). This research has utilised diaries, giving as much freedom to individuals as possible over the form and frequency of their entries.

The original methodological design incorporated a second interview to follow the diaries after a three-month period from the end of the first round of interviews, with justifications for this methodology being the same as for the first round of interviews. However, an ethnography came to replace this design in order to allow for a closer study of the trans community itself and provide a more detailed set of data. This decision was made so that focus could be placed on those activities of community members which influence others' experiences of waiting for gender-affirming care. Like diaries, ethnographies provide context-dependent and time-sensitive data in many forms, such as interviews or observation, depending on the nature of the research. This research has used what can be described as a native ethnography, that is, an ethnography conducted within one's own social group (Reed-Danahay, 1997). Reed-Danahay (1997) finds native ethnographers have specialist cultural knowledge, enhancing the credibility of their research. Simultaneously, the approach taken here can also be described as an activist ethnography from a feminist standpoint (Bell, 2015), given my proactive participation in conversations and events concerning the interviewees and their healthcare. Activist research can be difficult to negotiate from a researcher's perspective, as there is often some powerlessness to enact social change through the research, often due to the same socio-political power structures governing those being researched (Checker, 2014). During my observations as an active group member within the trans community I have been conscious of the socio-political strain on trans people. While waiting times do not improve due to limited political and public interest in the provision of gender-affirming care, trans people feel two forms of waiting, for healthcare and for socio-political affirmation. My own entrenchment in my community has allowed me to access important community knowledge, providing a greater understanding of the socio-political context within which my interviewees experienced their waiting.

This mixed methodology has included three opportunities for the interviewees to describe their experiences of waiting in their own ways: with me as the interviewer, privately in their diaries, and as they would in usual social community settings, when we naturally met. Centring the interviewees' voices in this way is crucial in feminist research and allows for an understanding of the participants' subjective experiences of waiting for care. This is crucial to this thesis' examination of the harm enacted upon the trans community by the inadequate practices of care provided to its members by the governing social and political entities.

### 3.2 Interviewee recruitment and demographics

This research aimed to focus on the experiences of trans adults in England waiting for gender-affirming care. Therefore, the criteria of participants for this research were threefold:

1. Aged over 18 and living in England.
2. Identified with a trans or non-binary identity.

> 3. Were at the point of referral to an English NHS gender identity clinic, or have self-referred to a private gender identity clinic at the time of the first interview, or at any point in their transition forward from there.

The requirement of age being over 18 ensured that all participants were adults within the adult gender identity clinics, reflective of the aim of this research, which was to assess specifically the waiting for the adult clinics' services. I purposefully advertised 'trans' written this way, without a '+' or '*', so that it could be freely interpreted without implying an ending, to not deter those who identified as transsexual, rather than transgender, for example. While identifying as trans or non-binary in some way seems like an obvious requirement of this research, some people who fit the descriptors of 'trans' or 'non-binary' do not identify with these labels or the trans community. As this research focused on trans community participation, self-ascribed identity membership was required. To ensure all individuals had encountered a waiting experience, I finally included that individuals should be at the point of referral to a GIC, meaning that they have reached out to a medical professional to discuss beginning their transition. I did not limit this to those who had asked for a referral but had not yet received one, as this reflects an additional waiting time required within the healthcare system.

Initially, interviewees were recruited from community members within my networks and via my wider group of trans acquaintances. At the time, I was an active community member and keenly involved with trans and wider LGBTQ+ activities at a community level. This allowed me to be acquainted with many trans people with other contacts; most interviewees were, therefore, recruited via snowballing. I also used a few trans Facebook groups to make a call for participants in the final stages of this research. This was to increase transfeminine representation, as well as to include more social and age groups across the interviewees, as the experiences of transmasculine students were dominating the research by the mid-point of interviewing.

Many dropped out of participation before the interviews began. Some who withdrew cited their reasoning for doing so as being due to the stress or anxiety over the waiting process itself. This was unfortunate, since the very nature of this research was to capture the emotional aspect of waiting, and it was clear that these individuals would have been able to provide valuable insight into the topic, given how prominent in their minds it was at the time. Others may have dropped out for other reasons that they may have elected not to give me. I could speculate that they imagined what they would say would not be of value, as many who participated expressed before and after the interviews. Others may have considered that this subject was too painful for them to reflect upon.

A total of twenty-six individuals were recruited. Twenty-five were interviewed; one individual only used the diary, as the interview was not judged as suitable, in a prioritisation of their mental health. The individuals ranged in age from 18 to 54, with a mean age of 22.56. Appendix 1 shows a table of all demographics collected, including occupation and economic class. Many individuals are students, as this group was most accessible to me as a trans student myself. However, as described above, efforts were made to counter this dominating occupation.

Each interviewee was sent an information sheet detailing the aims and methods of this research, how their data would be treated, an assurance of their anonymity and confidentiality, evidence of my ethical approval and several contact numbers of supportive organisations, as well as my contact details, and those of my supervisors (see appendix 2). They were also provided with a copy of the interview questions prior to the interview (see appendix 3). This gave the participants the opportunity to ask for clarification on any questions, to remove questions that they did not want to answer, or to alter or remove any questions for any other reason, such as relevance. Ultimately, participants did not remove research questions, however, some questions were altered in terms of tense to allow for reflection or consideration of the future depending on the individuals' positions in transition. This also gave the participants more power over how the research would be conducted in their specific cases.

With each interviewee, I took the time to explain to them the aims of my research and what it would entail to be as transparent as possible (Vincent, 2018). This was done in person or using an online video service on a day prior to, or on the day of, the interview, before it began. I told them about my personal motivations for doing this research and what I hoped to give back to the community once the research was complete. I explained my own experience of delays in gender-related healthcare, which made me recognise the suffering of others who were, like me, bearing the consequences of waiting, and how that translated into a desire to improve the state of transgender healthcare through this research.

## 3.3 Semi-Structured Interviews

The locations of the interviews were varied and depended on the interviewees. Some were interviewed online, so they could speak from the comfort of their own homes. Before these interviews began, I asked them to ensure they were comfortable and had a drink close by. Some interviews were held at the university campus, in different locations, such as within my office, or in an empty seminar room. When interviews were conducted in my office, which is a room consisting of seven desks at which one can sit, I sat in my desk chair and invited my participants to sit wherever they liked. If I considered that they may be too far away from me so that the recording would not be audible, I suggested that I move closer. Office interviews were held outside of normal working hours, and I pinned a notice to the door saying, “Interview in Progress”. I also communicated with my office mates when I held interviews to negotiate the space to myself. This allowed the interviews to remain undisturbed while not disturbing others. Others were held in participants’ homes in, again, various rooms. In the case that I was invited into participants’ homes, I asked where they would be comfortable to be for the interview and, after they took their place, I asked where they would like me to sit.

Before each of the recorded interviews I began by asking the participants for their demographic details. Participants gave a non-identifying name, their gender(s), and pronoun(s) to be referred to with throughout this research. The remaining demographic questions covered their: age, occupation, social class, relationship status, and sexual orientation.

I conducted a sound test before starting each interview to ensure that I and the participant could be heard in the recording. Following the audio quality check and after confirming that the participant was happy to continue, I proceeded with their first interview (see appendix 3 for questions and prompts) which began with their consent (discussed in the next subsection). I collected consent verbally in interviews, rather than in written form, to not overwhelm the participants with paperwork to read and sign. This formalizes the process of data collection and is likely to disrupt the supportive and friendly environment I aimed to create as I collected this data, as presented in my ethical approval document. The interview was presented in three sections; the first covered how waiting for gender-affirming care feels and its impact on their daily lives. The second focused on the mechanisms which the participants used to cope with the emotions brought forth by those experiences. The final section focused on social media use during waiting. Following the first two sections, I suggested that we take a short break before the next set. Some participants were glad to have a break, others said that they were content to carry on through to the end.

On average, the first interview lasted for two hours; the shortest was just under an hour, the longest was a little over 3 hours. The amount of time an interview lasted did not necessarily correlate with one’s progress in their medical transition. Rather, it was quite dependant on their individual personalities. The pilot candidate’s interview, for example, lasted for two hours, yet the next, who was in the same phase of waiting, spoke for one hour on the same topics. Each varied after that, but most remained between one and a half to two hours.

The recording of each interview was ceased after I asked the individuals if they wished I had asked any additional questions or if they would like to provide any additional comments. I did not thank the participants on the recording. Rather, each participant was individually thanked for their participation following the cessation of the interview. This allowed me to express my thanks in a way that was personal to each of them. I would comment on some of the things that they had said which would be particularly useful and highlighted to them that these items would be beneficial to the trans and non-binary communities. I asked each of them how they felt after having done the interview. Some found the experience cathartic, others were quite at ease, and a few commented that they were going to engage in a self-care practice to raise their mood. At least one I noticed had described their present situation as less than ideal and, in this instance, I offered them some coping mechanisms to assist their waiting phase, which they appeared to take on board.

The feedback from interviewees on how they considered the questions to cover the topic was also positive; many said that they thought the questions thoroughly covered their experiences of awaiting healthcare. A suggestion was made from an early interviewee to include a question about the emotions associated with getting to the end of waiting following the question on emotions during waiting. I agreed and added it in subsequent interviews. It proved useful, as it allowed the opportunity for the participants to consider what positive emotion they might feel later, if they had not already got to that point, or to reflect on where they had come to. It also allowed the flow of the conversation to move away from what was usually a negative emotion, as many had expressed feelings of depression, hopelessness, and suicidality when discussing the wait, towards a sense of positivity.

## 3.4 Diaries: Lived Waiting Experiences and Representations of Waiting

Those participants who agreed to participate in the diary were instructed on its use. Participants decided for themselves whether to participate in the diary after I explained what content to include. After the first few participants declined the option of a physical diary, I instead asked participants to have a document saved on their phone or laptop that they could access easily to make an entry, as all had the option to do so. I instructed them to only use the diary when waiting was already on their mind. As I did not want participation in my research to be the cause of their negative emotion, I was quite explicit that the diary should not be used or thought about where possible if they were not already thinking about the waiting. From what I had just gathered from the first interview, this waiting experience was in some aspect negative for all the interviewees. I made participants aware that the second interview should be conducted in the time after Christmas and before Easter, and made conversation with each of them, before concluding the meeting.

### 3.5 Methodological Alteration

Nearing the end of the first round of interviews it became apparent that a second interview was not the best course for this research, as I wished to focus on how the community works together during the waiting period. Instead, to enrich the data collection and utilise my active trans community status, I conducted an ethnography with individuals already participating in my interviews. I contacted the remaining individuals from the first round of interviews to inform them of this methodological change and reassure them that their contributions were valuable to the research.

### 3.6 Ethnographic Observation

My ethnography comprised sixteen entries over four months with multiple entries on one day, which reflected my own community participation rate of once a week on average. An information sheet was given, and written consent was obtained from five individuals who participated in the ethnography (see appendices 4 and 5). The choice to obtain written consent in this methodological technique, contrast to the more casual verbal consent in interviews, was driven by my need to fill two identities within the situation. As the ethnography was carried out during my usual community activities or time spent with the participants socially, I was in a position of researcher and community member simultaneously. I wanted this duality of myself highlighted to the individuals included in the ethnography so that they would be aware of the research practices I would employ during this time. As an active community member, advanced, compared to my peers, in age and transition, I would regularly provide knowledge and advice about healthcare to my fellow trans students who sought my help. Therefore, drawing focus to my role as a researcher formally gave them the choice to either not speak with me about their healthcare if they did not want it recorded formally, or to specify that they would like to speak with me only as a fellow community member. Ethnographic methodology well suited this research due to my community membership and involvement, as I could become an unobtrusive observer without making a significant change to the natural processes or activities of the community.

My entries comprised detailed notes of conversations and events that I observed and participated in with interviewees. The entries were usually made following the interactions, as I did not want to alter the environment by note-taking in the moment. Little time passed between the end of the observations and note-taking, to avoid recall depletion. As I kept my notes on my person, I was able to write as soon as the interactions ended. Infrequently I took notes with individuals, to take direct quotes, such as with Jestin at his revision surgery. Leaving time allowed me to continue to adhere to my activist role as I normally would and gave me time to reflect on the scenarios before recording them and proceeding to the analysis. I chose not to include much data from the ethnography, aside Jestin’s revision in Chapter 4, outside of this chapter, for two reasons. Firstly, I considered that, because the interview data contained the experiences of the participants in their own words, I may do them a disservice by repeating their experiences through my own lens, hence the greater use of interview data throughout the analysis chapters. Secondly, my ethnography did capture a significant event which I had included in the analysis but later decided to remove from the thesis due to the high chance of the individual being identifiable. In the interest of protecting that individual, I removed that analysis, resulting in one use of the ethnographic data in the first analytical chapter. However, the ethnographic data, along with the other data sets, were used in combination to derive the themes for analysis.

## 3.7 Data Analysis

I transcribed the digital recordings of interviews verbatim in Microsoft Word and collected together with the diaries and ethnographic notes. I analysed the data by hand following Joffe's (2011) instructions on theme analysis, using deductive coding, beginning with themes representing the research questions to focus the analysis. All interview transcripts, diaries, and ethnographic data were reviewed, and excerpts were extracted to fit the codes. Common themes in the data were identified and grouped under the original or newly emerging themes. For example, data relating to avoidant social media behaviours were regrouped together, as the original themes represented activity, as opposed to inactivity. The findings are presenting in the following chapters, set in their respective local literatures.

## 3.8 Data Security and Ethical Considerations

The University of Essex Ethics Committee approved this research. Considerations were made regarding the fact that the trans community can be categorised as a vulnerable group, due to high prevalence of co-morbid or unrelated mental illnesses in its members. Individuals participating in this research were asked to provide a name of their choosing for this research, providing them anonymity. Two participants chose the same pseudonym, so the second also chose a following initial letter, not corresponding to their real surname, to differentiate them. One chose a single letter to represent themselves; while this is not considered a proper pseudonym, I have honoured their request to be represented as M, an objectively anonymous name marker, in this research. I have been extremely selective in my use of the interviewees' data to protect them from being identifiable. Those participating in the semi-structured interview gave recorded verbal consent to participate at the beginning of the recording of their interview. Individuals participating in the ethnography signed a consent form, see appendix 5.

Digital files of the interviews, diaries and ethnographic notes were stored on my personal laptop, which is password protected. A single copy of the data was stored on an external storage device in a locked cabinet in my home. The data was only accessible to me and remains available to the associated interviewee only indefinitely, unless there is a request to destroy it.

The individuals whose experiences were studied have had the opportunity to cease participation and remove their data from the research at any time, and have that data destroyed. Due to the emotional nature of this topic, contact details for several mental health resources were provided on the research information sheet. This included charitable trans, LGBT, and mental health organisations. Proving these mental health resources ensured interviewees had access to, and a choice of, additional support during and following their contribution to the research.

### 3.9 Reflections and Reflexivity

In this section I will reflect on the experience of knowledge production as a trans-identified researcher working with trans people as interviewees. I will reflect on recruitment as a trans researcher, describe the pre-interview discussions I had with participants to establish a common language, as well as navigating the shared knowledge between myself and interviewees, and explore the analytical possibilities created by my participation in community activities during the ethnographic observation process.

I began this research process believing that my trans identity would enable me to locate many willing participants for this research. However, as I mentioned earlier in this chapter, many trans individuals were interested in the research topic, but some felt too disturbed by the waiting time to participate. These were individuals who were clearly suffering from the waiting- perhaps more so than those who did consent to participate. Sadly, due to the impact of the waiting itself, these experiences have been inaccessible for further study, and so could not be represented in the research.

Undoubtably, my own trans status did motivate some to participate. One interviewee, James C, mentioned before an interview began that they had been able to see on my Facebook page that I was trans from my profile picture, as my top surgery scarring was visible, and that this had motivated them to reach out. I told them the story of the image, which was of myself laying on the seafront road Kingsway in Brighton, being held up at a Trans Pride Parade by, presumably, protesters or traffic. The sharing of this story bonded us quickly through our shared identity, Pride experiences, and humour, in the moments prior to the interview. This also allowed us to share the language used within the trans community, which not only built common ground, but helped solidify the use of the common form of spoken communication between us that we, as trans people, already knew how to use. This exchange allowed us to see how the other wielded trans language and be mindful of the other's use of it; this resulted in an extremely clear and illuminating discussion of their experience during the interview. This was a common occurrence across the interviewees.

However, I have been careful not to allow common language and experiences to govern the interviews. Having built a good rapport with Thea, for example, it was clear that we communicated similarly and shared many beliefs and understandings of transness. Her frequent use of ‘you know’, or words to that effect, with my acknowledging it via nodding during our interview, demonstrated and confirmed her recognition of my understanding of trans experiences. While phrases such as “you know” were usually used at the end of clear explanations of participants experiences, in other instances I sought clarification using phrases such as “at the risk of asking you to state the obvious can you explain what you mean” or “I do but would you tell me anyway?”, letting them know within my question that I comprehended their experiences.. As we discussed how Thea coped, she said that self-medicating, i.e., using hormone replacement therapy obtained outside of sanction gender-affirming services, was helping her most as a coping mechanism. While I could have inferred what she meant by this, as she was clearly confident in her feminine presentation, I asked her to expand. The totality of her experiences and changes from self-medicating had allowed her to not only have validation and good interpersonal experiences, but, importantly, allowed her to feel as if she were by-passing the waiting time. Had I not probed for this, I could have assumed that self-medicating had merely allowed her expression of her gender identity and the ability to navigate her social world as a woman, with less experiences of gender dysphoria. However, freedom from feeling like she was waiting for the NHS was also important to her and something that she gained from self-medicating. This made it possible for her to view herself as positioned outside of, and no longer, waiting.

As an activist and a researcher, utilising my position in my local trans community through ethnographic observations was crucial to capturing the inner-workings of the trans community to show how we support and care for each other during the waiting time. As such, I was not a neutral observer during this time, as I impacted the environment, sometimes quite purposefully, in the interest of the interviewees well-being. I was involved in producing a safe environment for the individuals of the ethnography two-fold: as a researcher with a duty of care, and as an active community member with positions of power and responsibility within the university's social groups. My trans-specific knowledge has been integral to my experiences with interviewees and subsequent data collection. For example, when Oliver needed help to send forward his blood results, he asked me to come to his aid. Had I not been trans, it is unlikely that Oliver would have reached out to me for help in this instance, as I would have been unlikely to have any specialist medical knowledge of transitioning. Oliver would then perhaps have not found such an immediate solution to his problem and not had support through it. As a trans researcher, I was able to offer him more than a cisgender researcher would have in that moment of need. Most importantly, that experience showed that care within the trans community comes in many ways. Firstly, it often comes quickly, in the moment or on the day. Secondly, it comes from those with specific technical knowledge; intricate medical details of transitioning are complex and not common knowledge. Thirdly, it manifests through helping to reframe the perception of time, and, finally, through humour.

## Chapter Summary

This chapter has provided an overview of the methodological approach of this thesis and discussed a reflexive account of the research process. I have demonstrated that this mixed methodological approach fits within feminist post-modern epistemologies. It has shown the interesting and challenging process that has formed the data collection, detailing the challenges of finding willing trans individuals, the necessary changes in method, and the impact of my positioning as a researcher throughout. With the methodology established, the following chapters present the analysis of this thesis.

## Chapter 4. Emotions and Experiences of Waiting for Gender-Affirming Care

This first analysis chapter will present and analyse the empirical data collected to address the first research question: “How does waiting for gender-affirming care feel?”. Waiting is unavoidable in public and private English transgender healthcare systems, with waiting times for every NHS clinic exceeding 18 weeks, ranging over three or four years for an initial appointment at some clinics (NHS, 2023; NHS, 2023c). In this chapter I will show how my interviewees were emotionally affected by waiting, while being conscious of how widespread the negative impacts of the waiting are across the trans community. I argue that emotional harm is experienced by those awaiting gender-affirming care as an effect of the lack of medical care. This is caused by lengthy waiting times, as well as additional delays resulting from medical professionals’ incompetence. Such frustrating emotional experiences affect some of these interviewees’ intimate relationships and their ability for social and civil participation.

The structure of this chapter follows the transition timelines faced by the interviewees and presents their emotional experiences of waiting times. Some of the interviewees were still awaiting care at the time the interviews were conducted, while others, further along in their transition, were reflecting on their past experiences. Along the medical transition pathway, the interviewees charted their emotional and social experiences of waiting. Overwhelming difficult emotions were discussed by interviewees, with many having to postpone their social and intimate needs due to waiting for gender-affirming care. Prominently, frustration, anger, and a profound lack of autonomy were sensed through the community. Care, as in, consideration for their welfare, was not experienced generally, which led to self-care and intercommunity care being utilised as replacements by some interviewees. Waiting for transgender healthcare, I argue, is an emotionally and socially exhausting process, understood by trans people as a barrier to social life and a demonstration of power over them through non-prioritisation by decision makers of public health in the extreme.

Emotional analyses present an understanding of how wider social structures, such as work and healthcare, influence individuals' emotions and identity (Hochschild, 1983; Pearce, 2017; Stryker, 2002). Trans people waiting for gender-affirming care are in a position in which it is impossible to outwardly express their gender through hormone replacement therapy and/or gender-affirming surgeries. Their health and identity are delayed beyond their control, subjected to extensive waiting. This chapter shows the emotional and social difficulties experienced as a consequence of this delay across various periods of wait faced by those seeking a medical transition. The analysis utilises concepts derived from emotion studies and theories discussed in the Chapter 2 to understand how waiting for gender-affirming care feels for an individual. .

## Individual Emotional and Intimate Experiences of Waiting for Gender-Affirming Medical Care

In its structure, this chapter broadly follows the stages of transition that the interviewees experienced while seeking gender-affirming care in England, and analyses the emotional and personal impacts of the wait at each stage. The experiences of those waiting to start their gender-affirming journey- those, who are waiting to be on a waiting list- are examined first. Delays to joining the waiting list are twofold: self-imposed and externally imposed. Marked differences in experiences of autonomy are noted between these forms of delay. The waiting time prior to accessing gender-affirming care is under-researched, which this research seeks to amend; it identifies several sources of delay to beginning a medical transition, demonstrating the difficulties of engaging in public and private life in the process.

### 4.1 Effects of self-imposed delays to joining a waiting list for gender-affirming care

Three interviewees examined their self-imposed waiting experiences preceding requesting formal gender-affirming care, each with different reasons. Cayla, like participants of Vermeir, Jackson and Marshall’s (2018) research, delayed approaching her GP for a referral to a GIC specifically due to taking time to reflect on her trans status and consider her medical pathway options. Cayla feared she could be delayed in her care process if her doctor thought she was unsure of her gender or her aims for transitioning. During this time, she found work, but became depressed and underperformed because she was dejected from having to use her previous name and present as a man. She said that she would have preferred to wait for a referral before getting a job as that was seen as a “milestone” to show she was at the point of “living openly”: pre-meeting criteria for obtaining gender-affirming healthcare. Identity theorist Striker (2002) would surmise that living the contradiction of hiding her gender identity while presenting, and struggling to engage with, the identity she maintained in the workplace caused Cayla distress.

Once Cayla was on the waiting list, she decided to self-medicate with hormone replacement therapy because she felt despondent, demoralised and let down by the process of waiting. She described a combination of factors that prompted her to self-medicate, similarly to those shown in Vermeir et al’s (2018) and Rickett et al’s (2020) work, i.e. a completion of private deliberation of intent to transition and readiness to begin her medical transition. Additionally, she perceived the time she had already spent waiting and the time she would still have to spend on the waiting list to be manifestations of a futile effort, as she described in her diary:

> I had lots of thoughts about my transition and progress, the waiting list wasn't the main source of my being upset. But thinking about how far I had to go in the moment really disheartened me, and I saw the waiting list as a manifestation of it/embodying how long it would take me. (Cayla, 19, female, diary entry 9 February 2019)
>
> Today I received my confirmation letter from the GIC saying they have my referral and I'm on the list officially. I'm happy about this, to know I'm on the list, but I feel like I should be happier. It's been over 4 months since the GP referred me and I have only just now received the letter. I'm glad to have it, but the fact it has taken this long just reminds me of how long it's going to be, which makes me feel like it's a bit futile. (Cayla, diary entry 26 February 2019)

Self-medicating made waiting feel like "less of an issue" because she found that the medication was working while she was waiting for a clinic to take over. However, other diary entries showed that she was keen for legitimate care at a GIC; therefore, despite the usefulness of self-medication, it remained somewhat an issue for Cayla to not have sanctioned healthcare. Self-medicating did not negate her state of waiting or change her perception of the power of the healthcare service over her care. This situational appraisal (Hochschild, 1983) has resulted in Cayla feeling emotions similar to those she experienced before self-medicating, and, ultimately, she still felt just as powerless in relation to the GIC. Without this pathologizing imposition to care, through the swifter informed consent model[1] demonstrated by Ker

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[1] This model of transgender healthcare does not rely on mental health evaluations or a formal diagnosis when providing hormone replacement therapy and gender-affirming surgeries.

et al. (2020), many may not feel the need to resort to potentially dangerous self-medication for a semblance of care.

Jessica delayed obtaining gender-affirming care for many years while being married and having children. After a period during which she only dressed as a woman privately, she eventually came out as trans to her wife. At her wife’s insistance and to the detriment of her mental health, Jessica agreed to compulsion therapy to try to stop her desire to appear as a woman. As this equates to an attempt of conversion therapy, well known to cause harm to LGBT people, this treatment did not have any effect but to depress her further. Later, she turned to a local LGBT organisation, which meets in a physical space regularly. She saw a counsellor there for some time, came to embrace her identity and made a referral to a gender identity clinic.

However, as time passed with no movement from the NHS GIC, Jessica found the further delay to her transition, this time, forcible, caused by the healthcare system, rather than her hiding her true identity, intolerable. She sold many of her prized possessions and sought private gender-affirming care. A form of intimate conflict then ensued, as Jessica’s wife became less and less supportive of her transition. To balance this conflict, Jessica agreed to delay the start of her hormone treatment until after the final family holiday that they were going to take had finished.

Jessica desperately wanted to begin hormone replacement therapy but also wanted to remain close to her children. Again, readiness to begin hormones is commonplace in trans people who are at the point of accessing gender-affirming care (Rickett et al., 2020; Vermeir, et al., 2018), yet many do put their medical transition and gender expression on hold to protect family relationships, as shown in this research and elsewhere (von Doussa, Power & Riggs, 2017). Jessica was not a unique case, as having access to care but delaying it in wait for a family event to pass was experienced more than once within this group of interviewees. The conflict of gender identity and family identity can work to diminish both as they may exist in conflict; if both identities cannot exist together when the individual needs them to, they may suffer from an emotionally difficult experience (Stryker, 2004).

M was similarly positioned to be “tempted to make a private referral”, however, was putting this off because they had not yet come out to their parents. M wanted their parents to be informed of their medical transition’s progress and, therefore, was not willing to begin without their knowledge. M specifically perceived this as an additional waiting period in their transition: waiting for themselves to be comfortable enough to tell their parents, and to have the right opportunity to do so. A lack of opportunity to have conversations with family members is echoed in von Doussa, Power and Riggs’ (2017) research; however, in this case, M wanted to find the right time and space for the conversation, because their parents’ inclusion into their transition was important to them. This is unlike von Doussa et al’s findings, because their participants felt they were unable to have this conversation not due to distance, but due to having to negotiate intentional silences maintained by parents concerning gender identity. M anticipated being heard and accepted, even if they were not understood, by their parents:

> I set this boundary in my head of I’m gonna tell my parents before I make a self-referral. I have to stick to that now I feel like, coz it’s been like, I’m not guna do it behind their backs, in quotations behind their backs, coz I want them to be involved in the process even if they don’t understand. Um, so I’ve kind of made that rule for myself. And I do agree that I should stick to it. But it does make the wait longer, yeah. (M, 21, non-binary trans masculine)

M’s intention to involve their family speaks broadly to their personality, which is that of a person who uses positive social coping strategies to manage stressors, as documented in Chapter 6. Having their family know about their transition and the family being supportive through it should promote better well-being for M overall, as broad ranging support often constitutes good well-being in trans people (Puckett et al., 2019). Contrastingly, Jessica’s motivation to change her family relationship formation appeared to be more for the well-being or comfort of others around her, and was not particularly conducive to her own well-being. Both were trying to reconcile their trans identities with their family identities; however, their differences as individuals, as well as the difference in distance to their families,produced different ways of managing that process. Different well-being outcomes for these two interviewees could be anticipated, but that may be moderated by coping strategies examined in Chapter 6.

As a group, trans people are largely conscious of each other and others’ experiences, as they are readily available online. While reviewing their own, and others’, experiences of waiting for healthcare more generally in this section, interviewees were conscious of the suffering of others waiting for gender-affirming care, all commenting that trans people felt negatively. M understood that others felt upset and angry at the length of waiting, and that the situation felt unjust. Waiting is perceived and understood as a violation to trans people in a similar way other groups co-experience reactions to unjust situations (Yzerbyt et al, 2003), with a variety of emotional reactions from the community, besides mass anger. Though, anger as a result of appraising the waiting as unjust follows closely to appraisal theory’s contention that anger results from a misdeed of another (Hochschild, 1983). The ‘another’ here is the gender-affirming healthcare service violating trans people’s ability to access care in a timely manner. Additionally, acquiring private healthcare was antithetical to M’s philosophy on how healthcare should be provided; they were particularly mindful of others, like themselves, resentfully thinking of it as buying one’s way out of waiting.

> Most people who can take the private option because it’s you know, only uh under a year. Um, you know 6 months or something. So, they would pay the money, like I will pay the money, regardless of the fact that I overall don’t want to support a private healthcare system for my own personal reasons. But I will buy into that system because it will speed up my transition, yeah. I think that sentiment is probably common. (M, 21, non-binary trans masculine)

Not only are trans people, like M, aware that other trans people wish to speed up their waiting time to avoid it, but they are also aware that others are willing to behave against their own philosophical beliefs to wait less time. In terms of group emotions, this is an offensive and avoidant strategy under Yzerbyt et al’s (2003) classification of reactions. It is both, in that it reacts to the emotional responses elicited from waiting by acting in a way that negates the wait, and, consequently, subverts the power of the clinic to enforce waiting and the emotions associated with it. Buying private gender-affirming care, while not ideologically acceptable to many, is a rare opportunity to evade the waiting and its emotional impact, from which those who cannot afford private care are not spared.

While contemplating the nature of waiting for gender-affirming care on herself and other trans people, Cayla described the long waiting times to be “unethical”, as they are “quite harmful to trans people”. She went on to say that this apparent lack of concern from healthcare providers leads to trans people feeling “less important”, and, therefore, being marginalised within gender-affirming healthcare settings. Other interviewees concurred that the waiting times seemed to increase harm and marginalisation to trans people. As a group, they were aware of others' emotional reactions to waiting and, together, felt that their inability to access healthcare reinforced the marginalisation they already experienced; without the desperately needed gender-affirming care, they were harmed both by persistent dysphoria and the societal repercussions of being visibly trans. They are marginalised biopolitically, i.e. within healthcare and within political decisions, which result in limited funding and, consequently, long waiting times (Pitts-Taylor, 2020); the hostility and disinterest exhibited by policy makers sidelines trans healthcare. As a result, the burden of these societal problems falls onto trans people, who have to withstand the lengthy waiting times while also facing feelings of marginalisation. While Pitts-Taylor (2020) found this experience caused submission and weariness in her interviewees, combined with feeling and being unable to change their situation, some of my participants were able to take financial action to end their waiting, as Cayla and Jessica eventually did.

Those who self-impose delays to their trans healthcare felt conflicted because they wished to progress their transitions but had an important goal to complete first. Cayla's emotional experience was depression and distress- resultsof hiding her gender from her workplace while she explored her gender identity before seeking a referral to a GIC. M and Jessica both experienced the emotional tie of family, though in different ways. M felt compelled to share their transition journey with their family; meanwhile, Jessica feels compelled to hide her want of transitioning to spare familial relations. While these are self-imposed positions, they are also relatively powerless- when the decision is made to begin transition, these individuals are, once again, required to wait and cannot make the progression they desire at the pace they want.

Many, like Cayla, experience despondency and feel let down by the healthcare system as they wait to be seen at a GIC.

This section has shed light on how trans people feel when postponing their first approach to gender-affirming care. Some experience marginalisation before they begin their medical transitions, which solidifies in them the conviction that they need to be certain about their plans, as well as well-positioned socially, to obtain the desired results from their interaction with the healthcare system. This perceived need for additional criteria to be met only serves to double the, already almost insurmountable, difficulty in progressing through the different GIC processes. The parts of the interviews analysed here reveal the extent of these self-imposed difficulties and the bio-political marginalisation experienced by trans people seeking gender-affirming care in England, as well as the emotional impact of the wait in which these problems result. The following section will conduct a parallel investigation of how delays to my interviewees' transitions affect their emotional well-being when their progress is obstructed by external factors.

### 4.2 Effects of externally imposed delays to joining a waiting list for gender-affirming care

In addition to the intimate strains and other difficulties described by the interviewees whose experiences were discussed above, delays in transition imposed by an external source brought on a range of emotions for those interviewees they affected. The following analysis contributes to the often ignored time of waiting (or waiting time) that trans people need to endure, which, as I argue, causes them severe emotional turmoil and struggle. These experiences lead to the implementation of coping strategies, which I analyse in Chapter 6, and are closely tied to the experiences of stagnant or slowly passing time, the subject of Chapter 5. Keen senses of powerlessness, hopelessness and other symptoms of depression and stress are common responses to the situations these interviewees have found themselves in.

Vicky remembered that her GP had backtracked on agreeing to facilitate her gender-affirming care at the primary level. This was because the GP considered it a risk to her reputation to assist in the provision of hormones:

> She [the GP] was near retirement and didn’t want to ruin her reputation and open herself up to prosecution by the GIC for, um, using hormones and treatment that she didn’t understand. And um, I was devastated. Just completely fell apart. I went, I made an appointment to see her and, just tried to explain to her that she was denying me treatment. That effectively she was blocking my access to any treatment for this. What, what was wrong with me? And she wouldn’t shift. And we ended up in tears which was just bloody silly. And I ended up comforting her which is, bizarre. (Vicky, 54, female)

Vicky had been less than one month away from her first GIC appointment before it was cancelled, as she had been given a date before her GP had received the shared care agreement request. The last appointment, presented above, included Vicky comforting her upset GP, an event that has no justification in a medical setting. As a medical professional, a GP has a socially agreed upon role and should act within it to treat and support patients; instead, a patient was made to regulate her own emotional response while being forced to provide care to her doctor. That this denial of care was allowed to happen, and the fact that Vicky was forced to encourage her GP’s behaviour and attitude towards trans healthcare, demonstrates a power imbalance which is an inherent part of any care system that permits a medical professional to deny care based solely on their unwillingness to provide it.

Unfortunately, Vicky's experience with her GP is not entirely uncommon, as it reflects other older trans people's experiences of doctors who are reluctant to help or educate themselves in order to be able to provide care (Willis et al., 2020). Many patients are subsequently expected by their healthcare providers to, effectively, conduct the research and complete all the work that is usually required of the GP, in order to make their transitions possible. As one of Willis et al's (2020) participants notes, the GP would otherwise make an effort to become familiar with other illnesses of their patients, such as cancer.

Vicky recalls being unable to function normally at work despite being well established in her field and beginning anti-depressants at this time. Having been so close to an appointment, only to have it withdrawn at the last moment, caused an immense powerlessness for Vicky resulting in a withdrawal from her normal life. It was "all consuming... nothing else existed for a while apart from that". Rickett et al.'s (2020) analysis of loss of time and suspense in a vacuum in trans youth and their parents while waiting is reflected here as Vicky, the oldest of the interviewees, enters the same timelessness state of uncertainty while waiting. Her experience of this halt to her transition before its beginning as an adult, however, like that of other interviewees discussed below, additionally rendered her unable to participate in her work and family life. Vicky's diminished ability to socially participate demonstrates the consuming nature of waiting for gender-affirming care. Denying or postponing the expression of gender identity by medical professionals caused negative mental health in several of my interviewees. They experienced invalidation of their gender identity, a key figure in the presentation of the social self, and, consequently, socially withdrew.

Oliver, like Vicky, had to endure an additional wait caused by his GP refusing to make a referral because of an unrelated health condition, which would not have stopped him from accessing gender-affirming care at the GIC. Despite the irrelevance of this condition, the GP sought to control it before they would initiate his condition. At the time of his interview, which was just days after the GP's refusal, he stated:

I knew that the waiting times were long to start with but now it's been delayed … I don't even have a referral is the issue. So, I don't know how long I'm going to have to wait. So, it's just not knowing that's like the hardest part. (Oliver, 20, male)There was no concrete time scale for Oliver to anticipate, therefore, there was no future to anticipate. He said he felt "inferior to other people", and that being at that waiting stage, without a referral, was affecting his confidence and self-esteem. This feeling of powerlessness when it came to being referred for gender-affirming care was too overwhelming for Oliver. Several days after our interview he attempted suicide, which a mutual friend made me aware of. He requested my help, so I took him to hospital and remained with him there. I have never seen a person appear so defeated and so helpless and hopeless; it seemed to me that after his identity was denied, his drive for life ceased. While waiting for him to recover in a hospital bed, I also found myself not only helpless and hopeless, but very angry at the cause of this deep-felt distress. I was angry that his GP had overridden his right to his gender identity, and I was conscious of the fact that this was not an isolated incident. Although we shared this experience together, our emotional reactions differed due to our different positions within it. Later in this chapter I examine Siobhan's experiences; she discusses 'bailing out water' for herself and others in the community to keep herself and her community well. As a group, the trans community empathetically experiences the harms caused by external sources, as do other identity groups can (Von Scheve & Ismer, 2013). Oliver's reaction to his denial of care was withdrawal and depression, then followed by hopelessness and suicidality, whereas mine was much more focused on anger directed at the healthcare system that had refused care and caused his reaction.

Being in a scenario of stationary waiting, that is, a period of waiting in which the transition is not moving forward, is to be in a powerless state, in which one is unable to access gender-affirming care and is incapable of presenting or exerting one's gender identity in a way that would be obvious and acknowledged externally. Vicky and Oliver's responses to this removed access were those of anxious depression in terms of symptoms, similar to Stryker's (2004) and Hochschild's (1983) observations of those denied expression of a part of their identity across different settings. Moreover, Oliver's feeling of inferiority left him feeling less of a person, less extant; he was unable to externally embody his gender, unable to perceive his gender identity reflectively, and unable to, therefore, be seen and responded to as his gender by others. Trans people feel inferior within the healthcare system in general, due to cisheteronormative privileging of care and microaggressions; those, in turn, as seen in this research as well, cause mental health problems (Nordmarken, 2014). Suicidality, as a response for both Vicky and Oliver, derived from a lack of care from incompetent, or incapable, microagressive GPs. This, again, shows an ever-present,negative mental health effect of delaying care at most initial level of trans healthcare, i.e., the point of referral to a GIC from a GP. Thea was also delayed by several GPs at the time she tried to get a referral to a GIC, as she explains:

> One of the doctors was very old school. Apparently, he couldn't do anything about gender dysphoria on the NHS um, another doctor asked for definitive proof so when I printed out all of the you know forms and the NHS guidelines uh they said 'that doesn't count it's on the internet'. And the third doctor at the, I took all the documents in pre-emptively and she was just like yep that's, that's fine just go ahead… The doctors weren't like aware that they could do anything about it if that makes sense. And the fact that I had to educate the doctors about that was part of the problem. (Thea, 24, female)

It is an ongoing problem in healthcare that trans people, or their parents (Rickett et al., 2020), must educate their doctors on how to provide gender-affirming care. That some doctors do not know that gender-affirming healthcare is available as part of the NHS is another representation of cisgender privileging in healthcare, as argued by Nordmarken (2014). Similarly, the rejection of Thea's NHS documents on trans healthcare as illegitimate by a GP represents the privileging of cisgender knowledge, as well as the stigma of dishonestly attached to trans people. These initial experiences made Thea feel hopeless and helpless towards being able to obtain care, as she was not believed or supported. However, she often joked and laughed during the interview about her experiences, as few do in emotionally challenging circumstances (Yzerbyt et al., 2003). Thea's experience is in opposition with other research, which has found physicians to be open about their lack of knowledge on trans healthcare and presented a keenness to learn about trans health (McPhail, Rountree-James & Whetter, 2016).

It is not only medical professionals who stand in the way of access to gender-affirming care. While this research focuses on adults, Chris spoke about his time at the Tavistock and Portman mental health clinic, where he was seen for his mental health as a teenager. In a conflict of interest, he was seen by the same clinician as his mother, and it was through that clinician that she learnt of his attempt to make a referral. As he was under 18 at the time, his mother overturned that decision, and his referral was cancelled. He described how this situation affected him:

> It was affecting my mental health a lot um obviously I, at that time, at that point in my life um, when I was still at school um at high school, it was difficult um coz my, my whole family were not supportive, so I didn't have that support in home life. Um and I didn't really have that support at school either. Um, my only really kind of um support that I was receiving was through my friends. Um, which I mean, at, at school that made it easier. Um, but still with the teachers not um, cooperating fully with trying to make my transition easier because of my parents not being um supportive, that made it a lot harder on my mental health um and I struggled with self-harm for quite a while um during that time. Um, I've been clean from that for a while now um, due to my um social um considerations now what with my college being fine and my family, not my family, my friends being fine with that now. But at the time it was a lot more difficult to deal with. (Chris, 18, male)

Once again, trans healthcare is treated as a matter so inconsequential and trivial that Chris' clinician felt that this unnecessary breach of confidentiality was acceptable. This infringement on Chris' privacy further delayed his transition, adding more waiting time to an already long process, as he had to wait to get a new clinician who would be willing to refer him. This is one of many examples of unacceptable abuse of power in the healthcare system by medical professionals- situations whose occurrence is entirely unjustified and inexcusable. However, in Chris' case, it was made possible by the fact that he was in a position of powerlessness as a person under 18. Unsupportive parents leave trans youth more susceptible to poor mental health and suicidality (Matsuno and Israel, 2021), and for the clinician to break their patients' trust in such a way, particularly a child, speaks to an abysmal standard of care. This negative emotional experience has the potential to leave a lasting impression (Bericat, 2016), perhaps causing Chris to view practitioners with mistrust, which, in turn, may impede his relationships with future care providers. The resulting negative effects on his mental health, combined with a lack of support from all but his friends, caused great misery that could have easily been avoided with more care and consideration on the part of those involved in his care.

The cases discussed above present some of the experiences of interviewees delayed in accessing their healthcare by sources outside of their control. These stem from medical practitioners wielding their power over trans people in irresponsible, incorrect ways informed by their ignorance. The analysis shows, as in other research, the intimate and emotional harms resultant from this medical negligence. The urgency of the need for care is not felt by the practitioner, but it is increased by them through faulty practices of care imposing delays on their patients’ transitions, which result in oppressive mental states and experiences. The mental health of trans people suffers greatly during delays in this crucial beginning stage of transitioning, when gender-affirming care is placed out of one’s obtainability.

## 4.3 Waiting for the first appointment

This section analyses the emotions these interviewees experienced as a result of their time between their referral and first appointment at a GIC. As in the previous section, this section shows that these emotions are acute to the extent of qualifying as mental illnesses. Social withdrawal, depression, and internal invalidity are produced as effects of waiting for gender-affirming care. However, there is a stark contrast between those who can seek healthcare privately versus those who wait for the NHS services.

At the time of her interview, Anna had begun early correspondence with a private healthcare provider. She was keen to stress her gratitude for the privilege of being able to access private care, very aware of the NHS waiting times comparatively. She described her experience of waiting as a reflection on her early correspondence with the practice as official but vague:

> Well first of all, I’m very grateful that I’m in a situation where I can get private healthcare coz I know if I was on NHS, I would be waiting a lot longer …
>
> The fact that I’ve actually like initiated something with them like sending them emails and things was for me very much um, that was very much a symbol of making it official…
>
> So, there’s this weird feeling of like I’ve sort of made it official, I’m waiting for something to happen, but nothing has happened yet so it’s kind of like it makes me feel quite desperate. I’m coping with it so far but as I said it’s been quite early. The information I’m given from them in terms of how long I’m going to have to wait is quite vague…
>
> So, I feel like, in a sense quite left in the dark even though I’ve initiated something. Um, yeah it’s, as I said, I’m coping with it at the moment, but the only difficult aspect is this like ambiguity that I’m feeling about when I can expect something. (Anna, 19, girl)

Comparatively to the others in the analysis that follows, Anna had very similar emotions of desperation and frustration, but was more able to apply positive coping strategies. Differently to the others who were on NHS pathways, she had established personal contact with the clinic. She had been acknowledged by the clinic, whereas other interviewees had not. Her main struggle was, as the others in this section, waiting for a concrete appointment date:

> I just think I would find it a lot easier, the waiting process, if I had a date. Which obviously I will eventually. But, at the moment, it’s like I’m waiting for a date so that I can wait for that date, if you get what I mean, um I’m waiting so that I can do more waiting, which is kind of frustrating … The most awkward or difficult part of waiting for me is just not knowing, not having much of an idea of how long I’m going to be waiting for. (Anna, 19, girl)

Waiting for confirmation is to be simultaneously in and out of the healthcare system, and, therefore, in and out of its recognition, partial and side-lined. It resonates through individuals, through their emotions and their social actions, impacting them negatively and, for some, debilitatingly, in the interim. James C described their experience of waiting for their initial GIC appointment confirmation in retrospect:

> I just kind of paused life. I didn’t want to do anything, and I was depressed. And I just kind of sat in bed and didn’t, I didn’t do life (laughs) I didn’t participate… I didn’t socialise, I didn’t go play sports, uh I didn’t see my family. Uh yeah, I would say it affected all of the things really badly… I didn’t go to uni, I didn’t do the work for it, um I wasn’t seeing my friends who were there, I wasn’t socialising, like I was depressed, and it made itself worse because I wasn’t doing anything to get out of my little hole. (James C, 23, non-binary trans man, or anything in between)

James C felt they could not engage with others during this time. They did, however, have a supportive partner at the time, although James C considered that the emotional work of looking after their well-being may have been a strain for their partner to maintain. Again, strain on those closest to individuals waiting for healthcare also strains those who support and care for them (Rickett et al. 2020). James C’s deep depression was exacerbated by feeling like they could not engage with their normal activities or social life. This downward spiral of depression increased, as time passed on the waiting list, into a real hopelessness and helplessness: the harmful product of waiting for trans healthcare.

Marcy’s experiences were similar; she attributed her increasing dysphoria to be a consequence of her prolonged waiting. Feeling dysphoric caused her to seclude herself from engaging in social activities, even those of potential supportive LGBT groups:

> It, yeah makes me less productive and social especially and generally like less happy …the non LGBT people that I do hang out with um, it weighs on my mind coz it sort of, there's an anxiety of how I feel like I am perceived um which, like I'm always worried that I'm being perceived as male and I don't like that uh aspect. It's sort of has dissuaded me from sort of being social and some events.
>
> And then there's sort of like socialising with the LGBT community like, um, all I know of them is that there are events that are centred around that and what I do is try and take part in them. I'd be lying if I said there wasn't sort of some sense of invalidity in not really getting started uh that puts me off.
> (Marcy, 18, demi-girl)

Marcy was struggling with not feeling 'trans enough' in not having begun her medical transition. Like James C, she was withdrawn, as many others often are, from engaging in a social life, while waiting. Feelings of not being 'trans enough', and the invalidity experienced alongside them, is a detriment to trans people, and is associated with not being able to access gender-affirming care (Pearce, 2018). Waiting causes an elongated negative thinking process of feeling dysphoric and invalidated in their associated suffering by the absence of care, which can lead to trans people to socially withdrawing. Being left waiting for so long can leave trans people feeling not 'trans enough' or human enough to pursue life in the meantime.

Budge et al. (2013) contend that coping while waiting for trans healthcare, in an American sample, presents as cognitive or behavioural strategies. Of those, avoidant coping mechanisms are found to be a consequence of a lack of support. Within this research, Frank had tried to find a local support group, but it did not exist, so without social assistance he turned to avoidant coping strategies to manage his emotions:

> t was horrible, hence why I went private…um I felt like I was totally alone, I didn't have anyone to talk to. I tried to find groups and stuff but couldn't find any in my local area… try to fill the time by doing stupid reckless stuff is what I found myself doing. Um and yeah so it wasn't a very healthy time of life…do

> drugs a lot, sleep with too many people, oh it was just me trying to pass the time. (Frank, 20, FTM)

This was Frank’s coping strategy to pass the time, which I analyse in detail in Chapter 6. Frank’s tendencies towards harmful activities as time passing coping strategies are reflective of his state of mind in waiting, and desperation to escape from it. While these may have temporarily brought relief and distraction from waiting, Frank risked increasing his negative emotional symptoms in the long-term with these behaviours (White Hughto et al., 2017), and damaging his physical and sexual health with drugs and casual sex.

This section has analysed the difficulties and emotional strains experienced by my interviewees while they wait for their first appointment at their respective GICs. Waiting produces harm through symptoms of depression and desperation, causing individuals to feel lonely, desperate, frustrated, anxious, hopeless and helpless. Powerlessness to move their transition forward forces coping strategies to be used to manage this emotionally difficult time, as will be examined in Chapter 6. The following section mirrors the chronological progression of a medical transition, focusing on an analysis of the experience of waiting for the start of hormone replacement therapy and various surgeries.

## 4.4 Waiting for hormones and surgery

For those wanting a medical transition, i.e., hormones and surgery, more waiting is required after a diagnosis of gender dysphoria is made. This section will address the experiences of these interviewees attempting to obtain these forms of care. A profound sense of ‘not yet’, described by Pearce (2018) in her analysis of experiences of gender-affirming care, presented itself across their experiences.

Despite the differing ways in which this feeling manifested itself in my interviewees, its source remained the same for all of them: gender-affirming healthcare being unavailable to them.

Jestin reflected on his wait for confirmation of his hormone prescription for three months, deeming it unnecessary. This was a frustrating experience for him- watching peers around him progress through changes on hormones which were inaccessible to him despite the fact he was entitled to them. He was left in limbo by the clinician's painfully slow sending of medical instruction, powerless to alter the time frame of this wait. The inaction of the clinician meant that Jestin suffered. Jestin's autonomy over his gender was promised to him, in the form of hormones, yet did not come- as a result of delayed administrative services at the GIC. This later came to impact his decision to transfer his NHS surgical referral into a private one to decrease his waiting time for top surgery. He worked long hours and most days of the week at his retail job to secure funds for his surgery. While his top surgery happened before this thesis' beginning, my ethnography captured his revision.

I drove Jestin to his revision surgery and remained with him throughout that day, bringing him home that same evening. As this was his revision, he felt differently about how the end result would influence his life when compared to his first top surgery. While he was not very descriptive about his emotional experience, he commented that, after the surgery, he wanted to, "go back home, back to normal". Comparatively, his first top surgery had allowed to create this sense of a "normal" life that he longed to return to. His recovery after the first surgery was a time of hopefulness and joy; meanwhile, waiting to leave the hospital after his revision surgery was a hinderance to Jestin. He was not waiting for the surgery, specifically;

rather, his anticipation was for his return to work and a sense of normalcy. He was stressed in the recovery room after his surgery due to the perceived length of time he spent there. The period of less than an hour that had elapsed felt longer to him than the 4 hours that had passed between his leaving the hospital and my taking ethnographic notes on his time there. It appears that for him, similarly to Siobhan, whose experience follows, getting beyond medical hurdles and bureaucracy to be allowed to simply live is the goal of waiting.

Siobhan described herself as being “held hostage” by the GIC in advance of her desired gender reassignment surgery. Her surgery was being delayed because she was overweight and was required to lose two stone. Striving towards this was causing a negative impact on her mental health because she had been comfortable with her weight and resulting body shape:

> In fact, being fat um, and being a couple of years on hormones, I have been the happiest about the shape of my body and the way that I look I’ve been in my entire existence. And now to be told lose this weight. Um, ‘we know you’ve got boobs, but we need you to get rid of them and now’, like, it’s really uhhh distressing (Siobhan, 30, trans feminine)

This distress was manifesting in her life in the form of reducing her socialisation, as community events would often include food. Moreover, as she was content with the shape of her body, altering it by weight loss at this stage was likely to cause an increase in her dysphoria levels. However, this effect is not considered by the bureaucratic, overmedicalized, GIC processes of transition. These processes require patients to meet arbitrarily defined standards, which may differ from their desired presentation. This requirement is a removal of bodily autonomy and a source of creating gender dysphoria, the very thing the service is claiming to treat, and harms trans people’s mental well-being. Holding fatness as a condition to be treated as a prerequisite of gender-affirming healthcare re-enforces a heterosexist standard of gender presentation. This is especially problematic in the case of trans people, who often find fat to be a producer and enabler of their preferred gender presentation capable of changing their body shape (White, 2019).

Siobhan also reflected on the ever-lengthening waiting period, saying it felt as if those in a position of power over the processes of obtaining gender-affirming care did not care about trans patients. She finds the responsibility of care passes to the community, as its members need looking after in whilst unable to access care if they are to experience any quality of life. Providing this care is time consuming and stifles the potential of Siobhan’s activist work, which is quite reflective of my own experience of working in the trans community:

> I think, whether every one of us is aware of it or not, it indicates a lack of care from wider society slash uh the people of power in this country, which is a shame… its shit because it’s a thing that… I think people are aware of in a general sense like, that we as trans people are never going to matter to the people in power as much as we matter to each other. But it’s hard to be reminded of that all the time… it distracts us from our wider work… and it adds of support that we have to give to each other because it adds a layer to the stress that we all feel. So (sigh), not only am I bailing out water for myself because of society and also because of this waiting list but I’m bailing water out for my friends because of the waiting lists that they’re trying to survive through and um, the healthcare they’re being refused, and it almost feels like oppression. (Siobhan, 30, trans feminine)

Siobhan’s quote above ends with a remark which identifies this pressure, forcibly put on the shoulders of the community, as a form of oppression.. The energy of trans people as a group is drained from having to support its own members due to insufficient care from the location of power over medical transition resources. A cumulative burden is experienced within the community, even without the extra strain put on by the onset of COVID-19 (Van der Miesen, 2020) The burden of care should fall on the health service, at least while it claims the highest authoritative knowledge over trans identities and gate-keeps the processes of medical transition. However, the community's knowledge on how to care for each other goes unrecognised by gender-related care specialists, who ignore, or outright deny, its validity. This is caused by the current healthcare model, which considers the patient not well-positioned to have an awareness of their own needs; a problem which could easily be avoided if an informed consent model were implemented. Where this knowledge should be used to build a more patient centred model of healthcare, it is held at a distance to maintain gender clinicians' prestige and legitimacy of knowledge of trans identities. While this power is held out of reach of trans people by the institutionalisation of medicine, there will always be suspicion towards trans people acting autonomously towards their own or others' transitions, as they are not believed to have the true mental capacity, or sufficient knowledge, for it.

Rigid standards for a transition's progression delayed Lewis' movement through his transition pathway. As he desired top surgery before testosterone treatment, his clinic required him to attend an additional assessment for an additional referral, compared to the clinic's usual standard of two. Three clinicians, rather than two, meant that his total waiting time was extended to include an additional appointment. Hormone replacement therapy is not a prerequisite of top surgery for transmasculine patients and only one referral signature is required in the World Professional Association for Transgender Health treatment standards (2022). As this unnecessary waiting time passed, he became affected by the consequences of receiving no treatment while he progressed through his young adulthood to university. Where he has been able to be read as male in college, this no longer happened on a consistent basis at university, which impacted his mental health and ran contrary to his desire to be stealth, i.e. to not reveal his trans history:

> It’s so much mental pressure going out and going do I pass do I not pass. What do I do, I don’t know. Whether to assert myself as male or let them gender me and just deal with that. So, it's been very difficult I think also because in an ideal world I would be stealth. That’s kind of how I want to live my life. But I’ve had to come out to people. I’ve had to come out to my flat mates, I’ve had to come out to people on my course because otherwise they wouldn’t gender me correctly.

> When I’m in public I uh often can feel a bit panicky um, uh I try not to use toilets when I’m out because I’ve had some experiences of being in the male toilets, other people come in when I’m washing my hands and they step back to look at the sign on the door to check they’re in the right one and then go in again it’s been a little bit mumumumu yeah I try, I try not to talk much when I’m out in public. I either um, because I think my voice is something that gives me away quite easily um, but there have also been times um where I have skipped lectures or seminars or workshops or things and kind of stayed at home coz I just can’t go outside and can’t face people. (Lewis, 19, FTM or male)

Arbitrarily excessive re-assessments extending Lewis’ time without access to the desired healthcare caused an exacerbation to his dysphoria. These additional requirements, supposedly designed to facilitate best health practice, undermine the health of patients who deviate from medical gender ideals. Lewis was forced into a state of further, unnecessary dysphoria and poor mental health because of the GIC’s perception of what the correct pathway of receiving gender-affirming treatments was. Additional appointments further pathologized his experience of gender, which circularly impacted his mental health and his ability to enact his gender. This waiting time of increasing self-uninhabitability is a shared experience in these interviewees, and across the trans community waiting for gender-affirming care.

Inflexible standards of care are producing harmful effects in the trans population due to excessive waiting times associated with an overly bureaucratised process. Waiting is emotionally taxing and socially incapacitating; it is to be passive to a rigid healthcare structure, which can be distant from patient ideals of care. More waiting is the price trans people pay for straying from the ideal medical pathway until they are deemed suitable to proceed. The burden of waiting is continuous throughout transitioning and goes on until its end.

As in the previous sections, the interviewees presented here are keen to progress through their transitions- but cannot. Similarly, these interviewees have found it difficult to engage in their lives fully due to waiting for some portion of their healthcare, and have also been deeply emotionally disrupted due to waiting for these forms of care. The following and final section will analyse the experience of waiting from the perspective of those near their transitions' end, looking at it more broadly in its effect across the community.

### 4.5 Reflecting Back on the Waiting Time

Once the waiting is over and the transition is complete, many anecdotal trans histories highlight the idea that transitioning was 'worth the wait'. This I do not dispute; however, what I will dispute is that the issues caused by waiting for this healthcare are not resolved by the eventual act of obtaining it, especially when the wait extends into several years. Waiting causes emotional and social distress, as demonstrated throughout this chapter, and the reflections of James and Vicky in this section demonstrate a consciousness of that within the community. My participants understand, as does the trans community at large, that the waiting involved in receiving gender-affirming care can be frustrating to the point of being harmful to one’s mental health.

James was extremely conscious that, compared to NHS patients, his waiting times in private healthcare have been considerably shorter than others’, a fact he became aware of through his online activities in trans circles. James described seeing trans people discussing which clinics have the shortest waiting times, because it is well known throughout the online community that these waiting times are very long. He supposed they would then decide on which clinic to make a referral to, based on this online communication. James also mentioned how these lengthy waiting times can lead trans people to give up on waiting and resort to suicide to end their suffering. He discussed how, even after the end of their wait, they remain traumatised because of it:

> But then as soon as you get to the end of that wait you, you kind of see how it was worth it. It doesn’t make up for the fact that you just had a shit two or three years and you went to some really dark places. (James, 24, male)

Vicky also reflected on the fact that the waiting produced traumatising effects on the community as a result of governmental neglect. Commenting on the “Won’t die waiting protest”, conducted in late 2019 by a group of trans and allied protestors, she found it to be one of the first instances of a pushback from the trans community against the state of waiting times. Since that time, there has been further protests by the trans community. A “die in” took place on the fourth of December 2021 outside of NHS England’s headquarters in London, organised by the grassroots organisation Transgender Action Block. Organisers delivered speeches to the crowd, highlighting the impoverished state of trans healthcare and calling for an overhaul of gender services towards an informed consent model (Pinknews, 2021). The harms of the experience of waiting for trans healthcare are felt and shared across the trans community, prompting action by the community to draw attention to, and attempt to end, the very long waiting times. This is similar to the ways in which Von Scheve and Ismer (2013) show groups communicating their experiences and emotions to each other. The trans community proposes informed consent as a model of care as a replacement for the current service because it has reliably good results internationally, focuses on their autonomy, and takes much less time and pathologisation to access hormone replacement therapy. It is a reactive group effort to change the emotional waiting experience felt by the community which, as this chapter has shown, exists as a range of emotional damage and social consequences.

Each interviewee understood that their trans peers seeking gender-affirming healthcare were emotionally overstretched by the wait. Frustration and anger were key terms given repeatedly by different interviewees to describe how they imagined other trans people to feel about the waiting. They felt out of touch with the passage of time and suffered emotional and social consequences of waiting for care. Waiting enhances an already existing negative state of emotions in trans people, prolonging the suffering they already endure from dysphoria and amplifying it as they are forced to prove they are productive society members to demonstrate their readiness for care. The suffering present during this experience produces an elongated perception of time’s passing in trans people. It not only feels like waiting for trans healthcare is endless while one is actively experiencing it; looking back on it, even after completing one’s medical transition, that period of time still appears to be an infinite limbo.

Psychological literature understands depression as a factor of slow *subjective* time perception (Thönes and Oberfeld, 2015). Where these studies highlight that *physical* damage to the hind brain areas can cause poor time perception, they also open the door to *psychological* damage as another cause. Ogden (2021) also notes, on those experiencing poor time perception in COVID-19 lockdowns, that those who were already depressed are likely to be more susceptible to the experience of time’s distortion due the increased burdens of lockdown restrictions. Further, circularly, not being able to process time correctly impacts mental health (Holman and Grisham, 2020). Trans people often experience depression and other negative mental health states before enduring the lockdown-like state of waiting for gender-affirming care. They are restricted in their movements of gender expression, physically and socially, until the care can be provided. The emotional turmoil presented in this chapter is an inherent part of the restriction of freedom produced by trans healthcare processes, and has a clear, distorting effect on trans time. All the interviewees noted some distortion to their time perception during waiting for gender-affirming care, feeling its slowness keenly.

## Conclusion

This chapter has charted the emotional and social impacts across the timeline of the medical transition to highlight the difficulties caused by waiting for gender-affirming medical care. Throughout, this chapter demonstrates the harms of being made to wait for gender-affirming care, and how it has emotionally impacted my interviewees during their transitions.

Perhaps the most important contribution to the current research present in this chapter has been its identification of pervasive symptoms which align with multiple mental health conditions and which are a direct consequence of the experience of waiting. Interviewees frequently expressed feelings consistent with depression, anxiety and agoraphobia as well as social reclusion, all caused by waiting for healthcare. This thesis has found that living without the benefits of care is directly responsible for this distinct deterioration in the quality of life of transgender individuals awaiting gender-affirming healthcare under the NHS.

Powerlessness reigns throughout this analysis chapter, interwoven with descriptions of emotional symptoms worthy of mental health diagnoses. These are pervasive and continue until the end of individuals’ transition, reducing their ability to participate in civil life. The following chapter will analyse the temporal disturbances these interviewees experienced, as they are as prevalent and disorientating as the emotional and social consequences of waiting that have been described in this chapter.

## Chapter 5: Experiences of time while waiting for gender-affirming care

Time passing from a human perspective can be subjective and objective, prone to distorted perceptions of its speed (subjective) while at the very same time being a linear, constant, measurable phenomenon (objective). The focus in this chapter is on the subjective experience of time in the context of waiting for gender-affirming care. Baraitser notes that while subjective time in the modern European sense appears socially and technologically fast paced and ever moving, there is a “temporally elongated control of subjugated populations including … queer and trans people” (2017, pg. 7). Social positioning distorts time for queer and trans people, changing their experience of the passing of time. For those waiting for gender-affirming healthcare, finding themselves in a position of social relegation and subjugation compared to others in need of healthcare, time ‘slows down’. Trans temporality theories examine the experiences and reasonings for subjectively fluctuating time, helping to understand the varying experiences of interviewees of this research, as I further discuss below.

Trans temporality theories guiding this chapter, discussed in the Literature Review, examine the ways in which trans temporal experience differs from synchronous and heteronormative time experience. These theories give different, yet linked, understandings of the passing of time, being common in their separation from normative and linear time. This chapter presents further factors apparent in the transitioning temporal experience, and it shows the experience of temporal changes over time and how it differs between individuals.

Trans temporalities are notably various and offer multiple ways for temporal speed to be understood as fluctuating depending on experiences of trans healthcare. This chapter demonstrates this notable effect, while avoiding a monolithic description of trans temporality of the waiting time to account for the diversity of experiences that the data reveals.

Throughout this chapter I argue, based on evidence from the data collected, that trans people's experiences of time passing are indeed multiple, and their experiences appear to change over time. I will also argue that disturbing trans people's time experience with such extensive and unclear waiting times, such as what is offered under NHS England GICs, cause temporal warping with negative consequences for an individual's ability to manage and monitor time.

In the beginning of this chapter, I analyse the temporal qualities that interviewees associated with their experience of time while waiting for gender-affirming care. These are then contrasted with theories of trans temporalities, discussed in Chapter 2. This section highlights the concerningly poor temporal awareness that trans people are left with because of lengthy waiting times for gender-affirming care. The second part of this chapter analyses the similarities and differences that the temporalities of waiting for gender-affirming care have with other waiting periods previously experienced. This temporality is quite distinct from other experiences of waiting, but not completely dissimilar from other situations outside of an individual's control where institutional processes include the demand of waiting. What is clear in this chapter is the divergence from linear time experienced by individuals waiting for gender-affirming care.

I will also show that the most poignant differentiation made between waiting for gender-affirming care and waiting for another desirable event or activity is that the latter did not carry anywhere close to the amount of impact on my participants' lives. Other events and activities, such as holidays, or wholesome family memories, though memorable, do not change how a person is seen forever in the eyes of others, the way transition does. The medical transition intends to externalise the gender itself into visual permanency. Medically transitioning promises a change that trans people stake their lives on and feel unable to carry on with life's necessary activities without, as this data shows.

## 5.1 Temporality in waiting

As demonstrated in the previous chapter, the effects of being in the time frame of awaiting gender-affirming care elicits many particularly negative and impactful emotions. In this section I will analyse the temporal experiences of the participants' waiting through accounts across their transition. The long-term impact of waiting on time's experiential passing, which has not previously been examined sociologically, is also discussed. This chapter aims to inform those who would counsel transgender people in the long-term, as well as contribute to trans temporality knowledge. I asked interviewees: "how is your sense of time passing influenced by waiting?". There were various interpretations made of this question, as was anticipated and hoped for, given the abstract nature of time and its movement. Some drew references to what time in transition feels like, and others spoke more broadly to how their temporal experience in general was warped, both due to the nature and as an effect of the temporalities of waiting for gender-affirming care. There were also those who did not find their temporal experience influenced by the waiting time: M, and CJ, whom I discuss first below.

### 5.1.1 Waiting Time Decentred from Temporal Experience

M perceived no outstanding variance of time's passing due to waiting for gender-affirming care. They found ample ways to fill their time- to the point that little was left to give thought to the waiting. The awareness that they had a position on the waiting list and a rough 18 to 24 months wait prompted them to "take a step back" and attend to the needs of the moment rather than dwell because "you can't wait for every day for something that's a year away in your life … coz life's too short". M's ability to engage in work and socialising with friends regularly maintains their steady perception of time's passing without unprovoked distortion from attention to waiting. They did feel that more empty days simply felt longer and that those filled with friends and good times were particularly fast, an example of which will follow in the next section on factors of temporal speed. M's full participation in life's activities is shown as an effective coping mechanism of waiting in the next chapter and is close to CJ's experience, which helped them both organise their time to be without distortion. CJ specifically managed his time into small chunks and appeared well organised and knowledgeable about his calendar of events. CJ purposely broke his life into activities and events which kept him linearly in track of time and its continuous ongoing motion:

> I break my life up with like little sections, little things… the next thing I've got is my mums birthday meal on Saturday so that's my next big thing really, so I'll break my life up to that. And then after than I'm going to my mates next Friday so then it's that. And then after that whatever is next. But I break my life up into little things. So, it just makes it go quicker. (CJ, 20, Male)

Like M, CJ had many life events to think about and attend such as events with family and friends, as well as work and university, occupying most of his time. This will be explored as a coping mechanism in the following chapter. CJ said he focused on his transition a lot at its beginning. This made the time feel slower, showing that the experience of time passing during transition does not always remain the same, an experience echoed in others. Attenuation to time in waiting was discussed by some interviewees and felt personally resonating as a point of stagnant time, to be able to watch the clock move but not feel in existential motion with it. Focus on the forward timeline of transition invoked a sense of slowness in many interviewees at the beginning of their transition and was recalled by those further in their medical transition.

Through active participation in planned events within affirming environment, CJ and M have been able to orient their time more clearly compared to others in different circumstances. M's friends supporting and affirming their gender in social contexts and CJ's full participation of social events across a range of people in his life offer resilience which, as Pearce (2016) argues, factors into the motion of temporality. Further, as these interviewees look forward to their activities and events, they are offered continuous hope of an enjoyable future waiting for them, something that Pearce (2016) suggests is a factor of temporal experience. CJ's comparison to his previous experience of waiting earlier in his transition demonstrates the difference in his temporal experiences, depending on where his future attention was placed. In moving his focus to events outside of his transition, he has decoupled his sense of time association to transition, as, effectively, has M . They have sufficient support to figure, or refigure, in CJ's case, their identities in the spaces they exist in to not feel the time pressure of their medical transition. Carter (2013) suggests multiple temporalities are inhabited at once as identity becomes refigured across spaces during transition. That may be so, as these interviewees were still awaiting gender-affirming care; however, their engagement with activities and events superseded their attention to the temporality of waiting for gender-affirming care. The following section analyses the experience of dragging time, where environments do not give rise to the promise of time passing.

### 5.1.2 Dragging Time in Waiting

Time was reported as dragging or slow particularly in those considering the beginnings of their medical transitions. Time without hormones appeared stretched out in anticipation of their physical effects, as did time spent being conscious of the lengthy waiting time. These are not mutually exclusive; anticipating their effect and being conscious to the waiting time appears to have similar root cause in dysphoria related to gender misrecognition in social and civil aspects. The markers of the passing of time warp away from linear time and refocus on transitional movements as they are key to altering a person’s recognition by others. Several attributed this slow time to being simultaneously conscious of their desired embodiment and how long it will be until they achieve that through gender-affirming care. This is an uncomfortable temporality to inhabit, I would personally attest that it drags on painfully. Like CJ, Zac reflected on his time in waiting as slow during the initial stages of his care, an experience accentuated by its negative emotional accompaniment:

> Z: … I guess like it always felt really really really slow. But now I feel like as I’m coming out of the other end it, some parts of it looking back don’t feel as long as they did when I was going through them.
>
> S: Yeah... and why do you think that is?
>
> Z: um, I guess it’s just kind of how we review time passing in hindsight as opposed to at the time. Kind of, at the time it feels

> very emotional and you want things to happen as soon as possible and any length of time seems really long. But kind of... when you look back at the past at kind of time kind of, it feels different (Zac, 23, Male)

Zac’s time felt elongated during the waiting period as a function of his persistent negative emotional state. Contrastingly, he found time to pass perceptively faster after starting testosterone. In this visible movement of transition, he began markable hormone time, as Horak (2014) would describe it; in other words, time felt slower before he started hormone replacement therapy. Moving between the different temporalities of waiting for hormones to being on hormones has altered Zac’s perception of time to make it seem faster. He presents the metacognition that the previously experienced slowness is difficult to reckon with from the position of his new temporality. Attenuation to the waiting is rather not dwelling on the medical care per se, but on its ultimate effects in a future timeframe, which is in an unclear, but very long, amount of time ahead. It is a time of wanting to start, or continue, the process of becoming themselves. . This unclarity is a pervasive nuisance to the accurate experience of time’s passing in trans people around their transition, which can overspill into other facets of their lives. Wes also discussed dragging time around waiting for his chest surgery, which he felt was comparably longer than waiting for hormones, although “obviously not at the time”, meaning that some of those stages also felt slow. He created a metaphor of running a long race to describe his experience of waiting through stages:

> When you start a race, you start reasonably fast and then you slowdown in the middle and then you give it all you’ve got at the end. But, by the time you get to the end all you’ve got is probably no faster than you’ve done in the middle, probably slower. And that’s sort of how sort of various transition waiting slots have gone ... This bit currently is like the end bit where the

> end goal is in sight but it’s just so painfully far away. And every hour feels like it drags on and every day feels like it drags on but then you look back at the previous week and you can’t remember what happened coz nothing really meaningful did. (Wes, 22, Trans masculine non-binary)

Like Zac, Wes felt the need for expeditious medical interventions due to pressing health concerns, in Wes’ case- physical, around binding. This uncomfortable state, as with the others sensing elongated temporality, holds the consciousness to the time at hand which does not allow the self to just be. As in Carter’s (2013) description of trans temporalities as an experience of being partially between times, Wes is held to the past while looking to the future, painfully stuck in a temporality of wishing to have surgery. Wes drew on the lack of meaningful time that occurred, similarly to how Thea described time as being slow and unproductive when no transition related goal is achieved. In her comedic representation below, she tells of the waiting’s temporally distinctive shape; one without progress or any factors which might lead to her time moving on from her perspective:

> The faster things happen, the faster time passes. Um, where then when things don’t happen it just doesn’t feel like time is passing at all. It feels like you know, if, if I was looking at like my clock, my watch for something it’s like ten in the morning and then like I hadn’t done anything for a couple of years it would still be ten in the morning. Where (laugh) if I get the hormones and … if I get the letters, if I get the appointments, it’s like suddenly oh look its bedtime, woops! (Thea, 24, Female)

Thea’s analysis shows the immovability of time in waiting when the medical transition does not show signs of progressing in its early stage. Her temporal experience of waiting for gender-affirming care is divided between completely stopped, and brief flits through days when notice of her transition is provided. Other interviewees spoke of being out of touch with the motion of the waiting time. In Marcy’s words, without the concrete knowledge of a first appointment date, she noted of time’s passing that it was not necessarily slow: “this waiting time itself, it’s kind of always just been a mark on the calendar that I don’t even have yet”, and that the time feels as “less of a count down and more of a sort of just like a mound of time that is being slowly worked away at”.

Time exists as a barrier in front of trans people, one that is invisibly complex to navigate while awaiting medical care, causing unclarity about the movement of time. The waiting time has often intruded on time experience making it feel elongated beyond the relative time. It is a side effect of waiting, as the desired outcome is set too far away, or is not set at all. As will be shown in subsection 1.4, there appear to be lasting temporal disturbances in individuals brought on by enduring this elongated time. The following subsection will address those whose experience of time’s passing appears desynchronized in some instances of thought concerning the temporality of waiting for gender-affirming care.

There is a resonance throughout the experience discussed here with Pearce’s (2016) commentary on anticipation as a trans temporality in the context of dragging time. Waiting phases show a certain anticipatory not-there-yet in waiting. Concurring with Pearce (2016), waiting certainly contributes to anticipation in trans lives at the general level, and I add that anticipation factors into the temporality specifically of waiting for gender-affirming care, in the same way Pearce applies anticipation to other matters of trans lives. Time drags because the result of transition is at an unimaginable distance away, being held behind, sometimes hidden, barriers. Anticipating, wanting it to come, is a slow way to spend the time in this waiting period. Getting through the nothingness of waiting time can be very difficult, to the point that Pitts-Taylor (2019) interprets it as being worse than physical pain. Waiting time as a temporality drags on continuously and endlessly as nothing changes for these interviewees.

### 5.1.3 Out of Touch with Linear Time

The array of stages along the medical transition pathway offers individuals opportunities to lose touch with linear time, partially or wholly. A few interviewees shed light on their experiences of feeling in and out of waiting time, not moving in the passing time, or feeling like they are being left out of time. Cayla, who was at the very beginning of her transition, explained that she did not see her future in two or three years as temporally different to then because she knew that she likely would still be in an initial waiting stage:

> C: I guess thinking about the future is quite a lot different. I suppose, I suppose, I mean I'd assume most people when they look like 2 or 3 years in the future they sort of see, see uh their life in whatever way. Like I guess when I sort of look to the future I kind of like think well in 3 years' time I'll still, I'll still might be waiting for certain things … I know in 2 or 3 years like I'll sort of still be here in a way.
>
> S: mmm, do you feel like time will have passed in that 2 or 3 years jump?
>
> C: um, I mean kind of but in a way it's sort of.. a sort of, I'll still be waiting for the same. I mean I guess it's sort of like living in a sort of, it's almost like time's frozen I guess in a way. (Cayla, 19, Female)

The frozen temporality of Cayla's waiting is a product of the expected lack of progress across time. For two or three years to pass with little to nothing to show for it transition wise, Cayla is partially external to the time ahead of her. She is simultaneously in and out of the time, only partially able to participate. Chloe's sense of the temporality of waiting for the initiation of her gender-affirming care was similar to Cayla's, as she described herself as being "left behind almost", but not completely- because she also occupies a paradox of limited living in lieu of treatment.

Living in lieu of treatment is one temporality, another is Tomo's, which will be shared by all others in the space between GP treatment referral and GIC confirmation of its receival. Rather than being out of touch with linear time as Cayla and Chloe experience, Tomo is out of touch with the NHS waiting time:

> I'm still in the unofficial period of waiting, I do not have a clear or any sense guided idea of like a time frame. I mean I have a vague idea of a time frame from the um private healthcare clinicians, coz they use terms like months and weeks which sound very more appealing than years and general sadness. (Tomo, 19, Non-binary trans feminine)

Tomo had a vision of time as "this understanding that it, private, will take months, whereas NHS will take at least a year and the understanding that as a non-binary person I will have a longer time at it." This appears to be a clear understanding of time, despite not sensing a timeframe for NHS care. They intended to seek private care to navigate the NHS waiting list clearly recognizing the privileged differences between public and private care opportunities. Tomo expected swift communication from a private gender clinic in light of paying for the service and knew the service would provide them with a personally tailored healthcare care plan. This is completely contrary to Tomo's experience of awaiting NHS care which appeared as a limbo waiting stage pending confirmation of the referrals reaching the GIC, they could not give an estimation of this interminable waiting time.

Tomo’s agreement to engage in private healthcare to anticipate a much shorter wait for care provides a conceivable beginning of transitional time. Reversely, Cayla and Chloe’s experiences of being left out of time and frozen in time speaks to an inability to see a horizon of the beginning of their transitional time. Garde’s (2018) praxis that progressing through transition with hormones has an implicit connection to historical capitalist processes that made hormone replacement possible is reversibly reflected in Tomo’s understanding of private care. The appeal of the transition through the visualizable time frames of weeks and months through capital forms Tomo’s temporality of waiting for private gender-affirming care.

Contrarily, Cayla and Chloe lacked the financial provision to leave the, apparently, interminable and stagnant temporality of waiting for NHS care. Without resources to leave this temporality, hope for their future is lost to the waiting, extending their experience of feeling out of touch with time. They are not in a motion between temporalities (Carter, 2013), nor driving forward to an unknown, unspecified time (Halberstam, 2005). They are distinctly marginalised from time, removed from access to social mobility, and rendered unintelligible to themselves and others, in line with what Pitts-Taylor (2019) theorises about the effects of trans waiting structures of healthcare on patients.

Most interviewees, in addition to those mentioned here, did attribute some temporal disturbance to waiting for gender-affirming care; mostly speaking in terms of not quite feeling in touch with time. This temporal experience of NHS waiting lists places care and, consequently, their own futures out of sight, meaning only interminable time is perceptible ahead. Comparatively, private healthcare provides a conceivable timeframe for the beginning of care. Experiencing waiting temporalities of ongoing, unknown length causes immediate and lasting interference to time perception. An analysis of the lasting changes to my interviewees' time perception follows.

### 5.1.4 Changes in Time Perception in and after Waiting

This section suggests that the experience of time passing could be temporarily or permanently influenced from the temporality of waiting for gender-affirming care. That the waiting time feels variably slow to inconceivable in transition has been covered in the subsections above, along with comparisons to other literature. In this subsection, to highlight the impact of the temporal disturbances evident in the previous subsections, I suggest that time perception more generally can be warped from experiencing waiting for gender-affirming care. Three interviewees, late or finished in their transition, spoke to influences the experience of waiting had on their time, either retrospectively or immediately. The first presented is James, who reports feeling as though, while waiting for something in the short term, time passes relatively quicker now, after his experience with waiting for gender-affirming care:

> I mean I guess waiting a week for stuff now feels a lot shorter coz I waited for like two and a half years for something so (laughs) I mean, not much compares to like a two-and-a-half-year wait. The waiting times between like stages of surgery now feel shorter, coz I waited two and a half years for the first stage, I'm like completely chilled about when the next stage happens coz I'm like, it's not going to be two and a half years, it's going to be like 6 to 8 months, maybe a year ... But like, a 6 month wait between stage one and stage two feels a lot easier to deal with than the two and a half years. It feels like nothing, it's like ah I had stage one, I can wait. I don't really want surgery any time soon anyway like (laughs) I'm good. (James, 24, Male)

James was positive about the waiting in front of him between stages of his genital reassignment surgery. He was generally busy with his day-to-day life and at a contented point, nearing the end of his medical transition. His temporal awareness of what “six months” means was clear and manageable, indeed so visible that he “can wait”. This is a large contrast to the temporalities experienced in others waiting, particularly with Siobhan, whom I will shortly return to, who, at a similar stage, felt very out of touch with time. James instead, felt confident in being able to manage his time between the stages of surgery, as they were distinctly shorter than his two and a half year wait for his lower surgery referral, and had much more perceivable results. Like James, Vicky had a variation in time experience following waiting for gender-affirming care.

Vicky described herself as having been quite in touch with the time she occupied prior to transitioning, situating her clearly in the present. However, during the process, she became conscious of the fact that she was waiting for a future event. . On the impact of waiting on her sense of time passing Vicky said:

> Um, I’ve had a sense of time passing, I don’t think that the rest of my life, I haven’t really had a sense of time passing. Even if I’d got a holiday coming up or something like that, I don’t think I ever sat down and went ow few weeks ‘til my holiday or 14 weeks ‘til Christmas. I’m just not that sort of person I’m very live in the moment. Um, you know I can plan ahead but its more about, my day as it exists at this moment in time. And the last 2 or 3 years have been really about waiting for something to happen. So, I think I’ve, I’ve actually had a sense of time passing which I didn’t have before. yeah.
>
> S: is that a good thing or a bad thing or something else?
>
> V: [Thirteen second pause] Yeah life’s complicated. I can’t say it’s a good thing or a bad thing … It’s a different aspect now to my, to my life [seven second pause]. Yes, it’s, it’s just a different addition. … it was horrendous when it was happening, I’ll say that much. (Vicky64, 54, Female)

Vicky was particularly emotionally affected by the waiting, as discussed in the previous chapter, and she was disengaged from work and tasks around the home during some of the waiting time. Post-transition, she described herself as “back up and functioning”, and able to return to work. Being in touch with the waiting time, due to its emotional salience, appeared to have warped Vicky’s time experience. Her attention was focused entirely on the sensation of waiting, exacerbated by the need to meet clinical criteria, which affected the length of her wait. Vicky was aware that blood levels, BMI, and mental health could potentially influence the rate at which healthcare could be provided on top of the lengthy waiting time. This knowledge, provided to her by the community, was something Siobhan was quite familiar with as she attempted to prepare her body for surgery.

I asked Siobhan how her sense of time passing was influenced by the final part of her medical waiting, when she was not considering her weight or transition goals:

> Um, [seven second pause] I think I’m confused quite a lot (laughs) um, I occasionally struggle to differentiate between a memory of a thing that was last week and memory of a thing that was 2 months ago. … I’m so focused on healthcare and weight loss and the waiting to be a trans that s- uh things that are not to do with that can sneak up on me or, or I can feel like it’s you know, imminent but it’s actually a long time away. Um and so I’m much more reliant on … having a diary and being reminded of things than I ever have been … Which combined with sort of periods of ill health um, where I might not be so great at documenting the things I need to document, um, you know stuff gets a bit messy. Um, yeah I forget uh birthdays or meetings or I literally just, on, [3 second pause] yesterday? No not yesterday, at some point in the last week. See I don’t even know when it was. In some point in the last week I got a phone call saying um ‘is there a reason you’re not here?’ from the dole um, and I could’ve have been sanctioned for that and lost my entire income … yeah because my sense of time is fucked like I don’t know... (Siobhan, 30, Trans feminine)

Siobhan’s need to focus on her weight to meet the criteria for gender reassignment surgery was causing the time in her transition to become more salient. There is a wide disparity for Siobhan between her urgency for treatment and rate at which the treatment is provided:

> Part of the issue is the way that things feel urgent to me that don’t feel very urgent to the healthcare provider. Um, and that sort of sense of like I feel like times running out and this thing has to happen, and they think that they can just relax and take their time it’s like the contrast is really um I don’t know, like effects the way I think about time. (Siobhan, 30, Trans feminine)

This temporality was so overbearing and distracting that it altered her perception and regulation of linear time, disturbing her regular self-management. This was a distinct disturbance, despite her significant effort to manage her time using a calendar. As is clear from the above quote, she was evidently struggling with, at least, short-term memory of recent events. Siobhan’s poor perception of time is a result of her attenuation to the waiting time, exacerbating her experience of dysphoria. .

Few public or private mental health resources exist for trans people to cope with the time of waiting for gender-affirming care. Trans people respond by creating and utilising their own strategies to cope, which is the detailed subject of the next chapter. Coping strategies do give rise to faster experiences of time passing, or, at least, to experiences that are seemingly in line with linear time. From this research, whether lasting temporal disturbances are permanent is unclear. However, they are certainly varying and can be damaging to trans people during and immediately after transition. This is, at present and as far as can be researched, the first example of waiting-induced temporal interference impacting on a person’s life. As such, there is no literature on whether this is permanent and can be altered. These concepts should be explored in future research with the hope to aid those affected cope with this temporal interference.

This section has described and analysed the varying temporal experiences that my interviewees have experienced during waiting for gender-affirming care. There are multiple temporalities and individuals move through them, feeling a distinction between the subjective and ‘objective’ passing of time. A singular temporal theory cannot account for the multiplicities of experiences, as they can be manipulated by individual differences. The next section of this chapter will examine the comparisons made between the interviewees’ experiences of the temporality of waiting for gender-affirming care and other their waiting experiences.

## 5.2 Temporality Comparisons between Waiting for Gender-Affirming Care and other Important Life Events

To understand the significance of waiting specifically for gender-affirming care, I asked interviewees “Does this feel like any other kind of waiting that you’ve experienced?”. The responses were a clear divide between affirmation and negation, but their explanations were various. Interviewees who likened waiting for gender-affirming care to another waiting experience presented scenarios where their autonomy was somewhat removed in an institutional setting. Section 2.1 examines the similarities understood by interviewees between waiting for gender-affirming care and other events. Section 2.2 examines explanations from interviewees on how the significance of their temporal experience of waiting was incomparable to other, keenly anticipated, life events.

### 5.2.1 Similar Temporalities to Waiting for Gender-Affirming Care

Six participants spoke clearly as to the similarities between waiting for gender-affirming care and other waiting temporalities in their life experiences. Four of these interviewees' temporalities of comparison are similar: a powerless waiting experience they had within a governmental institutional setting. Others made comparisons to waiting experiences in their personal lives. Throughout, they highlight that both the motion of time, and their own individual potential felt similarly limited through waiting.

In institutional waiting settings, both Lewis and Nathaniel commented on how they experienced waiting associated with their education. Lewis recalled waiting for gender-affirming care was similar in its temporal quality to waiting for his examination results for his A levels. He described these waiting times as similar, since their end would both impact his future life significantly. They were waiting times that he wanted a quick end to, and they had the potential to affect and influence his future. What he had said, both during his exams and his GIC appointments, had been left with their respective assessor to decide his fate. Thus, the waiting experience in both these settings left him in an undesirable state of ignorance about how his own future might unfold, its course being predetermined by others' assessments of his past words.

Nathaniel also found his future was unable to unfold while he waited to leave an all-girls sixth form college. The similarity for Nathaniel, in this instance, was the emotion attached to these temporalities; they both carried a feeling of depression in their need to be over because of how they were delaying his ability to progress through his transition:

> And that was like, I was waiting for each day to be over … I just couldn't wait to be out of there. Um, and that was a period in my life where I had to wait … I just felt depressed all the time so that like for me is like a comparable experience with waiting … Coz I was just waiting for it to be over. Um, yeah and, and that was also difficult and, it made it like delayed my transition a lot because I was in a place where I had to be, pretend to be, someone I wasn't. And, yeah, I think that set me back a lot in kind of realizing who I am and stuff because I almost felt like I had to force myself to be this thing because that's what everyone expected (Nathaniel, 22, Male)

These, for Nathaniel, were both times of waiting for the opportunity to be able to explore the option of being himself. Both were delays imposed by institutions, which require a set time to pass and certain criteria to be met in order to progress through them successfully. He also grouped these temporalities together as his place in education meant he could not present his gender, nor begin to investigate the potential of transitioning. As such, these temporalities are not only similar, but are related- one delayed the beginning of another.

Differently, James compared waiting for gender-affirming care to another medical waiting experience that he had as a child. He implied that this period gave him some mental preparation for the waiting for gender-affirming care:

> I had ME when I was a kid and that was like, they didn't have any treatment for it, they didn't know when it was guna go away, so that was like 100% out of my control. It might go away, you might get better, you might be like this forever type thing, so with transitioning I found the wait time frustrating but it didn't affect me as bad as the waiting I'd had with other medical stuff because even though I knew it was going to take a while, even if I had to go back to square one and start again at some point, it had a finish line. Like it had a definitive end, they were like yeah the wait is 12 to 18 months for an appointment or whatever, I was like ok, that's horrible and that's too long, but at least it's not tomorrow to indefinitely. (James, 24, Male)

James’ ability to foresee an end to his waiting for gender-affirming care is quite dissimilar from most others in this data set, as many considered that the end of waiting for care was not quite within sight. His unique circumstances were a combination of the experience of uncontrollable waiting without a visible end as a child with ME, as well as the fact that he was given a horizon of 12 to 18 months, rather than a potentially endless temporality of uncertainty. While this did not make the time he spent waiting for gender-affirming care any less frustrating, it did resonate with his earlier experience, making the wait for gender care comparably more concretely visible and liminal.

Vicky was the final individual to describe a waiting experience within an institutional setting. She found herself in a continuous battle against outside criteria, in both her experiences of waiting for gender-affirming care, and through the adoption process of her child. The experience of waiting was punctuated by Vicky’s reliance on others with institutional power to make decisions to move her forward in both cases:

> As a patient or as a potential adopter you, you are *completely*, at the mercy of these people…It is a feeling of, of, of powerlessness. Of, feeling dissociated from the whole situation to achieve an aim an end. (Vicky64, 54, Female)

This powerlessness, combined with the sheer length of waiting expected in each of these processes, gives a dissociation from not just the situation, but also the time. It is reminiscent of the time of not yet, discussed by Pearce (2018), a persistent struggle towards the next step forward. Vicky felt held in temporalities structured by the stopping forces of criteria she may not meet. The paces of her temporalities were dictated by regulations of the institutions overseeing gender-affirming healthcare and those controlling the adoption process. The temporalities became separate from her, as she could not influence them.

These interviewees' experiences demonstrate the reaching power that institutions have over individuals- to the point that their experience of time becomes warped. This temporal manipulation by various institutions can be far reaching if individuals need the institution to progress forward with the life they intend to have. The temporal experience that Vicky described is similar to Ayuero's (2009) work with children in an asylum centre. Similarly to the children in Ayuero's (2009) research, Vicky finds herself dissociated from her waiting timeframe because of her powerlessness to change it. Institutional processes impact the temporal experiences of individuals to their detriment in many forms. In the case of waiting for gender-affirming healthcare, pervasive institutional regulations of care diminish trans people's perception of time, to the point of removing them from a normal temporal experience.

It is not only within public institutional settings where similarities to the temporality of waiting were drawn. Within his family setting, Oliver described his experience of time while waiting to leave his family home as temporally comparable to waiting for gender-affirming care:

> It's the same kind of feelings that I had the feelings I have now about transitioning were the same as the ones that I had before I moved out and yeah… I didn't want to be in um living with my family, and I just wanted to move away. It's not the same thing exactly but it's quite a feeling that is quite similar. But also, I knew that I was going to move out at one point. I didn't know when. (Oliver, 20, Male)

He analysed these as being comparably unsafe, since they had a similar, unknown projection of time until safety could be found, by leaving the home or medically transitioning. He placed equal importance to the goal of bettering his life on moving away from the family environment and transitioning. These were both situations where the end of the experiences was not presented clearly due to factors outside of his control: the institutions of family, education, and then, institutional waiting within gender-affirming care. Oliver's self-assessment of a generally poor sense of time may be a result of his constant feeling of a lack of safety as he moved from his family situation into waiting for gender-affirming care within a short period of time. While waiting for transitional healthcare per se did not register with him as altering his experience of time passing, the anxiety arising from it may well have impacted him generally.

Singularly among these interviewees, Anna likened the period of waiting for gender-affirming care to coming out as trans. She did not attach this waiting to an institution, but she described the similarities of these temporalities:

> This is probably because I'm very early in terms of waiting for transition and healthcare and things but, uh, the waiting to come out did seem a little more difficult. But ultimately, I think that's just because it lasted longer and eventually the waiting for different stages of healthcare is going to be even longer than that so I can't really say which ones harder yet, I guess. (Anna, 19, Girl)

The early stages of coming out as trans and waiting for healthcare have presented as difficult temporalities for Anna and truly highlights the multitude of trans temporalities within trans experience. She was quick to follow this explanation with why these experiences were unlike waiting for something unrelated to her transition:

> Waiting for transition is waiting for things to be how they should be which isn't, and how things should be isn't something I've experienced before because, well because I'm trans (laughs) um so yeah, I think the main difference is that I'm waiting, waiting for transition is waiting for something I haven't experienced before… (Anna, 19, Girl)

Anna was clear that she distinguished between waiting to come out and for gender-affirming care as separate from other forms of waiting. She clarified this distinction to be certain based on the lack of experience of gender that she had, she could not draw comparisons between these time frames and others because others had already been experienced. In so doing, she highlights the multiple temporalities that she has occupied soon into her transition. She was not waiting for the return of something, she was waiting for the start of something, a notion agreed upon by individuals in the following subsection.

This subsection has examined the comparisons interviewees made between their waiting experience for gender-affirming care and other temporalities of waiting present in their lives. While engaging with institutions for a service, these individuals have been pushed into stagnant temporalities outside of their control. However, the data shows that it is not always institutions of the public realm that influence individuals' experience of time. The following subsection will examine the experiences of interviewees who described the waiting temporality of gender-affirming care as distinctly different from any other experience of waiting that they had previously experienced.

### 5.2.2 Waiting for Gender-Affirming Care as a Distinct Temporality

Contrary to the above subsection, and to add to the variability of accounts of experiences of waiting for gender-affirming care, some interviewees describe this waiting in their lives as singular and distinct from other temporalities of waiting that they have previously experienced. I will draw on the experiences of five participants to discuss how this time in waiting appeared without temporal comparison. They spoke quite similarly to each other about the reasoning as to why the temporality of waiting for gender-affirming care was unlike any other waiting time. Each discussed feeling that there was not anything that had as large an influence on their lives as medically transitioning did. This temporality appears singular and distinct, due to the need for its eventual consequential result on the gendered embodiment of these individuals.

Zac felt that he needed gender-affirming care to function as a complete individual:

> I feel that I need this medical care in order to continue with my life in the way that I want to… I can't, be who I want to be until I have these medical, um like surgery or hormones… I think that's kind of part of why it feels much worse. Um, it feels like it's really something that I *need* (his emphasis) as opposed to just something that will help a little bit. (Zac, 23, Male)

James C, similarly, positioned getting gender-affirming care above other events within his experience in terms of importance to him:

> None of them were as long or meant as much to me. Umm, like I guess yeah getting into uni I guess was the big one. I knew I would get into one and I knew it wouldn't be a bad one. Um, and I knew I would find out on a certain date, and I knew everyone else would find out on a certain date... I knew I would be going to uni, it was just a case of which one. Whereas with this it was a lot of unknowns ... Like when will I hear? When will I get to see them? What will they say? Will they just not feel like

> giving me T for some reasons, is that what they'll do? … It meant so much to me … and my mental stability was dependent on it... Umm, like it meant everything, but getting to uni, waiting for jobs, that was all fine … I just don't care half as much… Like I will get a job, just maybe not at that place. Whereas this, it's like you've got one hit, this is it. And if it's a no, you're screwed. (James C, 23, Non binary trans man or anything in between)

For James C, the temporality of waiting for gender-affirming care is distinct, due to its unclear path and timeline, which is a shift from his normal guided timelines of his life's direction. He perceived that, while, with his choice of university or future job prospects he was capable of seeing any delays as simple obstacles and conceiving of a different path to achieve a given goal, any obstacles standing in his way during transition became insurmountable. This temporal experience is forcibly queer due to the unclarity of his future. This is unlike the queerness of Halberstam's (2004) time whereby queer time gives no destination purposefully. However, for James C, his destination is clear- but his time on the path to it, is not. He recognized this would impact his metal stability significantly, while he clearly did not apply or attribute the same mental weight or significance to his university choice and job prospects. Transition's certainty rests on an invisible precipice with too many unknowns, with an impact far wider reaching than other life changing events. Cayla, Marcy, and Alex paralleled James C's analysis of the magnitude of effect that transition poses in their lives. Cayla analysed why her waiting for gender-affirming care was so unlike any other waiting temporality:

> It's like such a big part of my, my identity and like my self-determination in a way … it's sort of being the person who I actually am … I guess nothing else really is that big like, has an actual effect … nothing else really compares to that. (Cayla, 19, Female)

Marcy agreed, again comparing the anxious temporality of the life-influencing wait for exam results to the wait for gender-related care and deciding: “nothing really even comes close … nothing’s taken this long and had these higher stakes”. She explained, “that end result is a lot greater in consequences as in it has much more of a bearing on anything in my life than any other wait that I’ve had before”. Alex concurred, stating that no comparison came close to describing waiting for gender-affirming care, centring his identity affirmation through testosterone:

> I didn’t feel like I was truly able to be myself until I had um started testosterone. Things started to change, and I was finally going through the puberty I was meant to. Um for me no other experience has been like that, like coming to university hasn’t made me feel like oh I’m finally where I’m meant to be or any of that. Yeah, I feel like for me it was just focused waiting for I don’t know, my real life to start. (Alex, 19, Male)

These are all deeply anticipatory desires towards the promise transition offers, and Alex attests to the new temporality that hormones offer;not specifically leading to an end, as Horak’s (2014) hormone time suggests- more beginning and ongoing, as Sudén (2015) proposes. However, Cayla suggests her experience is unlike both temporalities; instead, she sees her transitional future as a time of, to paraphrase her, being who she is. Her analysis places her firmly in the present, all the while showing her clear wish to be placed in a future time in her transition.

Multiple temporalities abound within individuals’ transitions and across their lives with varying impacts on their temporal experience. But, for the individuals in this subsection, the temporality of waiting for gender-affirming care was the most significant and outstanding to them over their life courses.

## Conclusion

My interviews revealed that, whilst waiting for gender-affirming care, often without a given end date, trans people had varied experiences of time passing. They perceived the passage of time to be slower than in reality, or they recalled feeling a disconnect from the passing of time. Across the interviewees, most experienced a certain fracture in time's passing during their medical transition, with some revealing occupation of multiple temporalities across that time. They were able to effectively identify and compare differences of the experience of time passing between waiting for the medical stages of their transition, and the experience of any other waiting outside of their transition.

These differences illustrate the temporality of waiting for gender-affirming care as distinct from waiting for other activities and events. This means that time is felt to deviate, significant and meaningful in its fluctuations, away from linear time. The variation of experiences across individuals' transitions complements and adds to the rich theory of trans and queer temporalities. I have engaged and collided with theories of trans and queer temporalities to demonstrate that the waiting is indeed anticipatory, hopeful, and multiple- in the moment and across time (Pearce 2016; Carter, 2013). Complementary to others, I contend that there are multiple temporal occupations available during a medical transition; however, they differ in their linearity and queerness, attachment to past and future, and interference with the rest of individuals' lives. I have asserted the novel claim that these lengthy waiting conditions are not conducive to an individual's ability to follow and co-ordinate with linear time. Moreover, I have found that the distortions to the perception of time discussed throughout this chapter are not contained to the period of waiting itself;

indeed, multiple interviewees what they described as time feeling slow even after their transition goals had been met and their waiting concluded. These findings will, hopefully, provide a foundation for further research on the topic of trans temporalities; additionally, they could contribute to a better understanding of how temporal perception is affected by waiting for healthcare in general.Poignantly, Siobhan's experiences demonstrate that waiting can use a disorder to the accurate perception of time despite efforts to maintain the visibility of its track. There is room for inquiry into long-term consequences of waiting on temporal experience in trans people, considering waiting itself can lead to suicidality. There is a great span of time spent waiting, which is extremely destructive to trans people emotionally and temporally, in the moment of its occurrence. This is not accounted for within healthcare, with no provisions supplied for such an extensive and intrusive range of temporalities.

In lieu of this lack of care, trans people must develop coping strategies to tolerate and abide the time; these create a sense of resilience which can help individuals get through the lengthy waiting times. The following chapter examines the coping strategies used by interviewees of this research across their transitions to mediate their orientation of time back to something recognisable. As will be seen, the coping strategies analysed are used to cope with the emotional, as well as temporal, fallouts experienced by these interviewees. Their extensiveness lends reflection on the multiplicity of temporalities across space, time, and individuals discussed in this chapter, which require coping with.

# Chapter 6. Coping Strategies used while Waiting

This chapter analyses the coping strategies enacted by trans people during periods of waiting to address the second research question: How do transgender people cope with the waiting time? Coping conceptually refers to “cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus & Folkman, 1984, p. 141). Therefore, healthy coping strategies for the purpose of this chapter are behaviours which result in wellness, and unhealthy strategies are behaviours that result in illness. What is considered healthy by trans people may not be considered so by medical professionals, for example, self-medicating HRT from unsanctioned sources. Self-medicating HRT is viewed as a form of self-harm by medical professionals, until they ultimately prescribe it. The end result of wellness is the same; therefore, what is viewed as healthy or as a positive coping strategy in the face of waiting for gender-affirming care in this chapter will be seen as what causes wellness to the individual. Internal and external demands are abundant through the medical transition process. However, the excessive demands and iatrogenic consequences of waiting, already discussed in the previous analysis chapters, give rise to the necessity for specific analysis of coping during waiting. Coping strategies are therefore presented here as the thoughts and actions adopted by individuals to manage the demand of waiting.

The need to manage the waiting becomes necessary in the context of the emotional, social, and temporal disturbances discussed in the previous chapters. As a result, trans individuals and the trans community employ various coping mechanisms during the period of absence of transitional care. Many studies on coping, discussed in Chapter 2, reveal the pressure within trans and queer communities to look after each other- even those designed to serve therapeutic practitioners still advise community immersion and reliance in many instances (Bry et al., 2018; Gorman et al., 2020).

The current research on trans coping has a singular focus on comparing coping mechanisms in terms of the participants' mental health outcomes in order to advise both therapeutic practitioners and trans people themselves. However, they fail to acknowledge how trans and queer people must be able to cope within their social circumstances as well; experienced professional support can be financially out of reach for many, and the availability of a supportive trans space is not guaranteed for all. This chapter uses previous coping research to understand the form and function of the many coping strategies used by interviewees of this research.

### 6. 1 Trans Community Engagement

The above works supply a theoretical basis for this chapter. It is anticipated that many of these coping strategies will be reflected; how they may be specifically applicable to waiting for gender-affirming care will be analysed. In interviews, I asked each person how they coped with the waiting time, and what advice they would give to others to cope if the wait was distressing them. Four broad themes emerged from the data: trans engagement, seeking trans knowledge, dysphoria management, and distractions. The advice given by the interviewees, which followed their own positive courses of action, is presented together in the analysis. Phrases of care and wishes of perseverance were offered to those who may receive them through this research. An analysis of the details of some coping strategies, divided into those four major categories, will follow, along with an evaluation of how useful participants deemed them to be, based on their own experience.

### 6.1.1 Community Socialisation On- and Offline, Cultural Engagement and Being Out

As discussed in the previous chapter, the shared experience and emotions of waiting create strength in the community and build community ties. Several individuals commented on the usefulness of engaging with the trans community and its various surrounding cultures. Socialisation with other trans people had rewarding benefits for many individuals and is available directly and indirectly, as it can lead to building small, localised communities, as well as online ones in various sizes. In terms of physical closeness, many interviewees spoke of their own friendship groups composed of trans people as a source of support. Siobhan commented on the importance of having a close trans social group. An outstanding factor of her group that made them appealing to Siobhan was their flexible approach to understanding gender identity, which she found healthy and affirming. She recommends the same for others:

> I always recommend to everyone … not just hanging out with trans people but like consuming everything that you can find. So, reading books by trans people um, and film, … art and like culture, trans culture is quite um important. And like, beneficial. (Siobhan, 30, trans feminine)

She finds “being able to retreat into trans events and spaces and art and culture is a real like tool for survival”. The benefits of consuming trans culture and trans-made content in this way can contribute to a positive change in wellbeing and help form a sense of belonging. Nearly all interviewees recommended reaching out to other trans people online or in person, or attending social or cultural events, regardless of their point in transition. Community engagement may take many forms actively, but trans content may also be passively consumed from online platforms. There is a keenness to engage with trans culture in some form, mostly as a method of support, to find a space that is representative and safe. Having this availability of the trans community, as Siobhan comments, has its benefits, giving a sense of belonging and a broad range of cultural information. It provides the opportunity to step into any trans area and seek support in a way that is suitable to the individual. This form of community connectedness is absent from other analyses, which may have led to the minimisation of its perceived importance (Puckett et al., 2019). This connectedness allows trans people to fall back on a foundation of transness, which exists to not only support trans people, but document the movements, actions and plans of the wider trans community. In decoupling their trans identity from medical approval, they are freed from the temporal constraints of waiting and are instead synchronised with other trans people’s experiences.

While Siobhan makes use of many physical and online spaces to immerse herself in trans culture, Tomo on the other hand used mainly online spaces to relate to trans femme people from a distance and more indirectly because there were none that they knew in their immediate trans community. They were able to find content suited to their gender identity within online trans communities. Online communities on platforms such as Reddit allow users to share content and communicate with others on specific subject matters under ‘subreddits’. There are over a million subreddits on Reddit, but far fewer are actively used. Trans specific subreddits allow users the chance to create and view trans content and share them with that subreddit community. Images are often used, namely ‘memes’ where a well-known image or scenario is varied slightly for comedy value for a specific purpose. Included in this are what Tomo identified as relatable memes of “modern humour” which were made or titled in response to experiences for waiting for UK based gender-affirming care by site users, examples of which will be presented in the following chapter. Tomo’s diary commentary on these memes showed the engagement levels (votes) with them relative to a categorisation of their own making.

The comedy value of following these subreddits for Tomo is “diffusing serious issues behind memes so as to come off as ironic while still addressing the main issue, making it potent and relatable.” Tomo posed that a meme categorized as openly sad received a low number of upvotes because it “appears to be a cry into the dark, thus is too relatable, and too real, and people move past it”. Moving past these memes without consciously acknowledging them entails an avoidance suggested by Gorman et al. (2020) and Bogert (2018) as a measure of self-protection, in this case to avoid this sad relatable experience of belonging to the community. Tomo finds that memes that are voted higher diffuse the horror of the experience through referential imagery. The referential memes are already well known to active internet users in these spaces, they have an expected humour result. The displacement in referential memes to an already accepted level of humour, as Tomo suggests, diffuses the negative experiences associated with waiting. They recommend enjoying memes, amongst other activities, in distressing waiting times. Thea also expressed her interest in memes in discussing her use of online spaces:

> I think it’s a big part of what relieved dysphoria. It sounds dumb but like when memes are made to laugh at like the darkest parts of humanity (laugh) like you know depression memes anxiety memes um, then it gets to like dysphoria memes and like you know uh memes about anti trans squads. And memes about the, especially the cartoon memes that are really uplifting and positive. It’s just, I think our generation communicated a lot through memes just coz there’s not really the language to express things any more so I think its just when someone sees the you know a relatable meme and they’re just like me too kind of thing, I think that’s how a lot of communication happens.

> I think that’s a lot of what helps people cope with dysphoria coz
> it makes you feel like you’re not alone and it makes you laugh
> at it slightly or like ‘aww’ (Thea 24, female)

Similarly, Blewitt-Golsch (2019) found trans memes across all their coding categories demonstrated elements of minority stress depicted through the images, as well as resilience in their use against such stressors, as Thea explains above. Engaging with these memes allows humour to take over the negative emotion associated with the experience described in them. McGuinness (2018) also found that memes were used as a coping mechanism in trans people using trans social media groups on Facebook. McGuinness (2018) suggests humour is used as a ‘buffer’ against the negative situation depicted in memes, which appears to be occurring for Thea and Tomo. However, these memes, which target dysphoria and waiting, also give trans people validation in the knowledge that their experiences are indeed echoed by other in the community, which creates a sense of solidarity. As Thea notes, memes are also made to minimise the impact of oppression from anti-trans groups. This is an interesting finding: while memes have been analysed in previous research in discussions of power, the primary discussion around them was focused on their use by anti-trans creators at trans people’s expense, such as in Sălcudean and Motoroiu-Stefan’s (2020) research. Memes are vocalisations of powerlessness, or are used to show powerlessness within specific settings, and can be liberating or harmful (Sălcudean and Motoroiu-Stefan, 2020). Their relatable and affirmative nature foster trans community connectedness, as well as having the potential to defuse some of the horror of waiting for gender-affirming care through referential humour.

Affirmation of gender identity or expression is a crucial factor to supporting a person in transition and an increase in its occurrence directly reduces mental health problems (Hughto et al., 2020). It is most readily available from the trans community itself, which can provide a safe, supportive space for gender identity expression, exploration, and development. Many interviewees highly recommended finding validating, affirming friendship groups and other trans people precisely because they provide the space for free and varied forms of self-expression without judgement. For example, in the trans community, trialling different pronouns with friends to get an experience of affirmative gendering is a safe way to experiment and explore one's identity. This, in turn, helps form conclusions about the gendered self and build confidence in exerting one's identity in other spaces; some of the feeling of immobility in the limbo of waiting to transition medically can be relieved thanks to this visible progression in social transition. Outside of trans-specific spaces, Zac found respect and affirmation of his identity at university, from his course-mates and society groups alike. Both offered him validation and respect which, consequently, gave him a higher sense of confidence:

> I was very active in the LGBT community, so I did make a lot of friends there. But I also made friends on my course, and friends at the catholic society who've always like respected me and accepted me, for who I am. Um, I just, I think I've been quite lucky that I haven't really had many problems with people. Um, I just found like a lot of people at uni to be kind of open minded and accepting. (Zac, 23, male)

Several student interviewees agreed that LGBT+ student societies could be used in this way - as safe spaces, where they could go and be openly trans with others who would be accepting. Similarly, M also commented that they found respectful validation from their cisgender friendship group. M enjoyed the merits of this social group in terms of activities and conversations, commenting that time flowed quickly in these settings, with the group providing opportunities for memorable experiences.

These validations, external to the trans community, reveal that, given societal validation from different social spheres, trans people are much more capable of forming successful, beneficial social connections. Social support therefore, as suggested by previous research, continues to be a major factor in coping for trans people. In terms of waiting for healthcare, it allows for meaningful experiences to form in the meantime of waiting- and despite it, since social circles give the space for trans people to live their intended gender without fulfilling physical or medical criteria or expectations. These social connections also take time and energy to build, providing a distraction, in addition to their ability to create a feeling of hope and anticipation for the moments of gender validation they provide.

Many take the time to contribute to the community's circular giving back process, evidence of which can be seen in other works investigating community connectedness (Hines, 2007, Pearce, 2018). This desire to aid others took a few forms in this research: CJ volunteered his time at a trans youth organisation, and Siobhan had taken part in several forms of trans activism. These caring or creative acts of togetherness, not just within the trans community, but also within local spaces and friendship groups which include supportive cisgender individuals, help build community empathy and create more accepting and habitable environments for trans people generally. They help share the historical and cultural knowledges and give a sense of belonging to those engaging with them; this can lead to the formation of grassroots groups and internet pockets of trans people, which give ample opportunity to find trans and transition related information. As will be shown in the following section, being knowledgeable about the processes and waiting timeframes surrounding gender-affirming healthcare aids management and navigation of the waiting.

### 6.1.2 Seeking trans knowledge: Process, Expectations, and Solidarity

Using the trans community to build knowledge about transitioning, the medical processes, and waiting time spans was a strategy most commonly used by interviewees at the beginning of, rather than later during, their transitions. Having a clear understanding of the prospective process and waiting time ahead can give a realistic expectation of the experience. Most seek information on the processes and waiting timing for initial and follow-up appointments from trans community spaces, rather than from the clinics directly, as sources are scarcely available and waiting information can be out of date on their websites. Nathanial explained how he was able to use an online community, even without interacting with others in it, to seek information and form solidarity with his community:

> [E]ven if I'm not interacting with the people directly like it's nice to just have that like community on Facebook of like people who I know that they're going through similar stuff. And them posting about their problems helps me coz then, a lot of the time they're things I can relate to and then the people in the comments give advice which like, I'm quite shy and also lazy so if someone posts something that answers my questions I don't post it myself. (Nathanial, 22, male)

Nathanial was able to discover all the information he needed from this comfortable distance; in this way, as a lurker, he was able to gather the knowledge he needed on his own social terms. Like Nathanial, James also made use of social media platforms as a source of information without directly interacting with others on the platform, opting, instead, to read about their experiences. This process of acquiring information passively is also known as being a watcher, or lurker, in online communities. Lurking is used for many purposes, and not posting may be reflective of numerous issues, including community rules regarding re-asking questions, the closeness of the group's members, or as a personal preference (Sun, Rau & Ma, 2014), which is closest to James' case:

> I don't interact with people on them, but it helps to hear other people talking about their experiences. Like even now, it's weird but just kind of knowing other people are waiting a year between stages, that sucks for everybody involved but it kind of stops you from panicking that you've missed something or that you're having to wait extra-long. And you realise that you're just in the same boat as everybody else and like, get support from that. (James, 24, male)

The knowledge extracted from these spaces also comes with the personal experiences of community members. This gives an individual not only an idea of the facts and stages of their transition, but an expectation of the emotions that will likely arise in relation to them. This sharing of experiences builds knowledge and community connection simultaneously, and allows trans people access to information unavailable elsewhere. In turn, these grants individuals undergoing transition the possibility of perceiving the broadness of the trans experience, as well as the chance of preparing for certain transition goals; Nathanial and Wes both mentioned researching surgery outcomes in this way. Being able to see surgical results well before a referral for surgery allows trans people to utilise their freedom to choose the surgeon most suited to their needs and preferred outcome. Additionally, in such communities, detailed descriptions of the passing of time from referral to surgery often presented. This helps build a realistic expectation of the possible effects of medically transitioning and grants a better understanding of the timeframes of waiting.

A significant emotional effort is put into sharing the details of transition, explained by the gravity and complexity of the information that needs to be conveyed. Sharing the images of top surgery results, for example, takes a notable amount of courage on the part of the sharer, given their assumed recent dysphoria in that body area. Entire community groups, dedicated specifically to the task of presenting information to its members in an accessible way, form on- and offline. James C and I discussed our shared experience of following a large trans masculine Facebook group, in which files on relevant transition information are easily searchable and regularly updated and top surgery results are easily available, with some posting updates of their healing over time. These images are crucial to the preparation for, and management of expectations before, surgery, giving trans individuals a better understanding of their expected healing process over time. Having concrete timeframes allows the possibility of the future to exist and is, as discussed in the previous chapter, much preferable a state than the anxious wait usually experienced by trans people in the context of transition.

Hargreaves et al. (2018) find that online forum groups, in the case of individuals affected with breast cancer and motor neuron disease, are used as a source of empowerment. The groups also allow their members to build powerful connections, formed on the joint emotional experiences of their illnesses, with each other. The same has occurred in the trans population in this research, but with different material and through further platforms than discussed in Hargreaves et al’s (2018) work. The consumption and sharing of knowledge and experiences was used by these interviewees to build not just empowerment and bonds of friendship, but also a sense of solidarity. Like those discussed in Hargreaves et al’s (2018) and Gorman et al’s (2020) work, Chris wanted to connect with others with whom he shared a common identity and at a similar stage of transition because of the ease of communication offered:

> [O]ne friend I met through that Facebook group ... we are in exactly the same position with waiting times. Um, we've both gone through the [youth clinic] route, both now getting referred to (GIC) and I think that, being so similar with our waiting times and in our positioning with our medical transition I think um, yeah it's, it's made it easier to talk to each other um, about personal yeah struggles. Because we see it from, from different perspectives I think being able to talk about that is really helpful. (Chris, 18, male)

In Chris' case, the waiting is managed through being known, because this information is difficult to come by. That is precisely why it is crucial for trans people to be able to connect with each other in order to learn about the processes of transition and expected waiting times. As discussed in Chapter 4, coming to terms with the knowledge that one could be waiting for many years with no medical assistance is absolutely devastating. It introduces a state of depression in which an individual needs support desperately, if not in the form of medication, then as management techniques. This desolation, combined with the simple fact of remaining without medical care, can perpetuate and increase feelings of dysphoria. The following section will discuss techniques of dysphoria management and argue that it is crucial to the support of trans people that dysphoria reduction methods be employed during the waiting time in order to cope with it.

## 6.2 Dysphoria Management: Supplementary Gender Affirmation and HRT

In the absence of hormonal or surgical gender affirmation, many make efforts to physically assert their identity through other means. Several interviewees engaged in dysphoria management techniques to abate the effects of prolonged waiting by experimenting with their clothes or hair to validate their gender identity. Both Alex and M made use of clothing experimentation to reactively combat their experiences of dysphoria, enjoying the validation they felt in their clothes. Alex discussed experimenting with different clothes to alleviate his dysphoria and “make it through the waiting period a bit easier”. M concurred, using a range of techniques to manage physically and mentally:

> I cope.. should say physically, I’ll split it I guess, um, with wearing a binder, wearing clothes that make me comfortable by.. um, acting the way I want to act and not worrying is its uh, female or a male stereotype. Um, my hair, how I do my hair, how I present myself like physically and things that physically make me feel better able things … and you know making people aware if I’m not .. feeling great about those things. Um, just so they know. Not for any reason they need to like, they can’t help me if I feel dysphoria about my hips or whatever. Just to be like ah, this feels rubbish. And usually the answer is ah yeah, that sucks, and it’s just the validation. (M, 21, non-binary trans masculine)

Undergarments, such as binders, which are used to affirm gender presentation in others’ eyes, as well as the wearers’, were mentioned by the participants. Access to shapewear and gender-affirming clothing reduces suicidality in trans youth (Trevor Project, 2020), and reducing this potential harm is crucial for trans people of all ages. Similarly, using minoxidil to stimulate facial hair growth, as in Alex’s case, or shaving the face and body prior to hormone replacement therapy are acts towards gender affirmation and physical realization. These acts are normal daily care routines, which gives them a sense of gendered normality, while also being gender-affirming self-validation techniques and helping individuals more accurately reflect their intended presentation. They allow trans people to simulate a future point in transition in which daily selfcare acts, such as shaving the face, will be required, thus creating the sense of one’s transition progressing; indeed, they can be seen as acts of transition in themselves. This allows trans individuals to situate themselves in a time of living, a time of change, as opposed to the time of waiting for transition; these acts of self-affirmation, therefore, remove the overhanging medicalisation of transness from one's perception, letting them live comfortably in lieu of treatment.

M also draws attention to reaching out to others in times of dysphoric experiences, particularly, to their cisgender friends, rather than the trans community. M comments that their friends' support is based on recognising the present discomfort and, simultaneously, offering reassurance about the future of their transition. M quotes their friends, who have said, "I understand that you're not comfortable. That's ok, you'll feel more comfortable later, or, if you won't then, there's other things to think about". This social validation of M's discomfort and experience is a coping mechanism that offers them hope for a brighter future; at the same time, their friends present a welcome distraction from their current situation. This support appears to be crucial to M's general well-being and management of time while they wait for gender-affirming care.

As powerful as these acts can be, they are not always enough to alleviate dysphoria to a liveable position. For some, the need for progress to a desired presentation, provoked by dysphoria and exacerbated by the lengthy waiting times, proves too much and they find alternative, unsanctioned sources of HRT. This results in those self-medicating having a sense of personal empowerment, a feeling rare in the process of medical transition. Perhaps more importantly, self-obtained HRT takes the control over an individual's transition away from medical professionals, placing it in their own hands, and allows them to start the process without being forced to wait for an indeterminate period of time.

Four participants shared their experiences of self-medicating with hormone replacement therapy as a coping method to alleviate the stress of waiting. I am deliberately classifying self-medicating as a form of self-care due to the motivators and results of taking the medication. The interview data revealed that each interviewee experienced a culmination of extended waiting, persistent negative emotional states, and dysphoria as motivating factors to begin self-medicating. The trans women particularly highlighted their dysphoric suffering in the absence of something to combat the effects of testosterone, such as hair loss. Each also appeared to perform a risk analysis; they shared their considerations of their health, wealth, and, briefly, the legal risks involved. Ultimately, the results of self-medicating they describe mirror the results of obtaining the same hormones at a clinic.

Thea, Chloe, and Siobhan all made references to the motivator of dysphoria, whose potency increased over time, exacerbated by the waiting. Thea and Siobhan both discussed their displeasure of losing their hair due to their continued masculinisation. Siobhan described herself as in “crisis in terms of like, testosterone”, as she recognised that she would not be financially able to correct her hair loss with implants. Chloe referred to her chest dysphoria, saying that she would suffer the cold rather than zip up her coat, which would give away the fact that her chest was flat to onlookers. They experienced a growing impatience for the healthcare service to provision them with care, inflamed by the awareness of how long they had already waited and the predicted length of the wait remaining until they would be prescribed hormones. This impatience and frustration combined with their persistent dysphoric states heightened the sense of urgency they experienced and appears to have motivated these interviewees to self-medicate as a coping mechanism. Thea relates how, prior to self-medicating, her emotional state was manifesting as “lack of self-care, depression or just suicidal tendencies”. She was also withdrawn during term time at university, and without the hormones she felt: “it was worse because it was just you know nothing was happening and I could just, it was like oh God I’m getting manlier by the day, you know, I’m losing my hair, you know I’m turning into a man”. Her exasperation, both at the lack of progress on the medical side of her transition, and the opposite of her desired effects manifesting in herself, was parallel with Chloe and Siobhan’s experiences.

These four interviewees all performed a kind of risk analysis, giving due consideration to potential difficulties they may encounter while self-medicating. They broadly considered their health and finances against their increasing mental health concerns, dysphoria, and the extended waiting time ahead. Chloe reasoned that there were minimum potential health consequences of taking the medication, because it came from a known, legitimate source, and because she was taking a minimal dose intermittently. She viewed it more as a successful placebo and a step in the right direction, a mechanism of coping with her dysphoria, than the actual start of her medical transition. The cost of buying hormones independently stopped Chloe from acquiring and taking a regular dose. Thea also considered the financial burden and balanced it against her increasing dysphoria and feeling of hopelessness:

> It was like, you know, you feel like nothing’s happening and that just spirals you down, as in its hopeless, nothing ever will happen. Um, you know I’m just getting worse rather than better. So I think that’s the biggest danger, I think when it comes to the wait uh for people who don’t take the hormones or go private or self-med it’s gotta be really hopeless for them coz it’s like you know uh it is literally just nothing… It did change when I started self-medding … it felt less urgent… like I could just sit there and wait for it to like happen. Um, and then like you know while I was just taking these hormones and I was just like ok I’m

> gonna be like severely broke coz you know they’re not cheap.
> But, it was, it was worth it. (Thea, 23, female)

The cost is often prohibitive when it comes to trans people accessing private or unsanctioned hormone replacement therapy. The resulting effects were psychologically and physiologically different between Chloe and Thea. While Chloe found her dysphoria eased in the moment of using hormones, Thea found that, over time and continued use, she began ‘passing’, which offered her longer-term effects of confidence in her appearance and lessened her “worry and pressure and stress” in the meantime of waiting for the GIC. Chloe recognized her use of hormones was short term aid that offered of hope that “something is coming in the future”, but also the awareness that “if [she] had transitioned now [she] could be better”. Thea experienced long-term positive effect from taking a regular dose compared to Chloe’s short-term positive effects.

It is unfortunate for Chloe that her financial situation did not allow her to access hormones, either at a full dose or through private medical care. Cost factors frequently as a driver towards self-medication in transgender people in other countries, such as the USA and Thailand (Xavier et al., 2013; Mamoojee et al., 2017). While self-medication offers multiple benefits, it also comes with potential hazards, which cannot be ignored, such as the possibility of receiving fake or tainted medication. Dosage also cannot be personally suited to the individual, as they will not have blood tests to monitor their hormone levels and allow them to make educated adjustments. Siobhan the quality of the hormones available to buy online and how they may affect her health, and presented this analysis of the risk, stating it compared favourably to the risk of not having HRT at all:

> It’s not the 90s. You’re not guna get a bottle of sugar pills you’re guna get Bayer, you know you’re guna get Big Pharma branded um, medications and obviously there’s some level of risk in that but honestly the risk of not having it at all is sometimes, it’s um worse. And um, you know they leave us to either wait patiently or take a gamble with our health. Like we’re always guna take a gamble with our health. (Siobhan, 30, trans feminine)

She also draws attention to the risks around her own and other’s mental health deteriorating during the prolonged waiting that she later discusses in more detail. By self-medicating, Siobhan was much more able to manage the waiting time. She also commented on the legality briefly, reflecting on the necessity in breaking the law to survive the waiting:

> [I]f there wasn’t someone, on the internet with a, a stock of illegal hormones I really don’t,.. know if I could have waited, I don’t know if I would have survived that long. (Siobhan, 30, trans feminine)

She, Thea, and Zac all mentioned self-medicating as a suicide preventative in their risk assessment. Zac, like the others, acknowledged that there were risks in self-medicating. But, again, mirroring the others, he found a positive change in his mental health as a result of self-medicating, “it just made me feel a lot more as ease. Like, obviously the changes are slow but even at the beginning you start noticing small things and it just made me feel a lot more comfortable knowing that, things would be going to change and gave me more hope for the future I guess”. These hormones give trans people in waiting their present and future back, both of which feel stagnated by the waiting for assistance from the GIC.

Self-medicating as a coping mechanism therefore offers an abundance of positive results, akin to receiving hormone treatment at a GIC, to those who can finance it.

These include the effects of the hormones in terms of feminization or masculinization, and a halting of the effects of the undesired innate hormone, e.g., hair loss experienced by the transfeminine participants. Self-medicating also produces an increase confidence in these individuals due to its effects, which lessen their experience of personally experienced dysphoria and lowers the risk of additional sources of dysphoria, such as public misgendering. Hormones provide a more concrete and positive outlook of the time ahead, thus allowing trans people to feel more in touch with the possibilities of their own futures. Suicidality is reduced as their mental health stability increases as a result of these positive outcomes. Self-medicating is therefore a self-care activity, as it brings an end to the nothingness of waiting by enacting the transition the individual is waiting for. The results of self-medicating mirror outcomes of those trans people under sanctioned care; better overall well-being and reduced suicidality are products of hormones replacement therapy (Allen et al., 2019). Those who begin self-medicating with hormones feel as relieved as those who receive formal care- in both cases trans people gain the ability to perceive their forward movement through time. Hormone replacement therapy and its physical and psychological effects, whether the hormones be obtained from a GIC or unsanctioned sources, produce the desired results of dysphoria reduction.

## 6.3 Actions and Distractions

All of those interviewed described some form of action or distraction (activity) they used to manage the waiting time. These fell into a two-by-two matrix of positive or negative, active or reactive activities, reflected in the subheadings below. Active activities were those, which occurred as moves to offset the induction of the negative effect of waiting. Reactive activities were those which occurred as a response to experiencing a negative effect from waiting. Positive distractions give rise to positive emotions or experiences; negative elicit the opposite.

### 6.3.1 Positive Active Activities

Some participants actively planned positive events to have things to do or look forward to in the closer future, or purposefully engaged with work or education. For example, Zack looked forward to going to music concerts; Nathanial and Cayla immersed themselves in their university studies. Siobhan and Jessica engaged actively with their local LGBT communities in ways that deliberately build and maintain ties and support to others, and Jessica noted that she enjoyed volunteering for the local community group where she had gotten counselling. Twelve interviewees sought trans people to watch or follow on online platforms and trans-related media online. This way of using online spaces use will be explored in Chapter 7.

Gaming was also engaged in by several to distract from waiting, with use being made of the games' value in immersion and character creation freedom. This distraction value of in-game immersion allows time to be spent in a synthesised temporality, which may be asynchronous with real time but, nonetheless, gives it the appearance of passing. As a bonus, free character creation can present the opportunity to operate and experience interactions with any (within the limits of the game) presentation. Trans people use this kind of character creation in games as a safe space to experiment with their expression (van Aller, 2018). This opportunity can be of value to those who may not have the space, even in the privacy of their own home, to take the time to express themselves in this way.

Vicky made use of the Trans Can Sport events that take place in Brighton. These gave her a positive, affirming trans community space where she could meet others, as well as exercise. Exercise can bring with it many health benefits, including improvements to mental health; for example, LGBTQ youth who engage in sport are less likely to experience depression (Clark and Kosciw, 2021). Clark and Kosciw (2021) noted the great mental health benefits that sport brings to trans people, in terms of their general social inclusion and psychological wellbeing, alongside the boost to their physical well-being. It is the combination of these points that makes Trans Can Sport so successful in improving the overall wellbeing of trans people. However, it is not only participation in certain events that can promote wellbeing in trans people, but also careful avoidance of others.

Anna and M were active in avoiding spaces online where anti-trans content could be found, thus practicing self-care in the form of protecting themselves through avoidance. Too many spaces online exist to diminish, or behave with hostility towards, trans people, and are unmoderated; they are an easily accessible source of spiralling negativity targeting trans individuals. These spaces seek to invalidate transgender people’s experiences, wrongly attributing transition desire to stereotypical gendered presentation or, as suggested by Blewitt-Golsch (2019), ridiculous expectations of cisgender people to include trans people, which result in their exclusion. They aim to create a suspicion of trans people, playing on unrealistic situational examples to spread fear. Avoiding these spaces is an act of self-care for trans people, because it actively disengages them from negative spaces where they will find nothing but hostility for their gender identity. Moreover, both Anna and M actively sought out their friends for comfort in their waiting time and much preferred to talk out their personal problems with their close friends, rather than people online.

This personal form of communication requires intimate trust between friends and depends on a base of validation. It proves successful to them as a coping mechanism by allowing them to discuss their problems and find help and understanding from their friends.

### 6.3.2 Positive Reactive Activities

There were many positive reactive responses to experiencing the time of waiting. Many shared their exasperation with others in conversation or expressed it in writing, alone. Although discussing waiting may not have brought a direct relief to its emotional impacts, sharing the experience gives an individual the opportunity for solidarity and validation of their unpleasant experience. Some gave voice to their pressing reaction to the waiting times in a safe setting, venting or moaning to their friends, as practiced by Dante and Thea. Others produced their emotions in different ways, for example by writing them down, demonstrated by Vicky and Chloe. Being given a voice to express these negative experiences, even privately, like Chloe did, gives a certain amount of direct or indirect relief for the emotions brought forth by the experience of waiting.

### 6.3.3 Negative Active Activities

Frank’s experience of seeking out romantic relationships stood out in particular as a negative action of coping with the wait for gender-affirming care. Frank sought out attachments with less that suitable partners, engaging in several relationships, all of which ended badly. He found that he would rather “be devastated and heartbroken” than focus on the waiting time.. Given the mental strain that is waiting for a medical transition, this is a proportionally distracting emotional state, while not being dissimilar to that, which he sought to displace. Converse to his approach, Frank recommended avoiding “unhealthy relationships”, recognising his previous behaviour, which he has since disengaged in, as potentially harmful. He also recommended healthy distractions to cope with distressing waiting, such as exercise or changing clothing. These are measures of self-care and dysphoria management that produce positive experiences for individuals, as shown in previous sections of this chapter.

### 6.3.4 Negative Reactive Activities

In terms of negative reactions to coping with the waiting times, participants voiced a range of behaviours. Distress is commonplace in waiting for gender-affirming care, as exposed by the previous chapter, and thus, naturally, some of the reactions were proportional to the distress experienced. Several commented that they would cry as a reaction to this distress, letting it pour over them and waiting it out. Others would experience depression, leading them to remain in bed and reclused from others; Vicky, for example, said that she would escape into her own head. Chloe described the need to leave social situations and withdraw away from her friends to contain the negative emotions to herself.

Some said they used alcohol or drugs to enter mental states that would not resemble, or even allow one to remember, the experience of waiting; a few commented that they experience self-harm tendencies. Siobhan used to use eating as a coping mechanism until her diet. These strategies would not have been deemed psychologically healthy forms of coping with distress. However, they are responses resembling reactions of other groups that experience an encroachment to their freedom, such as those incarcerated, or those in depressive states (Hawton et al., 2014; Goossens et al., 2009). Unsurprisingly, no participants offered these as viable coping strategies to those who are distressed by the waiting. I have categorised these as ‘negative’ as they are known to not be positively affective by those interviewed. They are not coping strategies as much as symptoms of distress at unresolved issues; in this case, the resolution required is the medical transition. Still, members of the community engage with them, particularly in instances where the future of transition seems most distant or precarious, with most being used at the start of one’s transition. Yet, Siobhan shows us, by engaging in drinking later in her transition, that it is the unavailability of gender-affirming care that moves individuals to negative and potentially harmful actions or distractions.

The mental health of individuals can be brought low at any time within the transition timeline due to the sense of powerlessness that waiting induces. These negative emotions can sometimes only be displaced in negative ways, via social withdrawal, bad romances, drink and drugs. These are the strategies of the powerless, commonplace in other socially vulnerable communities, such as among the homeless (Hawton et al., 2014), the impoverished and unemployed, populations who are not represented politically or who lack citizenship (Johnson, 1996). That poor or harmful coping strategies can be found along the transition timeline reveals the consistency of powerlessness experienced by trans people at the hands of sanctioned public healthcare. These strategies would not be necessary for some to turn to if care was provided in a timely manner, without excessive medicalisation that furthers societal out-casting.

### 6.4 Sharing Coping Strategies with Others

I asked interviewees how they would advise someone distressed by the waiting. Their answers suggested maintaining realistic hope, comfort in movement, and clarity of thought. These direct instructions of self-care aim to give hope, resilience, and courage in conviction, qualities these interviewees demonstrated having had to acquire along the process of waiting to cope with it. Together, these practices represent relinquishing the uncontrollable, i.e., the pace of care, and living presently in what can be self-created and ordered in the interim.

James C advised “don’t put too much hope on certain things”, suggesting maintaining a relative balance between desire and reality. They acknowledged in this the delays, the barriers, and the disappointments that go along with the waiting and are sometimes met at its end. However, it is rational to not expend all hope singularly as it is a factor of anticipation, a factor of the temporality of waiting (Pearce, 2016). If the anticipated result does not occur, then hope will be lost, the potentially fatal consequences of which cannot be afforded; therefore, hope should not be expended on a single pivotal transition point. Hope theorist Snyder (2002, p. 249) defined hope as “the perceived capacity to derive pathways to desired goals and motivate oneself via agency thinking to use those pathways”. By managing hope proportionately across goals, an individual can accumulate a reserve which will allow them to remain motivated in the face of disappointment; this reserve can then be used to seek help to manage one’s distress or to find an alternative route to a set transition goal.

Ruff, Smoyer and Breny (2019) find that transgender people may derive emotional power to progress through trans life’s challenges from a cycle of hope, courage, and resilience. Using resilience requires internal or external resources. Tomo advised that, even when hormones begin, the wait for their effects starts and a need to tolerate further waiting is required. They also recommended making use of “support groups, friends, memes, enjoy[ing] your life as much as you can” in the meantime. Tomo recognises that even at the end of waiting for care, hormone changes still take their own time. Internal resilience is required to wait for hormonal changes even after medication has begun. They recommend being tolerant of additional waiting and utilising sources of external resilience in the form of various support systems and taking joy from life’s interactions. Tolerating waiting can come from a mental mindset held by many trans people given by Chloe:

> I would advise them to, try to maintain a mindset that ... gender and sex are different. Like that’s like one of the main things that above all you have to either remind yourself or you need to almost distract yourself from general social understanding of it as being synonymous. (Chloe, 18, female)

Defining gender and sex separately can underpin gender validation, and it allowed Chloe to manage her dysphoria more effectively. This form of definition maintenance allows her to view herself as the correct gender, even without a physical transition or the need for medical validation. Courage in this conviction allows for validity in identity from within, which can be a source of resilience in the face of distressed waiting.

Vicky encouraged, “The fact you are living a life and people are affirming you as who you are is more important than what’s in your pants sometimes. Wise words from the Buddha”. She recommends finding affirmation and living in it, as did many others who found themselves in affirming friendship groups and recommended making use of affirming close relationships in times of distress. Mental and physical social activities, outside of transness, with affirming people, are important to Vicky, more so than surgical affirmation, in some instances. This needs to be keenly felt by those at the beginning of their transition and follows closely with CJ's recommendation to not feel overrun with the waiting.

CJ said, "I say to people to not let the wait rule their life". He also gave the positive thought to hold, "as long as you're on the waiting list you're getting somewhere". Waiting is a process that CJ understands must pass; he puts it into a perspective that is dynamic and forward moving. He lived his life in the same way, engaging consciously in his education at the time of interview, while also looking forward to his future and being able to see its progression. He was engaged with the passing of time and life outside of waiting. He was further conscious to not dwell on the waiting, but instead consciously shift focus to present needs or upcoming events that require planning. He was not alone in recommending events to look forward to in the meantime of waiting, which provide a positive anticipatory distraction.

James advised "realising that it has a definitive end" being important to coping with waiting. This is likely the most ungraspable notion to hold with conviction in the time of waiting due to the resources required. This requires hope, resilience, and courage, as there are many interruptions and obstacles possible in a transition pathway. In terms of accessing healthcare, these are extremely abstract concepts, though they are required to ensure the feasibility and manifestation of medical care. The demand of maintaining this and other efforts discussed here is inequitably placed on patients seeking gender-affirming healthcare in comparison to other healthcare services.

## Conclusion

In many instances, the literature guiding this chapter finds the individual well-positioned to act and to reach out to others, whose circumstances are similar, for connection and support. What is not acknowledged is the pressure already on these community members in terms of their own individual struggles. It is fortunate that many charitable groups, supporting trans people and allowing them to present whatever way they may wish, exist- but they are not spaces given to the community, they are spaces forged out of hope and community organisation, often at great personal cost. This cost is social and emotional, as well as financial; as the community is forced to care for its increasing number of members, it is ever more exhausted by the labour. Ever recommending that the community turn inwards, to itself, for support does not encourage wider trans social acceptance, nor does it encourage the acknowledgement of the social issued faced by these communities. Therefore, manifestations of care work in trans communities remain separate from legitimate forms of healthcare and the true nature of the skills of keeping each other afloat within these communities go unrecognised and unappreciated. This chapter has sought to recognise and appreciate these skills, created and applied by trans people to cope with their waiting times.

Coping with the waiting manifests in these interviewees, for the most part, as positive strategies geared towards progressing through transition. Social efforts are made to communicate with other trans people and build an understanding of the culture and medical process. In the absence of medical care, trans people make use of supplementary measures to alleviate their dysphoria, including clothing use, shapewear, and hormones obtained outside of sanctioned medical care. Naturally the effects of these coping mechanisms are positive, as they push individuals in the direction of their intended transition goals. The community has a deep sense of care for its members, with many recommending that others reach out for professional or social assistance where necessary to discuss issues.

Many positive strategies which aid towards functionality are presented in this chapter. These have positive consequences; many are referred to by their users as ‘solid advice’ to others in waiting management. These strategies often produce positive outcomes in coping with the waiting time by displacing one’s attention and giving, if only fleeting, relief. Interaction with the trans community, waiting aside, provides opportunities for online or physical communities or friendship groups to flourish. Comedic relief can also be found in certain spaces online in the form of memes, which appear to diffuse negative emotions through humour and experiences of powerlessness.

Active action to cope with the waiting experience also forms a sense of community; through discussion, similar experiences in others are found and bonds are formed on the basis of these commonalities. Some strategies are, from a medical perspective, more unhealthy measures with mostly neutral to negative experiential results, though those can vary. Strategy implementation does not follow a strict chronological pattern through the medical transition; they appear to be responsive to the perceived accessibility of future care in varying proportions.

Actions, and distractions particularly, took precedence in strategies used and advice given. Many had sensible, healthy, time-consuming distractions to reach for, such as short-term goals and events, or life’s other day-to-day activities. Others showed the darker side of waiting for gender-affirming care, which cannot go overlooked and which can be combatted with outside help. Without hope or resilience, a powerlessness, whose source is precarious or lacking care from sanctioned practices, as discussed in the previous chapters, remains, and results in reactions that may cause the trans individual harm.

The advice given by interviewees directly to other trans people experiencing the wait was to not expend all hope on one transitional point, to gather internal resilience which may come from external sources, to have courage in the cognition that validates one’s gender, to find affirmation, and live as well as possible beside the waiting until its end. This speaks to the community’s recognition of the fact that the medical transition may not follow an individual’s desired pathway. It acknowledges the internal strength required to sustain an existence during this time and the need for external pools of resources to be utilized at times. Great efforts are needed to hold enough power to progress through life’s activities; power that can be too easily removed when one is thrust into a temporality of waiting for gender-affirming care.

The interviewees' advice aligns with what has been revealed by the analysis in this chapter: while healthy, positive coping strategies may allow one's transition to feel more concrete, the strain caused by waiting means it is not always possible to employ these. In addition, I have found that the chronic mental health and wellbeing issues caused by extended waiting times are so overwhelming that even individuals who may, for a period of time, employ positive coping strategies, often turn to unhealthy ones as their transition remains motionless over time. Further research, building on this understanding of the value of specific coping strategies in the case of trans people awaiting healthcare, as well as the difficulties in implementing them in the context of extended waiting times, is necessary.

This chapter has briefly discussed the role of social media in providing humour and information to those waiting, as well as its use as a resource for the community in general. The following chapter explores the use of social media by trans people in greater detail in order to understand how the community can be aided by social media, both in the context of their sense of connectedness, and as a resource to manage the reality of the medical transition process.

## Chapter 7. Social media use during Waiting

This chapter investigates how social media is used by trans people to navigate their waiting time for gender-affirming care, and their transition more broadly, to address my final research question: How does trans social media use factor into transition management and waiting experience? The use of social media spaces within the trans community to understand and manage their waiting for gender-affirming healthcare in England specifically has yet to receive academic attention. Through this chapter I will use the term 'trans social media' to refer to spaces online where trans people can congregate and communicate, which are of great importance to those transitioning. Many interviewees in this research learned about the available gender healthcare systems and their waiting times using social media platforms. Trans social media research highlights practical advice, belongingness, and visions and experiences of possibility through watching others and taking part in community activities as key and beneficial outcomes of online community engagement (Cannon et al, 2017; Horak, 2014; Cipolletta, Votadoro & Faccio, 2017). This chapter applies those ideas to transition management, including its waiting time, and argues that it is also beneficial to some users to be a non-participant observer.

There are many social media spaces where trans people congregate for various purposes. These spaces can exist on the internet as stand-alone websites, such as Susan's Place, Empty Closets and the Beaumont Society[2], as well ast on hosting websites, as groups, forums, pages, blogs, and vlogs on websites such as

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[2] Websites such as these offer trans people free or paid membership to access forums and spaces to talk with other transgender people. Paid sites often have more resources and content output such as specialist advice, therapists, and magazines. For example, the Beaumont Society costs £35 per year to maintain a profile and for access to forums on the site to speak to other members, and a quarterly magazine. The Beaumont Society links news, events and helpful information on transitioning for free.

Facebook, Twitter, Tumblr, Reddit and YouTube. All these online spaces were used by interviewees in this research. These broad, accessible, evolving spaces provide trans people with communities in varying forms and sizes, where they can express their transness and document their transitions to share with others. The global scale of the internet means that trans people are not restricted by time or space in their relation to and communication with other trans people online. This feeling of simultaneous connectedness with the shared trans identity forms a sense of community that extends beyond the webpage and is internalised by users, as discussed in this chapter.

This chapter is formed of three distinct (but interlinked) parts. Each examines different ideas to inform a wider understanding of social media use by trans people. The first section reviews the interviewees' use of social media: what media they engage with and what they get out of it in relation to their healthcare and general well-being. I argue that there are many beneficial ways to utilise trans social media for the purpose of emotionally managing the waiting times. The variance in social media utilisation among interviewees appeared to be illustrative of their diverse needs and coping strategies. Some seek reassurance and connections with others while waiting, others keep to themselves and take what they need as non-participant observers. Some turn to comedic imagery, particularly memes, to cope with the temporal reality of waiting for gender-affirming care. The second part of this chapter concerns the documentation of transition, i.e., keeping a record of any transition-related changes over time. This begins with an investigation of why interviewees chose to document their transitions, followed by a review of what is gained from watching others transition. Finally, turning to community connectivity, I analyse the meaning of community connectedness to these participants and offer an alternative definition to Billard’s (2021) connectedness as a function of communicative interactions. Across these different interviews, there were participants who were selectively guarded against certain media, ideas, and community interaction. They carefully protected themselves and their interests by being selective and/or avoidant in their social media consumption, which is considered across the analyses.

## 7.1 Trans Social Media Use to Manage Waiting and Transitioning

All participants in my research described a discrete use of social media that was specific to trans people, including what they chose to put onto social media and what benefits they got out of it. The range of social media platforms for trans people offers varying degrees of privacy and security, both of which were taken advantage of broadly. This section is formed of three parts to reflect the broad ways in which interviewees used trans social media, which differed significantly. Some consumed information as lurkers[3], others were more socially and actively engaged and able to build strong friendships. The conflict between protecting one’s safety and privacy versus actively engaging in the community is one that several faced as they navigated the different areas of trans social media.

### 7.1.1 Active Engagement in Trans Social Media

When seeking advice and information on transitioning, many of my participants asked others questions on social media spaces. They did this to find information about the GICs, their waiting times, the time frames between stages of care, the

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[3] A lurker is an individual who reads but does not interact with online social spaces.

general process and surgeries. I asked Lewis what advice he tends to ask for on the private trans Facebook group he belongs to:

> [I]t has mostly been about waiting time actually. Um, at various stages just asking about waiting times…you can get a good amount of comments on a post so it's quite reassuring to have a lot of people comment and kind of getting a feel for different ranges, you can kind of see what the top limit seems to be what the bottom limit seems to be. Um, so here's like the average waiting time that it might be. (Lewis, 19, male)

Despite not getting a singular agreed timeframe for the wait, Lewis continued to find the information useful and reassuring because it was all truthful of the commenters' experiences and gave a perceivable limit to the waiting. Others also described using trans social media spaces to ask questions about the length of waiting times. Discovering the timeframes was informative and reassuring, as was knowing there were others sharing their experience, as was discussed in Chapter 6. Having this knowledge from others who are going through a similar process can work as a coping strategy to manage the waiting time; as Lewis said, useful limits can be found, as well as reassurance and solidarity. Dante, similarly, found Tumblr useful thanks to the available information about waiting times and how to move his transition onwards. However, this different social media platform relies on the user to search for existing information to find it, rather than ask other users in groups, as Lewis did using Facebook:

> [A] lot of these spaces have really good information about waiting times, what should I do if my GP doesn't want to do this, what should I do, you know all this kind of stuff I find really helpful coz um, just it's nice to have all that information handy. (Dante, 19, male)

Knowing how to navigate the gender care system and how long that might take was relevant to other interviewees in their social media use, and is emphasised again in the next section. Importantly, Lewis directly asked for help, while Dante sought information from an already existing source; there are multiple options of active social media use available to obtain the same information. These are just two ways in which one can get an understanding of the waiting times through trans social media. The spaces available to ask a specific question on waiting times, or search for an existing answer on the same, increases each time this question is asked on a social media platform. Questions like these then create space for many detailed answers, which may help other users seeking responses to similar questions who happen upon the post; common experiences can be quickly collected. While widescale interaction is possible, those who would rather find existing answers without interacting with others also have that choice.

Cipolletta, Votadoro and Faccio (2017) show that seeking advice is a motivator for joining an online community. While neither Dante nor Lewis involved themselves in online communities on a personal or intimate basis, others did use social media for emotional support, empathy, and to build friendships. Chris was able to build friendships with those he socialised with in trans groups on Facebook. He emphasised that it was helpful to connect with people and share the struggle of waiting. He found it particularly useful to talk to someone who was in the same stage of transition as himself:

> [W]e are in exactly the same position with waiting times. Um, we’ve both gone through the [youth clinic]route, both now getting referred to [CLINIC] and I think that um, being so similar with our waiting times and in our um positioning with our medical transition I think um, yeah it’s, it’s made it easier to talk to each other um, about personal yeah struggles. Because we

> see it from, from different perspectives I think being able to talk about that is really helpful. (Chris, 18, male)

The sharing of similar experiences produces solidarity, care, and can result in strong friendships like Chris had, which is reflective of Cipolletta, Votadoro and Faccio's (2017) findings; online help in the form of giving and receiving experiences and advice can provide users with social relationships. Occupying the same waiting time with others online in this close way made the waiting more manageable because Chris was conscious that his experience was shared, a feeling echoed by many others in interviews. Thea found a small group of people to communicate with online and described how she was able to find solace and reassurance from them as she progressed through her transition:

> [I]t started off with advice like you know how do I do this, what should I do, what's the best thing to do, what should I expect? That kind of thing. Um then it went on to like, the support like I'm really not doing well, help! Then other people are just like me neither help me. And it's just like you, you end up like a little family just helping each other out. Um which I really enjoy coz it was like you know, again it was like feeling like you're not alone. Feeling like you're not worthless coz you are with other people in the same boat. Um and then after the like advice and support it went onto reassurance as it were. It's just like is this meant to be happening or why hasn't this happened yet, or will this happen? (Thea, 24, female)

Finding others who share her experiences was crucial to Thea, even despite them not always being able to help her current situation. They could, however, empathise with her and reassure her that she was progressing through the slow changes of hormone replacement therapy as she should, helping her manage her worries. They gave her care in the form of love, friendship, and affirmation. Others commented that knowing they are not alone in the waiting process can be sufficiently reassuring to withstand some of the distressing effects of waiting and transitioning. The notion of shared experience as care, described by Hines (2007), emerges strongly here. Sharing the experiences of changes over time with each other serves as care, within Thea’s friendship group, as well as the wider trans community.

Quite distinct from the experiences shared above, was Tomo’s use of social media to make use of voice training videos:

> I have watched um how to, like lot of voice training things done by trans women. I’ve consumed a not inconsiderable amount of those and those are hosted by trans women. (Tomo, 19, nonbinary trans-feminine)

While Tomo did make other uses of social media, such as Reddit, they were the only one of this group of transgender people to mention using YouTube for the purpose of voice coaching. The availability of voice training videos on YouTube designed for transgender people is ever increasing as more trans people share their tips from their own formal voice training, and as vocal trainers produce free-to-view videos on the subject. They present an excellent way of removing years of the waiting time of accessing vocal therapy which is available by referral from a GIC and which has a waiting list of its own. This appears to be the first instance of navigating this form of trans healthcare using social media in research. This is an extremely resourceful use of YouTube’s vast content and shows trans social media as a form of trans healthcare.

While the above extracts from interviews show how waiting for gender-affirming care may be navigated using social media sites, others used trans social media for its socialising purpose. Jessica made use of the Beaumont Society, a website for trans people, which requires a paid membership, at the beginning of her transition. While it provided a safe space for her to find information and to talk with other trans people, she found its focus on a full medical transition as the expected goal somewhat overbearing. She made a friend local to herself who she continued to meet with in person after exploring other online social options, using the site as a springboard, as described by De Koster (2010), to enhance her community involvement offline. She moved to Facebook and created a LGBT social group which targeted her local geographic area, as there were none near to her hometown. She used this space to socialise and build local friendships, as well as receive and give support to others.

Siobhan’s involvement with her local online trans community was similarly, actively connective like Jessica’s, but on the scale of her city. She was keen to use her social media to bring local trans people together for physical meet ups and activities, as well as trans news, projects, and campaigns on the online “City” Trans spaces. Not only did she enhance her own experiences offline, but also those of others in her local vicinity. She accomplished this by finding them on different social media platforms used by “City” Trans and giving them the opportunity to gather in a physical space. Billard’s (2021) model according to which more social media involvement corresponds to more civic participation is true for Siobhan; she liked to find other trans people on the internet with whom she could discuss the anger she felt about the neglected state of trans healthcare. The model, however, does not account for increasing others’ participation, which Siobhan successfully did by engaging others in projects and campaigns. These positive influences on others spread liberation, empathy, and friendship across the community, and the community often relies on those who, like Siobhan and Jessica, are skilled and resilient enough to be a source of support.

Siobhan and Jessica’s online involvement leading to offline group activities show how crucial social media is as a tool of connection for trans people. The energy and action put in by these two interviewees gave physical life and space to trans people where those did not exist before. Creating and occupying online space in this way allows more interconnected communities to be created and to bridge the online/offline gap. Bringing others in, as Siobhan and Jessica did, based on shared identity and potential for future shared experiences, allowed both to feel wholesomely connected to their communities.

These have been the novel and interesting ways that these interviewees purposefully engaged with trans-focused social media. They connected with the trans community to understand and navigate their waiting and wider transition needs, as well as for the sake of community connectedness. Their uses of social media are as varied and multiple as these interviewees are different from each other. For most of the interviewees, finding others who know about the waiting gives not only the knowledge of time, but also a sense of solidarity. They described the different forms of care that can be received through the use of trans social media; trans healthcare in the form of voice coaching can be found, which removes years of medical waiting and can remove the need for medical care. This highlights the closeness of the community, and the understanding between its members that healthcare is required more quickly than the medical profession allows. Some care so much about the wellbeing of others that they provide care freely to strangers who would otherwise be faced with years of waiting and, potentially, financial expense. The following section presents how social media was used at more of a distance by interviewees, and the purpose and results of that kind of application of it.

### 7.1.2 Vicarious and Indirect Trans Social Media Use

While the participants discussed above preferred to interact with others on social media in their quests for knowledge, solidarity, and other trans related assistance, others preferred to use social media in a more distanced and vicarious manner. There was some overlap with individuals who actively interacted with others and consumed information without active engagement and participation at the same time. Others behaved as lurkers and simply consumed media related to transness and transitioning. The benefits of interacting with trans social media in this way remain similar to those found in active interaction: solidarity, reassurance, and affirmation. However, the benefits are received differently- absorbed vicariously, rather than given directly by others. Trans people can be observed interacting in trans social media spaces, discussing their individual lives and more political, national, or global issues. As some interviewees noted, having such a broad variety of spaces available makes it possible to cultivate a space online that is secure and beneficial for their mental health.

Tomo and Frank both followed trans people on Instagram to see their own pictures and their content. They described what interested them:

> I follow a lot of um, like trans, non-binary, androgyne people on there. Although um it’s not particularly a community so much as again like with *reddit* I just consume their content um, coz they’re all so pretty, um and they make such good memes (Tomo, 19, nonbinary trans-feminine)

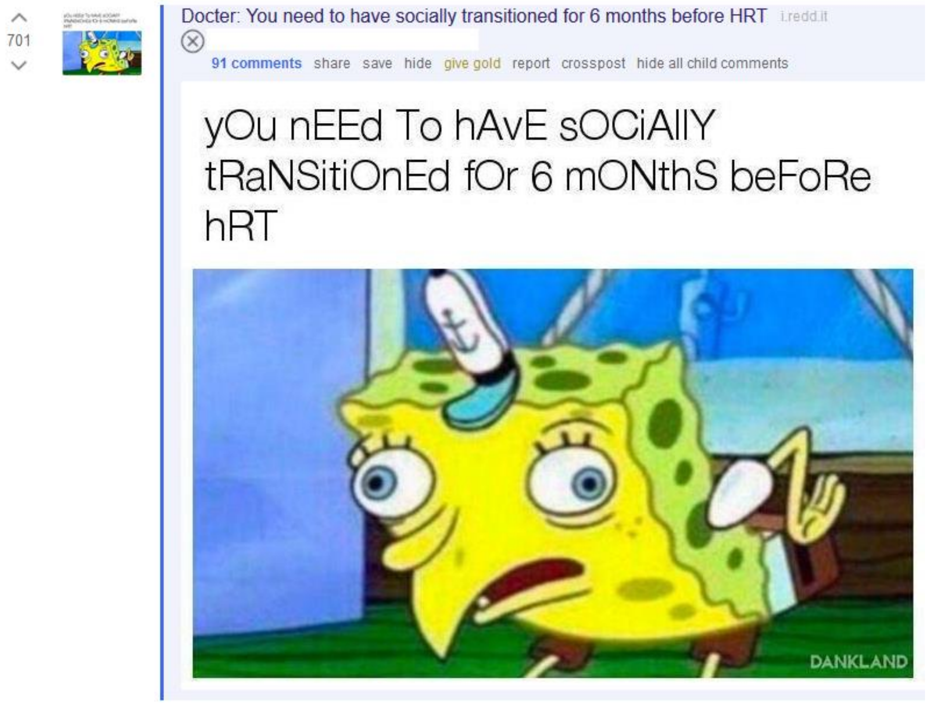
> Instagram is just seeing pictures of pretty trans people. But also like uh there’s one that’s called trans and topless or something

> so it shows off like scars and stuff so that interests me, well, just to see that kind of stuff (Frank, 20, FtM)

Both expressed an interest in seeing ‘pretty’ trans people. An interest in trans culture in this way separates transness from medicine and allows trans people to feel a part of something more than suffering the waiting times. This resonates with Pitts-Taylor (2020) who discusses how taking part in trans activities that are not medical unhinges the control of medicine on transition. This is an easy way to consume trans social media as Instagram personalities can be followed with a click and will appear in the users feed along with the others they follow effortlessly. The updates and content particularly helped Tomo, seeing others do well and enjoy themselves brought them vicarious joy.

The comedy value elicited from some of the memes Tomo came across on Reddit give rise to great amusement and are enjoyed broadly. Figure 1. shows 701 people have upvoted this image which makes fun of gender clinicians requiring real life experience in order to access treatment, an outdated practice which nonetheless continues to be used. This mockery, which includes the seemingly intentional misspelling of doctor, gives comedic relief to those enduring the strain of waiting for healthcare by reducing this problematic medical practice to cartoonish silliness.

Figure 1.



Docter: You need to have socially transitioned for 6 months before HRT

yOu nEEd To hAvE sOCiAllY tRaNSitiOnEd fOr 6 mONthS beFoRe hRT

SpongeBob Meme

Referential memes such as the SpongeBob meme (Figure 1.) and the Free Trial meme (Figure 2.) proved the most popular among voters. Tomo surmised that this was due to the irony the meme presented in general, while not neglecting the situation. Figure 3. shows an expression of anger through this Angry meme to show the creators’ exasperation at others’ attitude to waiting times, which remains popular to trans viewers. However, Figure 2 was upvoted far more than Figure 3, signifying a greater humour interest associated with increasing frustration of the unavailability of gender-affirming care than to problematic threatening tendencies to the same.

Figure 2.

1417

Me, trying to access gender therapy in the UK i.redd.it

47 comments share save hide give gold report crosspost hide all child comments

**imsoofuckingsad**

30 day free trial of being ok

**milkchocolateowl**

op wheres the link

**milkchocolateowl**

**wheres the link op**

Free Trial Meme

Figure 3.

When someone tells you waiting 2 years for hormones is good for "clearing your head"

Angry Meme

Siobhan’s interest in trans culture of art and modelling on Instagram allowed her to consume positive trans social media suitable for her, and separately from her interactive use discussed above. She favoured this form of media consumption, rather than general trans positivity posts, as it allowed her to see trans people being able to do something creative with their queerness:

> I follow a lot of artists and trans models and like personalities … it’s nice even if you’re having a day where you can’t get out of bed … at least you can go on Instagram and see that. And (sigh) not only that the world is still turning coz that’s not necessarily important or helpful at that time, but that trans people are still killing it and doing really well. Um, and you know seeing who who’s got the latest, uh you know expensive well-known brand modelling job or whatever. (Siobhan, 30, trans feminine)

This is not only a form of social media use, but a coping mechanism for depressive episodes associated with being trans, which is covered in more detail in Chapter 6 on Coping. To see trans people continuing with their lives and being successful while doing it was enough to raise Siobhan's spirits. She could follow and feel trans time as she watched others; the images and news of other trans peoples' successes on social media could brighten her bad day. She went on to say that being able to see intercommunity care in the online community helped her vicariously by showing her trans people continuing to fiercely care for each other despite their circumstances and distance. The joy that she was offered by those online was of great importance and cannot be understated. It is even more important to note that she did not have to communicate with these people to experience an affiliation with their joy. Vicarious care emerges from the sharing of good news from within the community and seeing care within the community. It is a product that can be absorbed without interacting with anyone and is valuable, particularly to those who may struggle to reach out for help or simply do not wish to interact with others.

As an introvert, Nathaniel described his use of social media as one that was not overly social, which was reflective of his personality. His form of trans social media use allowed him to learn and be supported within the community space online. He preferred to consult already existing posts within trans groups on Facebook to gain information, rather than to interact with others. He made use of the transgender image website TransBucket[4] to inform himself about top surgery outcomes by different surgeons. He also watched YouTube videos of others progressing through their transitions, which he found vicariously supportive. Nathaniel is a classic lurker, and a very successful one, as he was able to gain the exact information he wanted without unnecessary interaction. I discuss Nathaniel's use of others' documentations

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[4] At the time of writing, the website TransBucket is closed due to a media incident. It currently runs as a group on Facebook. It aims to share trans medical and health information and images.

later in this chapter and further demonstrate the emotional benefits he got from watching other trans people.

The experiences of these interviewees have shown that wellbeing can be found in comical trans spaces, as well as spaces that show trans people living their beautiful day-to-day lives. As the analysis conducted so far reveals, it is not necessary to interact actively with, nor participate in, the trans community in order to reap its benefits. Nathaniel shows that beyond the ability to acquire information passively, there is no need to engage in a verbal exchange to receive community support online. Having presented the possible benefits of active and passive use of trans-specific social media spaces, I will consider those interviewees who avoid using certain trans social media spaces in the next section.

### 7.1.3 Avoidant Trans Social Media Use and Avoiding Trans Social Media

Reflective of her personality as a self-described introvert, Chloe preferred to remain at a certain distance to the trans community online. She did this by following global and national discussions about transgender issues, rather than specific individuals, on Twitter. She was conscious of the dangers of parasocial relationships[5] and the danger of harassment online, which is why she avoided using more social media groups and spaces. While Woznicki et al. (2020) found that parasocial relationships with online personalities can be beneficial to the mental health of LGBQ youth with little family support, older literature views living vicariously through others as a symptom of depression (Wetzel, 1994). This difference in emotional reactions to others' transitions can simply be explained by one's individual personality, as was

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[5] A parasocial relationship is a one-sided relationship of attachment that can occur from watching a person, celebrity, or media personality. The subject of attachment may be aware of a fan base, however does not know of or return personal feelings.

the case with Chloe. Rather than having close bonds with the community she finds herself educated on the issues affecting the community and avoids various harassments:

> [A]gain that level of keeping it distant and not being at risk personally while online is something that I am very conscious of. Obviously, a lot of people online are always talking about how harassment is very, very common, how a lot of people are getting sent dick pics and all that kind of horrible stuff and threats of like harm or murder and obviously I don't want that. I also do want to feel like I am aware of what is affecting the community. And I think on twitter that's probably the best way of doing it. (Chloe, 19, female)

While Chloe described avoiding interacting in specific spaces, Anna described strategically avoiding certain areas of social media. Anna explained that was implementing a strategic avoidance of social media spaces where gender was treated as a concept for philosophical debate. Anna found, after some exploration, that she was not feeling well after engaging with spaces where gender was treated as a concept for philosophical debate, such as trans medicalist or select feminist spaces invalidating of trans identities. She also avoided watching or reading trans content which she found problematic. This action was important to her mental health as she was conscious that she was beginning to internalise the negativity other trans people were emitting:

> I decided to like tune out of those sort of areas. Like just because um, I wanted to prioritise like my mental health over any kind of debate at least for the time being. So, so there aren't like websites I avoid, just like particular sections. Oh and another example is like there was a trans woman on YouTube who I liked and she also started saying things that were a little like, disagreeable or problematic so I just sort of like avoid them for personal reasons really because I don't want to end up internalising those sort of ideas and being too hard, harsh on myself. (Anna, 19, Girl)

Anna alternatively used Twitter where she could follow trans people living happy and transitioned lives which she described as good for her mental health, as well as showing the value of role models such as described in Gorman et al's (2020) work on upward social comparisons. In implementing boundaries for herself she was able to focus on her own thoughts and opinions. These boundaries and adjustments she self-imposed are distinct from Cannon et al's (2017) boundaries of protection from being seen, such as privacy settings and anonymity. Instead of protecting herself from personal invasion, she sought to protect her mental health by guarding against what she knew to have a damaging effect on her.

### Social Media Use Summary

These forms of using trans social media presented above have allowed these interviewees to make use of the broad range of media available while considering their immediate and imminent needs, their personalities, and due regards for their own well-being and safety. I have demonstrated that active interaction with others on social media has had many benefits for these individuals because it created a space in which they can discuss and manage the pressures associated with waiting and transitioning. I also argue that it is not necessary to communicate directly with others to gain knowledge and support from the trans community. The following section analyses the ways in which the public and private documentation of their own or others' transitions is performed and consumed, and its effects on interviewees waiting for gender-affirming care.

## 7.2 Documentation of Transition: Consumption and Production

The plethora of social media sites and their various content modalities enables trans people to document their transitions, publicly and privately, in abundant ways. These forms allow the motion of transition to be recorded, edited and produced by trans people themselves, framed in whatever way they desire. As Horak (2014) demonstrated, hormone time can be carefully choreographed to appear as a smooth change over several minutes or staggered in the form of updates in a periodic manner; either allows the viewer a sense of the possibility of change. Other research on trans people who document their transition found individual empowerment can be achieved through watching others experience changes from testosterone (Raun, 2015). Researchers have, so far, not asked trans people how they feel about watching other trans people documenting their transitions. Documentation, for the purpose of this thesis, includes recording any kind of change about a person's transgender status or transition, publicly or privately, as those described in local research. This includes social and legal changes that affect the individuals, as well as corporeal and emotional changes they experience. This section will be formed of two parts; one examining the interviewees' use of others' documentations, and one which considers their own methods of documenting their transitions.

### 7.2.1 Consuming the Documentation Media of Others

Some interviewees' experiences can be made sense of with Horak's (2014) analysis that watching documentations of others' transitions on social media allows them to know change is possible over time and their own potential future is not abstract. Alex drew particular reference to the onwards moving of time, commenting that watching these videos helped him see that the processes of change were not "static". Similarly, Thea watched others to see time unfold for them and to take comfort in the fact that time would do the same for her. The promises of futurity are given to many who watch these videos, as well as the promise of hope. For some, these documentations of others' transitions allow them to connect with the potential of the movement and unfolding of transition. It reinforces their knowledge that their own waiting will have an end and that changes are to come.

The ability to relate to others' experiences was also particularly important for several interviewees. Those who followed YouTubers were able to make sense of their emotions by listening to others talk about theirs. Nathaniel had followed Alex Bertie's[6] transition on YouTube and was able to understand himself better and see that transition was, in fact, possible:

> [A] lot of the time people put into words things that I was feeling but didn't know how to express and couldn't figure out how to word it or understand, didn't even understand why I was feeling certain ways so it, it helped me to realise things, more quickly than if I'd just been left to think about it myself … I think if there wasn't kind of YouTube I don't think I ever would of sort of seen that it's possible to transition. Like I always knew I was trans, but like I think like watching Alex Bertie kind of made it more real and like, I think, yeah like that that I had this like moment of both like euphoria coz I realised what I need to do. (Nathaniel, 22, male)

Others also commented that they were able to relate to the emotions of others, which helped them negotiate and word how they felt about themselves. Dante further commented that documentations were useful for educational purposes and Chris agreed, also finding them reassuring that the possibility of transition is open to him. Interestingly, Kye found transition videos entertaining over and above informational:

> I think it's like good to watch like how much of a difference it does make. But for me it's not like wow I need to do that like, kind of thing, it's more entertaining than it is informative when they document their change. (Kye, 18, trans male)

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[6] Alex Bertie (born in 1995) is a transgender man who has publicly documented his transition online. He is a graphic designer and author of the book Trans Mission: My Quest to a Beard. He has hundreds of thousands of followers on his YouTube channel and tens of thousands following him on Twitter and Instagram.

This is reflective of Kye’s personal connection to the trans community, which was distant but not avoidant. He later described being uninterested in community activity and not orientated in general towards the LGBT community, as it fell outside of his interests. However, most others were quite positive about watching other people’s transition documentations in their various forms, though individual differences based on personality should not be overlooked, as these nuances inform a wider understanding of social media use by trans people. As it is quite well examined in local literature what benefits abound from watching documentations, it is now interesting to turn to the reasons why trans people may not watch others document their transitions.

Two interviewees were quite clear that they avoided watching or following documentations of other people’s transitions on social media. Tomo described how they had keenly followed trans American YouTuber Natalie Wynn, a philosophical and political commentator, who hosts the active channel ContraPoints. Tomo explains why they stopped following her videos as she started making visible progresses through her transition:

> Coz with like each video obviously she goes further into transition and her speaking voice becomes better, you know, from, you know, pre transition from being masculine to now where it’s utterly passable and she’s physically beautiful with excellent make up and lighting and production and all the related things so… despite the good grace of the good content I can’t watch them now. Like because I just feel so like, like, I guess it is jealousy, but I don’t know. Mmm I don’t know what the precise word is, coz obviously I’d love to be in that position but uh, I guess we’ll have to settle for jealously unless you can read minds. (Tomo, 19, nonbinary trans-feminine)

Oliver found it similarly difficult to pinpoint a word to describe their unsettling emotional reaction to watching documentations of others transitions, he explained avoiding them:

> Oliver: Um I try to avoid uh watching I mean I can listen to people talking about their transition but when it comes to like watching a like an actual timeline or like I don't know why I just can't do it. It's like even watching like seeing pictures of people with top surgery like just seeing the scars sometimes is just like I don't know. I think yeah just makes me more dysphoric I think (laugh)
>
> Sam: Yeah I was guna say like
>
> O: like
>
> S: you look like this is an uncomfortable zone
>
> O: yeah, on Queer Eye, you know the trans episode I don't know if you've seen that?
>
> S: Yeah, I did see that.
>
> O: at the beginning of the episode it just starts with um, the candidate just getting top surgery that's like I mean you don't see anything, but you know he's getting top surgery. And I had to stop, and I don't know why I just started crying when I saw it coz like I can't watch, I don't know I can listen to people talking about it, but watching it I can't, I don't, I don't know why I just can't do it.
>
> S: would you hazard a guess as to why?
>
> O: I mean I'm guessing its dysphoria but, I don't know. just also sometimes thinking about trans things makes me really um, not just sad but like I don't know just upset in general. (Oliver, 20, male)

Watching other's progressing through their transitions is clearly very distressing for Oliver, as it was for Tomo, which is not in line with any of the literature discussed in this chapter. Oliver supposed this response was dysphoria based while Tomo considered it to be jealously based. Both struggled to put into words how this felt, which was interesting because Tomo's vocabulary was quite extensive, and Oliver's command of English was fluent. Considering they were both in positions very early in their transitions without confirmation that they would be eventually seen at their chosen clinic, it is possible that this was an image of the future too far away and so ungraspable to give a single word for. It is certainly extremely upsetting for Oliver and Tomo to be faced with being so behind the time of those who can document their transitions. These cases are distinctly contrary to the promise of time unfolding (Horak, 2014) and to the potential of empowerment (Raun, 2015).

Those who can document their transitions have already passed barriers of time that Tomo and Oliver cannot yet see for themselves as possible. This unofficial state of effective transitional limbo combined with watching others progressing through their transitions is too much dissonance to bear. It is not helpful to see others move forward, instead it serves to remind them that they have not moved and do not have the means to. These two interviewees show that strategic avoidance is used on this form of social media to manage their dysphoria and jealousy. In not watching others transition they save themselves some potential of being reminded that they are still waiting.

This section has considered the ways in which watching documentation of others transition can be useful, in agreement with previous literature. It has also analysed why some feel unable to watch documentation of others' transitions, which is a new contribution to the field and is significantly different from the promises of forward motion commonly attributed to this form of social media use. This is significant because these two individuals in particular do not have the solidified knowledge that they are on the way to their transitions; perhaps being without this firm footing means they cannot find hope of the forward motion in time as shown by others, only despair at not being there. With this background in how others' documentations may or may not be used, the following section will analyse the personal documentation practices of the interviewees.

### 7.2.2 Interviewees Own Documentation Practices

I asked all the interviewees whether they were at the time of the interview or would document their transition in some form, since this area has not been focused on in wider research. Other studies have neglected to ask why trans people document their transitions, with their main subject matter being the benefits of consuming, not creating, these digital archives. This section, in an attempt to compensate for this lack of research, is investigative rather than analytical. Of the interviewees, James and Frank documented their transitions publicly. James hosts a YouTube channel and Frank ran a blog that he began shortly before commencing HRT:

> [I]t started as a little blog to help people understand almost like the politics of trans I guess it was, not the politics but like get their head round it um and then it was also to track my transition. So, every month for a year I did an update on testosterone, uh I did a voice comparison for 12 months as well. Um and then any sort of issues that people would ask me to write about or that I could think of like how, like using bathrooms and passing and different types of dysphoria (Frank, 20, FtM)

I asked him his motivations for creating a blog that others could take information from, as the content he described was both personal, in terms of his transition-related content, and highly time- and energy-consuming, for the latter topics. It seems he created content for most audiences but tailored some towards a cisgender gaze. This was to account for cisgender individuals' lack of knowledge in the hope of taking the pressure of prying questions away from other trans people:

> I realised that nobody really knows and I, instead of repeating it … if I was 100% honest they would know it and they wouldn't have to delve any further so like, and also so people don't have to feel awkward because obviously people want to know things but they don't outwardly want to ask it because it is rude. Um uh so yeah just to help people understand so that I didn't have to keep dealing with it. And also, I felt like if I have to deal with it the people who are way less fortunate than I am in my social circle have to deal with it in a way more negative way, so at least then people can read it from somebody who's comfortable talking about it or more comfortable talking about it. So, I felt that I would be saving other people hopefully the hassle (laughs).

This altruistic quality in Frank was also reflected in James, who started his YouTube channel to fill the space created by the lack of UK-based representations of transitions:

> I've always documented my transition. I started a YouTube channel pretty much just to document my transition and like UK perspective. Coz like 7 years ago there was like pretty much nothing about transition in the UK. Um and I still do, like I dunno nothing changes any more but like still talking about it. Less so documentation and more just like experiences, sharing like experiences and stuff. But like I really did document it like hard core at the beginning. And I have like way more stuff like privately documented than publicly (James, 24, male)

His content has changed overtime to reflect less happening in his transition and more happening in his life. Aside from his public YouTube channel, he also kept further photos, which he indicated covered most of his bodily changes over time and vocal changes. He enjoyed having these updates to look back on for reassurance that he had changed when he felt like he had not. It is difficult to see the effects of hormones in oneself: the changes are subtle and slow. James sought the reassurance that the time he had spent waiting for the effects to take place had not been wasted. Change over time was his desire and he was able to see that reflected in his public and private documentation.

Like Frank, James had a limit of what he shared with others and had clear boundaries regarding how much information he would share on certain topics. Privacy was highly valued by many of the interviewees and some only wanted certain audiences to view the documentation of their transition. Alex and CJ both made use of privacy settings on different sites to ensure that their viewership would only be trans people or select people that had been granted permissions. Both were conscious that they wanted their contributions to be useful to the trans community only, which differs from James' and Frank's more open use. CJ was content to post his top surgery healing process online to show other trans people, however, he would only share voice recordings with a close friend to make fun of himself and would not want others hearing them.

Others kept private documentations of their changes over time, including voice updates, photographs, and written commentaries. While these do, of course, provide valuable insight into trans people's experiences, they have been sufficiently researched previously. I took interest in those who had not previously documented, nor intended to document, their transitions. Vicky was conscious that others would share images of themselves but explained it would not be in accordance with her personality to have done the same:

> I wouldn't do that. And also, I've never documented like in a blog or anything like that. I've never felt the need to do that. and I don't, yeah, I'm not meticulous enough to go I'm going to take a photograph of myself once a month and do the same thing and see how I've changed. My brains not organised enough for that (Vicky, 54, female)

Dissimilarly, Chloe did not find it necessary to document her transition because she felt she did not have enough self-certainty or knowledge to provide others with meaningful transitional information:

> I don’t feel enough certainty about what I’m experiencing in specifics to feel able to properly talk to other people about it in a public situation yet… I just don’t feel like I’m an authority on that kind of information that should be listened to, there are a lot more people who have more knowledge who know what they’re saying a lot more in depth than I do (Chloe, 19, female)

Chloe’s and Vicky’s explanations of why neither of them would document their transitions were quite different. Marcy, again, was singular in her explanation of why she would consciously not document her transition when I asked if she planned to:

> I do not. Mostly out of the fear really of sort of, this, being able to see the shear lack of progress and not, yeah maybe it’s not strictly that lack of progress it may be just some anxiety. I definitely don’t want that to be a public record of any sort, it’s another level that I definitely don’t want to touch or get into… it’s right now a bit of an over complication and not exactly within the scope of my transition if that makes sense. (Marcy, 18, demi-girl)

Marcy’s reasons for not documenting her transition were multiple. Between the fear or anxiety of not seeing progress, wanting to maintain her privacy, and finding it to be beyond what she needs for her transition, she was quite put off by the idea. Marcy was also not particularly keen on watching others’ documentations; similarly to Chloe’s consciousness of parasocial relationships, she did not want to live in this vicarious way, which is quite a different reasoning for avoidance compared to others discussed earlier in this chapter. While concern for privacy is known to factor into safe social media use (Cannon, 2017; Horak, 2014), the other reasons that Chloe and Marcy present appear novel when it comes to avoiding trans social media. Marcy used others’ videos for information only, rather than to watch transitional differences, describing those who documented the end of their transitions as not useful to her. She was conscious to not follow documenters when they did not contain information relevant to her owntransition:

> [S]ince I can't really learn anything about it sort of I don't want to be sort of living vicariously through them either. That just seems a bit aimless and not really what I want to be doing or it's not healthy, put it that way. (Marcy, 18, demi-girl)

Marcy and Chloe differed significantly from those who benefitted from watching others transition or those who would document their own transitions. Their difference is interesting against a backdrop of research showing promises of futurity and change. For Marcy and Chloe, documentations do not bring these promises; instead, they have potential risks to themselves, both in seeing and creating them. Through their selective avoidance of some spaces, and conscious choices of others, social media was used to protect their mental health. These are more boundaries that trans people use to protect themselves, a fresh addition to literature such as Cannon et al's (2017) to demonstrate the breadth of online avoidance strategies implemented by trans people for their well-being.

### Summary of Digital Documentation Use and Creation

Documentation of transitions were used widely by interviewees to affirm the possibility of transition, and the fact that time *will* unfold during their transition. However, for a few interviewees, these videos are a source of jealousy and dysphoria, a reminder of the seeming stagnancy of their position in waiting for gender-affirming care. The interviewees who documented their transitions publicly did so seemingly as an altruistic act for the trans community, making their documentations widely available. They created content to fill spaces in knowledge, in general or for specific questions. These documentations were also used by their makers to reflect on their own changes through time. However, there are those who do not document their transitions and do not follow the progress of others for interesting reasons, these are a novel contribution to the field of transgender social media use. The next and final section of this chapter will analyse community connectivity felt by these interviewees.

## 7.3 Online Trans Community Connectivity

Online community connectivity is, rather vaguely, described in previous research as a function of network activity; as activity increases, so does community connectivity (Billard, 2021). I asked interviewees about their experience of online community connectedness, aiming to gain an understanding of how trans people understand their online connectedness to each other, and the meaning that the connection holds to them. Following presenting these data, I will analyse what meaning they hold for these interviewees and what is gained from these forms of connectedness. Experiences of online community connectedness in this research fell into three distinct categories.

I identified the first category of connectedness as *directly connected* to indicate several interviewees interacting regularly with other users. Alex described he felt very connected by virtue of having trans-related media attached to all his social media. Together with some trans men he met on Instagram, he worked to keep other trans men informed of new products relevant to them, such as good quality chest binders sold in the UK. His team also shared their transition updates for the information of others. Alex’s experience of connectedness was formed by caring for the community in this way and receiving feedback or questions. Connectedness, for

Alex, is the sharing experiences and knowledge with and taking the time to care for the community. James felt similarly, though not quite as personally, connected to the community. When referring to his place in the online trans community, James described himself as “there”. Alex and James’s differences highlight their individual differences, as well as reflect their forms of sharing information online with others, Alex is more interactive with others than James, though James’ YouTube channel contained a lot of videos designed to help others care for themselves while transitioning. Others reflected that they felt positive within trans community spaces; James C felt they could freely express their gender identity within these spaces and Jessica felt she had only had positive experiences with trans people. These in-group experiences offer them a sense of safety and belonging, as described by participants of De Koster’s (2010) research. Others who fell into this category described feelings of connectivity increasing as a function of their interaction with others, qualitatively, in line with Billard’s (2021) assumptions. Indeed, some reflection of Sherman et al’s (2020) proposal that connectedness is based on emotional and behavioural attachments to the community was evident in these interviewees’ experiences. However, as will now follow, it is not necessary to communicate directly with others within the community to feel well connected.

Belonging is not only received from direct interaction, as the second category of *allied connectedness* revealed. Tomo explained that they felt “allied” to the trans and non-binary communities from occupying the same spaces as those others. Chloe and Cayla concurred, feeling connected to the community by virtue of shared content. Nathaniel expressed this category most clearly, as a person who took a back seat in community activity, saying, “I feel connected to the community without actually doing that much to be part of it”. This category shows that community connectedness can be quite effortless for some, a by-product of sharing space and media with others. These interviewees found their connection to the community comes without conditions; there is nothing they feel they must do to belong to and in the places they occupy.

The final category described interviewees who did not feel connected to the online community, despite having a choice of online trans spaces. Kye and Dante described themselves as not connected to the online community. Kye, as previously mentioned, did not feel a great need to associate with the wider LGBT community outside of casual friendships. This was a conscious choice of Kye's, as he did not wish to be involved in any public or political events of activism. Dante felt he was not connected to the online community because he did not use those spaces often. He preferred the physical company of others instead, describing his friendship to trans people in a similar position of waiting for a medical transition as his community connectedness. The personal preferences of individuals again explain why some trans people chose to not use community spaces despite their availability.

These three categories identified in the data pose interesting and contradicting understandings of what it means to these trans people to be connected to the trans community, specifically online. Some do feel connected as a function of direct, personal contact with other trans people, and others feel directly connected by virtue of their presence online. A great sense of warmth came from participants who described themselves as closely connected to the online community, a sensation more intense and intricate than how other literature describes belongingness. Counterintuitively and contrarily to prior research, some do not need direct or observable interactions with other trans people to feel well connected to the community. The sensation of connectedness comes effortlessly to some, for various reasons. For some, it is simply a function of occupying the same space as others or consuming their content without entering themselves into the communication; for others, the media they interact with is connection enough to feel a meaningful bond. Finally, for some interviewees, a lasting sense of attachment or connectedness never forms, despite their observable interactions and communication with the community. These categories are the forms and experiences of emotional connectedness that are underexplained and over-looked in previous research (Sherman et al., 2020; Pflum et al., 2015). While studies show that interactions create a sense of connection (Cannon et al., 2017; Billard, 2021), the data here shows that community bonds are not always formed and are not always deemed necessary or wanted.

## Conclusion

This chapter has analysed interviewees' use of social media, their experience of watching others' or creating their own transition documentations, and the essence of community connectivity. Novel contributions of this chapter centre on why trans people do not make use of trans social media, do not create documentations and avoid the connectedness the community can offer, but not at the expense of an analysis of the benefits of those actions.

Uses ranged broadly from keen engagement with trans social groups, through lurking, and into various forms of avoidance. Information seeking was a key use of social media, as was communicating in general with other trans people and viewing trans news, events, and for comedic relief. Those who socially engaged did so out of a desire for knowledge and/or comfort, while those who avoided community interactions chose to do it in an attempt not to see content that would affect their mental health in a negative way.

Watching the documentation of other’s transitions was extremely helpful to some, giving a sense of time to come and the possibility of change. Again, avoidance featured here in interviewees early in their transitions; watching other people’s futures unfolding was not useful to those stuck in limbo, serving rather as a reminder of the length of their time ahead in waiting or eliciting jealously. This is a novel finding as previous work centres on avoidance behaviours being used as defence mechanisms for discrimination, as opposed to the findings here of avoiding dysphoria or jealousy. Similarly, in interviewees’ own documentations, there were those keenly involved, as well as those tracking changes for themselves, and those actively planning to not document their transitions. Those who created them viewed their own documentations as reflections they could return to, to consider their medical and emotional changes and experiences. Those who did not have also had their explanations for not doing so explored as novel findings in this chapter. Finally, this chapter has reviewed the meaning of community connectivity to these participants to arrive at, again, broad and contradicting descriptions of attachment and detachment. Those detached felt their time was better spent active elsewhere. Safety and belonging can be particularly easily felt within online community spaces, where sharing any information is helpful to others and offers care in many instances when relevant to health. Virtually occupying the same space as other trans people and knowing that the same content is being viewed, even asynchronously, is a valuable, pleasant source of connectedness for many. Previous literature understates the potential benefits to internet users who use do not interact, these individuals still view themselves as full community members despite their lack of direct communication with other users. These finding instead highlight the value these spaces have to those who would prefer to not directly interact with other users, yet still reap all the benefits of active users. These findings complement and add to other literature discussed in this chapter with a detailed examination of the practical forms of connectedness.

# Chapter 8. Concluding Discussion

## 8.1 Thesis summary

This thesis sought to answer three research questions using a mixed qualitative approach of interviews, diaries, and ethnography with thematic analysis. The questions addressed the experience of waiting for gender-affirming care in England by taking into account the contexts of emotional experience, coping with waiting, and the role of social media use in the above during transition. Waiting is one of the most substantial aspects of the process of obtaining gender-affirming care: initial appointments in gender clinics are generally obtained after many years of waiting, followed by many months between appointments. This puts a strain on trans people, which this research has explored through in-depth interviews with trans people to gain an in-depth understanding of their perspectives on and experiences of the process. The overarching research questions underpinning this investigation were:

- How does waiting for gender-affirming care feel?
- How do transgender people cope with the waiting time?
- How is trans social media used during the lengthy medical transition and the waiting it involves? How do digital documentations of transitional progress influence transition across waiting time?

By addressing these research questions, I aimed to address several gaps in trans health research. Firstly, on how waiting for gender-affirming care is experienced from the trans perspective. Prior research indicated that emotional reactions to difficult circumstances that exist outside of a person’s control can be those of frustration and anger, and difficulties with engaging with public life; these experiences can be shared across people in the same situation (Stryker, 2004; Yzerbyt et al., 2003; Von

Scheve and Ismer, 2013; Van der Miesen et al., 2020). Wating was found to contribute to many emotional states comparable to moderate to severe depression and anxiety. Coupling those ideas with trans temporality theories, revealing queer and trans time to be experienced differently (Halberstam, 2005; Carter, 2013; Horak, 2014; Pearce 2016), this research was able to focus on the waiting experience a second significant way in Chapter 5. This research has shown the trans community's experience of waiting comes with a notable fluctuating sense of time, with many unable or refusing to be passive to it as coping strategies are implemented to manage it. Being powerless to the waiting negatively impacts the mental health of trans people, as they described anxious, depressed, and oppressed states of mind in Chapter 4. In the second instance, trans people feel out of touch with the passing of time when their healthcare does not seem to be progressing due to very long waiting; for them time feels as if it is passing more slowly or is motionless. These are difficult experiences for trans people to cope with, therefore, this research aimed to investigate the coping strategies used.

Chapter 6 addressed the novel topic of the ways trans people cope with the lengthy waiting times' emotional and temporal effects. Trans people have a range of coping strategies to manage daily stresses associated with their trans status (Freese et al., 2018, Bry et al., 2018; Gorman et al., 2020). Coping strategies provide resilience and offer spaces for people to explore and come to terms with their gender with other trans people. Some of those strategies were commonplace in this research: when applied to waiting, many interesting active social and medical measures were used to manage the waiting. Others turned to actions and distractions of varying natures, with some being healthier than others, to pass the time.

Chapter 7 investigated the relevance of trans social media use, including online resources, and digital documentations of transition, to waiting for gender-affirming care, and community connectedness. Previous research has noted trans social media use for gathering information, socialising with other trans people and understanding their gender and transition (Cipolletta, Votadoro & Faccio, 2017; Cannon et al., 2017). This research has shown that trans people can get a clearer understanding of how long their waiting will be and online digital documentations of transition offer trans people hope for themselves and their futures (Horak, 2014); this thesis also investigated the public and private production of these, finding public creations are produced from a caring nature towards the trans community and private stores help individuals reflect on emotional and physical changes. Community connections are measurable to trans people (Billard, 2010; Sherman et al., 2020), therefore the form that this sense of connection takes for trans people was analysed, finding several descriptions of this phenomenon. In this thesis, trans social media use during waiting was wide ranging and interviewees tailored their online interactions to their own personalities, finding the information they wanted in the communication format they needed.

## 8.2 Summary of key findings

The data collected showed emotional and temporal disturbances as a result of the waiting times during the different stages of transition. More specifically, chapter 4 analysed how waiting causes great disturbances to trans peoples' mental health and their ability to fully engage in the social world, at work, and other public spaces. Specifically, in terms of emotions, waiting makes trans people feel powerless, depressed, less important than other people, and elongates and draws attention to dysphoria. Frustrations arise from its slow pace and from healthcare providers who are unfamiliar with, or are unwilling to participate in, the practice of trans healthcare, notably primary care practitioners. Many interviewees experienced poor mental health as an effect of waiting, which is not a reasonable outcome in a healthcare setting, healthcare should not cause harm. Their emotional experiences are reflective of emotional theories, showing negative emotional states as a result of invalidation of the self (Stryker, 2004), powerlessness, sadness, and frustrations due to their needs being placed out of their control (Hochschild, 1983); these emotional effects are known of and felt across the community as a shared experience (Von Scheve and Ismer, 2013).

Chapter 4 showed that delaying gender-affirming care through lengthy waiting time causes negative mental health effects in trans individuals and, by extension, throughout the trans community as they share the experience and care for each other. The emotional burden of waiting extends to, and exhausts, activists and is felt on a shared conscious level between members, as Van der Miesen et al. (2020) found in indefinitely delayed trans healthcare in the Netherlands. During the waiting, many experience a sensation of ‘not yet’, as described by Pearce (2018). Some interviewees noted their burden of waiting was also felt by those who loved them, their families and partners, as in Rickett et al’s (2020) research, others noted extra strain without support. Many emotional experiences are comparable to that of moderate to severe depression and anxiety and are continuous throughout the different waiting stages. Budge et al.’s (2013) research was reflected, cognitive and behavioural coping strategies were used by interviewees in varying forms while waiting for gender-affirming care, as in American care systems. Before coping could be explored in Chapter 6, the disparities in these interviewees’ perceptions of time warranted analysis.

Chapter 5 revealed that the experience of time perception during transition was regularly distorted and shown to be varying from feeling as though time was passing at a normal pace to slow to not feeling within time at all. It feels slow to many, so much so for some that there is a separation from the common understanding of the pace of time's progression. Specifically, the time felt like it was dragging when no progress was seemingly being made, and that there was a meaninglessness to the time spent waiting because it did not contain any thing productive towards transitioning. As queer temporality theories suggest (Halberstam, 2005, Carter, 2013) several interviewees felt out of touch with linear time, others felt stuck in time not able to envision a future different to now. The length of waiting time is so intangible for many that it cannot be mentally grasped, planned out for, or coped with easily. Time was not always perceived in this way during an individual's experience, certain experiences could give a sense of normality. These allowed them to live socially validated in their gender with focus spread across near future and tangible events. For some, temporal disturbances were experiences new to them with nothing feeling quite like waiting for gender-affirming care due to its importance in their lives. For others, these temporal experiences felt akin to other experiences outside of their control where a space of time with no clear end existed between them and their desperately wanted solution.

As a novel finding, it appears perception of time passing is altered in the long-term by those who have experienced waiting to its ultimate end. The prolonged distortion was different for each person, but each felt their post-transition or new-found sense of time as different from before their experience of waiting. This was reflective of trans temporality theories' contentions of abnormal or elongated time, enriching and adding to the differences between those theories. Many different personal experiences happened as a product of the same incident, in this specific case of waiting for gender-affirming care. Mental and social difficulties can arise from these temporal distortions. Therefore, regarded alongside Chapter 4, trans people have the potential to suffer emotionally and temporally during and after waiting for gender-affirming care; this experience is mediated by coping strategies.

Chapter 6 examined the many coping strategies that serve to distract from the waiting and manage the dysphoria maintained by it. Most coping strategies were found to be self or community reliant, rather than from professional services. Community socialisation and research provides knowledge about the length of waiting and transition process in detail which is empowering to individuals. It allows them to know a realistic estimate of the waiting time, because this information is not clearly given by GICs. It is managed through being known, through being made closer to concretely, rather than abstractly, in the future. Similarly, immersion into trans culture demonstrates and celebrates the strengths of the trans community in the sharing of others' creations, giving a sense of solidarity. This encourages participation in some and provides a nurturing space for all, centring trans experiences and creations as legitimate and worthy.

Validation goes far in managing the waiting experience; however, some prefer to take actions themselves to externalise their gender identity in the meantime of sanctioned care. Supplementary gender affirmation in the form of clothes and shapewear offer a reduction in dysphoria and created a distance between themselves and waiting for their care. Obtaining hormones external to sanctioned sources was used by most as a suicide preventative. Not only do these hormones save lives and offer hope, but they also allow trans people to progress their transition on their own terms, i.e., to treat their gender dysphoria, and relocate their transition's progress into their control. These interviewees continue to live because they took ownership of their transitions and moved them forward with their own means. However, not all are able to afford this path, and many suffer consequently while waiting.

This research found many actions and reactions as measures of coping with the effects of waiting distinct from those above. These varied widely, with positive actions relocating focus onto their broader lives, and reactions of processing their emotional experience of waiting with others or alone to the end of relief and an experience of solidarity. Negative reactions explored, which may be more prevalent than this data set suggests, centred on emotional disturbances ending in social withdrawal or behaviours not conducive to good well-being but which make the waiting forgettable for a time, such as drinking and taking drugs. To combat the more negative experiences, interviewees advised seeking internal resilience which could be found in various spaces which offer gender affirmation.

This thesis found trans social media to be a place for that gender affirmation and is a tool to learn, share, care, socialise, joke, forge fierce friendships and benefit from shared community strength while waiting for gender-affirming care and progressing through transition. Carefully used, for different levels of self-protection, users ranged from keenly interactive to silent observers, reflective of interviewee's personality and preferred communication styles. Particular to waiting, trans social media gives a strong indication on initial and follow-up appointment timings as many willingly share their experiences when asked and leave this information in spaces that can be found by other trans people. Trans social media is a great source of knowledge which is crucial to feeling empowered while waiting. Similarly, trans social media contains a huge range of trans made comedy. Comedy is a powerful tool the trans community use to relieving the burden of their healthcare being placed so distantly by humouring that fact and the paternalistic format of care. Memes are favoured by interviewees, enjoyed as the combined humour and mockery diffuses their feelings of powerlessness. Crucially, and contradictory to previous research (Billard, 2021), direct communication with other users was not necessary for interviewees to feel they had made the most of the community's available space and media.

The media of documentation of transitions were watched and created by some of the interviewees. Watching provided, as Horak (2014) discussed, a vision of possibility for themselves and the promise of the eventual movement of their own time. The images, videos and other media of trans people publicly also helped interviewees to make sense of the emotions they experienced, as they were able to hear their own thoughts clearly expressed by others. Interestingly, some interviewees purposefully avoided watching documentations of others' transitions to avoid negative emotional responses such as jealousy and distress at not yet being in a position near those they could watch.

Some interviewees documented their transition online in the form of videos, photos and journalling. Those who did rather publicly wanted to fill a knowledge gap for trans people to ease the process of understanding transitioning. Others documented their transitions in similar ways but only shared them with trusted people. These records offered the opportunity to look back for reassurance of their physical and emotional changes. The fear of not seeing these changes was reasoned for not creating a documentation of transition, as well as this form of record keeping falling outside of interviewees' interest.

Online connectedness to the trans community is a value measured more abstractly by trans people than previous research suggests as a functional measure of virtual or physical activity (Billard, 2021); sharing spaces anonymously or silently can produce similar feelings of connectedness as active individuals. Connectedness was viewed by interviewees as taking the time to care for others, whether by creating helpful content or directly answering the questions of others. It was also described as attachments to the community, safety, and good experiences. Connectedness to the trans community can be felt in direct communication with others and by virtue of sharing the same online space as other trans people and viewing the same content.

Conjunctively, these chapters reflect that the phenomenon of the free circulation of information and care and individuals' emotional management strategies, that are well documented academically, are also practiced out of necessity specifically during the experience of waiting for gender-affirming care. The trans community heavily mediates the mental health effects of waiting itself, as is much of the knowledge about waiting and transitioning, as opposed to formal healthcare sources. The effort that the trans community puts into and must use in order to endure waiting for gender-affirming care is tremendous and exhausting.

Trans people build communities of their choosing, create and spend time in trans spaces, giving them the opportunity to be trans in the time of waiting for gender-affirming care. It's a partial expression of agency of being trans in that trans people may decide how to react to and cope with lengthy waiting, without the agency of how their medical transition progresses. Some of the decisions made over transitioning that are taken outside of the formal healthcare system during the waiting are felt as forced choices, beyond normal activity, and sometimes contrary to philosophical standings on healthcare, that would not have been taken had care been readily available. The fact that trans people can wait together is the most central part of enduring waiting for gender-affirming care; a bittersweet conclusion, reflective of the trans community's will to survive and care for its own, but also of a healthcare system which, by failing to provide adequate care, forces trans people to rely entirely on each other.

## 8.3 Key Contributions

Waiting so long for such vital healthcare has long term yet unexamined consequences on transgender people's mental health and, crucially, their perception of time. There are innumerable ways to feel out of touch with time during the waiting process The community provides coping measures within itself at a higher quality than can be offered by professional healthcare, at a social cost to all.

This research has revealed that there are costly mental health effects on trans people while they wait for gender-affirming care. It is more than an extension of time onto the existent feeling of dysphoria, or its increase, which may be expected as a normal expectation of waiting for healthcare. The mental health experience of many of these interviewees are reflective of moderate to severe depression, stress, anxiety, and agoraphobia. These are pervasive conditions with distressing symptoms for the interviewees of this research, resulting from having to wait so long for care. It is not normally an expectation in healthcare processes to contract additional illnesses due to waiting for care, this research suggests that as a norm in trans healthcare. Waiting for gender-affirming care causes ill mental health as a side effect.

Most critically, this research has demonstrated the temporal toll waiting for gender-affirming care has on trans people. Perception of time was distorted for most interviewees in some way to feel slower or in some quality different from standardised time. Temporal distortions happened during the waiting process and remained in variously experienced forms as waiting ends and after it has finished. These distortions make individuals’ experience of time feel out of synchrony and therefore difficult to manage. The duality of the emotional and temporal experience requires a multitude of coping strategies to be implement by trans people to endure the waiting.

Necessary and healthy coping strategies are used in self-preservation against the effects of waiting. Knowledge and community solidarity is shared freely within the community, giving trans people information about the waiting times, preparing for their transition, and giving the waiting a concrete timeframe. Many active and reactive coping strategies are used to prevent and manage their emotional states caused by waiting. Most used strategies conducive to good well-being, however some turned to drinking alcohol, taking drugs, and casual sex as strategies of less healthy distraction. Crucially, drinking was noted later on in one interviewee’s transition process, whereas other unhealthy strategies were focused at its beginning. The latter case showed that waiting for surgery combined with a medical requirements of weight loss from a happily fat person can move them from helpful and socially active to unhealthy coping strategies and some reclusion.

## 8.4 Limitations and Reflections

I acknowledge that there are some limitations to the research in terms of data collection and demographics of the research population. I used a mixed qualitative methodology which yielded plentiful data in interviews and the ethnography, however less data than anticipated was collected from diaries, as not interviewees had documents to return. This is due to my research practice of not pursuing or compelling interviewees to create diary entries after the interviews, which I will explain in this section. Demographically, differences where quite few between interviewees due to the recruitment method used, which I will elaborate on. I will also reflect on my researcher experience in the latter part of this section, discussing my experience and recommendations of researcher mental health.

Comparative to other studies using diaries in social health research, which yield liberal datasets as researchers encourage their use, I rather encouraged individuals to only use them when they felt able, and to desist quickly if it made them feel worse. In doing so, I recognise that less data was yielded from the diary aspect of my methods than comparative research, such as Vincent’s thesis (2016). Ultimately, I wanted the interviewees to take charge of if how they engaged with the diaries to ensure their free and willing participation. However, some diary entries from this research provided valuable and otherwise uncatchable accounts of feelings in the moment of their occurrence. These private experiences have been invaluable to the analysis process of understanding how waiting feels to and impacts trans people and those around them, as have the interviews and ethnography.

University students heavily represented the ethnography and interviews. This reduced the variability in age range and so applicability of the research and ethnicity and disabled status were not collected. This group of trans people was not representative of non-white experiences, and this thesis did not discuss disability. Healthcare experiences for non-white and disabled individuals can be unequal (Hui et al, 2020; Gibson and O'Connor, 2010), it can only be assumed that this adds additional difficulty in waiting for, and progression through, their gender-affirming care. Below, I recommend future research directions to address these remaining research gaps.

My shared trans identity was undoubtably invaluable to the research process in terms of recruitment and forthcoming nature of the interviewees. Our shared experiences made building rapport simple as there felt to be an implicit understanding of the experience between us. However, I also suffered much ill mental health during the research process due to the heavy emotional experiences of the interviewees. I entered the research process knowing that I would experience compassion and empathy for the interviewees. Though, I did not anticipate, and was not prepared for, such an emotional toll during the process as what I experienced. Supportive systems were existent and used but the university's counselling service and cognitive behavioural therapy could not begin to manage my experience due to the interwoven nature of my research and lifestyle. I no longer participate in trans activism or online spaces purposefully to create space; however, this may be to my research's detriment in being distanced. Evidently, more emotional support is required for researchers in niche and emotionally complex topics to make the most of the research and analysis process.

## 8.5 Recommendations for practice and future research

### 8.5.1 Recommendations for Healthcare Practitioners

There are many areas of healthcare for trans people could be improved to relieve the waiting experience of gender-affirming care. This research has revealed that the first point of care at the GP can be poor and cause an extra waiting period due to limited knowledge. Resources packs could be devised for GPs by GICs to assist in the smooth running of their patients' care, available to download from their NHS websites, as presently GPs are receiving information about the continuation of trans care at the point of patient discharge from a GIC. Training for GPs on trans healthcare is available yet must be specifically sought out as part of their continuous professional development. While training is offered as optional it will be viewed as optional, and so too will trans healthcare, rather than as vital as it is. Trans people feel a lack of urgency surrounding their healthcare by providers, which needs to change so trans people may access care uninhibited. GP's, as the primary care provider, are the closest and fastest point of contact for care during the waiting process. They therefore need to be provisioned with information which can help trans people access care relevant to their transition, such as for mental health, in the meantime of waiting.

More broadly, other health services which serve trans people, such mental and sexual health services, may offer relief from negative experiences of waiting. These specialist services have staff well trained in recognising poor physical or mental well-being signs and have the facilities to let an individual voice their feelings in a secure environment, if only for a brief period. Demonstrative understanding of the patient at that point is critical in these instances. Health practitioners distant to gender-affirming care may familiarise themselves with the length of their trans patient's waiting times for care and how that impacts them, ideally through their own research rather than asking their patient details in session. This will save time for therapeutic practice to be applied in the session and give their patient confidence in their practitioners' medical knowledge and breadth of care.

It would, seemingly, be most prudent to reduce the waiting times to avoid the emotional and temporal disturbances left in its wake by implementing some practices of gender-affirming services into primary care. For example, preliminary information, such as results of blood tests and psychological scales of patients, that GICs presently request following receiving a referral, could instead be sent completed to GICs as the referral if this information was available to GP practices. The administration departments of GICs are overloaded, which delays letters being sent back and forth which also provide the crucial go-aheads of hormone and surgical care. Reducing the need for some outward communications from GIC in the form of information and requests would return time for processing their current patients and sending completed information.

Hormonal care is sometimes provided by GPs in the form of a bridging prescription before a GIC takes over. This is not a common practice, but it could be with the assistance of informed nurses and local endocrinologists, to spread the care of trans people further and into secondary care and offset some strain at GICs. Local endocrinologists can assess preliminary blood results and address any immediate concerns specific to base line sex hormone levels. Knowledge needs to be spread so that care can be spread around in this way. GICs need only publicise information they possess in key spaces where different practitioners can access it once. Sharing information within the medical community freely, like the trans community does, may also foster closer relationships between different medical practices and GIC services to create a more cohesive caring system for trans people.

Most ideal for trans people would be an informed consent model of care which does not rely on a diagnosis from a gender specialist to begin hormone care. Instead, these models, such as those applied at the Fenway clinic in Boston, USA, provision trans people with knowledge about hormone replacement therapy's possibilities and side effects and monitors progress and provides referrals to surgical practitioners. This method of providing care has shown to increase the well-being of trans people and foster good relationships between practitioners and patients Ker et al. (2020). An idyllic gender-affirming care service would empower patients which works cohesively with other services to share knowledge and care. Increasing primary and secondary case services responsibilities individually would be quite minimum but would benefit the very few GICs that currently exist. It would also make care for trans available from different places that are much more local and have a faster response time, reducing the effects of waiting and the need for such heavy internal and community reliance to manage the process alone.

### 8.5.2 Recommendations for Directions of Future Academic Research

Research into the emotional and temporal experiences of non-white and disabled individuals waiting for gender-affirming care is required. This should integrate healthcare, emotion, and temporality theories of non-white and disabled individuals with trans temporality theories to identify specific experiences of minority demographics. As within white spaces, LGBT-phobia exists in non-white spaces which can make seeking support from close friends and family difficult. This forces individuals to rely on support from a healthcare provider or online and physical trans spaces, as discussed in this thesis. These in turn may be under resourced in non-white knowledges required to help, as the community already feels overwhelmed by the waiting experience. Specialist research into non-white experiences of waiting may identify what exact support can be created for these individuals and recommend resolutions. Similarly, support groups for disabled people may not be equipped to provide support to their members who require help for the consequences of waiting for gender-affirming care. Distinct research may offer similar suggestions of resolutions for this group.

The intermediate and long-term consequences of waiting for gender-affirming care on trans peoples' time perception requires more research. Specifically, research should address mental health together with the ability to regulate and manage time during and after waiting. This thesis has demonstrated the extensiveness of temporal experiences during waiting and indicated that there are long-term temporal effects which are disorientating and detrimental. Both intermediate and long-term temporal experiences require researching separately with greater focus on the consequential psycho-social effects. The ability to manage and experience time in tempo with standardised time is needed to exist in synchrony with the social world. This research has revealed how difficult that can be in the time spent waiting for gender-affirming care. Novel research may reveal the extent of the psychological disturbance to time perception. It also may make use of temporal theories and psychological techniques to propose ways trans people may return their temporal experience to that of standardised time.

## 8.6 End note

Trans people are waiting a troublingly long amount of time to access gender-affirming care. This lengthy waiting causes ill mental health and distorted experiences of time. Currently services do not exist to manage the experience of waiting for trans people. Either these resources must be provided by health services or the current practice of providing gender-affirming care must change.

Trans people would benefit from an informed consent model of care with its beginnings of practice available at the primary care level, i.e. hormone replacement therapy prescriptions available from a local GP. Spread evenly across national GP practices, as the care becomes after discharge from a GIC, would reduce the overloaded nature of the GICs. GIC’s need only make surgical referrals following informed consent practices.

The need for a diagnosis exists as a cost assurance programme for medical practice under the processes of the NHS. The few and overcrowded GICs are not managing their patient numbers or needs under this form of practice. It is not logical to continue in this manner, considering also the findings of this thesis: the severe and extended mental health and temporal difficulties caused by waiting, which can nearly only be assisted from within the trans community. Trans people require more liberty over their access to gender-affirming care through faster care being available through more services. This requires a removal of the lengthy wait for a diagnosis of gender dysphoria at the beginnings of gender-affirming care.

## References

Allen, L.R., Watson, L.B., Egan, A.M. and Moser, C.N., 2019. Well-being and suicidality among transgender youth after gender-affirming hormones. Clinical Practice in Pediatric Psychology, 7(3), p.302.

Amin, K. (2014). Temporality. Transgender studies quarterly, 1(1-2), 219-222.

Auyero, J., 2011. Patients of the state: An ethnographic account of poor people's waiting. *Latin American Research Review*, *46*(1), pp.5-29.

Baraitser, L., 2017. Enduring time. Bloomsbury Publishing.

Bell, S.E., 2015. Bridging activism and the academy: Exposing environmental injustices through the feminist ethnographic method of photovoice. Human Ecology Review, 21(1), pp.27-58.

Bericat, E., 2016. The sociology of emotions: Four decades of progress. Current Sociology, 64(3), pp.491-513.

Biber, S.H., Hesse-Biber, S.N. and Leavy, P. eds., 2006. Emergent methods in social research. Sage.

Billard, T.J., 2021. Together We Rise: The Role of Communication and Community Connectedness in Transgender Citizens' Civic Engagement in the United States. Mass Communication and Society, (just-accepted).

Blewitt-Golsch, A.L., 2019. Transgender Experience Depicted through Memes: An Ethnographic Investigation of Minority Stress and Resilience (Doctoral dissertation, University of Denver).

Bogart, L.M., Dale, S.K., Christian, J., Patel, K., Daffin, G.K., Mayer, K.H. and Pantalone, D.W., 2017. Coping with discrimination among HIV-positive Black men who have sex with men. Culture, Health & Sexuality, 19(7), pp.723-737.

Bogart, L.M., Dale, S.K., Daffin, G.K., Patel, K.N., Klein, D.J., Mayer, K.H. and Pantalone, D.W., 2018. Pilot intervention for discrimination-related coping among HIV-positive Black sexual minority men. Cultural Diversity and Ethnic Minority Psychology, 24(4), p.541.

Britten, N., 1995. Qualitative research: qualitative interviews in medical research. British medical journal, 311(6999), pp.251-253.

Bry, L.J., Mustanski, B., Garofalo, R. and Burns, M.N., 2018. Resilience to discrimination and rejection among young sexual minority males and transgender females: A qualitative study on coping with minority stress. Journal of Homosexuality, 65(11), pp.1435-1456.

Cannon, Y., Speedlin, S., Avera, J., Robertson, D., Ingram, M. and Prado, A., 2017. Transition, connection, disconnection, and social media: Examining the digital lived experiences of transgender individuals. Journal of LGBT Issues in Counselling, 11(2), pp.68-87.

Carter, J. (2013) ‘Embracing Transition, or Dancing in the Folds of Time’. In: S. Stryker, & A. Z. Aizura, (eds.) The Trans Studies Reader 2. New York: Routledge, pp. 130-143.

Checker, M., 2014. Anthropological superheroes and the consequences of activist ethnography. American Anthropologist, 116(2), pp.416-420.

Cipolletta, S., Votadoro, R. and Faccio, E., 2017. Online support for transgender people: an analysis of forums and social networks. Health & social care in the community, 25(5), pp.1542-1551.

Crenshaw, K. W. (2017). *On intersectionality: Essential writings*. The New Press.

De Koster, W., 2010. Contesting community online: Virtual imagery among Dutch orthodox protestant homosexuals. Symbolic Interaction, 33(4), pp.552-577.

Dinshaw, C., Edelman, L., Ferguson, R.A., Freccero, C., Freeman, E., Halberstam, J., Jagose, A., Nealon, C.S. and Nguyen, T.H., 2007. Theorizing queer temporalities: A roundtable discussion. *GLQ: A Journal of Lesbian and Gay Studies*, *13*(2), pp.177-195.

Dolan, I.J., Strauss, P., Winter, S. and Lin, A., 2020. Misgendering and experiences of stigma in healthcare settings for transgender people. Med J Aust, 212(4), pp.150-1.

Elg, M., Witell, L., Poksinska, B., Engström, J., Mi Dahlgaard-Park, S. and Kammerlind, P., 2011. Solicited diaries as a means of involving patients in development of healthcare services. *International Journal of Quality and Service Sciences*, *3*(2), pp.128-145.

Freese, R., Ott, M.Q., Rood, B.A., Reisner, S.L. and Pantalone, D.W., 2018. Distinct coping profiles are associated with mental health differences in transgender and gender nonconforming adults. Journal of Clinical Psychology, 74(1), pp.136-146.

Friedman, E.J., 2007. Lesbians in (cyber) space: The politics of the internet in Latin American on-and off-line communities. Media, Culture & Society, 29(5), pp.790-811.

Garde, J. (2018) Archiving Feminist Futures – Temporality and Gender in Cultural AnalysisHU Berlin, November 1st-3rd.

Goossens, L., Braet, C., Van Vlierberghe, L. and Mels, S., 2009. Loss of control over eating in overweight youngsters: the role of anxiety, depression and emotional eating. European Eating Disorders Review: The Professional Journal of the Eating Disorders Association, 17(1), pp.68-78.

Gorman, K.R., Shipherd, J.C., Collins, K.M., Gunn, H.A., Rubin, R.O., Rood, B.A. and Pantalone, D.W., 2022. Coping, resilience, and social support among transgender and gender diverse individuals experiencing gender-related stress. Psychology of Sexual Orientation and Gender Diversity. 9(1), pp. 37–48.

Halberstam, J. 2005. In a queer time and place: Trans bodies, subcultural lives. NYU Press.

Hargreaves, S., Bath, P.A., Duffin, S. and Ellis, J., 2018. Sharing and empathy in digital spaces: Qualitative study of online health forums for breast cancer and motor neuron disease (amyotrophic lateral sclerosis). Journal of medical Internet research, 20(6), p. 222.

Hawton, K., Linsell, L., Adeniji, T., Sariaslan, A. and Fazel, S., 2014. Self-harm in prisons in England and Wales: an epidemiological study of prevalence, risk factors, clustering, and subsequent suicide. The Lancet, 383(9923), pp.1147-1154.

Hines, S., 2007. Transgendering care: Practices of care within transgender communities. Critical Social Policy, 27(4), pp.462-486.

Hines, S., 2007. Transforming gender: Transgender practices of identity, intimacy and care. Policy Press.

Hobster, K. and McLuskey, J., 2020. Transgender patients' experiences of healthcare. *British Journal of Nursing*, *29*(22), pp.1348-1353.

Hochschild, A. R., (1983) The Managed Heart: The Commercialization of Human Feeling. Berkeley: University of California Press

Holman, E.A. and Grisham, E.L., 2020. When time falls apart: The public health implications of distorted time perception in the age of COVID-19. Psychological trauma: theory, research, practice, and policy, 12(S1), p.S63.

Horak, L., 2014. Trans on YouTube: Intimacy, visibility, temporality. Transgender Studies Quarterly, 1(4), pp.572-585.

Hudson, K.D., 2019. (Un) doing transmisogynist stigma in healthcare settings: experiences of ten transgender women of color. Journal of Progressive Human Services, 30(1), pp.69-87.

Hughto, J.M., Gunn, H.A., Rood, B.A. and Pantalone, D.W., 2020. Social and medical gender affirmation experiences are inversely associated with mental health problems in a US non-probability sample of transgender adults. Archives of sexual behavior, pp.1-13.

Hyers, L.L., 2018. Diary methods. Oxford University Press.

Joffe, H., 2011. Thematic analysis. *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*, pp.209-223.

Johnson, T.P., 1996. Alcohol and drug use among displaced persons: An overview. Substance use & misuse, 31(13), pp.1853-1889.

Ker, A., Fraser, G., Fleming, T., Stephenson, C., da Silva Freitas, A., Carroll, R., Hamilton, T.K. and Lyons, A.C., 2021. ‘A little bubble of utopia’: constructions of a primary care-based pilot clinic providing gender-affirming hormone therapy. Health Sociology Review, 30(1), pp.25-40.

Lazarus, R. S., & Folkman, S. (1984). Stress, appraisal, and coping. New York: Springer.

Mamoojee, Y., Seal, L.J. and Quinton, R., 2017. Transgender hormone therapy: understanding international variation in practice. The Lancet Diabetes & Endocrinology, 5(4), pp.243-246.

Matsuno, E. and Israel, T., 2021. The parent support program: development and acceptability of an online intervention aimed at increasing supportive behaviors among parents of trans youth. Journal of GLBT Family Studies, 17(5), pp.413-431.

McGuiness, A., 2018. Facebook-mediated social support in the transgender community: a thematic analysis of user experiences.

McNeil, J., Bailey, L., Ellis, S., Morton, J. and Regan, M., 2012. Trans mental health study 2012. *Scottish Transgender Alliance.* Available at: http://www. scottishtrans. org/wp-content/uploads/2013/03/trans_mh_study.pdf (Accessed: 12 March 2023).

McPhail, D., Rountree-James, M. and Whetter, I., 2016. Addressing gaps in physician knowledge regarding transgender health and healthcare through medical education. Canadian medical education journal, 7(2), pp. 70-78.

Mizock, L. and Mueser, K.T., 2014. Employment, mental health, internalized stigma, and coping with transphobia among transgender individuals. Psychology of sexual orientation and gender diversity, 1(2), p.146.

Monro, S., 2000. Theorizing transgender diversity: Towards a social model of health. Sexual and Relationship Therapy, 15(1), pp.33-45.

Newman, C.E., Smith, A.K., Duck-Chong, E., Vivienne, S., Davies, C., Robinson, K.H. and Aggleton, P., 2021. Waiting to be seen: social perspectives on trans health. Health Sociology Review, 30(1), pp.1-8.

NHS (2023) *Waiting list update and appointment statistics.* Available at: https://ncth.nhs.uk/waiting-time-and-appointment-statistics (Accessed: 12 March 2023).

NHS (2023a) *Waiting times*. Available at: https://gic.nhs.uk/appointments/waiting-times/ (Accessed: 12 March 2023).

NHS (2023b 7 years) *Gender Identity*. Available at: https://www.dpt.nhs.uk/our-services/gender-identity/waiting-times Accessed: 12 March 2023).

NHS (2023c 4 years) *Gender Identity Clinic*. Available at: https://www.shsc.nhs.uk/services/gender-identity-clinic (Accessed: 12 March 2023).

NHS (2023d 5 years) *Waiting list/waiting times*. Available at: https://www.cntw.nhs.uk/services/northern-region-gender-dysphoria-service-specialist-service-walkergate-park/waiting-list-waiting-times/ (Accessed: 12 March 2023).

Nordmarken, S., 2014. Microaggressions. TSQ: Transgender Studies Quarterly, 1(1-2), pp.129-134.

Ogden, R., 2021. Distortions to the passage of time during England's second national lockdown: A role for depression. Plos one, 16(4), p.e0250412.

Pearce, R. 2016. (Im)possible Patients? Negotiating discourses of trans health in the UK. PhD Thesis: University of Warwick, Department of Sociology.

Pearce, R. (2017) Of conduct and controversy: trans health activism at EPATH. Available at: https://ruthpearce.net/2017/04/06/activism-at-epath/ (Accessed: 9 August 2023)

Pearce, R., 2018. Trans temporalities and non-linear ageing. Routledge.

Pearce, R., 2018. Understanding trans health: Discourse, power and possibility. Policy Press.

Pflum, S.R., Testa, R.J., Balsam, K.F., Goldblum, P.B. and Bongar, B., 2015. Social support, trans community connectedness, and mental health symptoms among transgender and gender nonconforming adults. Psychology of sexual orientation and gender diversity, 2(3), p.281.

Pinknews (2021) Protesters stage 'die in' outside NHS HQ in powerful demonstration against trans healthcare crisis. Available at: https://www.pinknews.co.uk/2021/12/06/nhs-trans-healthcare-crisis-protest/ (Accessed 2 February 2022)

Pitts-Taylor, V., 2020. "A slow and unrewarding and miserable pause in your life": Waiting in medicalized gender transition. Health, 24(6), pp.646-664.

Preciado, B., 2013. Testo junkie: Sex, drugs, and biopolitics in the pharmacopornographic era. The Feminist Press at CUNY.

Puckett, J.A., Matsuno, E., Dyar, C., Mustanski, B. and Newcomb, M.E., 2019. Mental health and resilience in transgender individuals: What type of support makes a difference? Journal of Family Psychology, 33(8), p.954.

Raun, T., 2015. Archiving the wonders of testosterone via YouTube. Transgender Studies Quarterly, 2(4), pp.701-709.

Reed-Danahay, D. E. (1997). Auto/ethnography: Rewriting the self and the social. Oxford, England: Bloomsbury Academic

Rickett, B., Johnson, K., Ingle, H., & Reynolds, M. (2020). Support for parents/carers of primary school aged gender diverse children in England, UK: A mixed-method analysis of experiences with health services. Health Sociology Review, 30(1), 9–24. doi:10.1080/14461242.2020.1857656

Rodriguez, R., Agardh, A. & Asamoah, B.O., 2018. Self-Reported Discrimination in Health-Care Settings Based on Recognizability as Transgender: A Cross-Sectional Study Among Transgender U.S. Citizens. Arch Sex Behav, 47, 973-985.

Rosky, C.J., 2013. Fear of the queer child. *Buff. L. Rev.*, *61*, p.607.

Ruff, N., Smoyer, A.B. and Breny, J., 2019. Hope, Courage, and Resilience in the Lives of Transgender Women of Color. The Qualitative Report, 24(8), pp.1990-2008.

Sălcudean, M. and Motoroiu-Stefan, R., 2020. Visual Humor through Internet Memes (II) From harmless humour to the discriminatory potential of (anti) memes. Case Study:"The Transgender Bathroom Debate". Transilvania, no. 11-12 (2020): 94- 100. https://doi.org/10.51391/trva.2020.12.12.

Sherman, A.D., Clark, K.D., Robinson, K., Noorani, T. and Poteat, T., 2020. Trans* community connection, health, and wellbeing: a systematic review. LGBT health, 7(1), pp.1-14.

Sherman, A.D., Clark, K.D., Robinson, K., Noorani, T. and Poteat, T., 2020. Trans* community connection, health, and wellbeing: a systematic review. LGBT health, 7(1), pp.1-14.

Snyder, C. R. (2002). Hope theory: Rainbows in the mind. Psychological Inquiry, 13(4), pp. 249- 275.

Stanley, L. and Wise, S., 2013. Method, methodology and epistemology in feminist research processes. In Feminist praxis (pp. 20-60). Routledge.

Stryker, S., 2004. Integrating emotion into identity theory. In Theory and research on human emotions. Emerald Group Publishing Limited.

Sun, N., Rau, P.P.L. and Ma, L., 2014. Understanding lurkers in online communities: A literature review. Computers in Human Behavior, 38, pp.110-117.

Sundén, J., 2015. Temporalities of transition: Trans-temporal femininity in a human musical automaton. Somatechnics, 5(2), pp.197-216.

Thönes, S. and Oberfeld, D., 2015. Time perception in depression: A meta-analysis. Journal of affective disorders, 175, pp.359-372.

Trevor Project (2020) National Survey on LGBTQ Youth Mental Health 2020. Available at: https://www.thetrevorproject.org/survey-2020/?section=Introduction (Accessed: 05/09/2020)

Van der Miesen, A.I., Raaijmakers, D. and van de Grift, T.C., 2020. "You have to wait a little longer": Transgender (mental) health at risk as a consequence of deferring gender-affirming treatments during COVID-19. Archives of Sexual Behavior, 49, pp.1395-1399.

Vermeir, E., Jackson, L. A., & Marshall, E. G. (2018). Barriers to primary and emergency healthcare for trans adults. Culture, Health and Sexuality, 20(2), 232–246. doi:10.1080/13691058.2017.1338757

Von Doussa, H., Power, J. and Riggs, D.W., 2017. Family matters: Transgender and gender diverse peoples' experience with family when they transition. Journal of Family Studies, 26(2), pp.272-285.

Von Scheve, C. and Ismer, S., 2013. Towards a theory of collective emotions. Emotion review, 5(4), pp.406-413.

Westmarland, N., 2001. The quantitative/qualitative debate and feminist research: A subjective view of objectivity. In Forum Qualitative Sozialforschung/Forum: Qualitative Social Research (Vol. 2, No. 1).

Wetzel, J.W., 1994. Depression: Women-at-risk. Social Work in Healthcare, 19(3-4), pp.85-108.

White Hughto, J.M., Pachankis, J.E., Willie, T.C. and Reisner, S.L., 2017. Victimization and depressive symptomology in transgender adults: The mediating role of avoidant coping. Journal of counseling psychology, 64(1), p.41.

White, F.R., 2019. Embodying the fat/trans intersection. In Thickening Fat (pp. 110-121). Routledge.

Williams, F. (2004) Rethinking Families. London: Calouste Gulbenkian Foundation.

Willis, P., Dobbs, C., Evans, E., Raithby, M. and Bishop, J.A., 2020. Reluctant educators and self-advocates: Older trans adults' experiences of health-care services and practitioners in seeking gender-affirming services. Health Expectations, 23(5), pp.1231-1240.

World Professional Association for Transgender Health. (2022). Standards of Care Version 8. Available at: https://www.wpath.org/soc8 (Accessed 12 March 2023).

Woznicki, N., Arriaga, A.S., Caporale-Berkowitz, N.A. and Parent, M.C., 2020. Parasocial relationships and depression among LGBQ emerging adults living with their parents during COVID-19: The potential for online support. Psychology of Sexual Orientation and Gender Diversity.

Wylie, K., Barrett, J., Besser, M., Bouman, W.P., Bridgman, M., Clayton, A., Green, R., Hamilton, M., Hines, M., Ivbijaro, G. and Khoosal, D., 2014. Good practice guidelines for the assessment and treatment of adults with gender dysphoria. Sexual and Relationship Therapy, 29(2), pp.154-214.

Xavier, J., Bradford, J., Hendricks, M., Safford, L., McKee, R., Martin, E. and Honnold, J.A., 2013. Transgender healthcare access in Virginia: A qualitative study. International Journal of Transgenderism, 14(1), pp.3-17.

Yzerbyt, V., Dumont, M., Wigboldus, D. and Gordijn, E., 2003. I feel for us: The impact of categorization and identification on emotions and action tendencies. British journal of social psychology, 42(4), pp.533-549.

Zucker, K.J., 2015. The DSM-5 diagnostic criteria for gender dysphoria. In *Management of gender dysphoria: a multidisciplinary approach* (pp. 33-37). Milano: Springer Milan.

# Appendices

## Appendix 1. Demographic details of interviewees

| Chosen Name for this Research | Age | Self Defined Gender Identity | Pronoun(s) | Occupation | Self Defined Social Class | Relaionship status | Self Defined Sexual Orientation | Transition stage at time of first interview |
|---|---|---|---|---|---|---|---|---|
| Alex | 19 | Male | he/him | Student | Lower/ Middle | Single | Bi | Waiting for top surgery |
| Anna | 19 | Girl | she/her | Student | Middle class | Single | I don't really know | Waiting for first appointment |
| Cayla | 19 | Female | she her | Student | Don't know | In a relationship | Bisexual | Waiting for first appointment |
| Chloe | 18 | Female | she/her | Student | Middle class | Single | Asexual | Waiting for first appointment |
| Chris | 18 | Male | he/him | Student | Middle class | Single | Bisexual | Waiting for first appointment |
| CJ | 20 | Male | he | Student | Working class | In a relationship | ? | Waiting for lower surgery |
| Dante | 19 | Male | he/him | Student | Middle/ Upper | Single | Bi I guess | Waiting for first appointment |
| Frank | 20 | FTM | he/him | Student | Lower class | In a relationship | Pansexual | Waiting for top surgery |
| Lewis | 19 | FTM or Male | he | Student | Middle class | Single | Heterosexual | Waiting for top surgery |
| James | 24 | Male | he | Student |  | Effectively married |  | Post transition |
| James C | 23 | Non binary trans man or anything in between | they/them | Engineer | Middle | Single | Queer | Waiting for top surgery |
| Jessica | 35 | Female | she/her | Vehicle body repairer | Low to middle | Married | Straight male at the moment | Waiting for first appointment |
| Jestin | 21 | Trans male, genderfluid with agender | he or they | Student/retail |  | Single | Pansexual | Waiting for top surgery revision |
| Kye | 18 | Trans male | he/him | Student | Don't know | In a relationship | Straight | Waiting for first appointment |
| M | 21 | Non-binary trans masculine | they/them | Student/part time employed | Middle class | Single | Pan/Queer | Waiting for first appointment |
| Marcy | 18 | Demi-girl | they/them | Student | Working class | Single | Bisexual | Waiting for first appointment |
| Nathaniel | 22 | Male | he | Student | Lower/ Middle | Cohabiting | Pansexual | Waiting for top surgery |
| Oliver | 20 | male | he/they | Student | No idea | single | Bisexual | Waiting for an initial referral |
| Siobhan | 30 | Trans feminine | she/her | Healthcare | Working class | Single | Asexual | Waiting for lower surgery |
| Thea | 24 | Female | she/her | Student | Working class | Its complicated | Bi/Pan | Waiting for an endocrinologist |
| Tomo | 19 | Non-binary trans feminine | they/them | Student | Lower/ Middle | Single | Pansexual | Waiting for first appointment |
| Vicky64 | 54 | Female | she/her | IT | Lower/ Middle | Married | Bisexual | Post transition |
| Wes | 22 | Trans masculine non-binary | he or they | Student | Low income | Open relationship | Queer | Waiting for top surgery |
| Zac | 23 | Male | he | Student | Middle class | Engaged | Bisexual | Waiting for lower surgery |
| Zack | 19 | Male | he/him | Student | No idea | Single | Bi | Waiting for top surgery |

## Appendix 2. Participant Information Sheet

### Participant Information Sheet

#### Invitation to research participation

If you identify as transgender, live in England, and have experienced waiting for gender-affirming care either through the NHS or through a private clinician you are invited to participate in this research.

#### Details and aims of the research

This research is being conducted by Ph.D. student Samuel Heyes (the researcher) at the University of Essex in the Department of Sociology. The current working title of the thesis is “Transgender people’s experience of waiting for gender care”. The first aim of this research is to discover the experiences of those awaiting gender-affirming care in the UK. Of experiences of waiting, particular attention will be paid to the emotions that surround waiting and what methods, if any, are used to manage this waiting. Further, this research also aims to discover if and how transgender social media use interacts with transgender identities during the waiting process and if this interaction changes over time.

#### Methods of the research

Participants are invited to two interviews which will be spaced approximately 3 months apart. They are also invited to keep a diary for one - three months following the first interview which will be provided for them with the means to return it to the researcher after this time. The interviews will consist of open questions to try to understand, from the participant’s perspective, how their lives are affected by waiting. Participants are encouraged to use the diary to document their day to day emotions and thoughts of the subject of the research.

#### Data storage and usage

The interviews will be recorded using an audio device and later transcribed and the text of the diaries will be typed up (or photocopied if they are drawings) by the researcher. Data will be securely stored on a personal password protected device. The researcher has opted to not consent to sharing of original data within or external to the University of Essex. As such, only the researcher will have access to the original data, and only his supervisors (detailed below) may have access to the transcribed data. All analysis and following writing will be performed by the researcher.

#### Participation in research

Participants have the right to anonymity should they choose it. They may choose a pseudonym and pronoun for the researcher to use to refer to them in the written work. Participation within this research is voluntary, and participants have the right to withdraw from the research process at any time. They may at this time opt to have their data destroyed if they wish.

## Risks of participation

During the interviews and diary keeping, participants may feel anxious or distressed due to the nature of the topic. Whilst every effort will be taken to reduce the impact of this, participants are advised to take breaks when they feel they are necessary and to discontinue their participation if they do not feel well enough to continue. The organisations detailed below can give emotional and mental health support:

Mindline Trans+: 0300 330 5468. This operates Mondays & Fridays 8pm to midnight.

Switchboard LGBT helpline: 0300 330 0630

The Samaritans: 0845 790 9090

## Funding

This research is self-funded by the researcher.

## Ethical approval

This research has been reviewed on behalf of the University of Essex Ethics Committee and approved.

## Contact details

The researcher may be contacted by email or phone: sheyes@essex.ac.uk 07784457628.

The supervisors of this project are Dr Róisín Ryan-Flood, rflood@essex.ac.uk phone: 01206 873551, and Dr Isabel Crowhurst, icrow@essex.ac.uk phone: 01206 873059.

University of Essex Research Governance and Planning Manager: Sarah Manning-Press, sarahm@essex.ac.uk phone: 01206 873561.

## Appendix 3 Interview Questions

How does waiting feel?

1. Can you start by telling me about what stage of your medical transition you are at now and about the length of the process you took to get to here?
    - Private vs NHS route?
    - Initial wait to the gender clinic, in-between appointments wait, surgery referral wait..?
    - Any hold ups? – How did these affect your life at the time?
2. How is being on a waiting list for gender care affecting your day to day life?
    - For e.g. work/school/family life
    - How does it impact your mental health?
3. Before you started, how aware of the waiting times for the different stages of transition were you?
    - How did you get this information?
    - How did it feel to know this information?
    - Did your expectation of how future waiting times would be experienced change after getting through stages?
4. In the case that there have been different portions of waiting in transition, i.e. wait for first appointment, wait for hormones, wait for surgery, how have these various stages differed or been the same in the experience of the time passing?
    - Did any particular stages feel longer or shorter compared to others despite their actual amount of time?
    - Where there any factors that made certain parts feel faster or slower?
5. What are the emotions that you associate with the waiting process in your transition?
6. How do you feel about the waiting being able to affect your legal gender recognition under the current gender recognition act?
7. Does this feel like any other type of waiting you've experienced?
    - e.g. something else medical, waiting for a loved one to return, something else outside of your control?
    - Are these comparable in your mind to the experience of waiting for gender care?
8. How is your sense of time passing influenced by waiting?
9. What do you think about the factors that affect waiting times? E.g. amount of professionals in the area, few numbers of clinics

How do trans people manage this waiting?

1. How do you cope with the waiting?
    - From how we discussed it affects you, how do you cope with those affects?
    - Are there places you go to which help? Online or rl communities or outside spaces? What is filling this time?
    - How much do these methods work for you?
2. How would you advise someone else to cope with this waiting if it was distressing them?

Online trans social media and trans identity

1. Do you use transgender focused social media space? (trans run by trans people)
    - Such as community groups on facebook or reddit
    - Which ones and what for? If not, why not?
    - Do you know any others?
2. What do you look for when you engage with trans social media?
    - Such as information, friends, advice, empathy?
3. Do you document your transition online or offline?
    - In photos/youtube/vlog/blog – did you want to?
    - How do you see others documenting their transitions?
    - Do you think this would show a change in identity as well as physical changes?
4. How has the way you use trans social media changed during your transition? Or do you think it will?
    - e.g. looking for advice to providing it
5. Have you seen the waiting times mentioned in any other media, like news, external to the trans community?
6. Has using trans social media helped you cope with the waiting times?
7. How connected to the community do you feel?
    - Is this online, offline or both? Do you feel a sense of community spirit? Has this feeling changed over time? How and why?
8. And lastly, what do you find the online trans community's overall feeling on the waiting times is?

Is there anything you wished I had asked today that seems important to you and relevant to the topic?

## Appendix 4 Ethnography information Sheet

### Participant information sheet – Ethnography

Invitation to research participation

You are invited to participate in this research if you are over 18, identify as trans or non-binary, and attend the University of Essex as a student.

Details and aims of the research

This research is being conducted by Ph.D. student Samuel Heyes (the researcher) at the University of Essex in the Department of Sociology. The current working title of the thesis is “Transgender people’s experience of waiting for gender care”. The first aim of this research is to discover the experiences of those awaiting gender-affirming care in the UK. Of experiences of waiting, particular attention will be paid to the emotions that surround waiting and what methods, if any, are used to manage this waiting. Further, this research also aims to discover if and how transgender social media use interacts with transgender identities during the waiting process and if this interaction changes over time.

Methods of the research

You may have already completed an interview within the first phase of data collection. The second phase will now be altered to an ethnographic approach. This means that the researcher will be observing the University of Essex’s trans and non-binary community’s discussions, behaviours, and activities pertinent to gender-affirming healthcare which occur naturally within the community. This will of course be limited to only those who agree to take part in this research. You may not necessarily be seeking gender-affirming care, however you may be involved in community interactions related to others seeking care. Note taking and informal conversations to clarify meaning of community interactions will occur.

Data storage and use

Data will mainly be in the form of note taking which will be typed later. Data will be securely stored on a personal password protected device. The researcher has opted to not consent to sharing of original data within or external to the University of Essex. As such, only the researcher will have access to the original data, and only his supervisors (detailed below) may have access to the transcribed data. All analyses and following writing will be performed by the researcher.

Participation in research

You have the right to anonymity should you choose it. You may choose a pseudonym and pronoun for the researcher to use to refer to you in the written work. Participation within this research is voluntary, and you have the right to withdraw from the research process at any time. You may opt to have data related to you destroyed.

Risks of participation

Whilst every effort will be taken to reduce the impact of risk, you are advised to let the researcher know if taking part is concerning you. The organisations detailed below can give emotional and mental health support:

Mindline Trans+: 0300 330 5468. This operates Mondays & Fridays 8pm to midnight.

Switchboard LGBT helpline: 0300 330 0630

The Samaritans: 0845 790 9090

Funding

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University of Essex Research Governance and Planning Manager: Sarah Manning-Press, sarahm@essex.ac.uk phone: 01206 873561.

## Appendix 5 Ethnographic Consent Form

## Informed Consent for Research Participation

This research is conducted by Samuel Heyes at the University of Essex as part of the completion of a Ph.D. Sociology entitled: Transgender peoples' experience of awaiting gender-affirming healthcare. The supervisors of this project are Dr Róisín Ryan-Flood, rflood@essex.ac.uk phone: 01206 873551, and Dr Isabel Crowhurst, icrow@essex.ac.uk phone: 01206 873059.

Dear Participant,

Thank you very much for considering participating in the ethnographic portion of my research. This consent form will detail the meaning and context of your participation, to which if you are agreeable to participate in this way, may be signed as such below.

This ethnography will take the form of observation by the researcher (Samuel Heyes). Observations of individuals or of the community's discussions, behaviours, and activities pertinent to gender-affirming healthcare, which occur naturally, will take place. Note taking by the researcher may occur.

This may also include follow up conversations to clarify meaning of community interactions after they occur, which can be held at your discretion.

You may also make use of online spaces to discuss or consume information related to gender-affirming healthcare. Informal conversations with the researcher again as to the meaning of these may occur at your discretion.

You have the right to withdrawn at any time without having to give a reason. Your data may be destroyed if you prefer.

I understand the above details of participation in this research.

Participant's signature:

……………………………………………..

## Appendix 6 Terminology

This section will define specific terms used throughout the work. Some of these terms are context specific and change in their meaning over time. However, the following definitions hold true throughout the thesis.

Gender – This term refers to the internal sense of womanhood, manhood, or non-binary identity. This differs from the term sex, which instead refers to a chromosomal value.

GIC – Gender Identity Clinic, these are tertiary medical practices that provide gender-affirming medical care in England.

GP – General Practitioner, the primary doctor to individuals in England.

Misgendering – The act of disaffirming a person's gender identity by referring to them as a gender they do not identify with or personal pronouns they do not use. This is the opposite of affirmative gendering.

Non-binary – A term used to reflect gender identities falling between, outside, or separately to the binary categories of man and woman. Examples include genderfluid, genderqueer, and agender.

Temporality – This term refers to the experienced perception of the passing of time.

Trans – This term is used specifically in this thesis to capture all non-cisgender identities, including, but not limited to, trans, transgender, transsexual, non-binary, and interviewees' individually described gender identities.

Trans social media – This phrase refers to spaces online where trans people can congregate and communicate with each other, either directly, through conversation, or indirectly, by viewing content created or shared by others online.