How do gender diverse young people who have accessed puberty suppressant treatment speak about their understanding and experiences of their sexuality? A narrative analysis of qualitative interviews with young people aged 16+ who have accessed puberty suppressant treatment.

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A thesis submitted for the degree of Doctorate in Clinical Psychology

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September 2023

Abstract

Care provision for transgender and gender diverse (TGD) youth is undergoing significant change within the UK. The service position regarding the use of puberty suppressant treatment (PST) using Gonadotropin releasing hormone analogues (GnRHa) has changed, and this treatment will now only be provided in the context of clinical research. PST has been subject to controversy, with some holding the view that accessing PST may negatively impact sexual development, functioning, and enjoyment. Elucidating the potential contribution of PST with respect to sexuality is an identified research priority. Research with adults indicates that gender affirming interventions exert some influence over their sexual lives. However, no equivalent research has examined the influence, if any, of PST in this respect. Adopting a Narrative Inquiry methodology, the present study examines the narrative accounts of four TGD young people speaking about their experience and understanding of their sexualities in the context of accessing PST. Through using the Listening Guide method (Gilligan et al., 2003), and Hammack and Cohler's (2009) Master Narrative Engagement approach, the young people's narratives were contextualised and interpreted with respect to the historical, discursive, and cultural context of their production. The findings are presented for each individual narrator, outlining the content and plot of their account before turning to the relationships between the polyphonic voices in their accounts, understanding this as representative of narrative engagement with wider discourse. The narrators indicated various relationships to PST with respect to sexuality, with some regarding it as specifically facilitative of their sexual engagement, and others attributing little influence to the treatment, positive or negative. In storying their accounts, the young people demonstrated agentic, dynamic, engagement with three main master narratives, cisnormativity, heteronormativity, and transnormativity, both reproducing and countering aspects of these. The clinical implications of the findings, limitations of the study, and future research are discussed.

Acknowledgements

I am so grateful to everyone who has supported me in this endeavour. Firstly, my supervisor, Dr Aaron Wyllie for his unwavering patience, understanding, and enthusiasm. Next, I'd like to thank Dr Jos Twist for their support and belief in my ability, when I was an Assistant Psychologist, and later as a Trainee.

I want to thank my family and friends, particularly my parents and my Granny, who love stories of all kinds and have shared their love of learning with me. I would like to thank Jane for helping me organize my time, and my tangents. I want to thank my partner Toby for his patience, his care, and his commitment to the bit.

Lastly, I would like to thank the generous and brave young people who agreed to speak with me about such a personal topic, during trying times. I hope I have done your stories justice.

Contents

Initialisms

AFAB: Assigned Female at Birth

AMAB: Assigned Male at Birth

BPS: British Psychological Society

DSD: Differences (or disorders) in Sex Development

EU: European Union

FTD: Fulfilled Treatment Desire

‘FTM’: Transmasculine

‘MTF’: Transfeminine

GAHT: Gender Affirming Hormone Treatment

GAS: Gender Affirming Surgery

GAT: Gender Affirming Treatment

GnRHa: Gonadotropin Releasing Hormone Analogues

GSM: Gender and Sexual Minorities

GIDS: Gender Identity Development Service

LG: Listening Guide

LGBTQ+: Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex and more

NHS: National Health Service

NI: Narrative Inquiry

NTD: No desire for gender affirming treatments

PMDD: Premenstrual Dysphoric Disorder

PMS: Premenstrual Syndrome

PST: Puberty Suppressant Treatment

TGD: Transgender and Gender Diverse

UTD: Unfulfilled Treatment Desire

UK: United Kingdom

US: United States

YP: Young Person/People

WPATH: World Professional Association for Transgender Health

Chapter 1: Introduction

This thesis interprets the narrative accounts of four transgender or gender diverse (TGD) young people who spoke about their experiences and understandings of their sexualities in the context of accessing Puberty Suppressant Treatment (PST). The aim of this thesis is to explore what the young people's experiences were, what meanings they made of these, and how, drawing upon, modifying, or rejecting, dominant narratives they described and communicated these in their personal narrative accounts.

1.1 Overview

1.1.1 Gender, puberty, and gender affirming interventions.

Gender is a key organizing principle of human life (Ken, 2010). For many, the genitals they are born with, and their other biological sex characteristics, correspond to their felt sense of their gender identity. However, the conflation of biological sex and gender presents a significant dilemma for those for whom their assigned gender is ill-fitting.

Previously termed 'Gender Identity Disorder' (American Psychiatric Association, 2000), Gender dysphoria is a diagnostic term which describes the discomfort and distress that living within a body and gender role that are at odds with one's internal gendered self can cause (American Psychiatric Association, 2022). This is also known as 'gender incongruence' (World Health Organization, 2022). In response to this experience, individuals may make changes to aspects of their gendered lives to feel more congruent, such as wearing clothing that feels good to them, or going by neutral or gendered names and pronouns that feel appropriate. This is often referred to as social affirmation, or making a 'social' transition, in that the person adopts,

amends, or rejects aspects of socially prescribed gender norms in a way that feels best for them (Sherer, 2016). This may represent a binary shift from one side of a dichotomous conceptualisation of gender to 'the opposite gender', or a transition to a non-binary or agender social role. This can also include seeking legal recognition of changes such as name changes.

In the majority of societies, externally discernible primary sex characteristics (the genitals) are routinely concealed by clothing. Therefore, upon making a social transition, pre-pubertal children are afforded inclusion into the sex category which feels best for them, provided this falls within the dichotomous taxonomy of male and female. Puberty, however, marks the development of the secondary sex characteristics which are less concealed/concealable, and also routinely used as a means of perceptually classifying fellow humans into pre-existing gender role categories (Federici et al., 2022; Kessler & McKenna, 1978).

Though puberty and adolescence are biologically and socially defined respectively, they are often viewed as so interlinked as to be synonymous. It is following puberty that young people may become more interested in romantic and sexual intimacy, including the sexual capacities of their bodies. This is attributed in part to fluctuating hormone levels and bodily maturation expanding their bodily functions (Fortenberry, 2013). However, interest and exploration of sexuality are also culturally expected aspects of adolescent development (Boislard et al., 2016).

Puberty is a time at which many individuals, whether cisgender or gender diverse, may feel unsettled by their bodies as they change and develop. For gender diverse young people, this time of life may feel particularly distressing, an unwelcome reminder that their material body does not concur with how they feel and how they may hope to look in future. This may prompt

them to engage in specific gender affirming practices such as *tucking* or *binding* (see terminology) among others.

Other gender affirming practices such as hair removal, the use of padded bras, and particular hairstyles and clothing choices are not unique to the gender diverse community. Gender affirming practices are something the cisgender majority engages in on a regular basis, ranging from tweezing errant eyebrow hairs to achieve a 'feminine' shape, using medications such as Viagra (Mamo & Fishman, 2001), or more drastic procedures such as breast reconstruction following mastectomy for cancer survivors (Schall et al., 2023).

For gender diverse adolescents who experience gender dysphoria (as it is not a given that all gender diverse people experience this), some gender affirming treatments are possible in addition to social transition. Until very recently, the clinical approach in the UK was similar to that of the Netherlands and the United States, in which young people could potentially access a treatment called Puberty Suppression Treatment (PST), colloquially known as 'the blocker'. The aim of this intervention is to pause further pubertal changes to afford the individual a reprieve from puberty and the associated bodily dysphoria of developing secondary sexual characteristics at odds with one's gender. The rationale for the intervention is to afford young people the opportunity to think about their experience of gender without the pressure of ongoing changes occurring in their body (Ashley, 2019; Gohil & Eugster, 2019). The action, effects and side-effects are described in brief below (see section 1.1.4 for consideration of potential role in the experience of sexuality)

PST is achieved using Gonadotropin releasing hormone (GnRH) agonists or antagonists, known as GnRH analogues (GnRHas) and colloquially as 'the blocker'. Gonadotropin

releasing hormone is produced in the hypothalamus and acts upon GNRH receptors in the pituitary gland to stimulate the release of luteinizing hormone (LH), and follicular stimulating hormone (FSH), which then in turn stimulate the production and release of testosterone by the testes, and oestrogen by the ovaries. GnRH agonists act to block pituitary gonadotropin secretions through the mechanism of desensitization, or downregulation, by providing a continuous GnRH stimulus. GnRH antagonists act to block the pituitary receptors, thereby blocking the LH surge (Kumar & Sharma, 2014).

GnRHas have been used to delay puberty in the case of central precocious puberty (CPP) since the 1980's (Fuqua & Eugster, 2022). GnRHas are used for various other purposes, such as androgen deprivation therapy in advanced prostate cancer, ovarian suppression breast cancer treatment, mood regulation in Premenstrual Syndrome (PMS) and Premenstrual Dysphoric Disorder (PMDD), and as part of interventions for endometriosis, uterine fibroids, and infertility (Saleh & Taylor, 2023). In fact, GnRH agonists are already in use as a gender affirming treatment option in the case of cisgender women with 'hirsutism' (Gathers & McMicheal, 2009; Kumar & Sharma, 2014).

There are various GnRH analogues, different drugs with different doses and methods of administration. There are also different brand names, for instance Triptorelin which is sold as 'Decapeptyl® SR'. Triptorelin was one GnRHa that could previously be prescribed to TGD youth (NHS England, 2024) and continues to be prescribed for precocious puberty (British National Formulary for Children, n.d.)

In a meta-analysis of the effectiveness of GnRHa in treating premenstrual syndrome the most common side effects reported were hot flushes, aches, night sweats, nausea and headache

(Wyatt et al., 2004). In a study of transgender adolescents hot flushes, mood swings, weight gain, and fatigue were reported by 65% of the young people accessing GnRHa (Jensen et al., 2019). However, these young people were also accessing gender affirming hormones, so this may contribute to some of their reported symptoms. Additional reported side effects include worsening acne, vaginal bleeding, pain, and itching, and fewer erections (Panagiotakopoulos, 2018).

1.1.2 Debates and differences in approaches towards the use of PST for TGD youth

One area of debate with respect to young people's access to puberty suppressant treatment is the concern that GnRHa is not specifically licenced for this use, though it is licenced for CPP. Giordano and Holm (2020) discuss GnRHa in its use as a puberty suppressant medication and argue that the framing of its 'off-label' use as 'experimental' is misrepresentative. On their prescribing in children webpage the British National Formulary (BNF) states "Although medicines cannot be promoted outside the limits of the licence, the Human Medicines Regulations 2012 does not prohibit the use of unlicensed medicines. It is recognised that the informed use of unlicensed medicines or of licensed medicines for unlicensed applications ('off-label' use) is often necessary in paediatric practice." (British National Formulary, n.d.).

PST through the use of GnRHas was first made use of in the Netherlands, in what came to be known as the 'Dutch Protocol' (described in van der Loos et al., 2023). This approach became part of the now World Professional Association for Transgender Health's Standards for Care, from 1998 (Levine et al., 1998), and the Endocrine Society's guidelines from 2009 (Hembree et al, 2009).

Attitudes and approaches toward puberty suppression treatment for TGD young people differ internationally and have changed further in recent years. Kiely and colleagues (2024) compared the 27 European Union countries and the UK in their approaches toward healthcare for TGD people, identifying that Finland, France, Norway, Sweden, and the UK have all recently introduced limitations and restrictions on the use of PST (see section 1.3.2 for potential reasons for these responses). The approach taken in the United States of America varies by state and twenty-four states have recently enacted statutes that ban the prescription of PST to TGD young people (Grossman, 2024). This shift took place in the last several years. For example, in 2019 an international survey of centres providing specialist care for TGD children and young people found that almost all were following the WPATH and Endocrine Society Guidelines (Skordis et al., 2019). Although it must be noted that only 14 U.S states were represented in the study.

Despite the fact that puberty suppressants are considered an appropriate potential option for the care of TGD youth by the World Professional Association of Transgender Health and the Endocrine Society (Coleman et al., 2022; Hembree et al., 2017), and there is an evidence base to support their use (Achille et al., 2020; Carmichael et al., 2021; Costa et al., 2015; De Vries et al., 2011; Kuper et al., 2020; Lavender et al., 2023; Turban et al., 2020; van der Miesen et al., 2020), this intervention is considered controversial by some (e.g., Cass Review commissioned in 2020). One aspect of the controversy is the role puberty and hormones may play in sexuality.

1.1.3 Puberty, sexuality, and the rationale for using PST

Puberty refers to the physical changes that occur in the body which culminate in sexual maturity (Belkind, 2021). Sexuality is understood to be influenced by the biological pubertal changes, personal development, and social context (Graber & Sontag, 2006). Puberty processes may

influence behaviour through hormones or through secondary effects of those hormones (reviewed in Berenbaum, Beltz & Corley., 2015 and Pringle et al., 2017)**.**

Animal and human studies indicate that hormones influence sexual motivation/desire, (Wallen, 2001; AlAwlaqi et al, 2017). Frequency and intensity of desire are what is understood by the term 'sex drive' (Baumeister et al., 2001). Sexual desire has been described as "an interest in sexual objects or activities or a wish, need, or drive to seek out sexual objects or to engage in sexual activities" (Regan & Berscheid, 1995, p. 346). Two kinds of sexual desires are proceptivity, the drive to seek and initiate sexual activity, and receptivity (arousability), the capacity to become interested in sex when encountering certain eliciting stimuli (Diamond, 2010). Proceptivity appears related to hormonal fluctuations (Wallen, 2001). Tolman and Diamond (2001) have cautioned against conflating sexual motivation, and arousability, noting that men with reduced sexual motivation due to low testosterone levels demonstrate arousability commensurate with those with typical levels of testosterone.

Puberty has the potential to influence sexualized behaviour due to the biological stimulation described above, the perception that sexual activity is now appropriate, seeing oneself as a sexual being, and having others respond to one's embodiment in new ways (Graber et al., 1998; Berenbaum, Beltz, & Corley, 2015).

Puberty has been conceptualized as occurring in a series of 5 stages termed 'Tanner Stages' (Marshall & Tanner, 1969; 1970). It is in Tanner stage 2 that physically visible signs of puberty begin. While the WPATH acknowledge that knowledge of factors which may contribute to gender identity development are not definitively known, TGD young people's responses to the onset of pubertal changes can contribute to professional assessment of their gender identity

development (Coleman et al., 2022). It has been proposed that TGD young people's responses to these physical changes can be indicative of whether they will retain a non-cisgender identity into the future, particularly where their gender dysphoria worsens following the onset of puberty (de Vries & Cohen-Kettenis, 2012). Tanner stage 2 is the point at which PST can be accessed if this is felt to be appropriate (Coleman et al., 2022; Hembree et al., 2017). One aspect of the rationale to offer PST where indicated, is that the physical changes that occur across the subsequent Tanner stages are irreversible. Should an individual undergo most of their endogenous puberty prior to accessing gender affirming treatments, they will often seek additional surgical intervention to achieve more congruent embodiment of their gender identity in adulthood. It is for this reason, and the potential dysphoria and distress an incongruent body may prompt for many young people, that it is not considered an ethically neutral act to withhold access to gender affirming treatments without sufficient cause (Giordano & Holm, 2020).

However, there are areas of concern and uncertainty regarding the use of puberty suppressant treatment in the care of gender diverse youth. Some of these are with respect to the potential impact of the treatment upon the body, as GnRHa has been shown to impact bone density, for instance (Coleman et al., 2022). A key concern that holds relevance for this particular research is that expressed by some stakeholders (such as a minority of former GIDS clinicians (Barnes, 2023)) who hypothesize that a proportion of young people who access PST, may have come to hold a non-heterosexual sexual identity, rather than seek to make a transition with respect to gender.

1.1.4 The potential role of GnRHa in the experience of sexuality when prescribed as a puberty suppression treatment for gender diverse youth

As PST impacts levels of hormones in the adolescent body with the aim of halting further pubertal changes, it may impact proceptive sexual drive. However, sexual expression is not

simply determined by levels of circulating hormones (Graber, Brooks-Gunn & Galen, 1998; Wallen, 2001). It may well be the case that for gender diverse youth, they feel empowered to engage in consensual sexual activity with themselves or others as a result of feeling some relief from bodily gender dysphoria once taking the blocker. Research into the use of GnRH in other medical fields, suggests that side effects from the blocker may also play a role in the experience and expression of sexuality for young people.

The influence of GnRH analogues and agonists upon sexuality have been identified and described in the context of their use as treatments for prostate cancer (Gryzinski et al., 2022), and endometriosis (Pluchino et al., 2016). GnRH analogues are used as part of what is called 'Androgen Deprivation Therapy' (ADT) in the treatment of prostate cancer. Reported sexual side effects include erectile dysfunction, low libido, penile shrinkage, testicular atrophy, hypogonadism and delayed orgasm or anorgasmia (Gryzinski et al., 2022). Other side effects with the potential to impact sexuality include weight gain, fatigue, loss of muscle mass/sarcopenia, decreased mood, and irritability. However, it is important to note that the subjective experience of such side effects may be quite different for TGD youth who desire accessing PST, compared to adult cisgender men required to undergo ADT as part of a treatment regime for cancer.

Sex steroid suppression is also used as a specific means of treatment in cases of sexual offending, with the rationale that a high level of sex drive and arousal may contribute to offending. GnRH agonists are used as antilibidinal medications, acting to reduce Testosterone to 'castrate' levels with the goal of reducing libido (Lewis et al., 2017). In a systematic review of the use of GNRH agonist treatment in adult male sex offenders, Lewis and colleagues (2017) found that a reduction in sexual thoughts/fantasies, and masturbation/intercourse frequency was found across the included 12 studies. Though the use of GnRHas as PST is very different,

not least that it is often a wished-for, affirmative, intervention, these findings indicate that the treatment has the potential to reduce libido and/ or impact sexual functioning, at least for those assigned male at birth.

It's possible that the impact, if any, of GnRHa, upon sexuality differs from that of other means of sex steroid suppression. For instance, in the case of orchiectomy, Incrocci and colleagues (2002) found that though some encountered sexual problems, such as erectile difficulties, but participants' interest in and satisfaction with sexual intimacy did not differ from age matched controls without orchiectomy.

From research regarding the use of GnRHa for other purposes, PST for TGD young people may impact on sexuality by reducing drive, increasing fatigue, contributing to mood swings or impacting body image indirectly via weight gain or physical discomfort such as hot flashes. However, for TGD young people, the impact of the subjective meaning the intervention has for them is yet to be explored. It is possible that they may feel more at home in their bodies in the absence or reduction of dysphoria and therefore more confident to explore their sexuality with themselves or others. This study will explore how gender diverse young people experience one of the gender affirming treatments they may access, puberty suppressant treatment, and the impact, if any, they feel this has on their sexual lives.

1.2 Definitions and terminology

1.2.1 Transgender and Gender Diverse (TGD) People

For the purposes of this thesis, I am defining *transgender and gender diverse* (TGD*)* people using the description used by the World Professional Association for Transgender Health

(WPATH) who define TGD people as "people with gender identities or expressions that differ from the gender socially attributed to the sex assigned to them at birth." (Coleman et al., 2022, p. 55). Gender diverse identities can most easily be understood alongside cisgender identities. The majority of people identify as *cisgender*, meaning they identify with the gender that they were assigned at birth, on the basis of the appearance of their genitals (Parisi et al., 2007). Gender diverse people do not identify with their assigned gender. They might identify as male or female, something in between, both, or agender. Some may reject the notion of binary gender along the lines of male and female and identify as *nonbinary.* Transgender and gender diverse individuals are grouped together by virtue of their differences from the cisgender majority, rather than there being any one way of being transgender or gender diverse.

1.2.2 Young People and Young Adults

In accordance with UK legal definitions of young people outlined in the Children and Young Persons Act 1933, in this thesis I define young people as those aged between fourteen and eighteen years of age. I define young adults as those aged 18-25, in line with Arnett's theory of emerging adulthood (Arnett, 2000, 2014).

1.2.3 Sexuality

For the purposes of this thesis, I am defining sexuality as a holistic term inclusive of distinct but related phenomena such as sexual identity, sexual behaviours/practices, sexual desire, sexual attraction/orientation, sexual pleasure, and sexual intimacy. I adopt the World Health Organization's working definition of sexuality as:

> "…a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction.

> Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors." (WHO, 2006, 28-31).

Within research regarding gender and sexual minorities (GSM) it is routine practice to offer a glossary of relevant terms to facilitate understanding. However, after reading Robinson's account of queer knowledge production (Robinson, 2022), in which they question cisnormative and heteronormative academic norms regarding which terms must be explained and which do not, I was prompted to reflect upon the connection between the societal and academic marginalization of LGBTQ+ people, and the expectation to continuously elucidate fundamental terminology. Therefore, I have chosen to locate a detailed terminology section in Appendix 1 to preserve the body of the text for its central focus.

1.3 Current assessment and care context

At present, the approach taken toward the assessment and care of transgender and gender diverse children and young people within the UK is under review and undergoing significant change. Service delivery is moving from a single national specialist provider, the Gender Identity Development Service (GIDS), to a model of regional hubs. The regional hubs will serve to support and advise local services with direct contact with referred young people as its primary remit, with "limited provision for direct contact with children and young people and their families" (Cass, 2022, p.20). The current interim service specification also indicates that the primary intervention of the service will be psychosocial, and that the commissioning (and therefore, prescribing) of GnRH analogues would only be in the context of formal research (NHS England, 2023a). The context for the shift in provision is relevant to the background of this project and will therefore be outlined in brief.

1.3.1 The Gender Identity Development Service 1989-2023

The Gender Identity Development Service (GIDS), founded by Domenico Di Ceglie in 1989, was a tier 4 mental health service commissioned by NHS England to provide specialist assessment, consultation, and care for children and young people who experience gender dysphoria. The therapeutic aims originally outlined by De Ceglie were underpinned by recognition, acceptance and respect toward young people's gender identity (Di Ceglie, 1998, 2009).

The service was nationally commissioned by NHS England in 2009. Di Ceglie reiterated in the same year that the aim of the model of care was not to change the gender identity of those referred, rather to travel alongside the child or young person, and their family, to develop a shared understanding of their experience, and a sense of whether their gender is likely to shift or endure over time (Di Ceglie, 2009). With the expansion of provision, referrals to the service began to grow (NHS Arden and GEM National Referral Support Service, 2023). GIDS adopted the use of Puberty Suppressant Treatment (PST) and Gender Affirming Hormonal Treatment (GAHT) following their use in the Netherlands (2011 onwards), an approach that is known as 'The Dutch Protocol'.

The most recent service specification for GIDS was in effect from April 2016 until April 2020 and conformed to the World Professional Association for Transgender Health Standards of Care, version 7 (Coleman et al., 2012). The approach was of staged care, akin to the Dutch model (De Vries et al., 2014), comprising four possible stages which in the specification are termed as follows; "assessment and exploration", "physically reversible interventions" (PST), "partially reversible interventions" (GAHT), and lastly, "irreversible interventions" (GAS),

which are only offered in adult gender clinics (NHS England, 2019). PST is considered a 'physically reversible intervention' in that puberty resumes when the treatment is discontinued, as demonstrated in studies of it's use for Central Precocious Puberty (Zhu et al., 2024). Though some research has begun to indicate that GnRH may play a role in aging processes, cognition and motor functions, research into its role in the central nervous system is ongoing (Wickramasuriya et al., 2022).

The Cass review, formally known as 'The Independent Review of Gender Identity Services for Children and Young People', was commissioned by NHS England and NHS Improvement in late 2020 to inform the commissioning and provision of services for children and young people "experiencing issues with their gender identity or gender incongruence" (NHS England and NHS Improvement, 2020, p1). The terms of reference state that the observed increase in referrals to GIDS and the introduction of the provision of medical interventions such as PST and GAHT have contributed to growing public and professional interest and concern regarding how the National Health Service (NHS) should assess, diagnose, and provide care for referred children and young people, prompting the request for an independent review. The NHS commissioned the review to report findings and recommendations for eight specific areas of interest. Regarding the use of PST in the form of Gonadotropin Releasing Agonists (GnRHa), the request related to "…treatment objectives, expected benefits and expected outcomes, and potential risks, harms and effects to the individual." (NHS England and NHS Improvement, 2020, p1). In the interim report it is noted that there is very limited research on the sexual outcomes of puberty blockers (Cass, 2022, p.19). Though there is limited research which centres specifically on the sexual outcomes of PST, there are some research studies which offer some information about this intersection (reviewed in Chapter 2). The assertion made in the Cass report fails to consider the wider research context in which medical interventions for

young people do not routinely examine sexual outcomes, though this might be prudent, as in the case of childhood cancer survivors for instance (Yang et al., 2024). Nevertheless, the relative lack of research examining sexual outcomes is a significant oversight, as several areas of concern and debate with respect to the use of GnRHa as PST centre sexuality and sexual functioning, as outlined below.

1.3.2 Perspectives regarding puberty suppressant treatment

Public debate (e.g., Barnes, 2023, NHS England, 2023b) and legal challenges (e.g., *Bell v Tavistock*, 2020; *Appleby v Tavistock,* 2021) regarding the use of GnRHa as PST forms a significant part of the broader context of shifting provision of care to TGD children and young people. At present, the draft interim clinical commissioning policy has proposed that PST is 'not routinely commissioned' and should only be provided as part of research, with prescription outside of research considered on an 'exceptional' basis and requiring consideration and approval from a national multidisciplinary team. This is due to the perceived lack of evidence supporting their safety and clinical effectiveness as a routinely available treatment (NHS England, 2023a).

Unfortunately, a comprehensive overview of the various areas of contention is outside of the scope of this research. I will therefore make brief mention of some areas of concern and controversy, before outlining those which hold more relevance for the topic of sexuality.

Existing research indicates that the majority of young people who access PST later access GAHT (Carmichael et al., 2021; de Vries et al., 2011; Wiepjes et al., 2018). Some have sought to argue that due to this phenomenon, young people should be required to demonstrate capacity to consent to the outcomes of *both* interventions prior to commencing PST (*Bell v Tavistock*,

2020). However, the finding that those who access PST frequently go on to access GAHT may simply be linked to their having been carefully assessed and appropriately offered each intervention (Coleman et al., 2022). Arguably, if very few young people went on to access GAHT having accessed PST it is likely that critics would then also question if the intervention was serving it's intended purpose. Another argument made by those concerned about the use of PST for TGD youth, is that TGD youth who access PST may have otherwise come to understand their experience as that of a cisgender sexual minority, such as identifying as gay, lesbian or bisexual (Temple Newhook et al., 2018). However, this concern largely stems from four studies in which a sizeable proportion of TGD youth who 'desisted', later identified as gay or lesbian (Drummond et al., 2008; Steensma et al., 2011; 2013; Wallien & Cohen-Kettenis, 2008). These studies have been criticised on several important methodological bases, not least the potential misclassification of participants who would not be considered to meet diagnostic thresholds at present, and as such it is argued that it is inappropriate to generalize from their findings (Temple Newhook et al., 2018, Winters, 2019).

With regards to sexuality, foci of debate include:

- The concern that accessing GnRHa/PST may reduce sexual interest in such a way as to circumscribe a young person's expected exploration of sexuality as part of a developmental process, with concerns regarding the social implications of this (Korte et al., 2008).
- The potential impact of appearing younger than same aged peers who have undergone endogenous puberty with respect to peer (and possibly intimate) relationships (Giovanardi, 2017).
- The concern that transfeminine young people may not undergo sufficient genital growth to facilitate later vaginoplasty using penile tissue, thereby necessitating the use of other

bodily tissues to construct the neovagina (should they wish to later access this particular gender affirming surgery) (Lee et al., 2022). This expressed concern on the part of critics of the use of PST is a rather cisnormative one, however, as it assumes that TGD young people and adults privilege the appearance of the genitals in their embodiment of gender. An alternative view is that a greater barrier to being recognised and accepted as a woman is the presence of male-typical phenotypes such as a deep voice, rather than the appearance of the genitals (Van de Grift et al., 2016). This is what Langer (2014) refers to as public aspects of the gendered body.

1.4 Problem statement and research questions

Adolescence is culturally synonymous with sexuality. The development of secondary sexual characteristics and the actualisation of reproductive capacity occurs in adolescence due to pubertal changes and it is considered a time of life when sexual desire and exploration begins. For TGD young people, pubertal changes can contribute to or exacerbate gender dysphoria, resulting in significant distress for some. This distress may link to an individual's intrapersonal and interpersonal experiences of bodily attributes, such as breasts and facial hair, which are socially gendered (Kessler & McKenna, 1978). PST is one means of relieving this distress and facilitating further exploration of gender (Coleman et al., 2022). However, in the UK, public and professional interest and concern have led to changes in provision. One aspect of the debate regarding the use of GnRHa as PST centres on concerns regarding the potential disruption of psychosexual development as noted above. However, one may also argue that the exploration of personal sexuality is more complex for TGD youth due to the bodily dysphoria they might experience and through how TGD people are positioned and responded to in society. The research reported in this thesis seeks to understand how TGD young people experience and understand their sexualities in the context of accessing PST. The overarching research question

for this thesis is: *'How do gender-diverse young people who have accessed puberty suppressants speak about their understanding and experiences of their sexualities?'* To address this question, this study seeks answers to the following three related research questions:

RQ 1: What are the experiences of gender diverse young people in receipt of puberty suppression treatment with respect to sexuality?

RQ 2: What master narratives do gender diverse young people draw on when describing their experience and understanding of their sexualities in the context of accessing puberty suppressant medication?

RQ 3: In what ways do the young people replicate, modify, or counter the master narratives they draw upon when storying their experiences and understandings?

1.5 Researcher position

My initial awareness of the need for research on gender diverse young people's experiences of PST arose from both my personal experience and my professional practice.

Over a decade ago, whilst on a study abroad year in the United States., a close friend of mine, Sam* (*Pseudonym) was on the precipice of accessing gender affirming hormones. As their friend, I was afforded a glimpse into their subjective experience of this. When they accessed hormones, they shared about how they felt that they were having a second 'proper' adolescence, and one surprising aspect was that they were much more interested in sex than before. They shared previously struggling to engage in sexually intimate acts alone or with others as they felt a high degree of dysphoria about their body but had now begun to value their sexuality in a new way. This shift was significant in that they now felt empowered to engage with their sexuality and began actively dating as a result, meeting their now spouse.

I later worked as an assistant psychologist with the Gender Identity Development Service (GIDS), the then national specialist service supporting young people to think and talk about their experiences of gender. For some young people, the service afforded them the opportunity to make changes to their bodies through accessing puberty suppression treatment and/or gender affirming hormones. For adolescents, sex and sexuality are routinely considered core areas of interest and exploration (Diamond & Savin-Williams, 2009). Some young people reported refraining from engaging with their sexualities due to dysphoria or even disgust. Others, however, reported enjoying their sexuality and having intimate contact with themselves and others and having romantic relationships. As part of the process of accessing any physical treatments, young people and their parents were supported to think about all the aspects and implications of these so they could make an informed decision. I was aware that accessing physical interventions had a number of side effects alongside their desired effects and was intrigued about the potential impact of the treatment upon young people's experiences of sex and sexuality.

These experiences informed my interest in this project. I wish to amplify and contextualise the voices of gender diverse youth in relation to this topic, as it is an area of controversy characterised by strong conflictual perspectives. The voices routinely provided a platform regarding gender diverse youth are most often those of cisgender people, be they lawmakers, commissioners, journalists or celebrities. Through this research project, I hope to contribute to the research regarding gender affirming treatments for gender diverse young people, foregrounding and contextualising *their* accounts of their experiences of accessing PST as this relates to sexuality.

As a Clinical Psychologist in training, I am particularly concerned with supporting people as individuals with respect to their unique experience of the contexts in which they are embedded at a personal, societal, and historical level. The role of a clinical psychologist is not just to reduce distress, but to support psychological wellbeing (Wood & Tarrier, 2010). This is relevant in this study regarding gender diverse youth's accounts of the impact, if any, of PST on their subjective experiences and understandings of sexuality. Subjective experiences are shaped by the worlds we inhabit and move between, and it makes logical sense that young people's accounts of their experiences draw upon and respond to the broader narratives regarding sex, sexuality, and gender, as well as media portrayals of sociolegal and clinical debate regarding best practice.

At this juncture I also must ask of you, the reader, to reflect upon your own relationship and responses to this topic. Richards (2011) notes that research regarding gender and sex/uality can induce strong feelings in a reader and proposes that readers consider their own prior knowledge and beliefs such that they can engage with research material reflexively.

1.6 Summary

This chapter has provided an overview of the rationale and different approaches to prescribing PST for TGD youth and how the current debates regarding PST are influencing current assessment and care contexts. In order to inform future debates and care provision the research reported in this thesis seeks to understand how TGD youth experience and understand their sexualities in the context of accessing PST.

Chapter 2: Literature Review

This chapter presents a review of the literature relevant to this research, focusing on what the gaps in knowledge are regarding the effect of puberty suppressant treatment on the sexual lives of gender diverse young people. A systematic search of the available literature with respect to TGD young people and sexuality in the context of accessing gender affirming treatment (GAT) was undertaken. Due to the limited research regarding sexuality in the context of accessing puberty suppressant treatment (PST), a scoping review approach was adopted (Munn et al., 2018). To maximize identification of relevant literature, a comprehensive and sensitive search strategy was employed (See Appendix 2).

2.1 Sexuality of TGD individuals in the absence of GAT

To appraise the potential impact of PST upon sexuality, it is important to develop an awareness of the ways in which the sexualities of TGD people may differ from their cisgender counterparts in the absence of any form of gender affirming treatment. In this section I will draw upon studies with TGD adults and young people that report findings relating to sexuality in the absence of gender affirming treatments, including puberty suppression treatment. Prior research has indicated that transfeminine people and transmasculine people differ in their sexual orientations, 'partnership constellations', and sexual practices with respect to masturbation. Prior research has also indicated that body image appears to impact sexual agency and sexual pleasure.

2.1.1 Adults

A number of studies have reported data regarding the sexualities of TGD adults prior to their accessing gender affirming treatments (Cerwenka, Nieder, Briken, et al., 2014; Cerwenka, Nieder, Cohen-Kettenis, et al., 2014; Nikkelen & Kreukels, 2018). These studies indicate that gender dysphoria and body dissatisfaction impact comfort with and engagement in sexual intimacy.

In their study examining the sexual behaviour of 380 TGD adults prior to accessing GAT, Cerwenka, Nieder, Cohen-Kettenis, et al., (2014) found that transmasculine individuals (termed 'FTM' in the paper) and transfeminine individuals (termed 'MTF' in the paper) differed significantly with respect to sexual orientation, with transmasculine individuals more attracted to members of their sex assigned at birth, compared to transfeminine individuals (for early onset, $\chi^2(1) = 32.751$, $p < .001$; for late onset: $\chi^2(1) = 13.794$, $p < .001$.). They did not find any significant differences in partnered sexual experiences based on sex assigned at birth (for early onset, $\chi^2(1) = 0.376$, $p = .540$; for late onset, Fisher's exact probability test, $p = .354$.), with approximately 80% reporting experience of this in both groups. With respect to involvement or avoidance of the genitals during partnered sexual intimacy, 60.4% of transfeminine and 50.5% of transmasculine participants reporting engaging in partnered sexual intimacy involving their own genitals, with no significant between group differences (for early onset, $\chi^2[1] = 0.007$, $p = .923$; for late onset: Fisher's exact probability test, $p = .080$). Of note, however, transfeminine respondents more frequently appraised orgasm less positively than transmasculine respondents, with those characterized as having an 'early onset' of gender dysphoria reporting their experience of orgasm as 'never pleasant' in higher proportions to those characterized as 'late onset'. (Participants were categorized as 'early onset' or 'late onset' on the basis of whether they would have fulfilled diagnostic criteria in childhood).

In a separate study, Cerwenka, Nieder, Briken, et al., (2014) examined the romantic and sexual partnerships of TGD individuals prior to accessing GAT. They characterized partnerships as 'complementary partnership constellations' (CPC) when the sexual orientations of each partner oriented toward the gender (rather than sex assigned at birth) of the other, terming partnerships where there were discrepancies in this, 'noncomplementary partnership constellations' (NPC). Participants in CPCs indicated more avoidance of involving their genitals in partnered sexual intimacy and more negative appraisals of genital sensations during sexual intimacy, something the authors proposed as being reflective of gender dysphoria, and therefore potentially responsive to GAT.

Writing in the context of critical counselling psychology, Richards' (2018) existential-phenomenological study affords some qualitative insight into the experiences of one participant prior to accessing GAT (indicated as GAHT specifically) where they describe a feeling of interference, cognitive dissonance and distraction with respect to their body when engaging in sexual intimacy. Another participant, in contrast, specifically spoke about their enjoyment of their body and their sense that there was an expectation that as a trans person they should not enjoy their body. This person had accessed GAHT and GAS, however. It is possible that the experiences described by both might link to the degree to which their desire to access GAT had been fulfilled. Additionally, there was a theme regarding increasingly congruent embodiment as a means of expressing one's sexuality, and an associated theme of time regarding the type of sexual expression possible at a any given point in transition/increasingly congruent embodiment (Richards, 2018).

Related to embodiment and sexuality across time, Nikkelen & Kreukels (2018) examined the sexual experiences of a nonclinical group of TGD people via survey, comparing the subgroups of those with no desire for gender affirming treatments (NTD) to those who had or had not accessed some GAT but planned to access more (unfulfilled treatment desire, UTD), and those with fulfilled treatment desire (FTD). Those with no treatment desire scored lowest of the three groups on sexual agency, the degree of control an individual feels they have over what occurs during sexual intimacy (with NTD transmasculine participants also scoring the least for sexual pleasure). It was found that body satisfaction accounted for the variance in between subgroups on all the indicators of sexual behaviour and feelings (all *p*s < .01), apart from masturbation, which the authors proposed could link more closely to hormonal profile. With respect to this last observation regarding masturbation, the results of Garz et al., (2021) may offer some additional information. In their examination of self-assessment questionnaires completed by 210 TGD adults, body image was *not* demonstrated to mediate the link between GAT and *sexual desire* specifically, suggesting that shifting proceptive desire (and perhaps therefore masturbation) may relate more closely to the effects of hormone treatment, rather than body image. They suggest that qualitative research examining connections between body image and sexual desire is pertinent. However, it also suggests that increased sexual agency (etc.) is not a function of increased sexual desire.

Though their study did not focus specifically on the experience of TGD adults who had yet to access GAT, Doorduin and Van Berlo's (2014) grounded theory interview study with twelve transgender people offers some useful areas of potential insight into how TGD individuals may navigate sexuality in the context of dysphoria (Doorduin & van Berlo, 2014). Participants described ambivalent feelings toward sexual intimacy, describing dysphoria, aversion, or feelings of disgust, alongside physical pleasure. Half described how incongruence between

gender identity, gendered embodiment, and social perception of gender impeded their ability to sustain arousal and experience orgasm. Participants described various efforts to manage the heightened dysphoria sexual intimacy could prompt. Some strategies were preventative, such as avoiding sexual intimacy or particular sexual practices altogether or avoiding having certain areas of the body touched. Other strategies were proactive, and affirming of their gender, such as ensuring their gender role within a sexual encounter was affirming with respect to culturally gendered acts and practices. Participants also described negotiating their dysphoria during sexual intimacy by disassociating from their bodies or arousal responses, visualizing a more congruent body, or directing their focus toward their partner/s. It is important to note that the average age of participants in Doorduin and Berlo's study was 43. This means that the experiences reported and interpreted in this study may hold demonstrably less significance for younger adults and adolescents, who aside from this difference in chronological age and sexual and life experience, access additional interventions.

The literature regarding TGD adults' experiences of sexuality prior to and during/following accessing GAT may overlap in certain ways with the experiences of TGD young people, for instance in how gender dysphoria may impact their experience of sexuality and how accessing GAT may inform their body image. TGD young people, however, differ from TGD adults in some key ways such as their age and life stage, their degree of sexual experience, and the gender affirming interventions they may access, such as PST. Experiences of GnRHa as PST are considered next.

2.1.2. Young People

Several studies have examined the sexual and romantic experiences of TGD young people prior to their accessing any form of gender affirming treatment (Bungener et al., 2017; Olson et al.,

2015; Ristori, Rossi, et al., 2020). Prior to accessing gender affirming interventions, transgender youth have been found to experience sexual and romantic milestones along a trajectory in which experience increases in both number and degree of sexual intimacy over time in a similar manner to their cisgender peers, but at a delay. The literature indicates that transmasculine and transfeminine young people differ in rate and range of sexual experiences, and that TGD youth report a range of sexual identities.

For instance, in a large Dutch comparison study of the sexual and romantic experiences of 137 TGD adolescents, none of whom had access any gender affirming treatments, inclusive of PST, it was found that gender diverse young people were less sexually and romantically experienced than their cisgender peers in the general population (Bungener et al., 2017). For instance, in the 12-14 age range, TGD young people reported engaging in petting while undressed at a rate of 6%, compared to the general population (31%). For those aged 15-17 this shifted to 43% and 69% respectively. With respect to 'sexual intercourse' TGD young people aged 12-14 reported engaging in this at a rate of 3% compared to 7% for the general population. This increased to 7% for TGD young people ages 15-17, compared to the general population (40%) of 15–17-year-olds. With respect to romantic relationships however, the majority reported having fallen in love (77%) and half reported experience of a romantic relationship**.** The TGD participants most often (65%) reported attraction to members of their assigned sex. Within group comparison indicated that transmasculine young people had more experience of most sexual experiences measured (sexual fantasies, French kissing, and petting while undressed) apart from sexual intercourse, (which the study defined as 'vaginal penetration with a penis') in which transfeminine young people were more experienced. There were no significant gender differences with respect to falling in love and experience of romantic relationships.

With respect to partnered sexual intimacy, a quarter had experienced petting and 5% reported having had sexual intercourse. Bungener and colleagues (2017) report that of those who were sexually active, 50% reported not using their genitals. However, it was unclear if this referred to those reporting petting as well as sexual intercourse, or sexual intercourse only. Of those in a current romantic relationship, about half (7 YP) described dissatisfaction with their sexual relationships, citing discomfort with their current bodies and genitals impinging upon their enjoyment of sexual intimacy. This was a higher rate of dissatisfaction than that reported by cisgender respondents. However, due to the small number of respondents in a position to comment on their sexual satisfaction, this may not be considered generalizable (Bungener et al., 2017). The overall group cited shame about their bodies because of gender dysphoria as the second most reported reason not to have intercourse. It is important to note, however, that most adolescents in the study had not made a social transition and therefore were likely being perceived and treated incongruently by others, including potential romantic or sexual partners. Additionally, this study defined sexual intercourse as 'vaginal penetration with a penis', thereby potentially precluding the identification, and measurement of other forms of sexual intercourse TGD youth may engage in, such as that involving the use of prosthetics and/or anal penetration. Further, the study items lacked sufficient sensitivity regarding young people's potentially differential experiences of sexual intercourse as the penetrative or receptive partner, something which may vary depending on their identified gender. Therefore, the degree of sexual experience of participants may be an underestimate. Of note, is that the majority had experience with romantic and sexual relationships, and there was an observed trend of increased sexual and romantic experience in relation to age, albeit it at a delay compared to cisgender young people (specified with reference to particular acts of sexual intimacy, outlined above).

Ristori, Rossi, et al., (2020) found similar results in their cross-sectional study of 50 adolescents without previous access of GnRHa. Transmasculine young people were almost 9 times more likely to have experience of at least one romantic relationship compared to transfeminine young people (Odds ratio of 8.65 with 95% Confidence Interval of [2.02–37.11], p=0.004). However, no significant differences were observed on the basis of sex assigned at birth for sexual orientation (majority heterosexual), likelihood of having fallen in love, and of having had one or more sexual partners in their lifetimes. The findings of both studies indicate that TGD young people demonstrate interest and engagement in romantic and sexual intimacy prior to accessing gender affirming treatment, despite the challenge of navigating both gender and bodily dysphoria.

In a study of the baseline physiologic and psychosocial characteristics of 101 TGD youth seeking care at a large US gender service, all but two had not accessed any form of gender affirming treatments, including PST (Olson et al., 2015). The majority identified as heterosexual (describing their sexual orientation with reference to their gender, not their sex assigned at birth), similarly to the studies discussed above. Approximately half of the 101 participants (46%) reported some experience of sexual activity, with more transfeminine people (55%) than transmasculine people (37%) indicating this. However, the authors note that the transfeminine participants were significantly older (t[94]=2.18, p= .03) than the transmasculine participants, therefore the ostensibly higher proportion of transfeminine people with sexual experience in the study may in fact be a function of age. Interestingly, just 57% of transfeminine youth compared to 94% of transmasculine youth had made a social transition at the initial study visit, with participants beginning to live in their gender role at age 16.8years on average. Therefore, for a proportion of the respondents, it is possible that some sexual experiences may have been with partners who viewed and engaged with them in an incongruent manner based

on a cisnormative assumption of their gender identity. As such, it is unclear what potential meaning such experiences held for the participants or how such experiences were navigated with partners. It is also possible that those who indicated sexual experience overlap entirely with those who had made a social transition. Also of note is the report that transmasculine youth demonstrated significantly higher levels of dysphoria than the transfeminine youth at baseline (55.9 vs. 50.1 respectively; $t\ [78] = -4.418$, $p < .001$), despite their having made a social transition to a greater extent. This may have been a contributing factor to their comparatively lower levels of sexual experience compared with transfeminine youth. Olson and colleagues note, however, that their sample contained a high number of young people who would be considered clinically overweight or obese, something which may contribute to body image in general, and specifically to gender dysphoria, as, for transgender men, nonbinary people, and cisgender men alike, body fat can be considered feminizing (White, 2019). For instance, in their autoethnographic study, Orr (2023) explores how their body size is an impediment to accessing gender affirming surgery to reduce their breast tissue. This is not always the case, however. In fact, one participant in Dozier's study (2005) noted that though he was 9 months pregnant, he was still recognized as male; attributing this to his facial hair, which may point to aspects of embodiment that are more salient in the construal/recognition of gender.

In contrast to the observed predominance of heterosexual identities in the above studies, in a relatively recent anonymous U.S internet survey study of 1,223 self-identified TGD adolescents aged fourteen to eighteen years old (Mean age of 16), a large proportion of the sample indicated a non-monosexual identity, such as bisexual, queer, or pansexual (66%), followed by gay/lesbian/homosexual (18.4%), asexual (7.6%) and heterosexual (3.1%) identities (sexualities indicated in reference to identified gender) (Maheux et al., 2021). Information was gathered regarding participants' engagement in various forms of sexual

intimacy, as well as their age of initiation for these, the gender of their partner, and experiences with sexually transmitted infections. The sample was predominantly assigned female at birth (89.9%) and most of the sample indicated that they had not accessed any form of GAT, (including PST), with 11.86% of the total sample having done so. Across the sample a little over half reported engaging in one or more of the four sexual behaviours measured (termed 'sexual touching', 'oral sex', 'vaginal sex', and 'anal sex'). Young people reported first engaging in sexual touching and oral sex around the age of fourteen, and vaginal and anal sex around age fifteen. The results are in accordance with those of Bungener et al. (2020) in the sense that TGD youth appear to engage in sexual behaviours along a similar trajectory to that of their cisgender peers. However, unlike the findings of other studies, there were no observed differences between the rate of sexual experience between transmasculine and transfeminine young people, and young people identified as heterosexual to a much lower extent. A potential contributing factor to the low number of participants who identified as monosexual or heterosexual may be the study's method of recruitment. Recruitment was targeted towards young people with indicators of an interest in gender diversity within their social media profiles. It is possible that monosexual or heterosexual TGD people engage less with such content for and were therefore less likely to be advertised the study. Iantaffi and Bockting (2011) suggest fear of harassment and violence may be one reason for this lack of engagement. As the study did not rely on an exclusively clinical population, the results may cast some light on the experiences of TGD young people who do not seek clinical support.

2.1.4 Conclusion

Gender diverse young people demonstrate interest and engagement in romantic and sexual relationships prior to accessing gender affirming treatment. Findings differ with respect to differences between transmasculine and transfeminine youth regarding the extent and type of

sexual activity they have engaged in. Similarly, findings differ regarding the proportion who indicate a heterosexual, LGBTQ+, asexual or other sexual orientation. The overview of literature pertaining to TGD adults has themes that could be reasonably construed as relevant for young people, such as the role of being in a 'complimentary partnership constellation', or the impact of fulfilled versus unfulfilled treatment desire upon sexuality. Like TGD adults, TGD young people indicate that gender dysphoria is a barrier to exploring sexual intimacy. As gender affirming treatments function to alleviate dysphoria (Coleman et al., 2022), it is important to discern the role these may play in informing sexual experience. This is the focus of this thesis.

2.2 Isolating influences by treatment type

A key critique of research regarding the influence of gender affirming treatments upon TGD individuals' experiences of sexuality, is the failure to examine the influence of gender affirming hormone treatments and that of gender affirming surgeries separately (Burns et al., 2022). In this section I first consider the findings of the adult literature with respect to the influence of gender affirming treatments upon sexuality. Next, I examine studies that subsume puberty suppression treatment under gender affirming hormone treatment, followed by those in which it is possible to draw out useful information pertaining to PST alone.

2.2.1 Effect of gender affirming treatments upon sexuality of adults

There is a wealth of studies regarding the sexuality of TGD adults both during and following access to gender affirming hormone and surgical treatments. Various studies have highlighted shifts in sexual attraction, desire, functioning and practices, which participants attribute in part to accessing gender affirming treatment. Though such studies are neither with adolescents nor

about puberty suppressant medication specifically, they highlight areas of reported change which likely hold relevance for this population and intervention.

Many studies focus specifically on the role of gender affirming hormone treatment (Auer et al., 2014; Costantino et al., 2013; S. A. Davis & Colton Meier, 2014; Defreyne et al., 2020; Hansbury, 2004; Ristori, Cocchetti, et al., 2020; Rosenberg et al., 2019; Staples et al., 2020.; Wierckx, Elaut, et al., 2011). Yet more studies examine the influence of gender affirming surgeries upon sexuality (Costantino et al., 2013; Cuypere et al., 2005; S. A. Davis & Colton Meier, 2014; Doorduin & van Berlo, 2014; Fein et al., 2018; Garz et al., 2021; Katz-Wise et al., 2017; Klein & Gorzalka, 2009; Laube et al., 2020; Lawrence, 2005; Lindroth et al., 2017; Monteiro Petry Jardim et al., 2022; Sheffield & Keuroghlian, 2018; van de Grift et al., 2019; Wierckx, Caenegem, et al., 2011; Wierckx et al., 2014).

The intersection of gender affirming treatments and sexuality indicates the importance of factors which transcend the individual, such as body image, which are at once personal and psychological, as well as socially and interpersonally mediated. As a thorough discussion of the adult literature is beyond the scope of this literature review, I will outline some of the findings from two review studies published within the last five years, before discussing broad trends with reference to some key qualitative papers.

Thurston and Allan (2018) conducted a review of the qualitative literature on transgender experiences, analysing seven articles and identifying two themes: 'Re-negotiating previous 'norms'' and 'Establishing identity'. The review included the perspectives of both transgender individuals and their partners but excluded mixed methods studies. The authors justified this approach by prioritizing studies that achieved 'conceptual saturation' (Thomas & Harden, 2008)

in addressing their review question. The review emphasized the impact of what they refer to as "the gender affirmation process" (p.40) on sexual desire and practices. They use this term to include things such as social transition, legal confirmation of gender, and accessing gender affirming treatments. Illustrative quotes link this to the process of transition in general as well as to the impact of accessing gender affirming treatments. Respondents reported adapting to their own or their partners' gender realization, as they understood and embodied their gender differently and/or accessed interventions that impacted their embodiment of their gender. Adaptations included navigating changes in sexual desires, opportunities, and practices (such as new or altered ways of engaging in sexual intimacy due to changed understanding and embodiment of gender), inclusive of shifting frequency of sexual activity (with some attributing increases in sexual desire to accessing GAHT, and others noting a reduction in sexual intimacy with partners) with this leading to a sense of sexual development and re-establishment of their sexual identity.

Another recent narrative review considered cross disciplinary literature pertaining to the associations between gender affirming hormone therapy and sexuality with respect to bodily changes, sexual desire, sexual satisfaction, experiences of sexual orientation/identity, and sexual behaviours/practices (Burns et al., 2022). The authors gave an incisive critique of some methodological and epistemological aspects of prior research regarding gender affirming hormone treatment and sexuality, observing seven limitations: the overrepresentation of retrospective studies, lack of recognition of temporal dimensions of existing research, overrepresentation of Western, white, binary trans participants, inadequate use of participant self-descriptors in favour of relabelling or working in dichotomies, overrepresentation of outsider researcher identities, clinical recruitment of participants, and a lack of attention to GAHT in isolation.

Following this, Burns and colleagues (2022) emphasized five key points originating from their review of the literature. Firstly, they found that reported shifts in solitary and partnered sexual desire among individuals accessing GAHT (specifically testosterone) tend to return to baseline levels within three years. Secondly, they proposed that physical changes resulting from GAHT may influence sexual satisfaction through the mediating factor of increased body satisfaction. Thirdly, they highlighted that changes in sexual orientation cannot be unambiguously attributed to GAHT but are likely influenced by an interlinked combination of social, cultural, and psychological factors in conjunction with GAHT. This interplay may lead individuals to adopt sexual orientation labels in keeping with their actualized gender, or allow them to take note of, explore, and act upon their sexual attraction in new ways. Fourthly, they suggested that shifts in sexual acts or practices associated with GAHT may be attributed to increased access to or acceptance of gendered practices or norms or may follow on from improved body satisfaction/reduced body dissatisfaction. Lastly, they noted that GAHT does not appear to affect practices related to HIV or contraception.

Of their five points, the second, third, and fourth appear likely to hold some relevance for the study of sexuality in the context of accessing puberty suppressant medication. The review suggests that GAHT interacts with sexuality through increased body satisfaction and the alteration of social gender signifiers such as the presence of facial hair or breasts. This suggestion is of interest with respect to the current study as PST is a considerably different intervention. Though PST serves to pause the (further) development of secondary sexual characteristics such as the above, the intervention exerts limited influence on that which has already taken place. Therefore, if a young person has already undergone significant pubertal changes at the point of accessing PST, they may not experience its primary benefit. As a result,

young people accessing PST may not experience an equivalent shift in their body dis/satisfaction or social, bodily, signifiers of gender. It is therefore important to seek to develop knowledge and understanding of the experiences and meaning making of young people in receipt of this particular intervention, with attention to the unique temporal, developmental, and social location they occupy compared to adults accessing GAHT.

Doorduin and van Berlo (2014) report that with respect to the specific impact and influence of gender affirming hormone treatment, the nine participants who accessed GAHT attributed changes in their experiences of sexual desire, arousal, genital sensitivity, and orgasm to the intervention. The transfeminine individuals who reported this (4/4 that accessed this intervention) noted an (initial) reduction in sexual desire and ability to sustain sexual arousal (taken to mean physiological arousal). In contrast, all of the transmasculine participants who accessed hormone treatment (5/5) reported reinstated or increased sexual desire. Subjective experiences of the reported change ascribed to hormone treatments, though predominantly positive among transmasculine individuals, varied among transfeminine respondents, with one individual voicing satisfaction at experiencing less of an urge to masturbate, and another noting disappointment at her blunted ability to obtain sexual arousal and orgasm. Transmasculine participants are reported as experiencing sexuality in a more congruent and enjoyable 'masculine' manner. Doorduin and van Berlo note that participants valued sexual functioning they felt corresponded with that of cisgender people in their gender category. Such gendered interpretations of subjective experience, in addition to physical effects of gender affirming physical interventions, point to the role of increased gender congruence in participants' capacity to engage in and derive pleasure from sexual intimacy.

Similarly, in a recent study, transmasculine individuals (n=16, aged 19-33 with an average age of 25) spoke to the contribution of Gender Affirming Treatment (GAT) with respect to sexual experiences (Engelmann, Nicklisch & Nieder, 2022). For some, as in Doorduin and van Berlo's (2014) study, the improved confidence and bodily changes resulting from GAT led to newfound comfort and satisfaction in receiving (previously avoided) pleasurable touch. However, regarding gender affirming hormone therapy specifically, one participant expressed increased genital dysphoria as his body progressively masculinized on GAHT, further reducing his comfort with receiving touch. Others noted that experiencing increased vaginal lubrication when aroused due to GAHT prompted additional dysphoria. Some cited gender affirming surgeries (GAS), particularly "top surgery" (bilateral mastectomy with associated chest contouring), as liberating, and reported feeling less self-conscious and more comfortable with their bodies during partnered sex.

Of note is Rosenberg and colleagues' (2019) qualitative interview study with 12 transwomen regarding their experiences with GAHT as it relates to sexuality. GAHT for transfeminine people typically consists of oestrogen combined with androgen blockers or medications which decrease the synthesis or actions of androgens, such as GnRHa (Angus et al., 2021). One potential effect of GAHT for transfeminine people is a reduction or loss of erectile function, which the authors note is typically cast as 'sexual dysfunction' in the literature. However, several participants shared their experiences of heightened sensitivity and the development of novel erogenous zones which enhanced their sexual lives. Some experienced reduced sexual desire which they attributed to the anti-androgen component of GAHT. For some this was a problem they sought to remedy via adjusting their treatment regimen, and others appeared to frame this as simply another aspect of the female experience.

2.2.2 Studies that examine the effect of PST combined with other interventions

Several studies report the effect of PST in combination with other gender affirming interventions with respect to sexuality (Araya et al., 2021; Bungener et al., 2020; Nieder et al., 2021; Warwick et al., 2022).

In a recent study by Bungener and colleagues (2020), questionnaires were administered to 113 transgender young people to gather information about their current and past sexual and romantic experiences, both before and after gender-affirming treatments (GAT) including puberty suppression treatment (PST), gender-affirming hormone therapy (GAHT), and gender-affirming surgeries (GAS). Participants completed the questionnaires at least one year after undergoing GAS. The items related to sexual and romantic experiences were adapted from a larger study on sexual health among youth in the Netherlands to facilitate comparison with cisgender youth of the same age. Most respondents valued sex (92.7%), relationships (94.6%), and love (93.7%) as moderately to very important, with most expressing satisfaction with their sex lives (66.7%). In comparison to their cisgender peers, transgender youth entered relationships at a significantly older age (mean = 15.4 [SD = 2.1] versus mean = 14.4; t_{85} = 4.3; $P < .001$) and also engaged in intercourse (mean = 18.5 [SD = 2.1] versus mean = 16.6; t_{34} = 5.3; $P < .00$), petting (mean = 16.4 [SD = 2.3] versus mean = 15.1; t_{80} = 4.96; $P <$ .001), and masturbation (mean = 15.4 [SD = 3.1] versus mean = 13.7; t_{68} = 4.54; $P < .00$) at an older age also.

The study also found that respondents reported engaging in sexual activities involving their partners' genitals at an earlier age compared to activities where they were the recipients of genital touch: (manual active, mean = 16.3 (SD = 2.6), versus passive, mean = 17.8 (SD = 2.1)

(t_{47} = 57.5; P < .001); oral active, mean = 16.6 (SD = 1.9), versus passive, mean = 18.3 (SD = 2.2) (t_{38} = 50.5; P < .001)). The study revealed that transgender young people reported increased sexual experiences after accessing GAT. Prior to GAS there were no significant differences between transmasculine and transfeminine respondents in relation to degree of sexual experience, with the exception of masturbation, which transmasculine youth engaged in at a higher rate (31.6% vs 69.4%; χ_1^2 = 14.05; P < .001).

After accessing GAS there was a trend in which all respondents reported increasing engagement in sexual activities involving their own genitals, and specifically in partnered sexual activities in which they were the recipients of sexual pleasure from a partner. Transfeminine individuals reported significantly more engagement in intercourse (from 13.2% to 60.5%); p<0.05), receiving oral (from 10.5% to 52.6%; p<0.001) or manual sex (from 15.8% to 68.4%; p<.001), and masturbation (from 31.6% to 89.2%; p<.05). Similarly, transmasculine individuals reported significant increases in partnered sexual activities (oral and manual sex) where they were the recipients (oral sex from 21.1% to 37.7%, p<.001; manual sex from 23.9% to 42.9%, p<.001)

The authors suggest that body image and body satisfaction may exert influence over respondents' increased engagement in various sexual activities, particularly those in which they are the recipient of genital stimulation. In addition, the authors suggest that the increase in sexual activity may also link with young people being perceived by others as their gender, rather than that which was assigned to them at birth, facilitating their access to and acceptance from prospective sexual or romantic partners.

The authors also note that the later age at which transgender youth report engaging in all types of romantic and sexual activities compared to their cisgender peers may be linked to the impact wider negative perceptions of transgender people may have on their likelihood of finding romantic and sexual partners. For instance, transfeminine young people reported fewer romantic relationships than their transmasculine counterparts (63.2% compared to 82.4%), which the authors suggest may link to higher levels of discrimination for trans women specifically.

However, the study was limited in several important ways. Firstly, the study's definition of sexual intercourse, 'vaginal penetration with a penis', may have shaped and circumscribed responses. Additionally, due to the use of questionnaires, the study offers little sense of the young people's subjective experiences of their romantic involvement, and their thoughts, feelings, and decisions around engaging in various sexually intimate acts alone or with partners. Crucially, the study failed to differentiate between the impact of specific gender-affirming interventions (e.g., PST versus GAHT versus GAS) and as such it is impossible to discern the separate influences of each. In addition, the exclusion of participants who were medically ineligible for GAS (n=4) limited the representation of views from those who accessed PMT and GAHT, but not GAS. The authors note the above limitations and emphasize the need for qualitative research exploring the experiences of transgender and non-binary young people regarding sexuality, inclusive of those who do not access GAT.

One such qualitative study, is that conducted by Warwick et al. (2022) regarding sexual health and sexual education which formed part of a larger study (Araya et al.,2021). The convenience sample consisted of 30 young people, including eighteen transmasculine and twelve transfeminine individuals aged 15 to 20, with an average age of 17 years and 6 months. Among

the participants, 23 reported engaging in sexual activity, and twelve were in romantic and/or sexual relationships at the time of the interview. Of the seven identified themes, the first three are relevant to this topic: definitions of sex, perceived impact of gender-affirming hormone therapy (GAHT) on sexual attraction, identity, and orientation; and perceived impact of GAHT on libido. Some attributed changes in their attraction and libido to GAHT, with some noting shifts in attraction from women to men or heightened attraction to masculine features. Of note, the individual that indicated a heightened attraction to masculine features indicated that this was linked to being treated more congruently by those she was attracted to. Changes in sexual desire varied, with some transmasculine participants reporting increased sexual desire or drive, which plateaued after about a year on testosterone. Others reported an increase in sexual desire leading them to seek more sexual relationships. Among the transfeminine individuals, one noted a decrease in sex drive, while another did not perceive any change and indicated this was surprising to her. Difficulties reaching orgasm were reported by a minority of transfeminine participants. For some, diminished libido was seen as a positive side effect, while others did not desire this change (no numbers specified).

The study had strengths in its specific focus on sexuality, qualitative approach, recruitment process, inclusion of participants without medical transitioning experience, and adequate number of participants with experience of sexual intimacy. Of note, the qualitative approach is a particular strength as it affords participants the opportunity to provide additional information that may not be anticipated and therefore not captured via quantitative means. The authors also note, “sex was identified by participants as any consensual contact with a recipient partner’s genitalia” (Warwick et al., 2022, p. 143) therefore, the results may be more representative of TGD young people’s experiences with sexual intimacy. However, there were limitations, including the loss of contextual information due to the coding into descriptive themes,

uncertainty regarding the uniqueness or repetition of quoted individuals, lack of clarity regarding the degree of consensus for themes, potential bias introduced by requiring parental consent for participants under eighteen and lack of clarity regarding the experiences of those without GAT.

Nieder and colleagues (2021) examined experiences of gender affirming treatment over time, gathering baseline data at intake and follow up data an average of 2 years later, and report some findings with respect to the sexual experience of young people accessing PST only. At follow up, eleven young people were accessing GnRHa in isolation (8 who were assigned female at birth and 3 who were assigned male at birth). With respect to GnRHa, 'libido'/'sex drive' is mentioned in the free text responses of young people with respect to areas of dis/satisfaction with their care. This is a similar finding to that of Lawrence with respect to reasons transfeminine participants gave for dissatisfaction post vaginoplasty, with 8 (approx. 3% of the sample) citing disappointment with physical or functional outcomes of surgery (Lawrence, 2003). In a similar manner to the findings of Doorduin and van Berlo (2014), perspectives differed. One young person in the GnRHa group cited 'reduced libido' as a point of satisfaction while two others note the same ('decrease in sex drive' & 'less libido') as points of dissatisfaction. The authors highlight that overall satisfaction for those in the GnRHa group, though high, was slightly lower when compared to that of the GAHT and GAS groups and they related this to fulfilled versus unfulfilled treatment desires. However, as the study did not gather additional qualitative data beyond the free text responses, it is unclear what subjective meaning and value the young people attributed to their experiences of treatment, particularly with respect to the influence they felt GnRHa held for their sexual lives.

2.2.3 Studies that examine the effect of PST in isolation

To date there are no empirical studies which have examined the intersection of accessing PST and subjective sexuality. Therefore, I will outline some of the empirical research in which dysphoria and body image were measured, as from the literature these appear to hold relevance for the experiences of sexuality of TGD individuals. An evidence review published by the National Institute for Health and Care Excellence [NICE] in March of 2021 sought to evaluate the available evidence with respect to the clinical effectiveness of puberty delaying treatment with GnRH analogues, noting that 'critical' outcomes are those with respect to gender dysphoria, mental health, and quality of life, with impact on body image and psychosocial impact (among others) also considered important (National Institute for Health and Care Excellence [NICE], 2021). From the research literature pertaining to TGD adults and young people alike, gender dysphoria and (poor) body image both appear to have the potential to curtail enjoyment and comfort when engaging in sexual intimacy (Bungener et al., 2017). Examining the review's findings with respect to the relationship between PST and dysphoria and body image may therefore contribute to our understanding of the potential role PST may play in young people's experiences of sexuality.

Dysphoria and body image were measured and compared in just one of the included studies, that of de Vries et al. (2011), in which 70 young people began accessing GnRH analogues at a mean age of 14.75 having been first assessed at a mean age of 13.65. Gender dysphoria was assessed at baseline and follow up approximately 2 years later using the Utrecht Gender Dysphoria Scale (Cohen-Kettenis & Van Goozen, 1997; De Vries et al., 2006), a twelve-item scale with three or four questions which specifically relate to the body for those assigned female and male respectively. Those assigned female at birth indicated significantly more gender dysphoria compared to those assigned male at baseline. Mean scores did not differ significantly

from baseline to follow up. Body image was measured using the Body Image Scale (BIS) (Lindgren & Pauly, 1975), a thirty-item scale in which respondents rate their satisfaction or dissatisfaction with certain body parts. The items are subdivided in terms of their significance as gender imbued bodily characteristics, with characteristics such as the genitals, or the presence or absence of features such as facial hair or breasts considered most important, next followed by items such as hips, appearance, or muscles alongside gender specific items such as voice, chest, and body hair. The last group is comprised of what were referred to as 'neutral' bodily attributes. These are attributes that are unresponsive to gender affirming hormone treatment, rather than considered of 'neutral' status as signifiers of gender, and include items such as Adam's apple, shoulders, and height (Lindgren & Pauly, 1975). Results indicated that BIS scores did not significantly differ between baseline and follow up for any of the three groups of characteristics. It was noted, however, that those assigned female demonstrated significantly increased dissatisfaction with their secondary ($F(1,55) = 14.59, p < .001$) and neutral ($F(1,55) = 15.26, p < .001$) sex characteristics over time compared to those assigned male. De Vries et al. (2011) also note that the young people's lack of improvement in gender dysphoria following accessing PST was unsurprising, linking this with previous findings that indicate that GAHT and GAS are the chief means of alleviating gender dysphoria (Cohen-Kettenis & Van Goozen, 1997; Murad et al., 2010;Smith et al., 2001.This raises the question as to how, if at all, accessing PST may influence TGD young peoples' experiences of sexuality as it appears to exert less of a measurable influence upon dysphoria and body image than GAHT and GAS.

2.2.4 Conclusion

Though gender affirming hormone treatments are understood to exert an influence upon subjective experiences of sexuality, it is not clear what the specific influence of PST is, or the

meaning those accessing it attribute to it with respect to sexuality. Most studies subsume this intervention under a consideration of GAHT more generally, despite their vastly different intended effects. Prior research indicates that PST has the potential to reduce sexual desire, with some perceiving this positively, and others negatively (Nieder et al., 2021). Gender dysphoria and body image, which both appear to influence sexual experience for TGD people, have not been demonstrated to improve with PST alone (de Vries et al., 2011).

2.3 Psychosocial impacts

The topics of sexuality and relationships for transgender people have largely been approached from a biomedical standpoint, with an emphasis on sexual dys/function with respect to gender affirming interventions (Marshall et al., 2019). Calls have been made for research using the biopsychosocial model to explore the psychological, relational, and social aspects of TGD people's sexual and romantic lives (Kennis et al., 2023). The most recent WPATH standards of care also emphasize the consideration of psychological and social influences upon the sexual functioning and pleasure of TGD individuals (Coleman et al., 2022). From the literature examined, certain findings appear to relate to the intersection of gender affirming treatments and psychological, relational, and social factors as they contribute to experiences of sexuality, and these shall be discussed in turn.

2.3.1 Dysphoria and body image: Simultaneously intrapersonal and interpersonal

Contrary to what may be assumed, genital body dissatisfaction has been found to have a limited association with overall dissatisfaction for TGD people, and in fact body characteristics that influence the social recognition of gender, such as face, figure, and voice have been found to

exert a strong influence on body dis/satisfaction for TGD individuals (Van de Grift et al., 2016). It is worth noting that GnRHa has no *active* influence on these characteristics. For instance, if a transfeminine young person has already experienced a change in her voice, accessing PST will not remedy this. However, if a young person accesses PST during Tanner Stage 2 of puberty, the impact of halting further incongruous pubertal changes can be significant.

This underlines the intersubjective experience of gender in/congruence, as the material body is experienced and interpreted socially as well as individually with respect to gender (Langer, 2014). A useful term in this respect is 'relational body image' which Pfeffer (2008) used to describe how body image can be part of a relational process between intimate partners as well as an individual's experience of themselves in response to external socio-cultural narratives, forces, and structures, "how the body image of one partner may affect both the body image of another, as well as the ways these bodies may relate (sexually and non-sexually) to one another." (Pfeffer, 2008, p. 331). Langer (2014 has conceptualized gender affirming bodily interventions such as GAHT and forms of GAS schematically using Venn diagrams indicating that some body changes are predominantly private, some body changes are predominantly public and some operate/impact at the intersection between public and private. Such intersections are of interest as it is here that the intrapersonal experience of the private body overlaps with interpersonal experiences and interpretations of the public body, such as during intimate sexual contact with a partner (Langer, 2014).

Martin and Coolhart (2022) conducted an interpretative phenomenological study focusing on how transmasculine people navigate body dysphoria in the context of sexual experiences. They identified three themes of mental, physical, and relational negotiation of body dysphoria. The ten participants ranged in age between 24 and 67 with a mean age of 39.7 years. Most

participants were in a relationship or dating, and two were single. Just over half identified as heterosexual/straight/attracted to women and the remaining four were queer, gay, bisexual, and 'uncertain/bi' respectively. The study did not report descriptive information regarding how many of the participants had accessed GAHT or GAS, but in the findings noted that at least one participant had not accessed these. Participants shared how they psychologically navigated body dysphoria during sexual experiences. One theme, mental negotiation of body dysphoria, described participants' psychological experience of their genitals, with some (specific number not provided), describing intrapersonal and interpersonal recognition of their genitals as a penis, while others described friction between their experience and the culturally mandated 'reality' which precludes their genitals from such recognition. Physical negotiation concerned the ways in which participants sought to manage dysphoria physically. This included physically altering their bodies through accessing GAT, making use of prosthetics, practicing boundaries such as keeping the lights off or negotiating with partners regarding how their bodies were engaged with sexually. Participants spoke about the role of their relationship with sexual partners in navigating body dysphoria during sexual experiences. Participants described how their gender identity influenced both their own and their partners sexual identities. They spoke about the burden of having to communicate their specific needs to their partner/s, and how pleasing their partners was complicated by their body dysphoria when their partners expressed interest in engaging with or seeing certain parts of their bodies, necessitating compromises. Communication was endorsed as a means of supporting sexual satisfaction and support and understanding from partners was highlighted as important. The findings of this study indicate the interrelated nature of psychological, physical and interpersonal means of negotiating dysphoria with respect to engaging in sexual intimacy.

Similarly, in a study of transmasculine individuals' perspectives on positive sexual experiences, participants shared selectively engaging in affirming sexual practices (such as penetrative sex as the insertive partner or having sex in complete darkness), while avoiding those that evoked dysphoria (Engelmann, Nicklisch & Nieder, 2022). Participants also emphasized the interpersonally contingent factor of feeling respected and affirmed by their sexual partners as a fundamental pre-condition for sexual intimacy. Similarly to the psychological negotiation shared by participants in Martin and Coolhart's (2022) study, they discussed the importance of partners engaging with their bodies in a manner consistent with their gender identity, such as through avoiding touching the breasts, or treating the clitoris similarly to a penis. This resignification of the body is something Latham has described as the sexual narrative practice of 'translation' (alongside 'mutual exclusion', 'alignment' and 'addition and distribution') in which TGD individuals and their partners "assemble their (multiple) sexual practices, pleasures and embodiments to achieve maleness" (Latham, 2016, p. 351). The concept of 'translation' has some resonance with Judith Butler's theories of 'performativity' (Butler, 1990/2006), and 'citationality' (Butler, 1993/2011). Performativity refers to the process through which identity is enacted or 'performed'. Citation is the name given to this repetition, or citation, of cultural norms when 'performing' gender (Butler, 1993/2011). Latham asserts that TGD individuals, or at least, transmasculine individuals, can agentically resignify their body with a sexual partner through certain aspects of performativity and citation.

2.3.2 Interpersonal factors: Perceptions of others

In secondary analysis of interview data from two larger U.S based research studies Schilt and Windsor (2014) examined the qualitative interview data of 74 transmen (18-64, mean age of 33, majority white) regarding what they term 'body modification decisions' with respect to sexual practices. The vast majority (96%) had accessed gender affirming hormone treatment or

planned to. With respect to gender affirming surgeries, 68% had accessed chest surgery, and 7% reported some form of genital surgery. The authors discuss the role participants' efforts toward more congruent *gendered embodiment* played in their *sexual habitus*, the dynamic relationships between gendered embodiment, sexual desires, established range of sexual practices, and identity. For some men (specific number not provided) in their study, accessing GAT led to significant shifts in their sexual habitus, such as identifying an attraction to other men, engaging in novel sexual practices, and developing a new identity as a gay man.

Sexual habitus is a helpful means of considering the lived experience of trans and gender diverse people due its ties to both material and social reality. The authors argue that while an individual may *desire* certain partners or sexual practices, what Green (2008) refers to as 'erotic habitus', accessing said partners or sexual practices relies on various aspects of gender identity, bodily configuration, and receptivity on the part of their partner/s.

Aside from the individual's subjective experience of emerging or altered sexual desire in relation to accessing them, gender affirming treatments such as testosterone and chest surgery inform various cultural signifiers of masculinity, such as facial hair, flat chests, and deep voices which can lead others to recognise an individual more accurately as male and treat them as such (Kessler & McKenna, 1978). This influence of gendered embodiment upon sociocultural recognition and relating naturally extends to opportunities for sexual intimacy. Schilt and Windsor note that an individual's gendered embodiment may limit or open potentialities for sexual partners and practices. In the case of their study, men with pre-existing or newly emerging sexual desire toward other men may be afforded, by virtue of their increasingly congruent gendered embodiment, access to sexual partners and practices previously unavailable to them (Schilt & Windsor, 2014).

Similarly, this relationship between embodiment and shifting access to certain sexual partners and practices is mirrored in a grounded theory study of transgender men (Dozier, 2005). They reported a theme of shifting attraction and desire as it relates to gendered dynamics in sexual intimacy, , with some men (specific numbers not indicated) with a preexisting attraction toward other men prior to their transition reporting feeling enabled to explore sexual intimacy with other men in new ways due to their being recognised and affirmed as men by these (cisgender indicated) male partners, rather than being perceived and treated incongruently as women. The majority of those who changed sexual orientation or attraction (specific number not indicated) did not have a pre-existing attraction towards other men. Dozier suggests that the relationship and power dynamic between two men is different to that between men and women, and notes that sexual interactions with other men can validate gender identity in TGD men. Some participants spoke about dating other trans men or cisgender men as a way of maintaining a valued identity as a queer person as well (Dozier, 2005). Sexual orientation and desire were considered linked to the gendered meanings created and enacted in sexual and romantic encounters between partners.

Additionally, the later age at which transgender youth report engaging in all types of romantic and sexual activities compared to their cisgender peers may be linked to the impact of wider negative perceptions of transgender people. For instance, transfeminine young people reported fewer romantic relationships than their transmasculine counterparts, which Bungener et al. (2020) suggest may link to higher levels of discrimination for transwomen specifically. Stigma at an interpersonal level was voiced by those interviewed in a phenomenological study by Araya et al. (2021). The young people in the study described the difficulties they faced in finding romantic partners, such as instances of transphobia when using dating apps and when

dating within the LGBT community. They discussed the challenges of disclosing their transgender or gender diverse identity when dating and being in relationships, noting that they disclosed their status to avoid future complications or confrontations, to gauge the other person's reaction, and because they believed the other person had a right to know this about them.

Related to stigma is the finding that difficulties with initiating sexual contact and fear of sexual contact were found to be the most common sexual dysfunctions in transmen and were also prevalent in transwomen (Kerckhof et al., 2019). These difficulties may be linked to TGD individuals' concerns over finding sexual and romantic partners who affirm their gender and respect them without objectifying them (Cerwenka, Nieder, Briken, et al., 2014; Cerwenka, Nieder, Cohen-Kettenis, et al., 2014; Holmberg et al., 2019).

2.3.3 Cultural factors

Wider sociocultural factors appear to exert some influence over the experiences of sexuality reported by TGD individuals. The study by Engelmann, Nicklisch and Nieder (2022), highlights not only the role of the body itself in informing pleasurable sexual experiences through its sexual function and response, and the role played by individuals' and their partners' interpretations and responses to the body, but also the role of social sexual scripts (Simon & Gagnon, 2003), with the potential to support or detract from sexual pleasure. Participants in the study by Engelmann, Nicklisch and Nieder (2022) noted that the sociocultural presumption that, as transgender people, they should not enjoy certain sexual practices involving the genitals they were born with, presented a challenge to negotiate in sexual relationships, as well as subjectively.

In their study, Fisher et al., (2016) note that despite significant reductions in subjective gender dysphoria, body uneasiness, and depressive symptoms in gender diverse people accessing GAHT compared to those who did not, those that accessed GAHT experienced a significant increase over time in social and sociolegal gender dysphoria, which they proposed related to the cultural context of the study, Italy between the years 2012-2105. The authors' comment regarding the increased social and sociolegal gender dysphoria on the part of participants is conceivably linked to the reported rates of discrimination on the basis of gender identity. Of note, a European Agency for Fundamental Rights 'FRA' report, indicates that the majority of Italy based respondents reported that discrimination towards transgender people was 'fairly' or 'very' widespread in the 2012 Eurobarometer (64%) and EU LGBT surveys (95%) (European Union Agency for Fundamental Rights, 2014). It is pertinent to hold such contextual factors in mind when interpreting the results of existing studies.

2.3.4 Conclusion

There is some evidence to indicate that gender affirming treatments have the potential to influence intrapersonal and interpersonal factors relating to sexuality. As gendered embodiment becomes more congruent following GAT, the sexual habitus of transgender people may shift in response to their own psychological responses to their body and to the responses of others within a wider sociocultural context.

2.4 Summary

Thus far, little research has examined the experiences and accounts of sexuality of gender diverse young people, particularly those who have yet to access gender affirming hormones and thus are accessing PST only. The research that has been conducted is largely quantitative

and descriptive in nature and fails to situate the meaning making of participants within the nested contexts of their lives. Additionally, TGD youth, in contrast to their adult counterparts, are situated in several ecological social contexts, such as school, peer networks and their families, all of which may contribute to how they understand and story their experiences (Bronfenbrenner, 1979; D'Augelli, 2005). Within the wider global context of competing and conflictual narratives about gender diversity and access to interventions such as PST, examining personal accounts with consideration of context is warranted.

Chapter 3: Methodology and method

The aim of this research is to explore transgender and gender diverse individuals' experiences of sexuality in the context of accessing PST. As noted in the introduction, the experience of sexuality is conceived as a biopsychosocial phenomenon. An approach that is sensitive to this intersectionality is therefore warranted, one which balances the corporeal aspects of sexuality with subjective internal experience and social context, inclusive of the micro context of the research interview and the macro context of wider societal discourses about sexuality, adolescence, and gender diversity, among others.

3.1 Ontological and epistemological position

Published recommendations for the design of qualitative research stipulate that methodological integrity is the basis for establishing trustworthiness (Levitt et al., 2017). Methodological integrity requires clear articulation of the assumptions taken about what kind of knowledge the research process proposes to generate through specific forms of data collection and analysis. This is to ensure a good fit between the research aims and process. This is typically achieved by situating a piece of research within a particular paradigm or conceptual schema with a distinct overarching ontology. In this research I have adopted an ontological position of critical realism and a pluralistic epistemological position. In this section I will outline these positions in more detail.

3.1.1 Critical realism as an ontological position for the study

Ontology is the philosophical study of being and existence (Hoffman & Kumar, 2020). Within research, ontological assumptions concern the position taken on the nature of reality, what

exists to be studied. The ontological position I adopted for this research is critical realism. A critical realist ontological stance posits that although 'reality' exists, our understandings of this are circumscribed by the upper limits of human perception and conceptualization (Bhaskar, 2008). Critical realism is a combination of ontological realism, "the view that entities exist independently of being perceived, or independently of our theories about them" (Phillips, 1987, p.205) and epistemological relativism, the view that our knowledge of reality is not an objective perception but a construction. This avoids what Bhaskar termed the 'epistemic fallacy'; "…that statements about being can be reduced to or analysed in terms of statements about knowledge; i.e. that ontological questions can always be transposed into epistemological terms." (Bhaskar, 2008, p. 26).

Expanding upon the premise that human knowledge of reality is separate from reality itself, Bhaskar distinguished between three nested domains of reality, *the empirical*, *the actual* and *the real* (Bhaskar, 2008). The *empirical* domain consists of our direct and indirect experiences, such as the experience of personally tripping and falling to the ground, for instance. Within the *actual* domain, events happen regardless of whether we experience them (such as the classic example of a tree falling, unheard, in the woods). Lastly, the *real* domain includes that which can produce events in the world, termed *mechanisms* (such as the gravitational pull that contributes to us or the tree falling down). This conceptualisation of a stratified reality reconciles the embodied, concrete, experience (falling over) with the conceptual (gravity), acknowledging that the empirical, that which is observed or experienced, is not all there is. Willis (2023) argues that discriminating between these three domains supports our analysis of qualitative data in relation to aspects of existence not specifically referred to in the text, such as the biological, social, and political, noting that ecological systems theories (Bronfenbrenner

1979; Bronfenbrenner & Ceci, 1994) may support such analysis. (How I have operationalized Bhaskar's concept of stratified reality is discussed in more detail in section 3.7)

This research seeks to learn about individuals' experiences with an intervention which exerts influence on the materially real body. The physiological consequences of accessing GnRHa are largely similar across individuals, irrespective of the intention behind the use of GnRHa (Hoofnagle, 2008). The same physiological process takes place within the body whether the intention is to provide relief from endometriosis, or precocious puberty, for instance. Naturally, some individuals respond a little differently to the intervention, and require adjustments to things like dosage, timing etc. but by and large the material impact of accessing the intervention is 'real' in that it leads to physiological change in the body of the recipient. Similarly, the human body's sexual arousal response differs little across history and society (Levin & Riley, 2007; Suschinsky & Chivers, 2021), though the meanings and subjective experiences of physiological arousal may differ.

However, cultural understandings and constructed knowledges about the sexed body and the experience of sexuality vary, as do individuals' subjective responses to their material bodies. Therefore, with respect to the focus of the current research, the physical body is conceived of as ontologically and materially real, but the meanings ascribed to the body are socially constructed, negotiated at the intrapersonal, interpersonal, and societal level. This fits with a critical realist ontology.

It is important to note that a fundamental aspect of debate centred on TGD lives is the degree to which the expressed experiences of TGD people are considered real as opposed to symptomatic or transient. In the Cass interim report this tension is described as follows:

> "At primary, secondary and specialist level, there is a lack of agreement, and in many instances a lack of open discussion, about the extent to which gender incongruence in childhood and adolescence can be an inherent and immutable phenomenon for which transition is the best option for the individual, or a more fluid and temporal response to a range of developmental, social, and psychological factors." (Cass, 2022: 16).

The above frames professional conceptions of gender incongruence in rather binary fashion which doubtless fails to account for the perspectives of many. However, what is clear is that at one extreme pole of public and professional opinion is the conviction that TGD identities could not possibly be real or valid. Such denial, denigration, or pathologization of non-cisgender identities is what Ansara and Hegarty (2012) describe as *cisgenderism*, a prejudicial ideology akin to heterosexist ideology in its function of "ignoring, invalidating, or derogating" (Herek et al., 1991, p958). It is with awareness of such fundamental denials of the lived reality of TGD people that I wish to assert that the critical realist ontological stance of this study acknowledges gender diversity as a genuine aspect of human experience and rejects essentialist conflations of assigned sex and gender.

3.1.2 A pluralistic epistemological position for the study

Research enquiries are underpinned by explicit or implied stances on what is real and exists "in" the world, typically organised into discrete conceptual structures, such as Guba and Lincoln's four paradigms: positivism, postpostivism, critical theory, and constructivism (1994). However, in a persuasive overview and critique of several such frameworks, Thomas Pernecky complicates the convention of compartmentalizing research approaches into mutually exclusive paradigms, arguing that the dominant conceptual schemata are no longer sufficient, and risk overlooking the diversity within approaches typically presented as interchangeable (Pernecky, 2017). As such, the epistemological stance of this research is pluralistic, incorporating aspects of interpretivism, social constructionism, and phenomenology as they

relate to human knowledge production. Interpretivist and social constructionist epistemologies are similar in their emphasis on understanding meaning making, with interpretivism attuned to context, and social constructionism attuned to the mediating role of language and social interaction (Chen et al., 2011). Social constructionism argues that what we think of as truth and knowledge more likely represents the current accepted ways of understanding the world constructed between people which vary across specific cultures and historical periods and are therefore subject to change over time (Burr, 2015). Phenomenological epistemologies emphasize the embodied lived experience of individuals as a source of knowledge (Adams & van Manen, 2008). Hammack and Toolis (2016: p359) assert that "An interpretive analysis allows for multiple (and often contested) perspectives and facilitates a consideration of meaning construction as an inherently social and political process rather than merely a reflection of the natural order of things."

3.2 Research Methodology

In line with my epistemological position, qualitative methods are best placed to explore what is fundamentally a subjective experience, sexuality. Research centred on sexuality has been criticized for reductive approaches which seek to collapse the rich experience of sexuality into discrete categories or scales (Galupo et al., 2018; Wolff et al., 2017). Further, quantitative means of examining sexuality and gender in health research suffer from impoverished conceptualisations and terminology for both constructs (Bragazzi, Khamisy-Farah & Converti, 2022; Eliason, 2014; Vanwesenbeeck, 2009).

In consideration of which particular qualitative method to utilize, referring to the research question and the epistemological stances taken offer some guidance. A social constructionist perspective argues that stories of lived experiences are constructed not just at the level of the

individual providing an account of their experiences but are also socially constructed in the past, present, and future. This study is interested in both what the young people share, and the manner in which they share it, viewing this as a co-construction sensitive to the influences and demands of multiple nested contexts.

3.2.1 Narrative Inquiry

In order to capture what gender diverse young people say about their experiences of accessing puberty suppressant treatment, I have chosen to employ a narrative inquiry (NI) approach. NI involves obtaining some phenomenological account of experience obtained from the person or persons under investigation and seeking to understand how the narrator makes sense of this experience (Josselson, 2011). As such, narrative inquiry is rooted in both interpretivism and phenomenology (Josselson, 2006) and therefore aligns with the pluralistic epistemology of this study as outlined in section 3.1.2. In this section I will briefly outline what NI is and map the four main characteristics of NI to my research.

Narrative inquiry posits that the primary means humans 'know' the world is through the medium of stories (Sarbin,1986). "Human beings live lives that are shaped by their experiences within personal, familial, social, institutional, professional, linguistic, cultural, and historical narratives. The stories we tell, stories that are told for and about us, and stories that we engage with influence our sense-making." (Caine et al., 2019, p. 3). Narratives are stories people tell about themselves and others. Narratives are stories in which the narrator tells their audience a story in such a way that the events described are given meaning and as such, they are a means of understanding and organizing personal experience (Denzin, 1989, Josselson & Hammack 2021).

NI encapsulates a range of means of interpreting storied language. Narratives have been construed as both events and experiences (Andrews, Squire & Tamboukou, 2013). I position my approach to NI as erring more towards experience centred than event centred (Squire, 2008). The experience-centred approach assumes four important characteristics of narratives:

1. Narratives are sequential in time and meaningful.
2. Narratives are definitively human and a means of human sense-making.
3. Narratives 're-present' experience, in the sense of reconstituting it; as well as mirroring it.
4. Narratives display transformation or change.

The first characteristic is pertinent to my research as I pay attention to specific events or experiences which hold significance for the speaker and all other aspects of the young people's experiences of sexuality shared within their narrative, this is because I wish to understand all sequential and meaningful stories of personal experience that they might share, not just those pertaining to specific biographical events. The second characteristic particularly applies to my research as I am interested in how gender-diverse young people make sense of their experiences of sexuality within the context of accessing PST. The third characteristic is pertinent to my research as I am interested in how the young people speak about their experiences and it is my assumption that their interactions with me as interviewer as well as wider social contexts will influence how they construct or re-present their stories. The fourth characteristic is relevant to my research since I am interested in the impact of the PST on young people i.e., what changes for them as a result of accessing PST.

I consider that there are four main advantages of adopting a NI approach in the current study. Firstly, NI affords a means of developing a nascent understanding of the *content* of participant's

experiences combined with the opportunity to move beyond the level of content to consider how each participant relates to and makes meaning of these experiences, and more specifically, *how* they communicate these to another. Secondly, NI retains respect for the unique experience of each individual participant. It allows individuals to construct their narratives as they see fit, without much imposition of structure from the researcher or their questions. However, it is not naïve to the influence of the researcher and the research setting, and views narratives as co-constructions between participant and researcher, acknowledging that the narratives created in a research setting will likely differ from those the participant may share with close friends or family, with their sexual and romantic partners and with their clinical team (Plummer, 1996). Co-construction therefore requires high levels of reflexivity on the part of the researcher. NI can accommodate such reflexivity (See Section 7.3.2 for how I achieve this through use of the Listening Guide). Thirdly, in this present social and historical moment, the voices of gender diverse youth are arguably lost within a broader discourse regarding transgender people. The media, policy makers, and governments all contribute to a wider discourse in which the lived experiences of gender diverse individuals can get lost, or worse, silenced (Barker & Langdridge, 2008; Fivush, 2010; Westrate & McLean, 2010). For this reason, a narrative approach was felt to be a good fit as it centres the voices of the young people in question and amplifies their accounts of their own experiences of the world, while simultaneously paying heed to the wider narratives regarding young people, gender diverse people, and sexuality more generally. Finally, narrative approaches place little restriction on what the participants choose to share and simultaneously afford them the comfort to dictate the conversation and tell the stories they feel to be important in relation to the overall research question. Furthermore, this opportunity for the participant to relay an account of their experiences on their terms can play a role in addressing the power differential that is often present in research focused on minority groups and youth alike (Adams et al.,2017; Vincent, 2018). Therefore, for a topic such as

sexuality, which is both personal and situated within an ever-shifting discourse, NI is ideal as it is a means to consider subjectivity and structural influence without privileging one over the other or reducing the narrative to a series of codes or numbers.

3.3 Sampling and recruitment methods

3.3.1 Sampling method

Purposeful sampling (Palinkas et al., 2015) was employed as the goal was to gain insight about individuals' experience rather than to generalize from the sample to the overall population of gender diverse youth in the UK.

Initially, participants were sought exclusively via the Gender Identity Development Service (GIDS). This was to ensure that they had ongoing psychological support and were accessing the hormone blocker with sufficient oversight. Later, recruitment was expanded to allow for recruitment outside of GIDS, for those who were aged eighteen and above, and therefore, young adults (Arnett, 2000, 2014).

Participants needed to have accessed PST for at least 3 months at the point of interview. This was to allow for any potential side effects to subside and to afford participants sufficient time to adjust to the intervention and notice any relevant aspects of the experience. This time period was informed by consultation with clinical staff within GIDS. Initially, participants were required to be accessing PST at the time of interview. However, considering challenges to recruitment, a decision was made to include participants with past as well as current experience of accessing PST. Recruitment of those aged 18+ occurred outside of GIDS, meaning that they did not represent a clinical sample. Participants were all over sixteen years of age at the time

of the interview and fluent English speakers, due to the nature of the subject matter and the manner of research. Exclusion criteria stipulated that participants must not have any severe mental health struggles at the point of interview that would influence their capacity to respond or render them unable to tolerate such an interview. As the initial majority of recruitment took place via young people's allocated clinicians within GIDS, it is likely that some young people were excluded based on clinical judgment of their suitability.

3.3.2 Recruitment methods

Recruitment information was first provided to clinicians in April 2021 in anticipation of ethical approvals being forthcoming. A more formal call for participants was issued in Nov 2021 when ethical approvals were at last in place (see Appendix 3a). One participant expressed interest and took part in Feb 2022. From clinicians' feedback, others expressed interest when informed, but did not make contact thereafter, and some young people, though interested, did not initially meet all the inclusion criteria.

To reduce administrative burden upon clinicians and young people, an amendment (see Appendix 3b) was sought to remove the requirement for young people to provide written consent to have their contact information shared for the purpose of initial contact to discuss participation. This consent was instead recorded in their clinical notes within the service as per typical practice. Additionally, with support from the internal GIDS research team, the clinicians of all potentially eligible young people were individually contacted and informed about the study. Following these changes, three further young people indicated interest in taking part. Of these, one took part, and the others fell out of contact or did not attend interview. Over time, more potential participants became eligible through meeting the criteria of having accessed PST for a minimum of three months. Of these, one further participant indicated their interest

and subsequently took part. Concurrent to this time period, a further amendment was sought to expand recruitment to those with prior experience of accessing PST ages 18+ (Appendix 3c).

In line with the above, permission was sought from multiple third sector organisations, and university LGBTQIA+ groups to share the call for participants (Appendix 3d). Several calls for participants were also shared with relevant online community forums on Reddit. From these efforts, one further participant made contact and took part. There were a number of unique challenges that I experienced in trying to recruit participants to the study. These challenges, and my responses to them are outlined in the following section.

3.3.3 Recruitment challenges and responses to these

Accessing participants for this study was very challenging in both anticipated and unanticipated ways. The nature and causes of these challenges were varied but included: unforeseen consequences of the Bell vs Tavistock ruling; imposter participants; research fatigue of third sector organisations; additional burdening of clinical staff; and research fatigue of sample population and related sensitivities. I will detail each of these challenges in turn.

Firstly, and most significantly, there was a reduction in the overall number of eligible participants as an unforeseen consequence of the Bell vs Tavistock ruling issued in early December 2020. To reiterate the salient circumstances, the case was related to whether young people below age sixteen could achieve '*Gillick'* competence (Griffith, 2016) regarding the decision to access PST. The ruling argued that to achieve and demonstrate Gillick competence to consent to PST, a young person would need to understand, retain, and weigh up not just the likely risks and benefits of PST, but also those of GAHT, and GAS, with these interventions positioned as contingent eventualities. The ruling was that those below age thirteen were

"unlikely" to be competent to give their consent and that it was "doubtful" that those ages fourteen and fifteen could achieve and demonstrate consent (*Bell v Tavistock*, 2020, para. 151). Though acknowledging that those aged sixteen and above are routinely considered competent to consent to medical treatment, the ruling stipulated that, in the case of accessing PST, authorisation of the court should be sought, due to "the long-term consequences of the clinical interventions at issue in this case" (*Bell v. Tavistock*, 2020, para. 152). Consequently, for a period of time, no new young people were granted access to commence PST. Those who were already in receipt of the treatment were required to undergo an individual best interest application process (a decision made by applying the Best Interest principle as indicated in the Mental Capacity Act via the courts). Further, some of those who were accessing PST and engaged in a process of consideration and consent with respect to accessing GAHT were impacted by the decision, as the Tavistock and Portman Trust suspended new referrals for GAHT in the immediate wake of the ruling. Therefore, those who were eligible for the study were potentially less likely to be informed of the opportunity due to the significant administrative burden upon their clinical staff in light of implementing the guidance to pursue best interest applications. Further, those who were aware were perhaps less likely to decide to take part due to both the demands of the above process, and possible feelings of disappointment and anger toward the service due to the disruption to their care following the judicial review.

In conjunction with the impact of the Bell v Tavistock ruling, there was demonstrable hesitation and/or barriers to taking part. Several eligible and interested potential participants from GIDS did not take part. Of these, one agreed to a telephone discussion about the project and agreed to take part, but subsequently did not make further contact as planned regarding their availability, nor respond to further correspondence. Another two young people responded to follow up emails some time after initial contact was attempted and indicated that they were still interested in taking part. We agreed a time to have the interviews, however, one then needed to

cancel this at short notice and did not attend the rescheduled interview or respond to further correspondence. The other did not attend and did not respond to contact following this.

Following one call for participants, a large number of what have been termed ‘imposter participants’ (Ridge et al., 2023; Roehl & Harland, 2022) made contact. These participants were noted to conform to an unusual pattern of engagement similar to that described by Ridge and colleagues (2023), such as responding to contact within minutes, all using one particular email platform, blank subject lines, and sending emails comprising little more than a sentence. Many entered their details seemingly incorrectly, with first and last names reversed (e.g., Bloggs Joe). Of those that indicated a wish to take part, many provided unusual or confusing information, such as claiming to have begun to access PST in their early 20’s, accessing the intervention for 8 years or more, or accessing PST directly via their GP with no involvement of an NHS or private gender service. One participant attended interview and (like what was described by Ridge and colleagues) initially sought to have their camera off, provided vague and incongruous answers, and was demonstrably distracted and otherwise occupied during interview. For instance, on multiple occasions appearing to be actively using their computer, typing etc., prior to answering questions. This interview was very brief and was not included in the analysis.

When inclusion criteria were expanded to allow for the inclusion of those aged 18+ who could provide retrospective accounts, it was still very challenging to access sufficient participants due to what might be described as ‘research fatigue’. I contacted various (8) third sector organisations to seek permission to share the call for participants (Appendix 3d). One agreed to share the information. Of the other two that responded, both noted they were negotiating large numbers of such requests. To mitigate these, one organisation had adopted a policy

requiring a process of consultation and collaboration from the proposal stage of the research process, prior to agreeing to sharing details with members, to ensure that such requests were in alignment with their values and approach. The other organisation noted several ongoing research requests and commitments at the time and felt an additional request may overburden the young people but agreed to circulate the request via their internal networks instead. In addition to contacting third sector services, I compiled a list of all the universities in the UK to contact with the call for participants, either via the contact details for the Student Union's relevant Officer, or any LGBTQIA+ Student societies and/or the named officers of these. I randomized the list and contacted 5 universities at a time, as I required few overall participants. In this manner I contacted 25 universities. Three responded, one to seek a version of the call for participants suitable for sharing via their society's Instagram page, which I did (Appendix 3e). One responded to confirm they had shared the details with group members. One noted they could not share such requests but that I was free to join the Facebook page for the group and seek permission to post there.

The initial recruitment strategy was via clinicians within GIDS. It is possible that clinical staff were overburdened with existing work commitments and did not have the additional capacity to hold the project in mind and undertake the administrative burden of contacting potentially eligible people on their caseloads. Given the context of the judicial review and public interest and debate regarding the care of gender diverse youth, staff may have felt scrutinized and disincentivised to facilitate further potential commentary on their clinical practice.

Young people who were informed, indicated their interest, but subsequently decided against taking part may have done so due to the sensitive nature of the topic and the wider tone and themes of surrounding public discourse. Conversely, some may have felt motivated to share

their own stories and experiences from a wish to respond to circulating discourses. It's possible that young people who scheduled but did not attend interviews did so for some of the above reasons, or for others such as competing priorities, like academic commitments. It is also possible that a proportion of those aware of the opportunity to take part were disinclined to do so due to research fatigue (Ashley, 2021). As indicated in the responses from two of the large third sector organisations, TGD people as a group are regularly approached with requests to participate in research (Vincent, 2018). With respect to qualitative research specifically, Clark (2008) notes that populations who voice frustration at being over-researched may do so as a consequence of experiencing little change following multiple engagements with research, or perhaps feeling that the research might serve to undermine the group's aims and interests. It is entirely possible that the socio-cultural context during the time period of this project was such that potential participants were more prone to decline to take part in research out of a sense of caution in the face of both experienced and perceived hostility toward transgender identities and lives.

As a consequence of these recruitment challenges, the recruitment phase of this project was significantly longer than intended, lasting 14 months, from November 2021 to January 2023 (fourth interview having taken place in October 2022).

3.3.4 Sample size

Initially, when developing the project, I took two main factors into consideration when planning the optimum sample size for the study: the potential size of the target population and sample size 'norms' within narrative research. With regards to the size of the target population, transgender and gender-diverse (TGD) young people, represent a very small percentage (~1%) of the 16-24-year-old population (Office for National Statistics, 2023); even less access PST.

One estimate of the number of young people in the UK. accessing PST is less than 100, though it is unclear on what basis the author makes this particular claim (O'Dowd, 2024).

In qualitative research, there are no definitive answers to the question of how many interviews are sufficient (Baker and Edwards, 2012). This is especially true for narrative research, where no universal rule governs the determination of sample size (Sarfo et al., 2021; Francis et al., 2010; Vasileiou et al., 2018). Creswell (2013) suggests a sample size of 1-2 for narrative analysis, unless constructing a collective story. Other scholars advocate for larger samples, such as Josselson and Lieblich (2003), who recommend between five and thirty participants. Vasileiou et al. (2018) argue that rather than focusing solely on numbers, researchers should assess 'data adequacy' (Levitt et al., 2018), taking into account both pragmatic constraints and the richness of the collected data. Levitt and colleagues (2018) note that there is no specific number of participants required for data adequacy, and prompt researchers to consider what kinds of sources of data will allow them to meet the goals of their research question, with differences among sources considered to add to the quality and sufficiency of the information.

Taking these two factors into account, I had initially hoped to recruit no more than 6-9 participants, as having too large a sample would preclude the in-depth analysis planned (Sandelowski, 1995). Josselson and Hammack (2021) contend that the key is having "enough people to have something interesting to say about your question" (p. 21). Ultimately, due in large part to the unanticipated challenges that I documented in the previous section and despite adjustments to my recruitment strategy, the sample size was smaller than originally intended. I managed to recruit four narrators who generously gave accounts of their experiences. In order to ensure data adequacy, I conducted a detailed and thoughtful analysis of these four accounts,

through adapting the Listening Guide Method to include Master Narrative Engagement (Hammack, 2011) (See section 3.7 for more detail).

Crouch and McKenzie name the approach taken in small scale research as a 'clinical' one, as it involves careful and thoughtful combination of material from individuals, with theoretical knowledge. They note that "just one "case" can lead to new insights if it is recognized that any such case is an instance of social reality" (2006, p.493). However, having multiple cases enhances the search for depth and meaning, with emphasis on 'intensive' rather than 'extensive' inquiry to produce persuasive and valuable findings. In this way narrative analysis has commonalities with research with small sample sizes, such as case study research, or autoethnography. For instance, autoethnography also explicitly acknowledges and works with subjectivity and storied experience, combining theoretical knowledge and lived experience to develop insights into aspects of culture for 'insiders' and 'outsiders' alike (Ellis, Adams & Bochner, 2011). The rich narratives combined with in-depth analysis, with an adaptation to include the additional analysis of master narrative engagement, means that it was possible to achieve data adequacy with four narrative accounts.

3.4 Participants

Four participants were interviewed in total, all via videolink. Table 3.1 outlines the demographic information collected for each participant. Age, age when commencing PST, and duration of relationship are provided as a range to afford some additional confidentiality to participants.

Pseudonym	Age Range	Own description of gender identity	Age range when began accessing PSM	What format	Ethnicity	Relationship or dating	How long with partner
John	16-18	Male	12-14	Injection	White British	Yes	1-3 years
Maria	16-18	Female	16-18	Injection	White other	No	N/A at time of interview
Rueben	18-25	Male/Trans	16-18	Injection	White British	Yes	4-8 years
Alex	16-18	Male	16-18	Injection	White British	No	N/A at time of interview

Table 3.1 Participant demographic information

3.5 Ethical considerations

Research with LGBT youth regarding sexual health is considered sensitive and is under-researched relative to heterosexual youth (Macapagal et al., 2017). This is linked with review boards' concerns that responding to questions regarding sexual behaviour and experiences may provoke distress or discomfort more than is ordinarily evoked in daily life, and the reluctance to grant waivers of guardian's consent to participate (Macapagal et al., 2017). Care was taken to consider various areas of concern for this specific population (British Psychological Society, 2019) as well as more usual ethical considerations (British Psychological Society, 2021a, 2021b). Considering public interest in the topic of gender diverse youth, thought was given to the best means of supporting young people to narrate their experiences with safety and dignity. Despite challenges and time pressures associated with the ethical approvals process and recruitment, abandoning the research topic was not considered, as to do so would be a disservice to the young people who had already generously shared their time and their stories.

Ethical approval was obtained from the North East - Tyne & Wear South Research Ethics Committee on November 9, 2021 (see Appendix 4a). Additionally, approval was granted by the HRA and Health and Care Research Wales (HCRW) on November 10, 2021 (see Appendix

4b). The University of Essex's Research Governance Team provided approval on November 11, 2021 (see Appendix 4c).

3.5.1 Anonymity and confidentiality

Participants were provided with an information sheet (Appendix 4d) and asked to sign an accompanying consent form (Appendix 4e). Interviews were recorded using a digital dictaphone and securely uploaded to cloud storage for transcription and analysis. The transcribed data was anonymized and did not include personally identifying information. Potentially identifying details such as geographic location and names of others were anonymized. Participants were given the option to choose a pseudonym of their choice. Most participants did not express a preference, while one participant indicated that they did not want a certain type of name. I consulted the literature on best practices (Lahman et al., 2022) and chose culturally responsive pseudonyms that felt representative of each participant, remaining mindful that pseudonyms, in the quest to afford privacy, might serve to alienate a participant from their own narrative.

3.5.2 Protection from harm

As the interview concerned sexuality, a topic with potential to cause distress, attention was given to ensure that participants felt safe and comfortable throughout. A statement was included in the interview guide (Appendix 5) to clarify that participants did not need to speak about anything they would rather not and were free to withdraw from the study at any point prior to thesis submission. In my dual role as scientist practitioner mindful of the capacity for this topic to elicit disclosures of issues such as abuse (Mustanski, 2011) I was primed to move from a more passive listening role to a more active clinically oriented role to risk assess and agree a

suitable course of action with the young person to ensure their safety or that of others. Participants were invited to have a debrief following the end of the interview and I was prepared to signpost to support services where relevant and appropriate.

3.6 Data collection

3.6.1 Narrative interview guide

The interview guide began with an open-ended 'generative narrative question' designed to elicit narratives about the research topic (see Appendix 5). This opening question was then supplemented by prompts informed by previous research literature. Prompts were used flexibly in response to the participants' accounts. This is known as 'narrative probing' and is a means to clarify aspects of the story, rather than to elicit entirely new information that participants did not introduce (Flick, 2015). A single main question was more in keeping with the epistemological stance of this study than a more tightly structured interview. Imposing further structure on the interview runs the risk of influencing participants' narratives through the researcher's additional performative input and framing of the research topic in their wording of questions for instance (Clandinin and Connelly,2000). However, an interviewer is also a co-constructer of a narrative even through the use of such facilitative actions such as nodding and clarification questions (Brinkman and Kvale, 2018).

Participants took part in a narrative informed interview of approximately one hours duration. Interviews ranged from 47 to 82 minutes. During each interview I was attentive to my own responses to the participant and my approach to them in the interview. After each interview I made reflexive notes of my felt experience and my impressions of the participant as well as any initial thoughts I was having about the form and content of their accounts.

3.6.2 Transcription

The approach to transcription taken in this study was underpinned by the epistemological positions of interpretivism and social constructionism. Therefore, accurately representing the felt experience of the interview was considered an impossibility, and the resulting transcription is itself an initial interpretation and a construction of sorts.

When transcribing, the inclusion of para-linguistic features such as pauses etc. is an effort to minimize premature meaning making. Such features assist in capturing the felt sense of the participant's words where possible, such as their speed, emphasis, laughter etc. Notations taken from the Jefferson transcription system as described by Hepburn and Bolden (2017) were added to the transcript (See Appendix 6). The transcripts, analysis or interpretations were not shared with participants. This reflects the position that the narratives participants provided are a co-construction unique to the research setting. Participants were asked if they would like to receive a copy of the research once written up.

3.7 Analytical framework

The analytical framework that I applied to the analysis of the interviews is Master Narrative Engagement (Hammack, 2011). Hammack and Cohler (2009) advocate for a theoretical approach to the study of individual sexual lives that incorporates historical, discursive, and cultural contexts ('actual' reality in Bhaskar's (2008) terminology), and affords a means of transcending the split between essentialist and constructionist views. This approach, *narrative engagement* serves to acknowledge historical relativity of lived experiences ('empirical' reality) through recognition of the role *master narratives* exert to both facilitate and constrain

an individual's sense-making and communication of their experiences in the form of a *personal narrative*.

Master Narratives are a part of the structure of society, the social reality (or 'actual' reality). They are culturally shared and inherited stories that influence thoughts, beliefs, values, and behaviours, and indicate how to be a 'good' member of a given culture (Hammack & Toolis, 2016; McLean & Syed, 2016). Hammack and Toolis argue that narratives are tangible embodiments of language and often exist in concrete forms in the form of cultural artifacts such as literature, film, educational textbooks, and recordings, as well as conversational exchanges between individuals (Hammack & Toolis, 2014). How the concepts of sex, sexuality and gender have been conceived of and responded to over time can be considered through the lens of what are termed *master narratives*.

According to McLean & Syed (2016) master narratives provide a template of how one ought to be (utility);they are pervasively present and represented across society such as through media representation and institutional practices (ubiquity); they are considered as a natural given, scarcely thought about by those in alignment with them (invisibility);adherence is expected and those who do not, do so at the risk of being oppressed (compulsoriness); they confer and maintain the privilege of those who adhere to them and who play a role in sustaining them (rigidity).

McLean and Syed assert that the master narrative framework is an ideal means of contextualising individuals' experiences (Bhaskar's the 'empirical' (2008)) within their sociocultural context. Through translating the influence of structural factors ('actual' reality) into the shared metric of narrative, it facilitates examination of the agentic and dynamic

relationship an individual has with the normative assumptions, expectations, and priorities of their society (McLean & Syed, 2016). They advocate for analysis which is attentive to not just an individual's personal narrative construction, but also to the structural factors which both facilitate and constrain such accounts. They describe two processes of narrative engagement, 'internalization', and 'negotiation'. *Internalization* describes the often-unconscious adoption of the master narrative template as a means of constructing one's own personal narrative. *Negotiation* is the dynamic process of both connecting with and differentiating from one's culture. It is retaining one's sense of self while maintaining a sense of belonging to the collective. Negotiation also encompasses resistance to hegemonic master narratives. Though individuals retain agency to negotiate and resist master narratives, there are limits to the extent to which this is possible due to the inherent hegemonic status of master narratives.

Hammack and Toolis (2016) suggest the process of narrative identity construction is likely more overt and salient for individuals who find the master narratives resources they have access to are insufficient to equip them to articulate their experiences and identity. Normative master narratives relevant to this research are those of cisnormativity and heteronormativity. Alternative narratives are constructed in relation to master narratives and therefore serve to inadvertently reinforce master narratives through reference to them. Alternate or counter narratives can themselves assume the hegemonic status of 'alternate master narratives' (Bamberg & Andrews, 2004), when specifically intended to counter the assumptions of another master narrative (Bamberg & Wipff, 2020).

In a US study, Bradford & Syed (2019) conducted four qualitative focus groups with fifteen participants to identify master and alternative narratives guiding transgender identity development and explore the mechanisms by which transgender individuals engage with and

are influenced by these narrative constraints. Drawing on the results of this study, they outlined how cisnormativity can be conceptualized as a master narrative as it meets all five defining principles. The aspects of cisnormativity voiced by their participants were, aversion, biological essentialism, danger, sexualization, and pathologization. Bradford and Syed (2019) also proposed that in the case of TGD individuals, a hegemonic alternate master narrative to that of cisnormativity, 'Transnormativity', has developed on the basis of the historical characterization of transsexuality by the psy and medical professions (Bradford & Syed, 2019). Bradford and Syed's conceptualisation of transnormativity as a hegemonic master narrative alternative to that of cisnormativity, frames it as simultaneously enabling and constraining opportunities for articulating identity as a transgender or gender diverse person (Bradford & Syed, 2019). The aspects of transnormativity voiced by their participants were medicalization, gender binarism, gender roles, nascence, victimization, gatekeeping, and legitimacy. In his original (2016) articulation of the concept of transnormativity, Austin Johnson completed a content analysis of nine documentary films, identifying the felt sense of being 'born in the wrong body' (nascence) as one overarching theme, and medicalization as the second overarching theme. Dominic (2021) offers a critical discourse analysis of the 'Wrong Body Discourse', which encompasses nascence and medicalization. Beyond, academic discourse, Jacobsen and colleagues examined how trans Tumblr users sought to define "who counts as trans", with some Tumblr users demonstrating internalization or acceptance of transnormative narratives and others contesting aspects of this, giving some insight into trans community voices, albeit just those who use Tumblr (Jacobsen, Devor & Hodge, 2022). A review of grey literature may afford additional insight into how TGD individuals navigate the master narrative of transnormativity, but an overview is beyond the scope of this work due to space requirements.

3.7.2 Polyphonic voices and The Listening Guide

Narrative engagement (Hammack, 2011) is a proposed means through which individuals draw upon, reject, or modify existing narrative templates, master narratives, to construct personal narratives. Through an adapted use of the listening guide method (Gilligan et al. 2003) it is possible to develop an understanding of the narrative engagement of narrators with respect to salient master narratives. This is achieved through close analysis of the contrapuntal voices present in their polyphonic account of personal experience and understanding, tracing the relationship between the narrator's self-voice and those which are identifiable as linked to master narratives.

The Listening Guide (LG) seeks to bridge the gap between person-centred and culturally centred narrative research approaches by providing a systematic and reflexive means of listening to the polyphonic voices present in an individual's narrative account. LG achieves this by recognising what's referred to as 'layered consciousness' (Tolman & Head, 2021, p. 154). The voice is considered an embodied manifestation of the individual's mind, with which individuals actively navigate the multiple voices which make up shared discourses ('actual' reality (Bhaskar, 2008)). The method allows for exploration not just of *what* is shared and *how* but also of what may *inform* its telling. "The Listening Guide" is most effective "when one's question requires listening to particular aspects of a person's expression of her or his own complex and multilayered individual experiences and the relational and cultural contexts within which they occur" (Gilligan et al., 2003, p.169) and is described as a form of analysis well suited to "marginalized experiences, including those involving social stigma" (Sorsoli & Tolman, 2008, p. 495). Indeed, in a review of methods used in the psychological study of sexuality, Frost and colleagues (2013) specifically name the LG as a narrative approach that is well suited to studies with a phenomenological aim of understanding the lived experience of

sexuality. They argue that the LG allows for the 'discovery of layered complexity (p. 131) and reveals a 'wide range of meanings' (p.131).

In the original use of the LG the emphasis is upon developing an understanding of people's inner worlds as they navigate aspects of their social and material worlds (Tolman & Head, 2021). However, in their use of the LG, Doucet and Mauthner diverge from the original focus on interiority, instead stating the aims of their third and fourth listenings as listening for relational narrated subjects and listening for structured subjects respectively. They dispense with aspirations of coming to know the 'real selves' of research subjects (Doucet & Mauthner, 2008; Mauthner & Doucet, 2003) and instead acknowledge that all that can be known is what is narrated. They therefore make the case for the use of the LG to capture a sense of the subject who is intentional, accountable, self-reflexive and autonomous, *as well as* constituted within and by the discourses of their sociocultural and historical context (Doucet & Mauthner, 2008).

The approach taken in this study is in keeping with Doucet and Mauthner's approach, in recognising that the narrative accounts of participants are the units of analysis, not the 'internal worlds' of the participants. However, the identification of contrapuntal voices was retained from the original iteration of the LG and its sequelae. This was felt to be a useful means of tracing the moments of polyphonic dialogical movement between the 'I' or self-voice of the narrator, their accounts of their relational self (in the context of their family, peer group, educational institute etc.), and aspects of their account which draw upon or otherwise reference master narratives. Analysis of the patterns and movement between the self-voices of narrators and the contrapuntal voices discerned in their accounts offers a means of tracing the interplay between personal and socio-cultural master narratives. This novel means of tracing narrative engagement using the LG has previously been used with respect to sexual identity (Davis,

2015). This adapted use of the LG affords further depth of analysis, with multiple readings providing rich data, even given the small sample size.

The LG weaves reflexivity throughout the research process, bringing oneself as the interviewer and analyst repeatedly into relationship with the narrator. This method allows for transparency with respect to interpretations of the narratives co-constructed in interview. LG analysis consists of five steps:

1 'Observing the Landscape and one's responses. Attuning oneself to the narrator and attuning oneself to one's responses to the narrator.
2 Listening for the 'I', the voice of the self.
3 Developing contrapuntal voices in relation to the research question
4 Voice analysis- how do the contrapuntal voices move through the interview in relation to the 'I'. Developing an interpretation and assembling evidence to support this claim.
5 Composing an analysis

A description of how I applied these five steps in this research is outlined below.

Listening for plot: I approached this first listening following Doucet and Mauthner's (2008) approach of combining the basic grounded theory question 'what is happening here?' with a focus on aspects of narrative analysis such as recurring words, themes, chronology, characters, plot and subplots. In practical terms, for this listening I listened to the audio of each interview while reading the transcript. I reflected upon my own responses to the material and how it was communicated. I paused frequently to make notes documenting elements of my thought process as I listened (For an illustrative extract see appendix 7). These notes included a range of things, such as the associations I was making to other research or theories, personal memories, and the content of other interviews. I noted the line numbers of the transcript in which there was a word

of phrase that had sparked my thought to facilitate recontextualization of the notes when I returned to them.

Listening for the 'I': During this step, I focused on understanding the subjectivity of each narrator. To achieve this, I created an 'I-Poem' (Gilligan et al. 2003) sequentially compiling all instances where narrators refer to themselves as active agents using "I" followed by a verb and included instances where they referred to themselves ('me', 'my', etc.). This process also served to highlight moments where the narrator shifts from narrating their subjective experience to other relational configurations like 'we' or 'you'. (Chadwick, 2016). Furthermore, I paid attention to paraverbal communications, such as laughter, tone, prosody, emphasis, and sighs, as they were potentially informative regarding their relationship to what was being said at those moments.

Listening for contrapuntal voices: Tolman and Head (2021) emphasize this aspect of the analysis as the focus of a research inquiry. In addition to the *content* of what the young people share, the goal was to learn more about *how* they storied experience and understandings and *what* narrative resources they drew upon to do so. This is informed by the assumption that narrative and experience are co-constitutive, and the means by which a young person stories their experience reflects their internal assimilation or rejection of the available narrative resources as they apply to their lived experience (Hammack & Cohler, 2009; McLean & Syed, 2016). During this step of the analysis, I read through the transcripts while listening to interview audio multiple times. While doing this, I directed my attention towards language, words and phrases that indicated or elaborated psychological processes (Tolman & Head, 2021). In my use of the LG, I paid attention to the moments of shift between the 'I' voice and other positions such as 'we', 'us', 'they', 'you' and 'people' as potentially representative of different

harmonious or contrapuntal voices. It was an iterative process in which each voice was identified and examined. Once a potential voice was identified, it was mapped through the narrative for consistent qualities until it was possible to describe and illustrate it clearly with contextual evidence from the narrative. This listening was attentive to social networks and close relationships indicated in the account, what Docuet and Mauthner refer to as 'Reading for Relational Narrated Subjects' (2008). This listening was also inclusive of what Doucet and Mauthner describe as 'Reading for Structured Subjects' (2008). This entails a specific focus on the structured power relations and dominant ideologies linking participant's accounts with wider cultural narratives, processes, and structures that influence their lives, situating the individual participant within a shared wider narrative context. With the additional lens of master narrative engagement, the analysis was afforded additional depth and nuance.

Voice analysis and assembling the evidence: This step involved analysing the contrapuntal voices that were identified alongside the 'I' one by one and establishing their relationships and movement in the narrative. This was achieved by means of visually tagging certain voices using font, text size, italicization, bolding, and colour. Where there were patterns in this it was possible to begin to make interpretations of these relationships. In line with the multivocality of narrative accounts, areas of the text were at times tagged as relating to more than one voice. Parts of the narrative that clearly demonstrated the identified patterns were located before proceeding to the final stage.

Composing an analysis: In this step I began to put together the evidence for my interpretations, rendering my analysis visible and credible to the reader to support my account. I articulated what it was that I heard in the participants accounts and how I came to hear this. I

sought to illustrate the narrative engagement perceived in each account, increasing the richness of the data.

3.8 Summary

To understand how TGD young people experience their sexualities in the context of accessing PST I have designed a study that ontologically is underpinned by critical realism and epistemologically adopts a pluralistic stance incorporating aspects of interpretivism, social constructionism and phenomenology. In order to capture what TGD young people say about their experiences of accessing PST I have employed a narrative inquiry approach. Analysis of interviews was underpinned by a Master Narrative framework. A purposeful sampling method was employed. With adaptation to this method to address a range of recruitment challenges, four participants were recruited into the study.

Chapter 4: Results

In this chapter, I introduce the four young people and using the steps of the Listening Guide, I aim to enable the reader to access something of each narrator's unique storied experience through a detailed re-telling of their stories. My listener responses, the reflections I took notice of whilst engaging with each narrative, follow the presentation of listening for plot and landscape. To retain fidelity to each narrator's account, I use exemplifying quotes and provide relevant descriptive information regarding affect, tone, and other aspects of the narrative that may not be readily discernible as a reader. For clarity, each account is minimally reordered such that events pertaining to the narrators' pasts come before content related to their present or recent experience. In NI and the LG method, it is important to retain the narrative as a contextualised unit of analysis, as to combine results would take away from the uniqueness of each narrative. De Fina refers to this as "The wholeness of the storytelling event" (De Fina, 2021, p.55).

4.1 John

John (16-18yrs) described himself as white British and male, noting that he would say transgender if asked, and if he felt comfortable with the person asking. He came across as confident, friendly, and communicative. His story spanned from childhood to the present day. He spoke about his romantic relationships with relative ease, speaking less fluently on the topic of sexual intimacy, and little about his experience of sexuality outside of the context of relationships. John spoke about having always been attracted to girls and at the time of interview was in a relationship with his cisgender girlfriend for several years.

4.1.1 Listening for plot and landscape.

John's story began with a cheerful account of his childhood self, who was aware of liking girls from a young age, identified as a lesbian, and was *'open'* about this at the time, telling friends at school and *'thinking nothing of it'*. He reflected that back then he was *'completely different'* to how he is nowadays.

> *"Ever since like I was young, it was, it was really weird, ever since I was young, I was always into like girls. So I obviously I was open I was always thinking I was a lesbian, so I was always open about that uh ((laughing)) I was actually like shouting like saying it to my friends in primary school, thinking nothing of it, like today, like if you was doing that in primary school you never know some people might hate against you, all that, back then, it was nothing, ((laughing)) it was quite weird it was for some reason I was comf- completely different to how I am now."*

John spoke about relationships in primary school and how this was *'sort of like just a title sort of thing'*. He remembered *'getting married'* in the playground and reflected that he has always wanted to be in relationships but thinks about this differently now.

> *"Because obviously now I, there's a lot more to being in a relationship than just being with someone, there's obviously there's sex to it there's like responsibilities that come with it you know there's you've got as well as your own family you've got that family and then their family…"*

John noted that he did not think much about sex or sexuality prior to his early teens, saying:

> *"I don't think I'd thought much of of it. I always thought 'that's always what adults do, it's nothing we should be doing'".*

He described simply viewing himself as one of the boys in his early childhood. He shared his early thoughts about sexuality as falling along the lines of gender norms.

> *"I always thought, at at that time before blockers I I think I always thought It should be like boys like girls, girls…like ... boys and then obviously I was like 'I like girls, which is like girl, like, girl like girl', I never really thought 'boy likes boy' it was really weird I always just thought it was them two and then obviously what I want.((both laugh))"*

John recalled learning about sex and sexuality via school and how his school did not have material about gender diversity, *"they only knew about gays and like that sort of bit, they didn't have anything about transgender until me really…".* He spoke about how his school played a role in framing his experience of gender in a new way *"they were the ones who found it all out for me they got me to GIDS*". He spoke about his surprise at other people's awareness of trans identities and noted that it was something he did not know about until he was told, *"…I didn't even know it was a thing, till they said about it.".*

He spoke about how attending sessions with GIDS helped as he could talk to people and could begin to see himself as being transgender. He shared that he was very worried about being bullied and he did not want people to know about his gender history. He outlined an incident in secondary school where some other pupils began to comment on his binder and asked him to lift his arms so they could see it. Following this, he has avoided wearing binders, saying, *"it's put me off them ever since".*

In secondary school, John began a relationship with another pupil at a time when lots of his peers were getting into relationships with each other noting *"At first it was like 'oh these people are getting together why don't we'".* He spoke about how he was prompted to think more about sexuality in secondary school as it was something that his peers were engaging with.

> *"Because a lot of people were getting with people and there was a lot of things happening like a lot of people were like saying like oh they've had sex with someone, and it was like at points there was like pressure saying like 'oh you need a girlfriend' but at same time it was like there wasn't, 'like you don't actually need one it's fine'*

Around this time John began to access puberty suppressants. He asserted he did not perceive any change to his experience of sexuality as a result *"I don't remember it having effect on it, um I remember obviously we would kiss and we would hug and all this, we were cuddling, but*

I don't remember it having much of an effect…". John spoke about the expectations among his peer group with respect to milestones of sexual intimacy and being called *'frigid,' "because you haven't done it".* He spoke about how his male peers would talk about masturbation and how this was *"never something that I've gone and thought 'you know what I'm going to do this'."*

He spoke about how his current girlfriend was supportive and understanding when he told her about his gender and noted his prior worry that she would not want to be with him anymore when he told her. He spoke about how her reaction boosted his confidence, stating *"if she doesn't care, then why sh- like no-one else does, and if they do have a problem with it, then so what".* He drew a comparison between his current girlfriend's acceptance and understanding and his previous girlfriend's response *"like with my first one, it was sort of there wasn't it's what 'if they're doing that, why aren't we?' and now I know 'if they're doing it it doesn't matter if we're not'."*

John spoke about his experience with the blocker and his sense that *"if I hadn't been on it my life would have been completely different, and I would have probably been miserable".* He spoke about feeling that his sexual desire has been *'normal'* and how he doesn't perceive any change attributable to the blocker.

> *"So, like where it's if you're with with someone there's sort of the build, not build up, but like, you're with them then like you get the sexual attraction with them so that sort of way, instead of like 'oh I've, uh the blockers making me more sexually attracted or have a higher sex drive or libido' or something like that, it's never, I've never been like that it's I uh wh from when, I guess, because maybe because I started when I was younger I didn't have that, it's maybe been normal if that make sense ((laughing))."*

John mostly spoke about sexuality in terms of sexual orientation and being attracted to girls. He spoke about the social aspects of sexuality and relationships within the school setting, and

the role that the institution of school played in his recognition of himself as transgender, and in developing his awareness of sexuality more generally. He drew on his experiences of this from primary school onwards inclusive of his early childhood relationships with peers as well as his current romantic relationship. He spoke about sexuality largely in the context of relationships with others, rather than his own individual sexuality. He spoke about viewing his participation in the project as a means of giving back to the GIDS, as he had felt supported by his clinicians there.

4.1.2 Listener response to John

This was the first interview that I conducted, and the impact of this was that I was perhaps overly quick to facilitate John to speak through further prompts. I identified with regret various occasions where I could have stayed with a topic a little longer to allow John to further explain his thoughts.

During our interview, and later when listening back multiple times, I developed a sense of John as someone who did not appear to identify as a member of the LGBTQ+ community. When I asked him what words he uses nowadays to describe his sexuality, he was initially unsure what I was asking and sought clarification, before saying that he just says that he is male. I remember smiling inwardly at what I felt was a sort of uncomplicated laddishness and was reminded of some of my younger cisgender and heterosexual cousins who I imagine do not have an awareness of the language and terms those in the LGBTQ+ community might use to describe their sexualities. This was perhaps a point of distinction between myself and John, as I identify with the LGBTQ+ community. This point of distinction afforded me a means of hearing John's account in a different light.

When listening to John's responses, I noticed a new sense of curiosity about his experiences with sexuality which was less palpable during the interview itself. In our interview I recalled feeling largely satisfied with his responses. Therefore, I was surprised to notice upon repeated listening that I did not finish with a clear sense of John's relationship to his sexuality. I realized that he did not clearly confirm whether he is sexually active, or if sexual intimacy formed part of his relationship at that time. I noticed John was at times remarkably absent from his narrative, for instance in response to a question about when *he* first began to think about sex and sexuality, he spoke about learning about sexuality with his schoolmates.

I wondered if perhaps he felt torn between a wish to communicate his experience, and feelings of bashfulness. This led me to wonder if perhaps something went unspoken in our conversation to do with his own feelings about sexual intimacy. Though I had felt comfortable to ask about his relationship to things like masturbation and consuming pornography, for some reason I did not ask direct clarifying questions about sexual experience, desire, or comfort with sexual intimacy. Struck by this oversight, I wondered whether I had made an assumption about John's experiences, or if something had occurred in the co-construction of John's narrative, in which John had, perhaps unconsciously, navigated our conversation such that he bypassed confirmation or disconfirmation of various things to do with his sexual life. I wondered about the challenge of opening up to another person about intimate things and reflected on the difficulty of the task I had set for John in our interview.

Noticing this, I was prompted to remember my own teenage years and (on my part) conscious efforts to evade revealing my queer sexuality, alongside choosing not to correct others when they assumed I was heterosexual and/or sexually active. This reflection supported me to identify a possible point of connection that might illuminate a process potentially at play

between us in the interview. However, I was mindful to hold this interpretation lightly, being that John and I were of different generational cohorts with respect to the sociocultural attitudes toward gender and sexual minorities likely encountered in our formative years.

Another point of connection I felt with John's narrative was his younger self's surprise at the existence of others like him, LGBT people. I wondered about the potential for this discovery to reduce feelings of being alone, but also perhaps to prompt disavowal of similarity between the self and those who are positioned within wider social discourse as 'less than'. The latter was a form of internalized stigma I remember experiencing and was therefore perhaps sensitized to potential indications of internalized stigma in John's account.

An area of disconnect occurred regarding my use of the word 'open' when asking about the nature of his romantic relationship. I was hoping to clarify if his relationship with his partner was monogamous or inclusive of romantic and/or sexually intimate relationships with others. When listening, I doubted that my intention was clear to John. His response centred on how his girlfriend is aware and accepting of his gender. This disconnect prompted reflection as to how John may have been perceiving me in the moment and I considered if perhaps he perceived the question as though I were asking if his girlfriend knew 'the truth', or something equally disparaging. This led me to become curious about the aspects of John's narrative that may have been evoked as a form of response to either myself or imagined others within a wider context. Lastly, I was struck by John's apparent categorization of his relationship as a family, something I would not have anticipated given his age. He spoke about being in a relationship and the responsibilities attached, how 'you've got your own family, you've got that family, and then their family'. I began to consider if perhaps he was consciously or subconsciously striving to

confer a certain legitimacy to his relationship, as a foundation from which he might be heard to speak as someone with authority through experience of 'serious' relationships.

4.1.3 Listening for the 'I'

The self-voice in John's 'I poem' was reflective and confident from the outset, drawing calmly upon an early sense of attraction to girls as representative of an enduring sexual identity. However, his 'I' also appeared to carry rather self-conscious awareness of the potentially hostile/invalidating perspectives of others. This was notable in the qualification of his early sense of his maleness as something he 'was just thinking', as though pre-empting challenge or negation of his personal experience. The below extract comes from John's response to the opening question.

I was young
I was young I was always into like girls
I was open
I was always thinking I was a lesbian
I was always open
I was actually like shouting like saying it to my friends
I was completely different to how I am now
I grew older
I started to transition
I was thinking I'm just a male
I I know
I know I wasn't
I was always just thinking it
I was doing everything boys were doing
I was always comfortable with that
I grew older
I knew more things about it
I was
I felt
I've always been attracted to girls
I've had no shift in pattern
I've seen research
I've always liked girls
I've always had a sexual attraction to girls

The self conveyed in John's account appears to suggest an inner experience that was perhaps challenged or altered through encountering 'transgender' as a descriptive category others might apply to him. He spoke about not knowing about transgender identities as a concept until school.

The phrase 'I didn't know myself up until the last year' struck me as emblematic of the self-voice within John's narrative encountering and negotiating the imposition of the views and perspectives of others. The line could be interpreted as speaking to a form of self-discovery ('I didn't know <u>myself</u>') or the discovery of new points of view held by others ('<u>I didn't know</u> myself'). In the context of his narrative and the tone and prosody used, I interpreted this as the latter. However, the contrast between this sense of discovery and his awareness of his stable early attraction to girls and sense of masculinity may also point to the temporality of experience conveyed through narrative in which a single speaking self encompasses multiple self-states.

The shifts and movements of John's 'I voice' were suggestive of a sense of perceived obligation to almost qualify or caveat his maleness, as though expecting his own coherent experience to be challenged by outside framings and perspectives which though recognizing his maleness, insist on subcategorizing this specifically as trans. The following extract originated in response to a question about how John felt more generally when he began to access PST.

When I was first taking it
I still saw myself as male
I didn't see myself as transgender
I mean
I still do that now
I obviously know
I am transgender
I put something down
I'd put transgender
I do see myself as a male

Similarly, the following extract originates in John's response to being asked what words he uses to describe his sexuality. The 'I' appeared to have pre-empted an unasked question, about gender, rather than sexuality.

> *I mean.*
> *I mean now I just say I'm male.*
> *if like it's something that I like need to say I'm transgender for*
> *I'm a male that's how I see myself.*
> *I know*
> *I am actually a female*
> *I am trans but in myself,*
> *I am male if that makes sense*

Through repeated listenings and readings of John's 'I poem', I noted the movement of his 'I voice'. In the moments where his 'I' shifted in musicality or became 'we', 'they', 'you' or 'people' I became sensitised to other voices present in his account.

4.1.4 Listening for contrapuntal voices

I identified seven contrapuntal voices within John's account (See Table 4.1)

1. **Cis-heteronormativity:** This voice was brisk and straightforward, as though simply supplying background or context to the account while anticipating universal understanding and recognition of intended meaning.
2. **Voice of un/acknowledged difference:** This voice was audible when John spoke about his categorization as a transgender person. It captures a sense of a friction between John's ongoing internal gender and the imposition of an identity label to be intelligible to external others. This voice was often rather inarticulate and was quietly audible in gaps and pauses, moments where it seemed as though John sought to balance his own straightforward maleness with awareness of others' foregrounding of his differences. This voice often had a tone of quiet thoughtfulness, nearing surprise, and appeared to indicate

a similar feeling, to that of viewing an optical illusion and noting that another view exists the 'other' view, as well as one's own, even if that view is invalid.

3. **Sexuality (individual):** This voice represents John's more personal accounts of sexual attraction, desire, and practice. This voice spoke rather self-consciously and hastily, in a slightly lower register compared to the surrounding speech.
4. **Sexuality (social):** This voice reflected how the social sphere of peers within the institution of school informed aspects of sexual practices and knowledge. This voice sounded rather amused, at times tinged with embarrassment. At times this voice was spoken in the present tense in the form of quotes from others or the self. (A subsidiary aspect of this voice is 'pressure', detailed in section 4.1.4.)
5. **Stigmatized difference (transphobia):** This voice reflected awareness of negative views of transgender people. This voice sounded sombre and rather flat.
6. **Voice of youthful naivety:** This voice conveyed the idea that children and young people are pre-sexual, and youthful relationships are inconsequential. Often this voice took the form of an interruption, a speedy bit of light-hearted commentary to provide contrast between previous views/actions and currently held views.
7. **Voice of transnormativity:** This voice spoke to the dominant narrative of transgender experiences. It was confident, self-assured, and direct. It was imbued with hope when speaking about the anticipated future. This voice was simultaneously personal, and impersonal, as though addressing a sceptical other.

Voice and attributes	Representative examples
Cis-heteronormativity This voice appears in **bold font**	**So I was doing everything boys were doing, so, my sexuality was obviously towards girls** and all that "Our school was quite good with all that sort of stuff but **they they only knew about gays and like that sort of bit, they didn't have anything about transgender until me** really it was quite funny ((laughing)) they made a whole PowerPoint on it
Voice of un/acknowledged difference. This voice appears in underlined font	Ruth: There was something surprising about that, that other people kind of knew about it? John: yeah I didn't I didn't, it's because obviously I didn't know myself up until the last year, so for other people to know about it was a bit like of a shock as well, I was like I didn't know, I did- 'cause like I didn't even know it was a thing, till they said about it, so yeah. when I was when I was first taking it I still saw myself as a male I didn't see myself as transgender. I mean, I still do that now, but I obviously know it's a bit like, I am transgender but if I put something down so for like my college application I'd put transgender, but like, I do see myself as a male, so on anything I would have male, so my passport it is male, if that sort of makes sense, so yeah it, yeah.
Sexuality (individual) This voice appears in light blue font.	…it's not like all of a sudden, I want to be with her and have sex with her now it's like it's not like that, it's the whole thing that like comes with it, it's like natural, I've never had anything that I thought 'oh the blocker may have had an influence on it', it is all sort of been natural sort of thing [mm] obviously I've known boys who have done it, and all this and at times that's all they was talking about at school but I've been like, not interested, but like, it's something that I wouldn't go sit at home and be like 'oh I'm going to go to masturbate or something' I've never been like, like that, if that makes sense
Sexuality (social) This voice appears in purple font ('Pressure' appears in red font)	Because a lot of people were getting with people and there was a lot of things happening like a lot of people were like saying like oh they've had sex with someone I think at first it was like 'oh these people are getting together why don't we' and obviously her, her friends were, some of my friends were, so it was sort of like yeah
Stigmatized difference (transphobia) This voice appears in dark green font	I was very scared of getting bullied I think as well. I didn't really want people knowing, because I know people have been hated for it, and got bullied for it. I mean I've always felt like I've been less attractive than other people because I'm obviously trans, or I'm on the blocker
Voice of youthful naivety This voice appears in Grey Comic sans font	I was very young and I said that I I uh I was going out with a girl so we were going out and it was like well it wasn't like obviously serious we were only in primary school so, but back then like people in like, people were going out with each other like it was sort of like um, not like how it is now like you're going out with someone there's a lot more different things to it. Back then it was sort of like just a title sort of thing if that makes sense? We were sort of same popularity so-at that point being popular was very, now you look at it you think 'it's stupid', but we were sort of there, were always in the same classes, so we were always with each other

Voice of transnormativity This voice appears in brown font	ever since I was young I was always I would say I was a male or I would always be dressed, playing rugby from a young age so I would say I'm male All the girls would be talking about how they they want like big boobs and all this and there's me thinking I want them smaller and it was always like other than that there's there's never been I've always felt better being on it, 'cos I know what it does and how it helps me a lot so yeah I mean with, ever since I've been on it, I have been happier. So, especially when I start this testosterone, I'm gonna be, I'll be a lot happier knowing that's the next step forward and and I'm starting to get it going now.

Table 4.1 John's Polyphonic voices with exemplars

4.1.5 Analysis of contrapuntal voices

As the focus of the study was both the content of narrator's accounts of experience and understanding of sexuality in the context of accessing PST**,** and their relationship to the narrative resources they draw upon, modify, or reject in their personal narrative construction, I have selected portions of the narrative where voices representing these are present and interacting.

At the level of content, John's narrative conveys the experience of a gender diverse young person for whom sexual orientation has not represented a challenge. Rather, John's account suggests that his longstanding attraction to women has been a helpful means of rendering his gender more easily intelligible to others. John spoke about accessing PST as something he is glad he did and shared his sense that PST exerts no influence upon his sexuality, highlighting that his experience of sexual desire is grounded in his relationship and he does not notice any fluctuation of this in line with his schedule of PST appointments.

The voice of individual sexuality is present but not fully owned by John in his account. At times John spoke about sexual desire in a way which indicated that he experiences this and enjoys sexual intimacy with his partner. At other times I wondered if perhaps I had in fact merely

inferred this and John was talking around the fact that he and his partner did not engage in sexual intimacy at present, or perhaps they engage in sexual intimacy in such a way that John does not feel confronted by the dysphoria this may prompt for him.

The voice of individual sexuality in John's account was largely inseparable from relationships with others, be they partners or peers. John spoke about first thinking about sexuality beyond who he fancied when he was in secondary school. In this section of the narrative, John's voice in the form of I statements was replaced by a more abstracted voice, which appeared to be neither clearly his nor clearly attributed to his peers when he says:

> *'a lot of people were getting with people, there were a lot of things happening, a lot of people were like saying like oh they've had sex with someone like at points there was pressure saying like 'oh you need a girlfriend' but at the same time it was like there wasn't, like 'you don't actually need one, it's fine'*

In this section of the narrative there was a sense that perhaps John was noticing the social expectations around having a partner and having partnered sex. What also came through in this voice is what struck me as a rather disembodied relationship to sexuality. One hears about sex and about partners, without getting a sense of the material reality of these. This voice could be interpreted to link with the social currency of sexuality and sexual experience for adolescents and may be perceived as both **Heteronormative and Cisnormative**. This voice speaks about sexuality in such a way that desire is not felt to be present, be that for John as he recalls it, or perhaps also for the peers he recalls engaging in sex. It is possible that this public discussion of sexual milestones was less a reflection of burgeoning sexual desire and explorations of sexuality, than a form of social capital given the cachet it afforded in the context of secondary school.

Furthermore, in this extract, the voice of social sexuality appears to shift into a subsidiary voice of 'Pressure'. It is unclear if this pressure was from others specifically, or if this was something John felt towards himself. In the narrative the voice of pressure is not attributable to any particular person and could be interpreted as linked to wider discourses and norms regarding sexuality in adolescence.

John indicated that the sexual activity of others was spoken about, perhaps as a badge of honour or as an accomplishment within a particular vision of masculinity. 'Pressure' here may refer to sexuality as social currency more generally, or indeed to sexuality as a particularly valued aspect of the adolescent experience for young men. In this way, I wondered if perhaps the voice of pressure John shares in relation to 'needing' a girlfriend, conveyed pressure not just to conform to the social standards of adolescence but more specifically pressure to affirm or 'prove' his masculinity in a new way.

In my interpretation of the pressure John spoke of, I wondered if, aside from the attendant pressures of social aspects of sexuality, he may have felt pressure to affirm his masculinity within the master narrative of heteronormativity (as well as sexist rhetoric regarding men's interest in sex in general) by claiming interest and experience in partnered sex. It is important to note that this is something the cisgender male majority also engage in (Connell & Messerschmidt, 2005) and it is of course not unique to trans men. However, to do so might risk compromising the legitimacy of his transgender identity, as to seek and enjoy sexual intimacy flies in the face of the hegemonic expectations regarding transgender sexualities culturally inherited from archaic constructions of transgender identities within the medical field.

John's self-voice is at times more or less harmonious with other identified voices. For instance, John's engagement with a voice of normativity about sexuality can at times be interpreted through a hermeneutics of faith or restoration. An example of this is when he speaks about how he and his girlfriend were both different to their peers due to their life experiences, and when he explicitly acknowledges difference with respect to sexual intimacy; *'I knew I'm different so it's going to be different'*.

Though John recognised his being different in his narrative, he did not routinely acknowledge normative views. These formed something of a backdrop to his more personal account, and as his listener I had the felt sense of certain normative ideology being assumed as mutually accepted in this lack of acknowledgement.

John did not speak directly to how his sense of being different to the cisgender majority may have influenced his perception of himself through an internalisation of **cis-heteronormative ideology.** However, the potential for this to have had some impact can be interpreted in his response to a question about his own sense of feeling attractive while accessing the blocker. He stated:

> *"I mean I've always felt like I've been less attractive than other people because I'm obviously trans, or I'm on the blocker".*

A hermeneutics of suspicion challenges the idea that this sentiment relates only to the idea of attractiveness and considers if this also connected to an internalization of a voice of transphobia, the idea that gender diverse people are 'less than'.

4.2 Maria

Maria (16-18yrs) described herself as white other and female. She was softly spoken, friendly, and self-possessed. She spoke somewhat carefully but with fluency, confidence, and nuance. She demonstrated sensitivity to my needs as a listener and would explain things fully without prompting on my part. Maria would often interrupt herself to offer additional information or some form of caveat regarding what she was in the middle of saying. There was a sense that she sought to convey her experiences authentically but was demonstrably mindful of how what she shared might be perceived by a wider audience.

Her story predominantly focused on her experiences of the last several years, with particular emphasis on her time since accessing PST. She spoke little about experiences prior to secondary school and a proportion of her account centred on thoughts about her future with respect to sexuality. She noted that she was attracted to men and was not in a relationship but was beginning to pursue dating.

4.2.1 Listening for plot and landscape

Maria was forthright from the outset, sharing in somewhat clouded terms that she has not yet experienced what is typically considered sex, terming it a *'weak spot'* for her. She spoke about recently feeling more open to exploring sexual intimacy, but not feeling ready to have sex, noting that she feels *"held back physically"* by her *"situation"*, meaning her being transgender. She noted that for her, sex is something which she feels apprehensive about.

> *"…in terms of sex, uhm, you know with another person, you know that sort of romantic, um it's always been quite a somewhat of a somewhat you know weak spot for me just because um you know, I've never, well, I've never been properly like, I'd say I'm, I'm better now but I still wouldn't feel like I'm ready because of you know I feel like I'm getting held back physically I think, you know, with my situation and how, how, you*

> *know, physically I am, um, yeah I feel like it's always been something that I've thought about very apprehensiously…"*

She spoke about not having much sexual *"drive"* to begin with, which has further dipped since starting PST. She stated that this is something she looks on positively as it means she does not experience arousal in a physical manner as much as she did before and emphasised that this is something she is happy with, giving the caveat of *"for now"*, indicating that perhaps there may come a point where she would want some of that drive back online.

> *"…in a way um I think that kind of helps ((laughing)) um in some senses um you know 'cos 'cos you know when a biological male gets physically aroused, that is not something I liked, at all. Obviously it's a natural, it's natural isn't it, it's not, you know, bad, in general but um, the fact that physically that's much harder for me now is something I look on, uh, very positively, it's something I like, um, there isn't much, you know, um, when whenever you know I'm kissing a guy or something, it's not, it when I'm in the moment it's I don't get those feelings I don't get that rush, as much as I would have before, there isn't as much and obviously you know depending on what I wear I do kind of fix things and you know, tuck things in, if you know what I mean but um, there isn't that feeling it isn't as strong, you know that arousal or the drive, which is something I personally, for now I'm like, I think obviously in the future um, it's something you know that I'd um, I'd think about more, but for now, it's definitely something I look on, you know, positively."*

She spoke about how the process of growing up is continuing all the time and the challenges of her *"situation"* when it comes to relationships and dating. She shared that she was hesitant to explore relationships and intimacy with others and was *"waiting around"* to do this but that accessing the blocker had felt like the first step of a physical transition and gave her some sense of comfort within her body, opening a sense of possibility to begin to explore physical intimacy with others.

> *"I remember last year I wasn't really um looking for much, neither am I now, but but I didn't go on dates I wasn't I wasn't that that um, I think it was a bit of insecurity because of my situation, um, which still lingers, um but in general just kind of waiting around whereas this year, um you know I think the booster* (sic.) *really has um, sounds like I'm selling it ((laughs)), no but but I'm being serious it really um it really has kind of I don't know put me on track It's the first kind of transitional physical intervention um which is a milestone and it's something I've been looking to do for so long um so I feel like it did give me that extra you know I suppose you know willingness to to go out and to do things."*

Alongside this, she spoke about having a new sense of having some control over her body and that her relationship to her body has improved as a result.

> *"…the fact that things are slower or just not progressing, makes me somewhat accept my body more, whereas before I just thought I had no control."*

She gave the example of how her body hair is less than it was before accessing PST and that this helps her to *'maintain'* her body more easily. She emphasised that though it was easier to maintain her appearance and feel more in control over her body, it was still a source of distress. She spoke about how accessing PST represented part of a process of coming to terms with the *"cold reality"* of her *"situation"* and developing an awareness that as a transgender woman she will have an ongoing relationship with medications throughout her life.

> *M: "…there will always be some form of something whether it be oestrogen or or something to do my transition um so so I I just go at it really you know I think there's no time like the present really because it won't change now even when you do have oestrogen um there will be changes but nothing down there nothing you know huge it's not going to, you know even if there are changes it's not going to give me what I want, that change would be far more drastic, that change would obviously be surgical…"*

She illustrated this with the metaphor "*there's a baby crying and it's still crying but it's getting rocked so it's not crying as much*", to indicate that accessing PST has *"calmed"* her dysphoria, but not eliminated it, as there is *"no magic fix"* to her insecurities.

> *"…I think in terms of of sexuality I don't think it's made me question it or anything I think in a way it's probably um you know helped me mentally just because it's made me, it's pushed me a bit to just get out there and start seeing you know new people and talk and share like experiences . Um, you know and obviously it's a somewhat you know big insecurity of mine, my situation, and that's something the blocker can't necessarily fix 'cos there's no physical changes, well none of what I'd want anyway, um you know it's not going to fix anything magically, which is obviously clear um when when starting it um there are certain things just in general being you know trans you know dating and that it's it's a scary world.*

She spoke about how being transgender renders dating and relationships more *"scary"*:

> *"...kind of telling that individual and their reaction- stuff like that really gives me anxiety [mm] because um, you know, because its, you don't know how they'll react but it's something that at times scares me."*

She spoke about her belief that *"teenage lads"* may reasonably expect sexual intimacy if she is doing other intimate things with them. In the context of this, she spoke about the idea of one thing leading to another and this informing her decision to not engage in any sexual acts aside from kissing with a partner who was not aware of her gender history. She spoke about imagining having to tell a sexual partner about her gender history and the uncertainty of how they might react, saying that it would need to be a *"special lad"* for her to consider having sex with them, or to tell them about her gender. She noted that it is 'a journey' and that she feels that she will be ready for sex when she has had surgery (indicated as vaginoplasty) but that she is aware that this might change, and she might feel differently in time (a year.)

> *"It'd have to be a special lad, it'd have to be a special lad for me to open up and um and more than that I'm not sure, I'm really not sure I think having sex before , is, and , you know, if we had a conversation in two years , I might say a completely different answer, but for now at my age, at my kind of , my mental state it seems unfathomable I'd have sex with my situation, obviously you know there's certain sexual acts that don't require that, but I feel like as soon as you're kind of in the moment, a lot of those kind of delicate you know like 'are you ready yet?' like 'do you want to do this do you want to do that?' kind of go out the window ((chuckle)) when you're both-yeah and it shouldn't but for teenage lad it somewhat does you know um so I never, I never do anything you know that doesn't require you know down there without telling them my history beforehand just because I feel like one thing leads to another kind of mentality that I wouldn't want, because nothing's leading to that..."*

4.2.2 Listener response to Maria

I enjoyed my interview with Maria. She struck me as thoughtful, and her account was smooth and articulate, rich, and nuanced. I felt she went beyond just speaking about events and instead centred her narrative on the meanings her experiences held for her. In the interview itself I wondered at moments if she had perhaps prepared notes on what she might like to say. I noted in the interview and when listening, that she often spoke as though to other imagined young

people who were about to access the blocker, positioning herself as an elder with insight to offer.

When listening back, I noticed that I was hesitant to cut in to ask any further questions. In the moment I recalled feeling that Maria was addressing aspects I was curious about and wanting to allow her to speak on her own terms. However, when listening back, at times I wondered if perhaps I was missing things as Maria was steering the direction of the narrative. I began to feel curious about aspects of her experience that Maria did not explicitly name or give much detail about.

I was struck by how thoughtful and open Maria was about her experiences, and considered if having the space to speak in such a way may have felt like a relief in contrast to the stringent 'privacy', and perhaps anxiety, of her day-to-day life with others. I felt this as a potential point of connection that could illuminate something of her narrative. As a queer person I considered my own experiences of times I could speak and feel heard and understood, contrasting these with the more routine experiences of feeling othered or reminded of one's difference to the majority.

In contrast, a point of disconnection I reflected upon was how Maria spoke about aspects of femininity in ways that I related to, but felt less beholden to. For instance, she spoke about the need for hair removal as a woman and about not always having the energy to put on make-up before going out. While I could relate to these things, I felt that some privilege I am afforded as a cisgender person is that if I were to go out with visibly hairy legs, or without make-up, I may experience negative attention, but would not feel as though my safety was compromised by the act. This reflection prompted consideration of the cultural aspects of embodied

femininity which perhaps felt more compulsory for Maria, as a young woman navigating gendered beauty standards and cisnormative presumptions regarding her body.

Maria spoke about her sense of self as a young girl and young woman and the difficulty of adjusting to the 'reality' of the 'situation' she lives with. I was moved by what I felt was her mature appraisal of this 'harsh reality' and the limits of what gender affirming interventions could offer to her. This felt similar to narratives of acceptance (Frank, 2015) and sparked some initial thoughts about what narratives may feel most reassuring to clinicians tasked with the challenge of supporting clients to understand the long reaching implications of various interventions. In contrast to this nuanced appraisal, Maria's description of her reluctance to explore sexual intimacy as 'not feeling ready' struck me as rather lacking in dimension. As I listened, what stood out to me was not Maria's physical dysphoria, though I did not doubt this was a factor, but rather her allusions to the potential difficulty, awkwardness, or even danger of sharing her gender history with a potential sexual partner. I felt a sense of sadness and frustration at the social circumstances which may lead her to feel stuck and 'held back' by her body.

4.2.3 Listening for the I

The self-voice in Maria's 'I poem' was contemplative and appraising, reflecting on the past and looking toward the future. In her account, Maria's self-voice shifts in accordance with the temporality of the content. The 'I' remembering the past is characterized by a sense of powerlessness:

I feel like
I didn't
express myself
who I am
I feel like

How I was physically.
I remember
Something I deal with now
but I remember
I don't have the energy
I'd do my makeup
I remember
I got like little hairs
I was like flabbergasted
I was like 'oh my god'
I felt powerless

In the same extract, Maria's self-voice undergoes a temporal shift with a sense of personal growth and more agentic adaptation to her circumstances, despite the ongoing challenge these present.

I really did not like it
I grew to
I grew to dealt with it
I think
I grew to deal with it
really bothered me
Still bothers me

Maria's self-voice later indicates a reconciliation of sorts with *"cold reality"* as someone who is transgender, suggesting recognition and mourning relating to aspects of life that are more challenging, without forgoing her sense of agency and self-direction.

I think
I thought
I thought 'this is my reality'
until probably I die
I'll be on some sort of medication
if I do have surgery
I won't have to
I I just go at it
I think there's no time like the present
it's not going to give me what I want

I think for me it's really opened my eyes to my reality
I don't discuss it openly, being a trans woman
for me, I'm just a woman
not something I discuss

I mean
I'm on that journey
I don't have to worry
in my life
I get an injection
I live my life

Similarly, with respect to sexuality, Maria's self-voice articulates a range of emotions, reflections, opinions, actions, and intentions. The below extract gives a sense of her self-voice negotiating multiple motivations underpinning her "*readiness to like be very casually flirty*" and kiss guys she likes, conveying a sense of both challenge and agency.

I would kiss him
That's me making up for other things
I feel like
I go at it as much as I want
For me
I feel like I compensate
I feel like
just so I don't feel left out, that's my way of coping
I suppose
Just so I'm not the odd one out
I deserve it just as much
I'm held back, by myself
I don't I don't feel it's my fault,
I wouldn't say I'm the only one holding me back I feel like physically I'm getting held back
I definitely you know compensate

Maria's I poem affords some sense of the self her narrative conveyed. Large swathes of her I poem were characterized by the use of 'you', 'we' and 'they' as she positioned herself with respect to others, both identified others and the generalized 'other'. The listening for contrapuntal voices, illuminated some of these relational aspects of her narrative.

4.2.4 Listening for the contrapuntal voices

Table 4.2 outlines the contrapuntal voices I discerned within Maria's account, each representing one aspect of the story voiced as an expression of experience. I identified seven voices within Maria's account:

1. **The voice of personal sexuality and desire:** This voice represents Maria's individual, personal accounts of sexual desire, attraction, and practice. This voice was soft and tentative, but always clear and unembarrassed.
2. **The voice of cold reality:** This voice represents Maria's appraisal of her gender modality, and the likelihood that she will require ongoing interventions to achieve lasting comfort in her body. This voice was soft yet clear, conveying a sense of 'it is what it is', but without any sense of anger or disproportional distress.
3. **The voice that positions the body as an additional obstacle:** This voice represents Maria's framing of her body as something of an impediment or insecurity she must personally navigate. This voice expresses a sense of resolve, tinged with sadness.
4. **The voice of experiential authority:** This voice represented Maria's knowledge stemming from her lived experience. It was fluent and assertive with a consistent tone and volume that conveyed confidence as though addressing a group.
5. **The voice of inexperience through delayed opportunity:** This voice was audible when Maria spoke about her experience of sexuality as compared with that of her friends. This voice was in counterpoint to the voice of social sexuality in her account.
6. **The voice of frustrated privacy:** This voice was audible when Maria spoke about navigating sharing her gender modality with others or having this shared against her wishes.

Voice and attributes	Representative examples
The voice of personal sexuality/ desire This voice appears in light blue font	the fact that physically that's much harder for me now is something I look on, uh, very positively, it's something I like, um, there isn't much, you know, um, when whenever you know I'm kissing a guy or something, it's not, it when I'm in the moment it's I don't get those feelings I don't get that rush, as much as I would have before, there isn't as much if you like, you know, uh, had experiences with yourself if that was something you're into you know um doing sexual things with just yourself in privacy um, you know I feel like um and uh, I wasn't really, because I'd always felt quite uncomfortable um with you know everything down there so it wasn't something I normally did, uh, I know some people do, um, but either way the drive goes down ((laughs)) like it's just, I don't feel the urge really
The voice of cold reality This voice appears in **bold grey font**	I think you know I thought about it and **I thought 'this is my reality' um for now until probably I die I'll be on some sort of medication some sort of blocker or hormone** um obviously you know if I do have surgery in the future I won't have to but **there will always be some form of something whether it be oestrogen or or something to do my transition** I don't I don't want to make it seem like 'aaaah it's so hard for me, you know 'look at me' um, but at times it was difficult **at times you know it's hard to wrap your head around the fact that that somethings will never change** or, or stuff like that I think that um you know especially **like the cold reality of it all I think when I first kind of, moved on from from from just being young and innocent, and being a girl [mm] um I've faced the reality of not only being a young woman, but of being a young trans woman** [mm] and certain things, you know, that you don't know until you're told, or you don't know because you are too young to think about.
The voice that positions the body as an additional obstacle This voice appears in red font	um it's always been quite a somewhat of a somewhat you know weak spot for me just because um you know, I've never, well, I've never been properly like, I'd say I'm, I'm better now but I still wouldn't feel like I'm ready because of you know I feel like I'm getting held back physically I think, you know, with my situation and how, how, you know, physically I am, um, yeah I feel like it's always been something that I've thought about very apprehensiously I think obviously my situation as I call it, 'my situation', um, it's somewhat of an add on, um it it's not the best add on… for now at my age, at my kind of , my mental state it seems unfathomable I'd have sex with my situation, obviously you know there's certain sexual acts that don't require that, but I feel like as soon as you're kind of in the moment, a lot of those kind of delicate you know like 'are you ready yet?' like 'do you want to do this do you want to do that?' kind of go out the window (chuckle) when you're both-yeah and it shouldn't but for teenage lad it somewhat does you know um so I never, I never do anything you know that doesn't require you know down there without telling them my history beforehand just because I feel like one thing leads to another kind of mentality that I wouldn't want, because nothing's leading to that
Voice of experiential authority This voice appears in this font (Agency FB)	…the blocker doesn't actually change anything physically it just pauses so you're still you still somewhat have what you had before just it's not changing… I think I'd tell anyone that was to start it that you will kind of I think you will somewhat um change just because um this is probably like your gateway into having the transition and obviously everyone is different um some people um stop the blocker

	and decide it isn't for them but I think for a lot of people on the blocker I suppose it's their first intervention um but not the last because they plan to have so much more so um I think it will somewhat adjust them to the the reality of their life to their future life because even though you're just starting now this is something you'll somewhat do you know depending on what you do , for the rest of your life even when you've finished transitioning there will always be some form of, of hormone that you'll have to take, if that's what you do
The voice of inexperience and denied opportunities This voice appears in red underlined font Social sexuality appears in purple font Personal sexuality/desire appears in light blue font, as above.	my friends um they're my age and some of them have just done it and you know they speak about it and to be fair you know even though I don't um, express kind of my my sexual drive um in that way , you know I don't go out and you know I'm not sex- sexually active person, um, I still definitely um express it in other ways it's not like I'm not, I'm staying away from it, NO I, I kiss, um, guys if I like them, and uh, that's about it really and, to be honest, it does sound like nothing it's like 'oh, a kiss' but before um that in itself was something that that I was like 'oh, will it happen' so you know, it's bit by bit, it's bit by bit it didn't happen to me, but, you know, it somewhat became a part of, part of my life [mm] just because it was spoke about, and, you know it was just something you know there was questions and we spoke and just kind of jokes and mature jokes, stuff like that really I think um I'd say my, my best mates ushered in that period um naturally, because it happened naturally for them, I wouldn't say it happened for me because um, you know I didn't have a boyfriend and I didn't start doing things but but they did, um and that made me think about it.
The voice of frustrated privacy This voice appears in green font	I feel like for me it would have to be someone like very special, not only to tell them, because um, because it's just something I keep private, I think, going through secondary school and you know having family friends that know me from my past, that in itself is already just um you know-I wouldn't say annoying but um it's at times it can be interesting because you know they can bring up such a , such a delicate subject in such a, at times you know painful subject so openly and do whatever they want and that's such a scary thought um-especially because at secondary school you know they can judge you for it, especially because at secondary school you know they can judge you for it, whereas at college, they didn't know so how on earth would they judge me, do you know what I mean [mm] I think, they can't , for them, it's just 'oh that girls that', but , for me it's my life, so I just, it's better for me to keep it private

Table 4.2 Marias' Polyphonic voices with exemplars

4.2.5 Analysis of contrapuntal voices

Maria's voicing of her experiences displayed a discernible pattern. When addressing the 'you' of an imagined audience of other young people, about to access the blocker, the voice Maria spoke from was confident and assertive, speaking fluently with a consistent tone and volume. At other points, the voice present became less authoritative, and the prosody became more

tentative and halting, with the pitch suggestive of asking questions, or offering ideas, rather than conveying information, as before.

Maria often referred to her being trans as *"my situation"*. When speaking about how her *'situation'* impacts upon her experience of sexuality, Maria framed this as though it is an individual insecurity that she must overcome, like the cultural scripts that exist around other bodily characteristics that are devalued.

However, what struck me as surprising was the absence of reference to the social and societal aspects of this in her narrative. Maria made reference to her *own* discomfort with her 'situation' but did not explicitly refer to the negative cultural framing of transgender women which may prompt discomfort in potential sexual partners. This could be understood as an ordinary wish to share the milestone of sexual intimacy with someone *"special"* that she truly feels close to and who cares for her. However, with an awareness of stigmatizing narratives of gender diverse individuals, this was interpreted as possibly linked to Maria's own awareness of potentially being devalued and the worry of a romantic partner responding to the news negatively or perhaps even with violence.

The psychological logic at play here may be that for Maria it was more comfortable and empowering to position herself as seeking to overcome this insecurity and 'get out there', than to concede some power to parallel processes which may impede her access to safe, loving, and appreciative sexual partners. Naturally a 'not all men' caveat must be stated here, as of course there are men who do not feel their masculinity is threatened when they find a trans woman sexually or romantically desirable.

Therefore from the movement of the voices in her narrative, it is unclear if Maria's choice to keep this aspect of herself "private" rests solely on the basis of personal comfort (as recognising the **'cold reality'** of her body as it is at present may be distressing and dysphoria inducing) or if this decision is in part a response to an awareness of transphobia and a wish to protect herself from those who may judge her or otherwise treat her unkindly.

When speaking about the impact of the blocker, something which felt surprising was Maria noting that though she feels the blocker has clearly reduced her sexual drive and physiological sexual arousal response, she in fact feels more interested and able to explore her sexuality as a result of accessing the intervention. Maria spoke about how "for now" the reduction in her physiological arousal was "brilliant" and something that she likes, going on to speak about her gratitude that the arousal she detects in her make out partners does not happen for her. The sense from this part of the narrative was that, for Maria, the reduction in physiological response when aroused felt like a relief as she would not have to worry about concealing it from those she is being intimate with.

Later, Maria spoke about the **social aspects of sexuality** and how she speaks with friends about sexuality, and it feels as though it is something that is normalized for them. She spoke about feeling happy and excited for her friends who are exploring their sexuality within relationships with boys while simultaneously finding it difficult 'to be the slow one'. Maria spoke about not feeling ready to have sex, which I understood as penetrative sex within the typical collective association of the word 'sex' to mean penetrative sex involving the genitals (as opposed to penetrative sex involving the fingers etc.).

The voice of sexual desire/sexuality (light blue) interacts with the voices of *social sexuality (italics)*, heteronormativity and transphobia (underlined) in the following excerpt where Maria speaks about how she navigates her 'unreadiness' to have sex. Maria's self-voice is highlighted in **bold.**

> but sometimes there's you know a voice in the back of my head that likes **'ugh, why did it have to be me**, ***why do I have to be the slow one*** because **I don- yeah I'm not ready at all'** [mm]. **I feel like my unreadiness to have sex um is you know shown in my readiness to like be very casually flirty** and um and I wouldn't say desperate at all but you know *out of all my mates* **if I saw a lad that was good looking** and we'd obviously spoke for like a couple minutes or something, **probably I would kiss him** and um you know it sounds kind of bad but, in a way **that's me making up for other things** *because they might be more reserved but, I feel like once they open up, there's more to offer* [mm] *but so in a way I feel like they they have the the power to be more reserved than- so do I, so do I but they have the power* because once their like, 'oh, you know they could see a couple guys but you know it could be one and it could be like 'all right we'll see', and then they could do other things, whereas **with me you know I go at it as much as I want** because there is nothing else to offer there is no you know this could lead to this **for me it's like this is just this**[mm] um and that's that, there's nothing more um so **I feel like I compensate for for the fear** and for the you know complete unreadiness, by doing small things like that, um, yeah I feel like that's quite, um, quite important, um, **just so I don't feel left out, that's my way of coping with it I suppose** [mm mm] ***just so you know I'm not the odd one out*** you know that gets gets nothing **because of my situation** and it's not about getting things, *it's about you know feeling you know somewhat normal you know* ***'if everyone else is having experiences ,you know, I deserve it just as much*** [mm] um and in a way **I'm held back**, by myself, but also physically, I don't I don't feel it's my fault, um ((knock on door to room I was conducting the interview from)) **I wouldn't say I'm the only one holding me back I feel like physically I'm getting held back** …

In this excerpt, Maria speaks about her *"unreadiness"* to have sex and how she both expresses her sexuality and "makes up" for her 'unreadiness' by being more "casually flirty". Maria notes that for her she is freer with flirting and kissing those she desires, compared to her friends. This can be understood as Maria's feeling empowered to be intimate with others when she wants to and on her terms. However, Maria also speaks about compensating for her 'fear' and 'unreadiness' and it is unclear if this compensation is for her partners who she feels may anticipate further intimacy, or compensation for herself, as she may want this intimacy too, but feels that she cannot have it at present due to her *'situation'*. Maria acknowledges this as a

transgression from the (heteronormative) norm, in which women are more reserved, noting 'it sounds kind of bad', before offering a justification. She allows herself to kiss people when she wants to, as she feels that, unlike her friends, she cannot *'see a couple guys'* to seek someone with whom she could see herself *'going further'*. The fact of her transness seems to be a non-negotiable barrier to the notion of further sexual intimacy with a partner. What remains unclear is how much of this barrier stems from Maria's internalisation of societal views of trans women as less sexually desirable, and how much links to Maria's own discomfort and distress relating to her body as it is at present. It is clear from her account that Maria is interested in having experiences, just like her friends, but that to her, her 'situation' means that this is not a possibility. Her interest in having further experiences may reflect not just her sexual desire, but also her wish to feel 'normal' and to participate in the social aspects of sexuality alongside her friends as they discuss these new experiences and developmental milestones.

The cost of 'passing' and of not speaking with others about her gender appears to come in the form of a loss of spaces in which Maria can talk openly about her reality and how she navigates sexual intimacy as a result. Maria notes that she felt that the interview was an opportunity to be open as it was a safe environment to do so. She remarks on multiple occasions that her gender is something she feels is *'private'*. An alternative view of this is that it reflects the lack of safe spaces for gender diverse people to discuss their intimate lives without this being perceived as titillation etc. Maria appears to have made a bargain in which moving through the world without being recognised as a trans woman lends her the comfort and peace of feeling she will not be judged or have the subject raised by others but denies her the recognition and freedom to speak about her life experiences openly. Similarly, accessing PST appears to have allowed Maria to begin to explore her sexuality with others in ways that previously felt too daunting. One aspect of this is the reduction in physiological arousal she experiences and the

inference that she feels this is a positive aspect of the intervention as it renders her less likely to be read as trans. She notes repeatedly, however, that this is something she likes ‘for now’, and in doing so indicates that this trade off may lose its appeal over time. Maria’s ‘for now’, may also link to her anticipation of accessing gender affirming hormone treatment, and the physical changes this will bring. She may be anticipating further increases in her confidence and comfort with sexual intimacy following these changes and may feel differently about PST’s influence upon her threshold for physiological arousal then.

4.3 Rueben

Rueben (20-25yrs) described himself as white British and male/trans. He had accessed PST in his late teens (16-18). He was in a monogamous relationship of several years with his cisgender boyfriend at the time of our interview. During our conversation he was friendly and quick to laugh, with a slight initial nervous energy which eased over the course of the interview. He spoke in a slightly halting way, as though choosing his words with care, or perhaps feeling a bit shy or embarrassed. He spoke confidently and thoughtfully about his experiences. His story spanned from childhood and centred largely on his experiences with respect to gender and sexuality in the context of his secondary school years.

4.3.1 Listening for plot & landscape

Rueben began his account with a general consideration of his sexual orientation and attraction in relation to the blocker, stating that he had identified as *"mostly gay, bi"* from the age of fourteen but had anticipated that accessing PST might lead his sexual orientation to change, *"I think partly 'cos people reporting, like sort of you know seeing other people posting about how blockers or hormones have, had affected their sexuality and so I sort of, coming into getting on the blocker with sort of more of an expectation that things would change, but, it didn't".*

He noted that, prior to accessing PST, he had wondered if perhaps it would change his sexuality such that he would become more comfortable with his attraction towards women as a result of feeling less vulnerable to the dysphoria he experienced when comparing his body to cisgender women's bodies.

> *"I thought it might in that sort of my body being sort of less obviously female would make me more comfortable with being attracted to women because it wouldn't make me sort of less dysphoric because I'm not seeing them as some sort of mirror of myself but then I don't think that really happened ((laughing)) so kind of a change expected but then didn't come about."*

He then noted that he goes back and forth between referring to himself as gay or bisexual, stating that he feels *"90% gay",* saying:

> *"can I really call myself bi because it's definitely not a sort of equal attraction and also I'm in a same sex relationship so and that's yeah, there's not really much, apart from sort of thinking of people and saying oh they're pretty like you know we are very committed and monogamous and plan to spend the rest of our lives together so it's so I've not really had any active sort of relations with women."*

In his account, Rueben spoke about his early memories with respect to sexuality and noted that long before puberty he remembered having crushes on tv show characters and sports people. He shared a sense of realizing he was bisexual aged nine when he developed a crush on a female friend. He remembered feeling perturbed, as his crush linked to his sense of gender, and as such he tried to avoid thinking about it further at the time.

> *"I was sort of that was a kind of the first formed sort of thought of oh I'm attracted to her, uh, like, as, in the the position of a man, I was like oh, oh dear ((laughing)) squash that thought and I managed to like ignore it for then I think another sort of four or so years and then I started to think a bit more about gender and was like, OH. ((laughing))"*

He noted that he grew up *'fairly religious'* and that this informed his early feelings about his crush and the gendered aspects of it, in which he felt both were *'bad'*. He shared with respect to *"same sex sort of stuff, I kind of had a knowledge of you know 'that's bad, shouldn't be thinking about that' and then like I didn't know trans men existed until I was about thirteen but I knew about trans women and from media and sort of childhood gossip and there was nothing positive so I was like 'ok that's a bad thing don't have sort of cross gender inclinations."*

He reflected that as he grew older, aged ten or eleven, he became more comfortable with the idea of being bisexual but noted that *"considering gender was still a bit of a taboo thing"*. He shared that this was a time where he began to question what he had been taught and that this contributed to his shifting views regarding sexuality:

> *"I became sort of less religious as the sort of tween rebelling against my upbringing so that sort of got me to thinking about you know maybe what I was taught isn't what should shape my feelings toward myself or whatever."*

His prior view of transgender identities as *'bad'* shifted when an older pupil came out as transgender and was accepted by the students at his all-girls high school. He noted *"that sort of got me thinking like 'OH, that's possible!" ((laughing))"* and was a catalyst for his reconsideration of his own latent feelings *"...that it was sort of possible and the sort of latent feelings I'd been having it was like 'uh, MAYBE there is something I can do about it ((said laughingly))"*.

He spoke about joining *"the LGBT crowd"* when his sibling's best friend approached him and offered him a space to talk as she felt that he was *"not straight"*. He reasoned that this was

perhaps linked to his using his initials as a nickname and dressing androgynously. He described how the group was spread across different classes in the school and how they would chat via a forum after school, a mixture of *"silly friendship chatting"* and *"thinking about identity or thinking about sexuality and stuff"*. He shared approaching the first person, his sibling's friend and shared that he thought he might like to use male pronouns. She shared this with the group and they began to refer to Rueben with male pronouns. He noted that it was *"very much a space to sort of explore"* and *"it was quite a good space for everyone to sort of put thoughts in writing in a sort of non-judgemental way"*.

Rueben began dating the pupil that had come out as trans some time before, stating that this was,

> *"probably my first like, serious relationship where you actually sort of you know it's more than sort of kissing in the cupboard or something or holding hands in the playground it was, you know [mm] an actual sort of developed relationship with a sort of view to the future as it were".*

With respect to sexuality, Rueben shared that in his early teenage years, prior to meeting his first partner, he explored his sexuality through daydreaming and writing stories which were *"mostly fairly erotic ((laughing))"*. Following his accessing PST, Rueben noted that he still engaged in this, but generally to a lesser extent, something he attributed to *"growing up"*. He added, *"I think sort of I wrote more when I was single a couple of them sort of and an outlet to sort of funnel sort of sexual thoughts into"*.

When considering his experience of sexuality in the context of accessing the PST, Rueben reflecting on the *"honeymoon period"* of his first, pre-PST, relationship, with that of his current relationship, which began when he had been accessing PST for quite some time, noting "*I think it was much the same really."*

Rueben was in a different relationship to those mentioned above when he first accessed PST. He noted that upon commencing PST, his *"sex drive"* and comfort with being sexual with his then partner increased for a short time. He attributed this shift to a psychological shift in how he viewed and gendered his own body, stating:

> *"…the sort of psychological aspect of being sort of, not positive towards my body, but less negative towards it, sort of very neutral because it you know it was neutral hormonally so it was like 'oh this is you know less kind of marked as female' so I think for a bit I got more comfortable with doing sexual stuff and like being naked around him because I was sort of on that initial high of like 'yes! No longer female hormones!' but then I think that quickly sort of faded because sort of 'oh actually nothing's hugely changed".*

As Rueben spoke about this shift in his perception of his body, he shared how he was led to think about his first relationship with the fellow transgender pupil while at school, comparing this to his current relationship, which began while he was on the blocker for some time. He noted that perhaps being on the blocker when beginning his current relationship supported him to feel less negatively toward his body, but then reflecting that he would have also expected to also feel more comfortable with his first partner, as due to their both being transgender, his former partner would have understood the need to be sensitive and aware of how to engage with his body:

> *"it could just be the fact that I got you know several years older and so I think it sort of but I again more comfortable, less uncomfortable being naked around my partner, whereas like back in that first relationship, even though we were both trans guys, we're both sort of you know who else better to know your and be sort of respectful of your body and the sort of dysphoric elements, but even then I was still feeling sort of prefer to kind of cover up"*

When reflecting on the initial increase in *"sex drive"* he attributed to accessing the blocker he attributed this to the meaning he attributed to the change in his hormonal profile:

> *"I think it was sort of the fact that like in a kind of psychological shift from the sort of 'right oh this is a female chest and a female body with female hormones' just to like 'this is a chest, this is a body' and it kind of lost the sort of gender tag in my mind even*

> *though I wasn't particularly comfortable with my body it didn't and it wasn't sort of screaming female at me."*

He reiterated that this impact upon his sexual life had been unexpected, in contrast to the side effects he was aware of, such as hot flushes, diminished energy levels and the potential impact upon bone density which he was *"very (laughs) heavily sort of prepared for that (laughs)"* in the several years he was with the GID service prior to accessing PST.

He emphasized that though the impact it had upon his sexual desire was short lived, the psychological impact upon his perception of his body was enduring and something he appreciated as an unexpected effect of accessing PST:

> *"I kind of expected sort of my relationship with my body to be exactly the same continuing and sort of you know versus just sort of two years that needs to be toughed out of same status quo until I can get testosterone but it was definitely like an unashamedly good thing like it was like the just that having that sort of nothingness and then being like then to like going on testosterone if like if I'd had to have two more years sort of of periods and oestrogen before testosterone I think that would've been a lot lot tougher to deal with.".*

He shared that accessing PST influenced how he felt about himself, and supported him to have the confidence to meet people and get into relationships *"I definitely felt a lot better about myself so I think that probably helped with sort of confidence into actually like interacting with people and therefore getting into relationships because I generally felt more good about myself and more sort of I don't know not more comfortable in my own skin but less uncomfortable."* He described this as "mostly psychological" as aside from no longer having periods, "my body wasn't really changing on it". He noted that despite the lack of discernible changes to his body it supported his relationship with his body *"... I mean even though it didn't, it didn't make me pass any better, because I still had a high pitched voice and you know, looked like a twelve year old when I was eighteen but I think again it's the sort of psychological effect of you know letting you know 'I'm a I'm a sort of nongendered blank slate of hormones' made me made me feel 'this is a lot better than having a sort of actively female hormone profile".*

4.3.2 Listener's response to Reuben

When listening to Rueben's narrative I noticed how little he spoke about his family. I noticed how Rueben was aware of certain feelings in childhood and chose to deliberately ignore these out of a feeling that they were 'bad' or wrong somehow. This was something I could relate to, as well as to his Catholic upbringing. This particular point of connection led me to imagine how impactful it may have been for Rueben to bear witness to a fellow trans pupil being accepted by their peers, as I imagined the homophobic slurs that were used to describe pupils who were thought to be 'not straight', whether they were or were not, was immaterial. I noticed that Rueben was reluctant to lay claim to a bisexual identity on the basis of not having experience of sexual/romantic intimacy with women. This piqued my interest about the interrelated nature of identity and practice.

4.3.3 Listening for the 'I'

The self-voice in Rueben's 'I Poem' highlights a temporal and subjective shift in his understanding and view of gender and sexual minorities in his narrative. The 'I' in his account shifts from a position of seeking distance from sexual and gender minorities, to later agentically claiming and articulating this aspect of identity. The below series of extracts highlight this shift in his I voice across the narrative.

I realized
I was
I was
I did quite a bit of thinking
I'm not gonna think
I sort of half developed a crush
I was like 'ooh, that's strange'
I was sort of
'oh I'm attracted
I was
I managed
I think

I started to think
'.. I should not think about that
I mean
I was, grew up, fairly religious
I kind of had a knowledge
I didn't know
Until I was
I knew about
I was like 'ok that's a bad thing…
I came out
I went by my initials
I dressed quite androgynously
I guess
I don't really remember
I do remember being like
'…I think
I'd like to start
I think
I started at university
I did make more of an effort
I moved in
I went to the LGBT society

It is notable in the above extract that aspects of his past voiced self were conveyed in the present tense, such as in his statements relating to his reaction to his first crush, "I'm not gonna think", "ooh I'm attracted" and "I should not think about that". The temporality of these I phrases gives a sense of a self in the narrative in which the echoes of such former views may linger on.

Another aspect of the self-voice in Rueben's 'I poem' concerns the experience of gender dysphoria, which is powerfully conveyed in the below extract.

I think
my mind
I wasn't
my body
screaming female at me

4.3.4 Listening for contrapuntal voices

Table 4.3 outlines the contrapuntal voices I discerned within Rueben' account, each representing one aspect of the story voiced as an expression of his experience. I identified six voices within Rueben's account.

1. **Voice of received wisdom (heteronormativity, homophobia, and transphobia):** This voice was reflective of former inherited views about certain identity categories and appeared to anticipate shared understanding. This voice was chiefly matter of fact and emphatic in tone, with a suggestion of irony.
2. **Voice of sexual desire:** This voice represented Rueben's description of his own sexual feelings. It was lower in register and faster than surrounding speech, giving a sense of mild embarrassment and amusement.
3. **Voice of intersubjective recognition and support or lack thereof:** This voice spoke to the role of intersubjectivity for gender diverse people in which their experience of themselves is recognised and affirmed or ignored or invalidated by others. This voice sounded light and warm in tone when referring to peers and friends, and rather clipped when referring to 'school'.
4. **Voice of normative sexuality**: This voice represents the received understanding of sexuality and normative milestones, inclusive of positioning earlier sexual desire and relationships as immature. This voice was conversational and relaxed in tone.
5. **Voice of transnormativity:** This voice was reflective of presumed norms about the transgender experience. It was self-consciously precise and at times imbued with wry humour.
6. **Voice of cisnormativity:** This voice spoke to the dominant narrative which positions the body as deterministic of gender. It was matter of fact and self-assured in tone.

Voice and attributes	Representative examples
1. Voice of received wisdom This voice appears in underlined font	I mean, I was, grew up fairly religious, so, sort of, same sex sort of stuff I kind of had a knowledge of you know ' that's bad, shouldn't be thinking about that' and then like I didn't know trans men existed, until I was about thirteen but I knew about trans women, from media and sort of childhood gossip and there was nothing positive so I was like 'ok that's a bad thing don't have sort of cross gender inclinations'.
2. Voice of individual sexuality This voice appears in light blue font	I think briefly after I stared the blocker I think my sex drive kind of increased a little within the bands of that relationship I mean I sort of like I don't know ((laughs)) daydream about stuff or like ((laughing)) or write like stories and stuff so it was like very sort of conscious about it and and sort of imagining things and [R: mm] Um, I think they were mostly fairly erotic ((laughing)) when I was a teenager and um the sort of the shoehorning in a plot just to make sure it wasn't completely just smut but like it was definitely sort of relationship sort of driven sort of writing about relationships and sex and stuff
3. Voice of intersubjective recognition and support or lack thereof This voice appears in purple font	…all my classmates were all really, like, cool about it they were like you know 'his name is {name} and, and that's his name now' there was no sort of weirdness it was just 'yes'. I think, he did have problems with the school and I had problems with the school but I, all of like my classmates were all fine looking up and seeing this this older child coming out and they just accepted it no problem ((Laugh)) and then they were fine when I later came out a couple of years later. Uhm, one of them was the best, one of the girls was like pretty much the best friend of my {sibling} in {their} class so and I think she approached me when I was sort of when I was just {age} and she was basically like 'I have the inkling you're not straight do you wanna like you know chat about it do you need, you know, do you need some sort of, you know, older sort of supportive people to talk about your feelings with' I was like 'okay' and then, after a couple o- about a month or two of hanging out there was like 'actually I'd quite like it if you started referring to me with male pronouns' and they were like 'yeah sure' and then I came out to all my school friends just a couple of months later 'cause, so there was sort of a tribe round me essentially for coming out
4. Voice of normative sexuality This voice appears in *italicized font*	I guess like sort of *who you're attracted to and sort of what you sort of engage in your sort of habits, your sexual habits really the kind of whole picture of sort of who and what you do* Yeah I had but like I would say it was, he was probably my first like, *serious relationship where you actually sort of you know it's more than sort of kissing in the cupboard or something or holding hands in the playground* it was you know [mm] *an actual sort of developed relationship with a sort of view to the future* as it were.
5. Voice of transnormativity	I definitely felt a lot better about myself so I think that probably helped with sort of confidence into actually like interacting with people and therefore getting into relationships because I generally felt more good about myself and more sort of I don't know not more comfortable in my own skin but less uncomfortable [mm] Because you know I was I felt you know I was only on

This voice appears in brown font	the blocker with a view to getting Testosterone but GIDS don't put you directly on testosterone so I mean just that like I kind of went into it expecting to sort of not get that sort of little bit of a boost of a sort of psychological knowledge that there are no female hormones going on anymore so like I kind of expected sort of my relationship with my body to be exactly the same continuing and sort of you know versus just sort of two years that needs to be toughed out of same status quo until I can get testosterone
6. Voice of cisnormativity This voice appears in green font	Yeah just sort of I'm not a hugely confident person but sort of being less shy to sort of interact with people becas… I mean even though it didn't, it didn't make me pass any better, because I still had a high pitched voice and you know, looked like a twelve year old when I was {age} but I think again it's the sort of psychological effect of you know letting you know 'I'm a I'm a sort of nongendered blank slate of hormones' made me made me feel 'this is a lot better than having a sort of actively female hormone profile' Not hugely sure but I think it was sort of the fact that like in a kind of psychological shift from the sort of 'right oh this is a female chest and a female body with female hormones' just to like 'this is a chest, this is a body' and it kind of lost the sort of gender tag in my mind even though I wasn't particularly comfortable with my body it didn't and it wasn't sort of screaming female at me

Table 4.3 Reubens' Polyphonic voices with exemplars

4.3.5 Analysis of contrapuntal voices

Rueben speaks about how he had anticipated that he might experience a shift in his sexual practice upon accessing the blocker. He spoke about his bisexual identity and how he struggles to lay claim to this as he has not had sexually intimate contact with women. I found the below extract surprising in that he had expected to feel more comfortable to act on his attraction to women if he was feeling less gender dysphoria following accessing PST. This may speak to an aspect of the wider 'gender critical' discourse, which argues, among other things, that transgender youth are young people that are uncomfortable with acting on their 'same sex' attraction, and therefore seek to transition to fit more in line with heteronormative expectations (Thurlow, 2023). Rueben's experience stands in direct contrast to this view, as he had spoken about being less worried about his sexuality than his gender, and then makes reference to how sexual intimacy with women could prompt further gender dysphoria for him as it highlighted his lack of male body parts and characteristics.

> *-I thought it might in that sort of my body being sort of less obviously female would make me more comfortable with being attracted to women? because it wouldn't make me sort of less dysphoric because I'm not seeing them as some sort of mirror of myself but then (inhale) I don't think that really happened ((laughing)) so kind of this change I expected but then didn't come about.*

Rueben's account clearly articulates the harmony between his **self-voice** and the voice of intersubjective recognition and support. This is apparent from the below extract in which the recognition afforded him by another student allows him to access a supportive space in which he was later affirmed and recognised as male, something he had perhaps long felt but possibly not had witnessed and appreciated by another.

> *Uhm, one of them was the best, one of the girls was like pretty much the best friend of my {sibling } in {their} class so and I think she approached me when I was sort of when I was just {age} and she was basically like 'I have the inkling you're not straight do you wanna like you know chat about it do you need, you know, do you need some sort of, you know, older sort of supportive people to talk about your feelings with' I was like 'okay' and then, after a couple o- about a month or two of hanging out there, was like 'actually* ***I'd quite like it if you started referring to me with male pronouns'*** *and they were like 'yeah sure' and* ***then I came out to all my school friends just a couple of months later 'cause, so there was sort of a tribe round me essentially for coming out***

Where Rueben's 'I' voice intersects with the voice of sexuality there is the echo of the voice of *cis-heteronormative sexuality*. For instance, he describes his first relationship as being one where he might expect to feel most comfortable, as his partner was also transgender and would understand the need to negotiate a balance between sexual contact and the dysphoria that such contact could potentially provoke for him.

> *I think I'm trying to compare like that first relationship with the trans guy and to my current relationship and how that started I think I mean it could be due again due to the blocker sort of again making me feel sort of less negative towards my body or it could just be the fact that I got you know several years older and so I think it sort of but I again more comfortable, less uncomfortable being naked around my partner, whereas like back in that first relationship, even though we were both trans guys, we're both sort of you know who else better to know your and be sort of respectful of your body and the sort of dysphoric elements but even then I was still feeling sort of prefer to kind of cover up*

Something that was notable but unsurprising in Rueben's account was the overlap between his **self-voice** and a negative, stigmatizing voice with respect to minoritized sexualities and genders which do not conform to the culturally prescribed 'norm' of cis heteronormativity. He shared noticing that he had a crush on a female classmate aged 9, and further noticing that this was linked to gender in that he was attracted to her 'in the position of a man'. He noted that he made efforts to ignore his feelings and described himself as thinking " 'that's bad and **I should not think about** that any further' " and " that's a bad thing **don't have any sort of cross gender inclinations**". In these extracts the voice of stigmatized difference threatens to engulf Rueben's self-voice as he presents the negative thoughts in the present tense, something then mitigated through the acknowledgement that this is something a previous version of himself thought. Rueben places his old views in the context of his religious upbringing and the media available to him at the time, which only had negative depictions of trans women, and nothing about trans men at all.

The psychological logic at work seems to be to locate his previous beliefs firmly in the past. When Rueben speaks about the shift in his feelings, his self-voice moves from the past to something phased as active and ongoing "**I became** sort of less religious as the sort of **tween rebelling against my upbringing** so then that sort of **got me thinking** about, you know, 'Maybe **what I was taught isn't what should shape my feelings toward myself** or whatever.

4.4 Alex

Alex was 16-18 years old and described himself as white British, a trans man, pansexual, and aromantic. He had been accessing the blocker for over six months at the point of interview and was not in a relationship or dating, having had a recent breakup. From the outset, Alex described his sexuality as having remained stable but noted that his understanding of it had

developed. Alex began puberty *"quite young"* and accessed PST approximately five years after his puberty first began. He described his frustration with the process he underwent to access PST as this had changed due to the ruling of the Bell v. Tavistock case. He described a sense of disappointment that PST did not improve his gender dysphoria and in fact he found himself focusing more on his body and the dysphoria it causes him.

4.4.1 Listening for plot & landscape

Alex's responses can be organised into a cohesive narrative spanning from his early experiences in primary school to the present day. He remembered being made fun of and bullied in primary school by peers who thought that he was a lesbian. He spoke about when he told people about his gender identity, they made fun of him.

> *"um I did get made fun of for a bit actually [mm] um because- I wasn't out as trans at the time so there was a lot of jokes, about me being a lesbian [mm] but, I, then again, I was like 'but I'm not', a) 'not a lesbian' because I had, I had come out to my parents but not my rest of my classmates so it was very uncomfortable situation for me [mm] so I went, 'I'm just- I didn't know all the terms so I just went 'I'm <u>not</u> I'm just, here.' so yeah.*

He was bullied throughout secondary school by pupils some years below him and this led to his frequently missing school.

> *"I've had, I've walked onto school and I've had threats thrown at me, yelled at me, and I, I couldn- I I never could catch my bus {day} mornings just because I have to sit upstairs and that's where all the people who did all these things still are [mm] as my school did not respond to it well and they just let them continue [mm] I would like to say that they have gotten better, but ,at the time I think I was the reason they had to get better"*

He was the only out trans pupil in his year and felt that he was therefore the school's *"trial and error person".* He described having had invalidating experiences with school staff, *"I've had plenty of transphobic teachers, who would just refuse to call me by my pronouns"* and gave a clear sense of feeling let down by his school for their lack of successful intervention to prevent further bullying, " *the school would be like 'oh you should have been dealing with it, because you're older' when really they are being homophobic and transphobic to us [mm] and the school wouldn't really do much*". He spoke about his own efforts toward improving the school's understanding of gender diversity.

> *"Not many students come out as trans until ve- the end of their time at school. That's what I've seen, and so I'm, I'm the <u>only</u> trans student in my year. There are some non-binary students but they aren't, they aren't like <u>'out'</u> to everyone [mm] so I'm the only 'out' trans student. The school, they definitely have been doing better as they had- I got to do a talk last year to all the teachers about my identity and experiences I've got to go through."*

He also spoke about how he and his friends successfully encouraged some bullies to quit targeting them by shooting nerf gun bullets at them when they harassed them.

Alex spoke about not caring about his sexuality and feeling pressured into labelling himself so as to be intelligible to others.

> *"I think there was a point where I was like -uh I don't know how to describe this, wait um- I was kind of I was always, It was almost like I <u>had</u> to name I had to name my sexuality because otherwise people wouldn't understand [mm] so I was in more that kind of stage then but once starting I think I'd more come to terms with I am- I think my ( )- it's kind of been like I was kinda just vibing then it went to I've like labelled myself 'I am this', 'I'm tha't and then it's gone to 'I'm just here'."*

He spoke about his recent relationship and how he broke up with the person as they were insistent on telling others that they and he were together and this made him uncomfortable. He outlined how the blocker has made it easier for him to 'pass' in that he does not have to conceal that he is menstruating for instance. He noted that others respond to him differently depending on whether he has made them aware that he is trans. He spoke about waiting until he knows people for a while before sharing his gender history as he has had lots of negative experiences in which people have treated him differently due to seeing him in a different light.

> *"I have recently stopped coming out to people, um, I used to just be like 'oh yeah, I'm trans by the way', quite recent- early on to friendships with people, now um, people I've known for a couple of years are still not aware, um I've told someone recently and they had not known for {duration}, and even longer because we had met before then but weren't properly talking. It's just kind of almost a defend thing now I do just because I've had so many negative experiences coming out [mm] I've just decided that it isn't worth my time to deal with something until I'm <u>sure</u> someone won't do anything."*

Alex spoke about his experience of accessing the blocker and how this was impacted by the ruling following the Bell v Tavistock court case. He expressed his disappointment and frustration at the delay this led to in his accessing the blocker and the process he had to undergo to demonstrate his capacity to consent to the intervention.

> *"...then I had to do a two hour long int- what I actually had to do was a two hour long meeting where I had to pretty much defend my own self for being trans (mm) and to explain why I needed it and the UK um- the NHS could decide what they wanted people to answer on it and they would change it <u>constantly</u> and so it was always like a gamble to see if I would get through or not and so it was really quite worrying that I wouldn't get through."*

He described this as *"people debating if you're trans enough"*. He spoke about how the public and media interest in the blocker led him to expect more from the medication as it was so controversial.

> *"I thought that it would help my gender dysphoria a bit more and I thought it would have at least a bigger effect because if the news and the public are making such a big deal about this one medication, I think I kinda got caught up in the 'it has to have some good effect on me, right?' And then when I was on it I was like 'this is not that serious' …"*

Alex spoke about his frustration with the mismatch between what he feels 'people' and the public think about the puberty blocker and his own experience of it.

> *"A lot of people have quite negative opinions on puberty blockers when honestly it's just, it's nothing like they're saying it is, they all have different twisted versions of what it is when really it's just this and it's really not that complicated"*

He expressed regret at the delays he faced and how he now considered the treatment as rather a means to an end instead of the *"good effect"* he had hoped for.

> *"I think if I started at the time where I was meant to start I-before the court case it would have had much more of an effect on me and I probably would have been a lot happier (mm) but, because of the court case I got pushed back and it got to a point where I think 'I'm just on it so I can get on to the next stage'*

He spoke about feeling that he has become more self-conscious since accessing the blocker due to directing his attention to his body more, noting that he had always felt his gender dysphoria would worsen as he got older and that being on the blocker has just made him more aware of his present body.

> *"…my gender dysphoria I think has gotten worse since I've started the blocker [mm] as I've become more aware of the changes that have happened to my body as it's been*

almost under scrutiny, as people are like 'Oh! You-this is the changes it will stop' and it's like I've c- I've been paying attention to it and it's like 'this hasn't had the effect' and that is because I ha- I did start quite late [mm]"

He shared that despite this, he also has a sense of hope since accessing the blocker as he is closer to accessing gender affirming hormones which will lead to desired changes in his body.

"'Cause I knew my gender dysphoria would get worse as I got older [mm] but I think the puberty blockers have influenced it so it's been worse than what it could have been [mm] but at the same time it also (put/it's just put) a sense of hope within me because I'm on the puberty blockers I can get onto the next stage I can get the changes to my body that I want [mm mm] it's not as far away as I think it is [mm mm]".

Alex's narrative largely centred on his experiences in relation to other people. The main people Alex made reference to are his peers, from primary and secondary school. He made brief reference to his parents, noting that they are very supportive, and to his sibling and friends. He also made reference to his GIDS clinicians by name. Alex spoke about his frustration with the mismatch between what he feels 'people' and the public think about the puberty blocker and his own experience of it.

4.4.2 Listener's response to Alex

I remember when speaking with Alex I felt quite stirred up by his accounts of harassment and bullying, and his experience of feeling on trial as part of the process to access PST. Alex spoke carefully. Though eager to speak, he seemed to find this difficult without scaffolding. Certain moments stood out to me as reminders that Alex was telling his stories to me as a researcher in a specific context, such as when he asked, 'Was that what you wanted me to go into more detail with?' after giving a particular response. This was paralleled in my approach at times, where I

asked Alex to unpack a term he had used “for the benefit of the interview”. I wondered what impact this degree of self-conscious awareness exerted on what Alex shared in his stories.

When listening to Alex’s account I was struck by the extent of negative responses he had encountered as he simply went about his life as an ‘out’ trans person. I was moved by his pain and his anger as he described his harassment and bullying. His description of the responses of others upon learning his gender history was striking and thought provoking. I was led to consider the interrelation we have with others as we depend on them as they do upon us to recognise salient aspects of ourselves. I was impressed by Alex’s resilience and commitment to educate others as a means of improving the situation and also noticing part of my response which was a wish that Alex would ‘keep his head down’ to avoid further targeting. When reflecting upon this reaction in later readings I wondered if the feeling somewhat mirrored what Alex had shared regarding the tension between being known and protecting himself from the reactions of others by keeping aspects of himself private from them. I was prompted to consider the power the institution of a school has over its pupils and the apparent abuse of this by teachers who refuse to acknowledge the wishes of gender diverse students by persisting in referring to them with incongruent pronouns despite institutional statements of tolerance and acceptance. When listening, I noticed how little Alex spoke about other aspects of sexuality beyond sexual orientation and wondered if Alex was perhaps more interested in sharing his experience with the blocker and his experiences more generally as a means of redressing some of the views he ascribed to hostile or ignorant others within the wider public. I reflected on my own responses to his account and how upon reflection I felt I had perhaps unconsciously equated his aromantic identity with asexual identities. I wondered if perhaps this disconnect represented a generational gap between myself and Alex.

4.4.3 Listening for the 'I'

Alex's 'I Poem' conveys a sense of his experience of being consistently misunderstood or misrepresented, and how infrequently he has been accurately recognised by others. Alex's self-voice conveys sensitivity to the role others play in affirming or challenging gender and the enduring and painful gaps between his sense of himself and the responses of others.

I did get made fun of
I wasn't out
There was a lot of jokes, about me being a lesbian
I
I was like 'but I'm not'
I had
I had come out to my parents
I went
'I'm just-
I didn't know all the terms
I just went
'I'm not. I'm just, here.'

In addition to other's misrecognition of him, the self-voice in Alex's 'I poem' conveys a sense of a conflict between allowing himself to be known and being selective and cautious about sharing aspects of himself.

I think it's just
I
I won't
I will say it
I will tell people my sexuality
I have tended to try to hide it
I have a pride flag surrounding my house
I've just tend to keep it a secret

He later gives context to this approach, as it may serve a protective function for him.

I have recently stopped coming out
I used to just be like
'Oh yeah, I'm trans…'
People I've known for a couple of years are still not aware

I've told someone recently
A defend thing I do
I've had so many negative experiences
I've just decided that it isn't worth my time
Until I'm sure someone won't do anything

With respect to his being trans, Alex voiced the dilemma of being fully known to others and the impact this knowledge can have on how they respond to him, sometimes in such a way as to be invalidating of his gender. In this extract, Alex's self-voice articulates the active, conscious, negotiation of other's perceptions of him such that he can have his gender accurately recognised.

I think it's made me
I'll be more aware
I I'll be more aware of how they see me
I think
With me coming out
I'm not too sure
If I can see that
Due to the fact that I am trans
People are seeing me
I've worked- sadly had to work really hard
I shouldn't have had to
I definitely pay attention
While I'm speaking to people
I'll be treated like one of their female friends
I think the only way
Is to change their perspective
I just don't think that
I tend to stay away from people who still do that

The self in Alex's I poem is one which is keenly aware of the listener audience and must continually negotiate a balance between connection with others and protection of the self.

4.4.4 Listening for contrapuntal voices.

Table 4.4 outlines the contrapuntal voices I discerned within Alex's account, each representing one aspect of the story voiced as an expression of his experience. I identified 4 voices within Alex's account.

1. **Voice of stigmatized difference:** This voice is lower in tone and regularly tinged with sadness, it is tentative and halting and at times melds with the voice of anger becoming mocking or clipped.
2. **Voice of expected social sexuality and gender identity:** This voice is breezy and matter of fact, with some lightness. Statements made in this voice assume the attribute of known facts or accepted truths. This voice references the aspects of sexuality and identity that are navigated within the social sphere at times functioning to render the self-intelligible to others. Valued aspects of sexuality and identity can function as a form of social currency. This voice overlaps with the voice of stigmatized difference and Alex's I voice.
3. **Voice of Anger:** This voice sounds clipped and firm, with an exasperated tone at points. In this voice he also represents others mockingly with a higher pitch. This voice is rather condemning. The voice of anger was clearly audible.
4. **Voice of pride and self-determination:** This voice sounds light and playful and as though Alex was smiling or on the point of laughter. This voice appears to serve the function of softening a previous statement by demonstrating Alex's ability to overcome or mitigate his circumstances. This voice narrates Alex's refusal to be defined by his difficult experiences and indicates something of a self-possessed nature.

Voice and attributes	Illustrative examples
1. The Voice of Stigmatized difference This voice appears in green font	"I don't have many memories of when I was a child except sadly being made fun of by my peers for my, um, sexuality and gender identity. Um it's, I remember the day that everyo- I told everyone and I went to go and hide in a corner because people were making fun of me…" "…um some of my other friends at school have actually had negative experiences due to their sexuality and we've had kids in like, people who've just joined the school when we were just about to finish, come up to them and hurl insults at them because they're dating each other, and then they would move on to me and question my gender identity…"
2. The Voice of expected social sexuality and gender identity This voice appears in purple font	"Um, I mean, I just don't care, I can be with whoever I want it to be with, it's just so-for my friends I do identify as pansexual…" "Not many students come out as trans until the end of their time at school. That's what I've seen, and so I'm, I'm the only trans student in my year. There are some non-binary students but they aren't, they aren't like 'out' to everyone [mm] so I'm the only 'out' trans student"
3. The Voice of Anger This voice appears in red font	"I'm fully aware that I could come off them but I also think they- a) I have to be on them because of the fact that you can't go on to next steps without being on puberty blockers for a year and the are b) useful, and so I'm trying to get back in touch with CAMHS about it, but it's CAMHS and I was meant like to get something back like two weeks ago and I haven't yet, either that or my GP has forgotten, which he does tend to do." "I was just about to start when the court case went through, I had consented and then my consent got taken away."
4. The Voice of Pride & Self-Determination This voice appears in light blue	"…it's happened about twice but we got them to stay away from us, from, from then on because um 'someone' brought in a nerf gun and whenever it would start 'someone' might-may have shot them with a nerf gun ((both chuckle)), they did try to rip the bullet and failed. That was quite funny." "I got to do a talk last year to all the teachers about my identity and experiences I've got to go through. I also did get to call out some teachers in that talk, it was great, and so, it's getting better, I'll say that."

Table 4.4: Alex's Polyphonic voices with exemplars

4.4.5 Analysis of contrapuntal voices

The voice most audible in Alex's account is that of The Voice of stigmatized difference. Alex recounts multiple instances of stark transphobic harassment and many more subtle indicators of stigmatized difference such as the invalidating change in other's treatment of him upon learning his gender history. In the below extract, the impact of this voice appears to overlap at times with Alex's **self-voice**, isolated in the 'I poem', apparently leading to a psychological stance of assuming responsibility for how one is viewed and treated by others, a form of

impression management. Alex's, '**I**' shifts to a 'you' in the latter half of this extract, and this could be interpreted as his presuming that this is a normative experience for trans people. His use of 'you' may also serve as a means of creating some distance between himself and this demonstrably invalidating and frustrating /disappointing experience.

> *Ruth: And I wonder, kind of having had those experiences um, how does that kind of interact with sort of sexuality and kind of, in all of its meanings sort of you know, fancying other people, or not, or feeling safe to kind of, to kind of think about that kind of thing?*
>
> *Alex: I think it's made me more aware, as um,* ***I'll be more aware of how people were treating me****, in so and so relationships and things like I****, I'll be more aware of how they see me*** *and that is something that* ***I think has increased with me coming out*** *and possibly puberty blockers but* ***I'm not too sure, but, it's the way they treat me compared to other people*** *[R: Mmm] and so if* ***I can see that um people in the past have treated me more feminine, due to the fact that I am trans*** *and so that's just something that just makes me completely uncomfortable but it's just way they- people are seeing me and so* ***I've worked- sadly had to work really hard to try and change that*** *[R: Mmm], which is something* ***I shouldn't have had to do****, but it is something* ***now I definitely pay attention to while I'm speaking to people for the first time.***
>
> *Ruth: Mmm, say a bit more about, about that.*
>
> *Alex: Um, it's just, it's very obvious how someone is treating me, um, because you can see how the, you can see how people react with their male friends and their female friends, and usually* ***I'll be treated like one of their female friends****, and* ***I think the only way to change that is to change their perspective****, and* ***I just don't think that would be possible*** *for a lot of people,* ***so I tend to stay away from people who still do that****, but, in terms of almost relationships its incredibly evident of how they are, how they do it, of just ways they talk to me, ways they come up to me and things, it's very uncomfortable to know a person who is partic- talking to you does not see you for who you are"*

When speaking about sexuality, **Alex (self voice)** appeared to negotiate the tension between social expectations of others that he should express his sexuality in a stable and understandable manner, and his own self-defined personal experience of *"just vibing"*. He positions accessing PST as supportive of his confidence to resist the imposition of other's definitions.

> *"****I think I was a bit more sure of my sexuality*** *I think there was a point where* ***I was like*** *-uh I don't know how to describe this, wait um-* ***I was kind of I was always, It was***

> ***almost like** **I had to name I had to name my sexuality** because otherwise people wouldn't understand (mm) so **I was in more that kind of stage then but once starting I think I'd more come to terms with I am- I think**)my (own/answer)- it's kind of been like **I was kinda just vibing** then it went to **I've like labelled myself I am this, I'm that** and then it's gone to **'I'm just here'**"*

It is notable that Alex's narrative, though resulting from a prompt to do with his experience of the blocker as it pertains to his experience and understanding of his sexuality, centred chiefly on his experiences as a transgender person and how he has been perceived and misrecognized by others. This will be expanded upon in the discussion section.

4.5 Summary

This chapter presented the results from the Listening Guide Method of analysis of the participants' narratives. The results provide details of the content of the young people's experiences and the meaning they made of these. In addition, the polyphonic contrapuntal voices audible in the young people's accounts were identified and described. In their contrapuntal voices each individual narrator was shown to relate to and replicate some aspects of master narratives as well as demonstrate agentic negotiation of these, highlighting how dominant discourses can both facilitate and constrain expressions of personal experience and identity.

5. Discussion

Each narrator's account offers insight into their subjective experiences of accessing PST and the impact, if any, upon their experiences of sexuality. In the analysis of the contrapuntal voices present in each narrative, there were clear areas of crossover. For instance, within both John and Alex's narratives I identified voices I referred to as 'stigmatized difference'. However, there were differences in their narrative engagement with this voice. In line with the emphasis NI places on respecting the unique experience of each individual participant, a deliberate decision was made to avoid directly comparing the narratives provided. The intention behind this is to preserve each narrative as a unit of analysis in and of itself, a co-construction unique to each individual within their individual context. Each research question will be addressed in relation to the participant's narratives.

The overarching research question of this study was: *'How do gender-diverse young people who have accessed puberty suppressants speak about their understanding and experiences of their sexualities?'* In answering this overall question, three sub questions sought to consider young people's understandings and experiences of sexuality and the impact, if any, they felt accessing puberty suppressant treatment had upon their sexual lives, with consideration of the narrative resources they drew upon when conveying their experiences and understandings, and their relationship to these within their accounts. In this chapter the findings for these sub questions are summarised and discussed in turn.

5.1 What are the experiences of gender diverse young people in receipt of puberty suppression treatment with respect to sexuality?

5.1.1. Sexuality before PST

To provide context for the findings relating to the young people's experiences of sexuality while accessing PST. I will first outline their experiences of sexuality prior to accessing the treatment and consider these in light of existing research literature.

All the young people spoke about sexuality as something they engaged with dynamically. John, Rueben, and Alex described revisiting their conceptualisations of sexuality on account of their evolving understandings of gender identity and vice versa, highlighting the manner in which gender and sexual identity development occur in intersecting and sometimes contingent ways (Hereth et al., 2019). Some of this appeared purely linguistic, as with John's self-defining as 'lesbian' prior to his learning of trans identities, which may represent impoverished access to the means of putting experiences into words, moreso than shifting experience (Weststrate & McLean, 2010).

The young people held a range of sexual identities. In step with the convention of considering sexuality as equating to sexual orientation (van Anders, 2015), they typically identified themselves based on their experiences of sexual attraction to others. In describing his sexuality, John initially stated his gender, before noting that he is exclusively sexually attracted to women. Maria noted that she likes men, Rueben described himself as 'mostly gay' but bisexual, and Alex noted that he is pansexual and aromantic. Rueben spoke to the difference, and in his case tension, between sexual identity and sexual behaviours/practices (Richards & Barker, 2013) when he noted that he hesitated to describe himself as bisexual, as he had not had sexual contact

with women. Moreover, this comment reflected what Flanders et al. (2016: p161) have described as ‘the burden of proof’ placed upon non-monosexual individuals to evidence their claim to their identity.

Prior to accessing PST most of the young people indicated an existing interest in exploring romantic relationships and sexual intimacy with partners, as well as solitary sexual activities such as masturbation, similar to the findings of prior research (Bungener et al., 2017). Both John and Rueben were in relationships at the time they first began PST and had experiences of earlier relationships as well. They both framed their earliest relationships as less serious than their later ones, something which corresponds to the manner in which the participants in the study by Araya et al. (2021) study characterised earlier relationships as counting for less than those they engaged in at later ages. When young people mentioned masturbation, they noted that they felt they engaged in this less than peers. None of the young people spoke about particular sexual practices, and therefore it is not possible to consider these in light of prior research. The exception to this was Rueben’s brief mention of how he would prefer to cover up (which I understood as remaining at least partially clothed) when being sexually intimate prior to accessing PST. This is something that could be understood as a physical means of negotiating dysphoria such as that described by Martin and Coolhart (2022). Maria’s comments about generally feeling ‘held back physically’ may have indicated dysphoria was a complicating factor for her engagement in sexual intimacy which mirrors the findings of Bungener and colleagues (2017); Doorduin & van Berlo (2014b), and Engelmann, Nicklisch & Nieder, (2022). However, within the context of her overall narrative, my interpretation was that her feelings of being held back may have linked more strongly to concerns about other people’s reactions to her gender modality moreso than her own feelings of dysphoria.

The young people's narratives about whether PST exerted any impact upon their experiences of sexuality varied. John asserted that PST did not influence his experience of sexuality in terms of his sexual orientation or sexual desire. Neither did Alex link his accessing PST to any shift in his experience of sexuality, but he did note that as he felt less anxiety since accessing PST, he felt more comfortable disclosing his aromantic and pansexual identities. Rueben and Maria, however, endorsed accessing PST as specifically supportive of their confidence regarding engaging in sexual intimacy.

5.1.2 PST as supportive of sexual engagement and exploration

Although PST is a physical intervention, with physical, biological, consequences (Hoofnagle, 2008) the most striking findings related to the meaning the treatment held for the narrators, and the consequences these meanings had for their experiences of sexuality. GnRHa is commonly assumed to reduce sexual interest (Gryzinski et al., 2022, Lewis et al., 2017). However, TGD people report differing subjective experiences and appraisals (Doorduin and van Berlo, 2014; Nieder et al., 2021; Warwick et al., 2022).

A striking and novel key finding was that some young people endorsed PST as specifically supportive of their engagement with, and exploration of their sexualities. The young people referred to the physical impact of the treatment and the role this played in their relationships toward their bodies, as in Maria's case, and the psychological impact accessing the treatment held for them, with respect to their relationships with their bodies (for Maria, and Rueben) (Bungener et al., 2020) and their relationship to their sexualities (for Maria and Alex). This is an important finding. Gender dysphoria and body image have not previously been demonstrated to change for TGD youth following their accessing PST (De Vries et al., 2011) but the young people indicated that accessing PST led to shifts in their feelings about their

bodies in this research. This may relate to a perception of PST partially fulfilling their treatment desire (Nikkelen & Kreukels, 2018), as they all expressed wishes to access further interventions. Alternately, it may represent an affirmation of identity, or a sense that their identity has been recognized and legitimized in a profound way (Schilt and Windsor, 2014). The young people's accounts of the role PST played in supporting their engagement with and exploration of their sexualities is considered and discussed alongside prior research, starting with physical impacts.

5.1.3 Physical impacts of PST

As the majority of research has taken place with participants who accessed GnRHa in the latter stages of puberty (NICE, 2021), and population estimates indicate that by age fifteen and a half young people have typically reached full sexual maturity (Brix et al., 2019), it is unsurprising that the young people's accounts largely do not reference physical changes resulting from PST, with some notable exceptions, as above.

The narrative accounts of the young people in this study included some reference to physical sequelae of accessing PST with respect to menstruation (John, Rueben, and Alex), cessation of breast growth (John) and a reduction in the growth of body and facial hair (Maria). In reference to physical side effects, such as an increased tendency toward bruising (Rueben), and reduced physiological arousal (Maria), it was only Maria who framed these as positively contributing to her confidence and comfort in exploring sexual intimacy.

Though the influence of GnRH analogues and agonists upon sexuality have been identified and described in the context of their use as treatments for prostate cancer (Gryzinski et al., 2022), and endometriosis (Pluchino et al., 2016), no research has specifically examined the subjective

relationships TGD individuals have with the intervention with respect to its perceived impact upon their sexual lives. Maria indicated that accessing PST reduced her feelings of sexual desire and physiological response, a known side effect of the treatment (Gryzinski et al., 2022; Pluchino et al., 2016) that is indicated in the literature regarding TGD individual's experiences of GAT (as transfeminine people often access GnRHa alongside GAHT, at least prior to GAS if they choose this option). What was striking, however, was Maria's positive appraisal of the reduction in physiological arousal she experienced, framing this as facilitative of her sexual engagement.

From the literature, transfeminine TGD individuals report both positive and negative relationships to their experience of sexual desire and physiological response, prior to (Cerwenka, Nieder, Cohen-Kettenis et al., 2014) and following GAHT (Doorduin & van Berlo, 2014; Rosenberg et al. 2019, Warwick et al., 2022). This variability across perspectives appears to also be the case for reduced 'libido' when accessing PST specifically (Nieder et al, 2021). We currently lack insight into respondents' reasons for this differential characterisation. The narrative accounts from this research therefore represent some contribution towards contextualising positive interpretations of this phenomenon. I interpreted Maria's positive appraisal of this particular side effect as relating to both reduced dysphoria, and to increased confidence that physiological arousal would no longer have the potential to compromise her agency to decide whether or not she wanted to disclose her gender modality to her make out partners. I felt that this perhaps linked with Maria's own wish to be recognized and treated in accordance with her gender in general (Anderson et al., 2020), but more so contextualised her satisfaction with respect to the threat of victimization and violence for transgender people (Coleman et al., 2022). Further, in contrast to the other participants, this may be especially important to Maria as a young transwoman who is sexually attracted to men, as heterosexual

men are typically far less supportive of transgender individuals (Worthen, 2016) and may react to the disclosure with violence out of a homophobic need to disavow their prior attraction to someone they may now perceive as having 'deceived' them (Bettcher, 2007; Billard, 2019; Schilt & Westbrook, 2009).

Further, Maria's account indicated a temporal aspect to her satisfaction, as she indicated that 'for now' this was something she looked on positively. Maria inferred that perhaps with time (Richards, 2018) and/or as a result of accessing GAHT, which may further improve her relationship with her body Nikkelen & Kreukels (2018) she may feel differently.

5.1.4 Psychological impacts of PST

Another aspect of accessing PST that supported the young people's sexual engagement was the meaning it held for them psychologically. Both Rueben and Maria shared how accessing PST prompted a psychological shift in their perceptions of themselves, in such a way that they felt more inclined to explore sexual intimacy. For Rueben, this linked to his relationship with his body. He noted that accessing PST enabled him to think of his body as a *"nongendered blank slate of hormones"*. This reappraisal of his body led to a short-lived increase in his comfort with being sexually intimate with his then partner as a result feeling less negatively toward his body. This corresponds to prior research findings in which TGD individuals report feeling less self-conscious and more comfortable with their bodies during partnered sexual intimacy following accessing GAHT (Engelmann, Nicklisch & Nieder, 2022) and findings which indicate that improved body image contributes to comfort in engaging in partnered sexual intimacy (Nikkelen & Kreukels, 2018). However, unlike those accessing GAHT, who experience increasingly congruent embodiment through gendered physical changes, Rueben noted that his body was not changing to become more congruent with his gender, and that his

initial increased sexual desire was therefore not sustained over time. However, in contrast to the participants in De Vries and colleagues' study (2011), Rueben did not share an experience of his relationship with his body worsening over time.

For Maria, the psychological impact of accessing PST was related to the role it played in her relationship to her identity as a transgender person. She framed this as recognition and acceptance of her *'reality'*, the understanding that as a transgender person she will be in receipt of various forms of affirming treatments throughout her life. She noted that accessing PST represented '*a milestone'* as the first physical intervention she accessed and that rather than thinking further about other potential future interventions it *'calmed'* her and allowed her to think *"there's no time like the present"* with respect to exploring her sexuality. My interpretation of Maria's account of the role accessing PST played in her sexuality was that it prompted her to confront her differences from the cisgender majority and perhaps mourn the fact that she may not feel fully comfortable with her body for some time, if indeed ever. Her characterisation of accessing PST as the beginning of a lifelong relationship with gender affirming treatment appeared to support her to permit herself to begin to actively explore her sexuality without feeling the need to wait until some predetermined point of transition. My perception of this was that PST supported Maria to begin to consider selectively engaging in sexually intimate practices that she felt comfortable with (Engelmann, Nicklisch & Nieder, 2022). Doorduin and van Berlo (2014) found that increased gender congruence (in terms of gendered interpretations of desire, arousal, genital sensitivity, and orgasm) supported participants' capacity to engage in and derive pleasure from sexual intimacy. In a similar fashion, Maria's narrative indicates the role PST played for her. Though arguably PST didn't really 'do' much for Maria physically, aside from reduce the growth of body hair, it supported

her to appraise and accept her specific identity as a transgender woman, and in doing so opened up the possibility of starting to explore her sexuality.

Alex also noted a psychological shift in his feelings about his sexuality as a result of accessing PST. He did not feel that accessing the treatment exerted any direct influence on his sexuality, but that rather, he felt less anxious in general, and this meant he felt less concerned about having to define and explain his sexual identity for the benefit of other people.

5.1.5 PST and other experiences that have a secondary or indirect influence upon sexuality

Alongside perceptions of PST as supporting sexual development, there were a range of other responses to the intervention. John noted that he had wondered if accessing the blocker might change his sexual orientation, as it was something he had heard sometimes happened for other TGD people when they accessed physical interventions, which has been demonstrated in the literature (Auer et al., 2014; Kuper et al., 2012, Rowniak & Chesla, 2013). He noted that, for him, he felt that his sexual desire was *'natural'* and in response to those he was attracted to or intimate with. From his account, and from Maria's account of how she still experienced feelings of arousal, despite having less physiological arousal, it is possible that PST exerts a differential impact on proceptive, versus receptive sexual desire (AlAwlaqi et al., 2017; Tolman & Diamond, 2001; Wallen, 2001). This may be something to consider in the design of future research on this topic.

In a similar fashion, Alex's awareness of circulating discourses influenced his expectations regarding PST. In his narrative, Alex shared that, though thoroughly informed about the limits of the treatment by his clinicians, he was led to anticipate a more profound sense of change

upon accessing PST due to its characterisation in public discourse. He expressed his anger and upset and how the sociopolitical climate had both disrupted his access to PST and contributed to this sense of underwhelm and disappointment upon accessing it. He noted that the additions to the process he underwent to be deemed capacious to consent were a source of frustration and upset in their own right, and even more so as he underwent further irreversible pubertal changes during this time. Alex's account of the role the surrounding discourse played in his experience links with another key aspect of the research findings, the narrative engagement of the young people with relevant master narratives and discourses, which is considered next.

5.2.What master narratives do gender diverse young people draw on?

The young people drew upon various narrative resources when describing their experiences and understandings of their sexualities in the context of accessing puberty suppressant medication. These included normative narratives such as the master narratives of cisnormativity and heteronormativity, as well as alternative master narratives, such as transnormativity. Each young person engaged with and voiced such master narratives in unique ways, at times replicating aspects of a master narrative as a means of conveying their experience in the most readily digestible way, and at other times constructing their experiences through referring to how these diverge from the stipulations of certain master narratives. This section names the master narratives the young people appeared to draw on and considered the manner in which they engaged with these.

5.2.1 Cisnormativity

Cisnormativity is a normative master narrative which positions cisgender identities as natural and preferable to non-cisgender identities (Berger & Ansara, 2021, Bradford & Syed, 2019). Cisnormativity means that others expect that an individual is intelligible as male or female, that an individual's attire and presentation correspond in a predictable way to their assigned gender. It includes beliefs that biological characteristics are deterministic of gender identity. As TGD people, each of the young people exist outside the normative expectations of cisnormativity. However, in their construction of their narratives, the young people agentically drew upon aspects of cisnormativity in the service of conveying their personal experience.

For instance, the young people's shifting appraisals of their bodies as a result of accessing PST appeared to link with their body image, something which the research literature has demonstrated holds relevance as a likely mediating factor between gender affirming treatments and sexual engagement and satisfaction (Nikkelen & Kreukels, 2018), though not sexual desire (Garz et al., 2021). Further, as in Maria's case, satisfaction with gender affirming treatments links with the impact it exerts upon socially gendered aspects of her embodiment, such as body hair (Kessler & McKenna, 1978; Lindgren & Pauly, 1975; van de Grift et al., 2016). It is possible therefore, that part of Maria's improved relationship to her body within her narrative may link to a degree of internalization of cisnormative gender standards. Bockting et al. (2020) note that investment in being perceived as cisgender ('passing') can be an adaptive means of affirming a binary gender identity and can serve to safeguard TGD individuals from discrimination, but if overemphasized may represent a manifestation of internalized transphobia. Similarly, John's comment regarding feeling less attractive than others due to accessing the blocker, or being trans, may represent an internalization of cisnormative standards for embodiment and attractiveness as a man (Richburg & Stewart, 2022). Of course,

it is important to note that internalization of cisnormative gender standards is not unique to the TGD community and cisgender people too strive to embody their gender in accordance with socially valued standards for presentation, such as through choice of clothing (Strübel & Goswami, 2022). Additionally, the burden of challenging presumed/expected norms for gender presentation need not fall solely on TGD people. Particularly, as historically, there are examples of the cisgender majority challenging expected norms, for instance when there was a shift in the perceived appropriateness of women wearing trousers in the 18th Century (Turunen, 2021).

5.2.2. The master narrative of heteronormativity & 'expected sexuality'.

Each young person engaged with the master narrative of heteronormativity (Allen & Mendez, 2018), which I expanded upon, adding 'expected sexuality' to include normative expectations regarding sexual interest, monosexuality, and progression through sexual milestones as a function of age.

Some of the existing literature highlights the interconnection between understandings of sexuality and gender, and how TGD individuals may experience multiple reappraisals of their sexual and gender identities over time, as each informs understandings of the other (Hereth et al., 2019). This iterative process of understanding also appeared within the accounts of the young people in this research. I wish to propose the facilitative and constraining role of the master narrative of heteronormativity in this process.

For John, the master narrative of heteronormativity appeared to offer a robust means of articulating his gender in line with normative sociocultural expectations, as his attraction toward girls and women fit with cultural expectations regarding the objects of masculine sexual desire. Through an implicit endorsement of the heteronormative tenet that *"boys like girls"*, he

drew on his stable attraction toward girls in service of communicating his gender in accordance with cultural assumptions (Connel & Messerschmidt, 2005). (It is of course possible that he simply likes girls, but this interpretation is drawn from John's response to the question asking him how he describes his sexuality, in which he responded, "I mean now I just say I'm male", which indicates that perhaps he assumes a shared (heteronormative) presumption that the majority of men are attracted to women).

John shares in his narrative that his understanding of sexuality and gender was iterative, in that he called himself lesbian for some time and was confident and open about this with peers, before learning about transgender identities and having new terms to express his experience (Hereth et al., 2019). In addition, as he was aware of his sexual attraction toward girls and women from a young age, this aspect of his narrative was harmonious with the hegemonic alternate narrative of transnormativity with respect to the principle of 'nascence' as well (Bradford & Syed, 2019).

Similarly, in Rueben's account, heteronormativity represented a narrative resource he drew upon to render his personal experience intelligible to a listener. Rueben's experience of a crush on a female classmate was a catalyst for his initial recognition of a sense of incongruent gender as well as an awareness of diverging from heteronormative expectations. He noted that the thoughts regarding his gender were something he sought to ignore, as his understanding of transgender people from the world around him held *"nothing positive"*. With time, he began to question the heteronormative assumptions he had internalized from his religious upbringing noting *"maybe what I was taught isn't what should shape my feelings toward myself"* and thus began to feel more comfortable with the idea of being bisexual, but that for him, *"considering gender was still a bit of a taboo thing"*.

In their accounts, both Rueben and John appear to have engaged with the master narrative of heteronormativity as a means of making sense of their experiences of gender. Other aspects of the young people's narratives of their sexualities prior to accessing PST drew upon what I termed master narratives of expected sexuality, and it is these I turn to next.

5.2.3 Expected sexuality

I subsume what I refer to as the voice of 'expected sexuality' within the realm of the normative master narrative of (hegemonic) heteronormativity (Allen & Mendez, 2018). In addition to the presupposition of heterosexual sexual attraction, behaviours, and identity, compulsory aspects of normative master narratives of sexuality include the expectation of sexual interest, and monosexuality (Allen & Mendez, 2018).

Alex constructed his narrative with reference to the expectations of others with respect to sexuality. This was not specifically in relation to heteronormative expectations regarding sexual orientation, but rather normative assumptions that sexual and romantic interest are universal experiences and sexual orientation is monosexual. He shared his experiences of being labelled by others as lesbian due to his gender presentation, and later pressure from friends to adopt a sexual orientation label so that they could understand and categorize him. He noted that, for him, his sexual orientation remains something he does not care to label, and he adopts an identity label of 'Pansexual' as this most closely describes his sexuality.

5.2.4 (Heteronormative) Social sexuality

The young people in this study spoke about the role of others aside from sexual partners in facilitating (or indeed mandating) their exploration of their sexualities. For some this was a process they were eager to engage in, such as in Maria and Rueben's narratives in which they referenced friends as supporting their engagement with their burgeoning sexualities. For John and Alex, however, this was narrated as a less reciprocal process, with John describing a general sense of pressure to get a girlfriend, and comments from his first girlfriend and peers at school regarding intimacy milestones. Alex described his peers' emphasis upon his defining his sexuality as irritating at best, and persecutory, at worst. This aspect of what I termed 'social sexuality' was demonstrably absent from prior literature with respect to the sexuality of TGD youth, though present in wider literature pertaining to the sexuality of adolescents (Moore & Rosenthal, 2007).Bungener and colleagues (2020) found that respondents reported engaging in sexual activities involving a partner's genitals at an earlier age compared to activities in which they were recipients of genital touch. The role of others in the exploration of sexual identity, as identified in this study may be pertinent here. It may be that young people engage in sexual intimacy in this way prior to being the recipients of sexual touch in part due to a complex process of negotiating expectations regarding sexual engagement (social sexuality), their own sexual desire (as voiced by Maria, for instance), experiences of gender dysphoria (Cerwenka, Nieder, Briken, et al., 2014; Cerwenka, Nieder, Cohen-Kettenis, et al., 2014; Richards, 2018), and, possibly, concerns regarding their safety (again voiced by Maria) (Bettcher, 2007; Billard, 2019; Coleman, 2022; Schilt & Westbrook, 2009).

In a chapter regarding the conceptualization of sexuality in research about transgender young people, Sinclair-Palm (2018) highlights the need for research which explores how TGD young people negotiate sexuality at school and how the environment of school influences their

understandings and expressions of sexuality. All of the narrators spoke to the role friends, or peers within the wider school environment played in their understanding and experience of their sexualities. The voice of what I termed 'social sexuality' was clearly present in John and Maria's accounts. This voice represented aspects of normative narratives of sexuality that do not exist between sexual partners, but rather between an individual and their social sphere. Both young people appeared to relate to this voice in different ways. In John's account, it appeared that social expectations regarding sexuality at times were experienced as compulsory pressure. For Maria, in contrast, locating her sexual interest in accordance with that of her friends offered her a means of communicating her sense of feeling *"held back physically"*. Through paying attention to the counterpoint between Maria's wish to explore her sexuality just like her friends and her simultaneous positioning of herself as not feeling ready, or feeling held back, I was led to consider Maria's negotiation of normative expectations of sexuality as perhaps an instance in which she wished to accentuate her agency over the constraints she experiences as a TGD person. Though prior literature indicates that gender dysphoria is a key contributor to young people's reasons for not engaging in sexual intimacy with partners (Bungener et al., 2017), I was led to consider the relative weight of Maria's experiences of gender dysphoria in her account compared to her allusions to the challenges she may face as a TGD person.

In contrast to previously published accounts of the sexualities of gender diverse young people, the impression I gathered from the young people's accounts was not so much that they did not have an interest in sex due to feelings of body dysphoria (Bungener et al., 2017; Doorduin & van Berlo, 2014b; Engelmann, Nicklisch & Nieder, 2022), though this of course featured in their accounts, but rather that they were less sexually experienced than their peers due to a reduced sense of personal confidence in their desirability, and, perhaps their safety, as

transgender people. Therefore, their accounts outlined aspects of the social function of sexuality as adolescents, as a means of keeping developmental pace with one's peers, establishing themselves as desirable and successfully embodying their gender, and as a social currency within peer relationships (van de Bongardt et al., 2015).

The voice of social sexuality was related to aspects of heteronormativity and expected sexuality in this way and at times overlapped with what I termed 'the voice of stigmatized difference', an aspect of both cisnormative and transnormative master narratives that position trans identities as other. All the young people, in different ways, acknowledged the work they did to ensure that they were recognised as their gender. Feeling secure that they would be validated in their gender by a partner was framed as facilitative of sexual exploration and comfort (Latham, 2016; Martin and Coolhart, 2022).

Several of the young people spoke about making active choices regarding when and with whom they shared details of their gender history. John noted that his tendency to tell people he is transgender only if they ask represents a significant departure from his previous openness about his sexual identity in childhood. Maria conveyed a wish to maintain her privacy and safeguard herself against others' casually or insensitively, raising her past without consideration of her ownership over her own life story. Alex similarly framed his decision to no longer 'come out' to new people with specific reference to the burden of managing how others perceive and respond to him, something he found would sadly change when he disclosed his gender history. At such moments I interpreted the young people as constructing their narratives in dialogue with the normative narrative voices of cisnormativity, expected sexuality, and the alternative master narrative of transnormativity, specifically with respect to the victimization aspect (Bradford and Syed, 2019). I interpreted the young people as tacitly or actively engaging with

the essentialist conflation of sex and gender within cisnormativity (Berger & Ansara, 2021, Bradford & Syed, 2019), with the awareness that disclosing their gender history rendered them vulnerable to having their identity overshadowed and invalidated by others' privileging their assigned sex over their expressed gender.

Another aspect of their engagement may have been with the victimization aspect of transnormativity, in which they may have anticipated stigmatization of their transgender identity (Bettcher, 2007; Billard, 2019; Schilt & Westbrook, 2009). This corresponds to one of the themes in Araya and colleague's study (2021) in which the young people spoke about experiences of transphobia when dating and the challenge of disclosing their gender identity to partners.

Such decisions about identity disclosure hold relevance for young peoples' sexual lives, as to feel safe enough to become sexually intimate with another person, requires mutual understanding, respect, and positive regard (Engelmann, Nicklisch & Nieder, 2022).

5.2.5 Perspectives regarding the intervention

Previous studies have evaluated the impact of PST by measuring improvement (or not) in gender dysphoria (e.g. Cohen-Kettenis & Van Goozen, 1997; De Vries et al. 2011; Murad et al., 2010; Smith et al., 2001). However, the results of this study suggest impact can be experienced in different ways. Some of the young people in this research indicated that accessing PST could be supportive of their confidence to engage with and explore their sexualities. However, from their accounts it appears that a key aspect of this was the meanings they attributed to accessing the intervention, rather than any specific effect of the intervention in and of itself.

Among the participants in this study, only John accessed puberty suppressant treatment (PST) in early adolescence, while the others all began between ages 16 and 18. Rueben and Alex both expressed a sense that accessing PST at a later age limited its impact, as they had already undergone significant pubertal changes that the treatment exerted little influence upon. They both noted that, for them, accessing PST was therefore chiefly of benefit because it enabled them to access gender affirming hormones at a future point. This requirement is indeed the case, irrespective of a young person's physical maturity. The current service specification for TGD youth requires that young people access PST for a minimum of one year before accessing gender-affirming hormone treatment, which they become eligible to be considered for at age 16 (NHS England, 2023a). However, with consideration of the average age young people access PST in the research literature (NICE, 2021) and what is known about population estimates of the age at which young people reach physical maturity (Brix et al., 2019), it can be inferred that accessing PST after a certain age confers limited benefit in achieving its intended purpose. This may provide some context as to why some young people frame the treatment chiefly as a prerequisite for accessing GAHT and why the NICE evidence review concluded that PST lacked sufficient empirical evidence with respect to its impact upon gender dysphoria.

5.3 Strengths and limitations of the study

5.3.1 Strengths

This study is the first to seek contemporary narrative accounts of gender diverse young people with current lived experience of accessing PST in isolation from other gender affirming treatments. As three of the four narrators were in receipt of the treatment at the point of

interview, their accounts therefore afford some insight into aspects of the experience of accessing the treatment without the risk of hindsight bias (Burns et al., 2022). Additionally, the three narrators in receipt of the intervention at the point of intervention were accessing it amid the present sociopolitical context regarding gender diversity and physical interventions in the UK, and therefore their accounts can be interpreted with respect to this.

One of the key strengths of the methodology was the freedom afforded to participants to make their own decisions about what they felt was both relevant and comfortable to share in the interview context. This allowed for a perhaps a more realistic account of experience, comparable to that which might be given within a clinical session. Though participants were at times asked more direct follow up questions, this was typically on the basis of something they had already raised independently, and they were reminded that they could always 'pass' on a question they did not wish to speak to. Several of the young people noted at the end of the interview that they had appreciated the opportunity to think about the topic, as it was not something they had opportunity to do on a day-to-day basis with others such as friends. However, despite the open format of the research interview and its similarity to clinical practice, the use of interviews brought certain limitations. The data was naturally limited to what the young people wished, or felt able, to communicate in the interview setting. In their discussion of phenomenological methods in sexuality research, Frost et al. (2013) note that relevant aspects of participants' sexual experience may remain uncommunicated due to things such as stigma, impression management, limited self-understanding, and the ineffable or as yet un'languaged' aspects of sexual experience. While the two former may be partly mitigated through the anonymity of other methods, such as internet-based research (Kanuga & Rosenfeld, 2004), the latter remain a challenge.

Though qualitative methods and narrative methods in particular are not intended to generate generalizable results, the method adopted in this study holds relevance for the work of clinical psychologists as there is a significant amount of crossover. The relational nature of the LG privileges recognition of the intersubjectivity of the clinical relationship between clinician and client.

5.3.2 Limitations

One of the potential drawbacks of the chosen methodology is the small sample size (n=4). There are two main reasons why this might be considered a limitation: i) concerns over data adequacy and ii) concerns over generalisability by analysing a small number of participant accounts, at the expense of accessing a wider breadth of experience from a larger number of participants. Addressing the first concern, I would argue that given the study's ontological stance of critical realism, and the exploratory nature of the research, the depth of analysis undertaken (by combining the Listening Guide with the Master Narrative Engagement Analytical Framework), with the four narratives provided adequate data to achieve the study's objectives despite its small size. Crouch and McKenzie (2006) argue that small sample sizes can be sufficient when realism underpins the research, as interviews must be understood within their broader social context. As noted in the introduction, TGD people are socially categorized together solely on the basis of being anything other than cisgender. With respect to research with TGD individuals, it would be remiss to seek to extrapolate findings to the entire population of TGD people as the shared experience of gender diversity is an insufficient basis to define a group in a truly meaningful way. Instead, as Crouch and McKenzie (2006) propose, participants "embody and represent meaningful experience-structure links" (p. 493). In this study, participants' accounts represent the intersection between subjective experiences of accessing puberty suppression treatment (PST) and broader social structures. Emmel (2013) reinforces

this notion, describing samples as fragments of a larger system, with the researcher's task being to demonstrate how these fragments contribute to explanation and interpretation (p. 155). Somers (1994) argues that the repertoire of narratives within a society or culture are limited, and therefore the narratives of the young people in this study may hold relevance for others with similar experiences.

One key limitation of this study was the recruitment challenges experienced. Though the choice of methodology imposed an upper limit on the number of potential participants from the outset, recruitment also proved very challenging (see section 3.3.4). The process of recruitment was thought provoking and points to the challenge and impact of wider systemic factors such as the COVID-19 Pandemic, service provision in the face of ongoing scrutiny and change, polarized public discourse centred on the topic of gender diverse youth and their access to various interventions, and the more typical barriers of time and finances. An additional consideration is that all participants were self-selecting and the majority of these were also initially informed about the project by their clinicians within GIDS. This is a limitation as it is possible that some young people did not have the opportunity to take part due to accessing PST outside of NHS provision. However, as GIDS was the national specialist service for gender diverse youth when recruiting, the population accessing the service represented a significant proportion of those accessing PST in England and Wales. Naturally, those who chose not to take part, may differ in significant ways from those who did choose to share their stories. However, due to the extent of recruitment efforts, it is reasonable to suggest that perhaps the nature of this topic and the temporal context of the research meant that only those who were particularly motivated to take part would have come forward in any case. All participants were above the age of 16 at the point of interview and therefore all spoke from a perspective of an older adolescent, though the choice of this age range meant participants were not limited to those with parental consent. All

the participants endorsed a binary gender identity. It is possible that inclusion of non-binary participants would have evoked differing narratives of experience. Additionally, those who responded to the public calls for participants via their university LGBTQ+ societies, or online forums, may belong to a demographic within the overall population of gender diverse youth who are 'out' or engage with this aspect of their identity more publicly than others may choose to.

5.4 Implications of results

Though the narratives of the young people who took part are unique to them, there are aspects of the findings which could be of benefit to consider in the context of clinical practice.

5.4.1 Implications for clinical practice

As clinicians we engage individuals and groups in conversations in which both our own and our client's realities converge as we seek to develop new understandings. For TGD young people, the presumed and prescribed reality of cisnormativity is at odds with their reality, representing a constraint on their construction of readily understood personal narratives from this impoverished storehouse of narrative resources (McLean &Syed, 2016).

As professionals, we can name and consider the potentially constraining impact of the dominant 'legitimate' narrative of trans identity stemming from the historical construction of TGD individuals. We can reorient ourselves to ways of relating with clients that enable their articulation of their personal experiences through reflexive examination of our own relationship to dominant narratives.

Moreover, though this research was conducted with TGD young people, much of what they voiced in their accounts holds significance for cisgender young people alike, who are not immune to the constraints of heteronormativity and hierarchical conceptualisations of gender and sexuality either. Indeed, many individuals we encounter through our clinical work may sit outside prescribed narratives of gender and sexuality, among others, and as such, may have less resources to story their experience in the service of making themselves sufficiently understood to benefit from therapeutic input. For instance, those who are sexual minorities, such as LGBTQ+ people, non-monogamous people, or those who engage in sexual practices that are considered niche may have unequal access to support compared to those who conform to the cisgender, heterosexual, monogamous majority. This is due to the unfair burden such individuals often shoulder in creating understanding between themselves and their clinician/s where their clinician lacks knowledge of their experiences (Bauer et al., 2009). Similarly, those who are not just underrepresented in cultural narratives of sexuality, but routinely storied as nonsexual, such as the elderly, or physically and/or intellectually disabled, may struggle to have their sexuality taken seriously, or even considered a relevant topic to explore.

As professionals with a commitment to supporting our clients equitably, it is inexcusable to merely commit to learn from clients where their experiences fall outside our realm of professional experience and knowledge. Our clients' (and our own) differences from the presumed norm may or may not be salient to the clinical encounter. We must actively welcome our clients to speak to all aspects of their distress and not presuppose what aspects of their personhood might relate to this. As TGD individuals must seek formal diagnosis as a means of accessing GAT, something of a 'clinician's illusion' (Cohen & Cohen, 1984) may occur, in which TGD people are consequently viewed as necessarily requiring clinical support. When this highlights a gap in our awareness, we must commit to learn more, not just from clients, but

through personal study, and practice what Fielding terms ‘ethical curiosity’ when seeking information from clients (Fielding, 2021). We may also consider making accommodations to the therapy schedule to account for the time lost to explanation of a characteristic, identity, or practice that we lack familiarity with.

5.4.2 Implications for future research

The current study affords some insight into the experiences and meaning making of four TGD young people who have accessed PST. However, the young people were all aged 16 and over, self-selecting, and took part during a time in which PST was subject to professional and public scrutiny. Given the controversy surrounding the care of TGD young people in this current socio-historical moment in the UK, more needs to be done to involve young people themselves in decisions that affect their lives. Research is needed that acknowledges the myriad, valid, realities of TGD youth and considers the perceived and genuine constraints upon personal expression resulting from the legacy of the historical construction of socially ‘legitimate’ trans identities via the medical and psychological professions (Bradford & Syed, 2019). One key element of this is providing opportunities for TGD people to articulate their own experiences, with recognition that TGD youth are not a monolith and the voices and views of some young people who are provided a platform may not correspond to those of others.

Future research could longitudinally examine the experiences of TGD young people both prior to and while accessing PST, making use of narrative methods and the master narrative framework as a means of situating their individual experience within the wider context by placing these on the same metric. Additionally, with consideration of the limits regarding what individuals may feel comfortable sharing in the context of a face-to-face interview, a pragmatic

mixed methods approach may offer a means of collecting data pertaining to specific experiences of interest.

5.5 Conclusions

This study is the first to seek the narrative accounts of gender diverse young people with current lived experience of accessing puberty suppressant treatment in isolation from other gender affirming treatments, with a specific focus on their experiences and understandings of sexuality. What came from this study was an appreciation of the unique experience and sense-making of each narrator. Though they were all drawing on common cultural discourses of cisnormativity, heteronormativity, and transnormativity, among others, each young person demonstrated unique dynamic engagement with these master narratives when storying their experiences. The overall findings relate to both the content and construction of the young people's accounts, what they shared, and how they framed their experiences within the context of the research interview, and wider nested systems.

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Appendices

Appendix 1: Terminology

Binding: Binding refers to the practice of compressing breast tissue to achieve a flatter appearance as part of gender expression. It is a reversible, non-medical, gender affirming practice.

Cisgender: The term cisgender refers to those who identify with their sex assigned at birth.

Cisgenderism: Cisgenderism is the term given to a system of oppression involving concepts, language and behaviour that privilege cisgender identities over non-cisgender identities.

Cisnormativity: Cisnormativity is a normative master narrative which positions cisgender identities as natural and preferable to non-cisgender identities (Berger & Ansara, 2021, Bradford & Syed, 2019).

Cissexism: Cissexism refers to prejudice or discrimination against people who are perceived by others as trans, regardless of whether these perceptions are accurate. (Ansara & Berger, 2021).

Gender modality: Gender modality is a term suggested by Florence Ashley as a means of describing a broad category that includes cisgender and transgender among other positions an individual might hold in relation to their gender assigned at birth (Ashley, 2019).

Heteronormativity: "Heteronormativity is a system and set of beliefs that uphold heterosexuality and the sex and gender binaries as the norm and default, thereby affecting

societal views on and attitudes toward sex, gender, sexual orientation, and family dynamics." (Goldbach, Knutson, & Kler, 2021, p.376)

Monosexuality/Mononormativity: Monosexuality refers to romantic/sexual orientation towards one gender category. Mononormativity refers to the assumption that monosexuality is the standard from which others depart.

Nonbinary: Nonbinary people may have a range of diverse identities and embodiments and are considered nonbinary by virtue of their rejection of binary gender.

'Passing': Bockting et al. (2020) note that investment in being perceived as cisgender ('passing') can be an adaptive means of affirming a binary gender identity and can serve to safeguard TGD individuals from discrimination, but if overemphasized may represent a manifestation of internalized transphobia. The term passing is contested as it serves to reify binary gender and cisnormative gendered expectations for appearance.

Puberty Suppressant Treatment: The earliest medical intervention for trans youth is puberty suppressant treatment which is possible to consider once a young person has reached Tanner Stage 2 of puberty. Gonadotropin releasing hormone (GnRH) agonists and antagonists which inhibit oestrogen and androgen synthesis are used. Gonadotropin releasing hormone is produced in the hypothalamus and acts upon GNRH receptors in the pituitary gland to stimulate the release of luteinizing hormone (LH), and follicular stimulating hormone (FSH), which then in turn stimulate the production and release of testosterone by the testes, and oestrogen by the ovaries. There are various GnRH analogues, different drugs with different doses and methods of administration, and different brand names.

Sex assigned at birth: Sex assigned at birth is one's sex designation on the basis of the appearance of the genitalia.

Sexual orientation: Sexual orientation is based on an individual's sexual interest and typically refers to sexual attraction, behaviour and sexual identity, however these terms need not coincide for an individual to claim an identity as belonging to a given sexual orientation.

Tucking: Tucking is a gender affirming practice in which individuals who were assigned male at birth minimize the appearance of their original genitalia by moving the testes into the inguinal canal/ or moving these and the penis to sit flat against the crotch to achieve a flatter profile. It is a reversible non-medical practice.

Transfeminine: Transfeminine people are those who were assigned male at birth who identify more with femininity. Transfeminine people may identify as women, nonbinary, or in other terms.

Transgender: Transgender people are "people with gender identities or expressions that differ from the gender socially attributed to the sex assigned to them at birth." (Coleman et al., 2022, p. 55).

Transgender identity: Denotes an individual's identity as a member of the transgender community.

Transmasculine: Transmasculine people are those who were assigned female at birth who have a gender identity that encompasses masculinity. Transmasculine people may identify as male, non-binary, or in other terms.

Transnormativity: Transnormativity is a normative view which considers trans people's experiences within a specific binary and medicalized framework which serves to position some transgender people as more 'legitimate' over others.

Appendix 2: Outline of systematic literature search strategy

To maximize the identification of relevant existing research literature, a comprehensive and sensitive search strategy was employed. Two complementary searches were conducted using Scopus and the EBSCOhost platform (MEDLINE, CINAHL, and APA PsycInfo). Keywords and synonyms representing the four interconnected aspects of the topic (gender diversity, adolescence, gender-affirming interventions, and sexuality) were identified. Boolean operators were used to combine terms and phrases for each concept separately before merging the searches. As the majority of literature I was aware of was exclusive in its focus on the experiences of adults, I first combined the searches excluding the search comprising terms for adolescence. I then filtered the results by language and resource type, such that the results comprised articles in English only. In this manner I identified 943 articles. After saving these results to a reference manager, I completed another search combining the searches for all four concepts, again filtering the results based on resource type and language, identifying 357 articles. Once I had combined these searches and screened out duplicates, I had 281 potentially relevant articles in total. I screened these at title level, ruling out any which lacked relevance to the topic such as those with an exclusive focus on LGB identities to the exclusion of transgender or gender diverse participants, or those centred on interventions for HIV. I then reviewed the remaining articles at abstract level, again discarding those which did not provide relevant information for the topic. Relevant articles were selected for full-text reading. Many additional articles were of interest, and I sought full text versions of these as part of my background reading and to examine if they contained reference to the topic of sexuality at the intersection of gender diversity and gender affirming interventions.

As this was a systematic search rather than a systematic review, the chosen papers were eclectic, interdisciplinary, and not limited by method, specific GAT intervention, or age range. Notably, no papers specifically examined the experiences of gender-diverse young people accessing puberty suppression treatment in isolation, although such experiences were partly captured in studies with a broader focus on the sexualities of gender-diverse individuals. Additional relevant literature was obtained through the examination of references in papers closely related to the research area. Lastly, though a targeted search of grey literature was not conducted, relevant policy papers were identified based on existing knowledge and references within relevant articles.

Appendix 3a: First formal call for participants via clinicians November 2021

University of Essex

Call for Participants. Do you have any young people on your caseload who may be appropriate to take part in the below study?

Title: How do gender-diverse young people who **are accessing the hormone blocker speak about their understanding and experiences of their sexualities? A narrative analysis of qualitative interviews with young people aged 16+, who are accessing hormone-blocking treatment.**

Sexuality is often an important and central part of adolescents' lives. Studies with gender-diverse adults accessing physical interventions such as gender-affirming hormones have found that many individuals attribute changes in aspects of their sexuality, such as attraction and drive, to these interventions. No equivalent studies have taken place with respect to young people's experiences or with the hormone blocker specifically. This study aims to give voice to young people's own accounts of this with respect to the wider narratives they draw upon when communicating their own storied experiences.

Eligible participants

- Young people who are currently in receipt of the hormone blocker
- Aged 16 years or older
- Accessing the blocker for at least three months at the time of their participation in a qualitative interview.

Exclusion criteria

- Severe mental health struggles at the point of the interview which would compromise the participant's capacity to consent or indicate ongoing risk of harm to self or others e.g. Psychosis/ severe depression requiring inpatient admission.
- Participants with an ongoing eating disorder.
- Participants who for whatever reason lack capacity to provide informed consent at the point of the interview.

As clinicians, if you feel that an invitation to take part would be appropriate on the basis of your knowledge of the young people you are working with, please raise this with them and share the information sheet with them. They can make contact with me to discuss further. If they prefer, they can provide their permission for their contact details to be shared with me and I will contact them on that basis. Young people will take part in a confidential qualitative interview of approximately one hour. One main generative question is asked, followed by prompts to allow them to expand on topics raised. The interview is non-directive and the young person can decide what they wish to share regarding their experiences.

Ruth O' Gorman,
Trainee Clinical Psychologist
Email: [redacted]
Telephone: [redacted]

Appendix 3b: First amendment to call for participants via clinicians

NHS
Health Research Authority

[redacted]

19 April 2022

Ms Ruth O' Gorman
[redacted]

Dear Ms O' Gorman

Study title:	**How do gender-diverse young people who are accessing the hormone blocker speak about their understanding and experiences of their sexualities?A narrative analysis of qualitative interviews with young people aged 16+, who are accessing hormone-blocking treatment.**
REC reference:	**21/NE/0173**
Protocol number:	**N/A**
Amendment number:	**ETH2122-0317**
Amendment date:	**22 March 2022**
IRAS project ID:	**279857**

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion: Favourable Opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Completed Amendment Tool [Amendment Tool 279857]	v1.6	06 December 2021
Copies of materials calling attention of potential participants to the research [Recruitment information for clinicians 279857]	Version 1	08 March 2022
Participant information sheet (PIS) [Information sheet 279857]	Version 3	08 March 2022

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Amendments related to COVID-19

We will update your research summary for the above study on the research summaries section of our website. During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you have not already done so, please register your study on a public registry as soon as possible and provide the HRA with the registration detail, which will be posted alongside other information relating to your project.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

IRAS Project ID - 279857:	**Please quote this number on all correspondence**

Yours sincerely

PP.

[redacted]

[redacted]

E-mail: [redacted]

Enclosures: *List of names and professions of members who took part in the review*

Copy to: *Ms Ruth O' Gorman*

North East - Tyne & Wear South Research Ethics Committee

Attendance at Sub-Committee of the REC meeting on 14 April 2022

Committee Members:

Name	*Profession*	*Present*	*Notes*
[redacted]	Assistant Director of Pharmacy	Yes	Chair, Meeting Chair
[redacted]	Clinical Research Nurse	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
[redacted]	Approvals Administrator

Appendix 3c: Second amendment to call for participants via clinicians

NHS
Health Research Authority

North East - Tyne & Wear South Research Ethics Committee

[redacted]

Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

11 July 2022

Ms Ruth O' Gorman

[redacted]

Dear Ms O' Gorman

Study title:	**How do gender-diverse young people who are accessing the hormone blocker speak about their understanding and experiences of their sexualities?A narrative analysis of qualitative interviews with young people aged 16+, who are accessing hormone-blocking treatment.**
REC reference:	**21/NE/0173**
Protocol number:	**N/A**
Amendment number:	**ETH2122-0317**
Amendment date:	**28 June 2022**
IRAS project ID:	**279857**

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion: Favourable Opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Completed Amendment Tool [Amendment Tool 279857]	Version 1	06 December 2021
Copies of materials calling attention of potential participants to the research [Poster call for participants]	Version 1	07 June 2022
Copies of materials calling attention of potential participants to the research [Call for participants]	Version 1	07 June 2022
Participant consent form [Consent form with visible edits]	Version 4	07 June 2022
Participant consent form [Consent form without visible edits]	Version 4	07 June 2022
Participant information sheet (PIS) [Participant Information Sheet with visible edits]	Version 4	07 June 2022
Participant information sheet (PIS) [Information sheet without visible edits]	Version 4	07 June 2022

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Amendments related to COVID-19

We will update your research summary for the above study on the research summaries section of our website. During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you have not already done so, please register your study on a public registry as soon as possible and provide the HRA with the registration detail, which will be posted alongside other information relating to your project.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

IRAS Project ID - 279857: **Please quote this number on all correspondence**

Yours sincerely

pp.

[redacted]

[redacted]

E-mail: [redacted]

Enclosures: *List of names and professions of members who took part in the review*

Copy to: *Ms Ruth O' Gorman*

North East - Tyne & Wear South Research Ethics Committee

Attendance at Sub-Committee of the REC meeting on 07 July 2022

Committee Members:

Name	*Profession*	*Present*	*Notes*
[redacted]	Assistant Director of Pharmacy	Yes	Chair, Meeting Chair
[redacted]	Manager Newcastle Brain Tissue Resource	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
[redacted]	Approvals Administrator
[redacted]	Approvals Administrator

Appendix 3d: Call for participants via third sector organisations

Text of email sent:

Hello,

I am getting in touch to ask if it might be possible to have your support in sharing a call for participants with the young people accessing the service, perhaps via some of the upcoming youth group sessions or via sharing the call on social media?

I am conducting my doctoral research with gender diverse young people who have experience of accessing the blocker, either currently or in the past. The study is seeking to hear accounts from young people about their experience of taking the blocker and what impact, if any, they feel this has had on their sexual lives in terms of drive, attraction etc. The aim of the project is to augment the voices and accounts of young people themselves and to support clinicians and young people to know more about what sorts of things they might expect when starting blockers. Young people would be asked to take part in an interview in which they speak about whatever they feel is relevant to the topic. There is no expectation or pressure to speak about any aspect of their experience or sexual lives in particular.

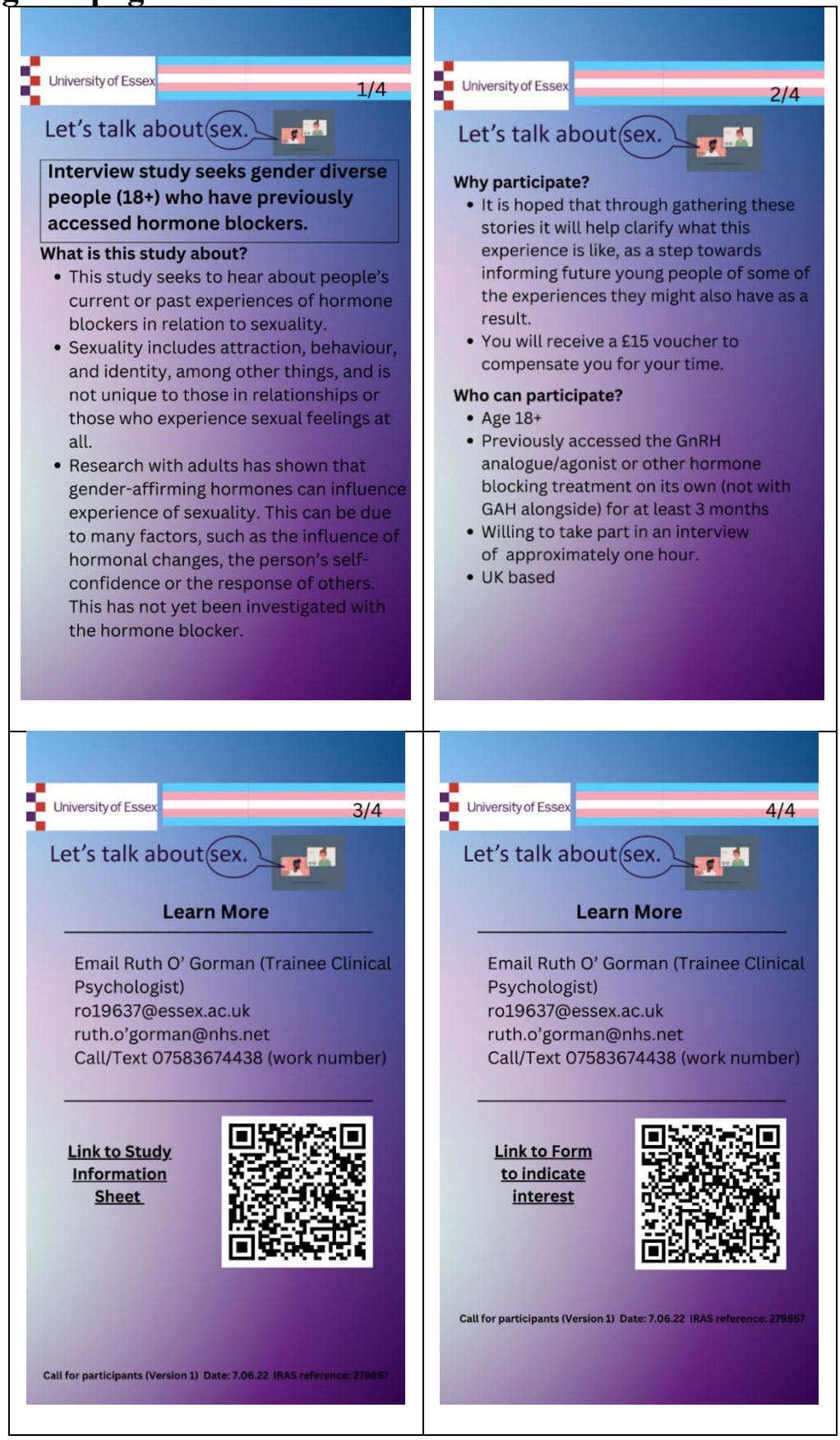
The study has been given ethical approvals from NHS research ethics and the Health Research Authority, as well as my university ethics committee and the GIDS research team. I have been recruiting within GIDS but am now also seeking to invite participants who are over 18 but who have had the experience of accessing blockers for at least a three month period in the past.

If this sounds like something you might be able to help with, I would really appreciate it! Please let me know of any questions. I can send over the full information sheet and a shareable version of the call for participants for your consideration as well.

Thanks for your help and all the best,

Ruth O' Gorman (she/her)
Trainee Clinical Psychologist

Appendix 3e: Call for participants via University Student Society Instagram page



Appendix 4a: Approval notification from Tyne & Wear South Research Ethics Committee

NHS
Health Research Authority

[redacted]

Telephone: [redacted]

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

09 November 2021

Ms Ruth O' Gorman
Trainee Clinical Psychologist
[redacted]

Dear Ms O' Gorman

Study title:	**How do gender-diverse young people who are accessing the hormone blocker speak about their understanding and experiences of their sexualities?A narrative analysis of qualitative interviews with young people aged 16+, who are accessing hormone-blocking treatment.**
REC reference:	**21/NE/0173**
Protocol number:	**N/A**
IRAS project ID:	**279857**

Thank you for your letter of 29 October 2021, responding to the Research Ethics Committee's (REC) request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation

as revised, subject to the conditions specified below.

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results
3. informing participants
4. sharing study data and tissue

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a publicly accessible database within six weeks of recruiting the first research participant. For this purpose, 'clinical trials' are defined as the first four project categories in IRAS project filter question 2. Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by or on behalf of the Research Ethics Committee (see here for more information on requesting a deferral: https://www.hra.nhs.uk/planning-and-improving-research/research-planning/research-registration-research-project-identifiers/

If you have not already included registration details in your IRAS application form, you should notify the REC of the registration details as soon as possible.

Further guidance on registration is available at:
https://www.hra.nhs.uk/planning-and-improving-research/research-planning/transparency-responsibilities/

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit:
https://www.hra.nhs.uk/planning-and-improving-research/application-summaries/research-summaries/

N.B. If your study is related to COVID-19 we will aim to publish your research summary within 3 days rather than three months.

During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you haven't already done so, please register your study on a public registry as soon as possible and provide the REC with the registration detail, which will be posted alongside other information relating to your project. We are also asking sponsors not to request deferral of publication of research summary for any projects relating to COVID-19. In addition, to facilitate finding and extracting studies related to COVID-19 from public databases, please enter the WHO official acronym for the coronavirus disease (COVID-19) in the full title of your study. Approved COVID-19 studies can be found at:
https://www.hra.nhs.uk/covid-19-research/approved-covid-19-research/

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

After ethical review: Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report
- Reporting results

The latest guidance on these topics can be found at
https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/.

Ethical review of research sites

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of sponsor indemnity 279857]		01 August 2021
Interview schedules or topic guides for participants [Interview Guide 279857]	Version 1	19 July 2021
IRAS Application Form [IRAS_Form_26082021]		26 August 2021
Letter from sponsor [Letter from sponsor 279857]		17 August 2021
Other [Consent to contact form 279857]	Version 1	19 July 2021
Other [Ethical Review Amendments table 279857 v1]	Version 1	29 October 2021
Other [Consent form 279857 v2 tracked changes]	Version 2	29 October 2021
Other [Information sheet 279857 v2 tracked changes]	Version 2	29 October 2021
Other [Confirmation of supervision 279857]	Version 1	14 October 2021
Other [GIDS Managing Urgent Concerns Procedure]	Version 1	18 January 2021
Participant consent form [Consent Form 279857]	Version 2	29 October 2021
Participant information sheet (PIS) [Information sheet 279857]	Version 2	29 October 2021
Research protocol or project proposal [Proposal]	Version 1	18 April 2021
Summary CV for Chief Investigator (CI) [Summary CV for Chief Investigator (CI) Ruth O' Gorman CV 279857]	Version One	24 January 2021
Summary CV for student [Summary CV for student Ruth O' Gorman CV 279857]	Version One	24 January 2021
Summary CV for supervisor (student research) [Summary CV for supervisor Vasilios Ioakimidis CV 279857]	Version One	16 November 2020
Summary CV for supervisor (student research) [Supervisor's CV Aaron Wylie 279857]		11 May 2020

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at:
https://www.hra.nhs.uk/planning-and-improving-research/learning/

IRAS project ID: 279857 Please quote this number on all correspondence

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

Yours sincerely
p.p.

[redacted]

[redacted]

Email: [redacted]

Enclosures: "After ethical review – guidance for researchers" *[SL-AR2]*

Copy to: [redacted]

Appendix 4b: Approval notification from HRA and Health and Care Research Wales

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

N/AMs Ruth O' Gorman
Trainee Clinical Psychologist
[redacted]

Email: [redacted]

10 November 2021

Dear Mrs O'Gorman,

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

Study title:	**How do gender-diverse young people who are accessing the hormone blocker speak about their understanding and experiences of their sexualities?A narrative analysis of qualitative interviews with young people aged 16+, who are accessing hormone-blocking treatment.**
IRAS project ID:	**279857**
Protocol number:	**N/A**
REC reference:	**21/NE/0173**
Sponsor	**University of Essex**

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

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

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

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

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

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

What are my notification responsibilities during the study?

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

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

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

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

Your IRAS project ID is **279857**. Please quote this on all correspondence.

Yours sincerely,

[redacted]

[redacted]

Email: [redacted]

Copy to: [redacted]

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of sponsor indemnity 279857]		01 August 2021
Interview schedules or topic guides for participants [Interview Guide 279857]	Version 1	19 July 2021
IRAS Application Form [IRAS_Form_26082021]		26 August 2021
Letter from sponsor [Letter from sponsor 279857]		17 August 2021
Organisation Information Document [Organisation Information Document 279857]	Version 1	09 August 2021
Other [Consent to contact form 279857]	Version 1	19 July 2021
Other [Ethical Review Amendments table 279857 v1]	Version 1	29 October 2021
Participant consent form [Consent Form 279857]	Version 2	29 October 2021
Participant information sheet (PIS) [Information sheet 279857]	Version 2	29 October 2021
Research protocol or project proposal [Proposal]	Version 1	18 April 2021
Schedule of Events or SoECAT [Schedule of Events 279857]	Version 1	19 July 2021
Summary CV for Chief Investigator (CI) [Summary CV for Chief Investigator (CI) Ruth O' Gorman CV 279857]	Version One	24 January 2021
Summary CV for student [Summary CV for student Ruth O' Gorman CV 279857]	Version One	24 January 2021
Summary CV for supervisor (student research) [Summary CV for supervisor Vasilios Ioakimidis CV 279857]	Version One	16 November 2020
Summary CV for supervisor (student research) [Supervisor's CV Aaron Wylie 279857]		11 May 2020

IRAS project ID	279857

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
There is only one participating NHS organisation therefore there is only one site type.	Organisations will not be required to formally confirm capacity and capability, and research procedures may begin 35 days after provision of the local information pack, provided the following conditions are met. You have contacted participating NHS organisations (see below for details)HRA and HCRW Approval has been issuedThe NHS organisation has not provided a reason as to why they cannot	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	No study funding will be provided to sites as per the Organisational Information Document	The Chief Investigator will be responsible for all research activities performed at study sites.	No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance.

	participateThe NHS organisation has not requested additional time to confirm. You may start the research prior to the above deadline if HRA and HCRW Approval has been issued and the site positively confirms that the research may proceed. You should now provide the local information pack for your study to your participating NHS organisations. A current list of R&D contacts is accessible at the NHS RD Forum website and these contacts MUST be used for this purpose. The password to access the R&D contact list is Redhouse1.				

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix 4c: Approval notification from The University of Essex's Research Governance Team

Decision - Ethics ETH2122-0317: Ms Ruth O'Gorman

ERAMS
Thu 11/11/2021 11:20
To:O'Gorman, Ruth <[redacted]>

University of Essex ERAMS

11/11/2021

Ms Ruth O'Gorman

Health and Social Care

University of Essex

Dear Ruth,

Ethics Committee Decision

Application: ETH2122-0317

I am writing to advise you that your research proposal entitled "How do gender-diverse young people who are accessing the hormone blocker speak about their understanding and experiences of their sexualities?A narrative analysis of qualitative interviews with young people aged 16+, who are accessing hormone-blocking treatment." has been reviewed by the REO Research Governance Team.

The Committee is content to give a favourable ethical opinion of the research. I am pleased, therefore, to tell you that your application has been granted ethical approval by the Committee.

Please do not hesitate to contact me if you require any further information or have any queries.

Yours sincerely,

REO Research Governance Team

Ethics ETH2122-0317: Ms Ruth O'Gorman

Appendix 4d: Participant Information Sheets 16+ and 18+

University of Essex

Participant Information Sheet

Project title:

How do gender diverse young people who are accessing the hormone blocker speak about their understanding and experiences of their sexualities?

A narrative analysis of qualitative interviews with young people aged 16+, who are accessing hormone blocking treatment.

Who is carrying out this study?

My name is Ruth O' Gorman and I am a Trainee Clinical Psychologist at the University of Essex. I am inviting you to take part in a research study. This study is being undertaken as part of a Doctoral qualification in Clinical Psychology. Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

What is the study about?

The study aims to allow young people to give their own accounts of the experience of taking the GnRH analogue or 'hormone blocker'.

Research with adults has shown that physical interventions such as gender-affirming hormones can influence their experience of their sexuality. This can be due to numerous factors, such as the influence of hormonal changes, the individual's self-confidence or the response of others to them, among other things.

This study is interested in hearing from young people about their experience of the hormone blocker in relation to sexuality. This includes attraction, behaviour, and identity, and is not unique to those in relationships or those who experience sexual feelings at all. The aim of the study is to hear what it has been like to take the hormone blocker and if it appears to have had any influence on the experience of sexuality. It is hoped that through gathering these stories it will help clarify what this experience is like, as a step towards informing future young people of some of the experiences they might also have as a result.

This study will run until late 2022 when it will be written up and submitted as part of a Doctorate in Clinical Psychology qualification.

Why have I been invited to participate?

You have been invited to take part as you are over 16 years of age and you have been, or will have been, accessing the hormone blocker for at least 3 months, or more, at the time of interview. You will have been invited via your allocated clinicians within the Gender Identity Development Service (GIDS), who, through working with you, feel that this invitation is appropriate at this time.

Do I have to take part?

Taking part in this research is entirely voluntary. If you wish to take part, you will be asked to provide written consent and you will have the opportunity to ask any questions you wish. If you choose to take part and then later change your mind, you are free to withdraw for whatever reason and without explanation or penalty. You can withdraw your information up to the point of anonymization and write up.

Your decision to participate or not participate will have absolutely no impact on the access, care, and interventions you receive from the Gender Identity Development Service. No individual information will be shared with any clinicians involved in your care, with the sole exception of information pertaining to your safety or that of others. If this is necessary, it will be discussed with you in advance.

What will I have to do if I take part?

If you would like more information about the study, or would like to take part, you can contact me and I will arrange a good time with you for a discussion or an interview. If you attend the Tavistock for face-to-face appointments, this will ideally happen on the same day as your appointment at the Gender Identity Development Service, COVID-19 measures dependent. This can also be arranged to be over video link.

You will be interviewed once for this study. The interview will take no longer than 1.5 hours. It will take place in a confidential clinic room in the Gender Identity Development Service or via video from your own home, whatever is the most comfortable and convenient for you. The interview will involve just you and the researcher. It is important that you feel comfortable to speak openly so if you are participating from home, it will be important to find a place where you will not be interrupted by anyone else. If you wish, you can invite someone you trust to join you for the interview. The interview will still be an individual interview, but they can be present with you throughout. If this is something you would like, we can discuss this when setting up the interview.

The interview will be audio-recorded and afterwards, it will be typed up (transcribed) by the researcher. You can choose a pseudonym for your interview and once transcribed, the original audio files will be deleted.

It is unlikely that the interview will be emotionally distressing, but sometimes talking about one's personal experiences can be difficult. If you become distressed or upset in the course of the interview we can think about what might need to happen to support you to feel better. This can include ending the interview, taking a break, agreeing to reschedule, or withdrawing from the research entirely. We can then think together about your support needs beyond the scope of the interview itself. If following the interview, you feel you would like some support, or would benefit from talking about these experiences more, you can contact me and I can signpost you to some resources to support you with this. With your permission, your clinicians within GIDS can be informed that this is a topic you would like to think about further as well. You can make contact at any point after taking part.

During the interview, you will be asked questions about your experience of taking the hormone blocker in relation to your experience of sexuality. You are under no obligation to

answer any particular questions if you do not wish to. The interview will be determined by what *you* feel is relevant to discuss in relation to the topic.

Is what I say in the interview confidential?

Anything you share in the interview is confidential. The exception to this is if you share anything that leads me to have a concern that either you or someone else, is at imminent or extreme risk of harm, either physically or emotionally. I will then have a duty of care to share the information to help everyone remain safe. If this is the case I will endeavour to speak with you first about the need to pass that information on to the clinicians responsible for your care, but this may not always be appropriate or possible.

If you agree to take part in the study your information will be stored on Box, a secure cloud storage system at the University of Essex, which will only be accessible to me as the researcher. This project may be published as a research paper and if quotations from your interview are used, your identity will be anonymised by changing your name and any other identifying features. You will be invited to choose a pseudonym for yourself, or I can assign you one if you prefer.

What are the possible disadvantages and risks of taking part?

The costs of taking part will be your time. It is not expected that taking part will be distressing, however it is possible that the content discussed could be distressing as the topic of sexuality can be emotive. You are free not to answer any questions if you feel uncomfortable. If you do feel upset or distressed at any point we will pause the interview and focus on your needs in that moment before deciding whether to resume the interview or end it as necessary.

What are the possible benefits of taking part?

The benefits of taking part include having a confidential space to talk about your experiences which is entirely independent from, and unrelated to, your support from the Gender Identity Development Service. You will also be directly contributing to the development of our understanding of the experiences of gender diverse young people accessing this intervention and the support that is offered to them. You will also be offered a £15 pound voucher to compensate you for your time.

What information will be collected?

In the interview, you will be asked to provide some information about your experience of taking the hormone blocker, in relation to your experience of sexuality. This information will not be identifiable as yours once it is transcribed from the audio recording. You can choose a pseudonym that you would like to be known as in the write up of the research.

How will my information be used?

We will need to use some personal information from you for this research project.

This information will include your name and your email address. This is so you can be contacted to discuss the research further and to arrange an interview.

answer any particular questions if you do not wish to. The interview will be determined by what *you* feel is relevant to discuss in relation to the topic.

Is what I say in the interview confidential?

Anything you share in the interview is confidential. The exception to this is if you share anything that leads me to have a concern that either you or someone else, is at imminent or extreme risk of harm, either physically or emotionally. I will then have a duty of care to share the information to help everyone remain safe. If this is the case I will endeavour to speak with you first about the need to pass that information on to the clinicians responsible for your care, but this may not always be appropriate or possible.

If you agree to take part in the study your information will be stored on Box, a secure cloud storage system at the University of Essex, which will only be accessible to me as the researcher. This project may be published as a research paper and if quotations from your interview are used, your identity will be anonymised by changing your name and any other identifying features. You will be invited to choose a pseudonym for yourself, or I can assign you one if you prefer.

What are the possible disadvantages and risks of taking part?

The costs of taking part will be your time. It is not expected that taking part will be distressing, however it is possible that the content discussed could be distressing as the topic of sexuality can be emotive. You are free not to answer any questions if you feel uncomfortable. If you do feel upset or distressed at any point we will pause the interview and focus on your needs in that moment before deciding whether to resume the interview or end it as necessary.

What are the possible benefits of taking part?

The benefits of taking part include having a confidential space to talk about your experiences which is entirely independent from, and unrelated to, your support from the Gender Identity Development Service. You will also be directly contributing to the development of our understanding of the experiences of gender diverse young people accessing this intervention and the support that is offered to them. You will also be offered a £15 pound voucher to compensate you for your time.

What information will be collected?

In the interview, you will be asked to provide some information about your experience of taking the hormone blocker, in relation to your experience of sexuality. This information will not be identifiable as yours once it is transcribed from the audio recording. You can choose a pseudonym that you would like to be known as in the write up of the research.

How will my information be used?

We will need to use some personal information from you for this research project.

This information will include your name and your email address. This is so you can be contacted to discuss the research further and to arrange an interview.

What should I do if I want to take part?

If you want to take part you can email me at [redacted] or [redacted] or call me on [redacted] and I can answer any questions you might have and arrange the interview at a time that suits you. You can also let your GIDS clinician know that you are willing to take part and they can, with your written consent, pass on your contact information for you to be contacted, if you prefer. I aim to recruit and interview participants between now and Jan 2022, but this is flexible.

What will happen to the results of the research study?

The results of the study will be written up as a Doctoral Thesis as part of the requirements of the degree of Doctor of Clinical Psychology. The results may be written up as a conference paper or presentation or as a journal article. Any results will be anonymised, and individual participants will not be identifiable. A copy of the final thesis can be provided to participants if they would like this. If you would prefer, a shorter summary of the research findings can be provided as well.

Who is funding the research?

This research is being undertaken as part of a qualification in clinical psychology and it is unfunded.

Who has reviewed the study?

The study has been reviewed by NHS Ethics Review:

Concerns and Complaints

If you have any concerns about any aspect of the study or you have a complaint, in the first instance please contact the principal investigator of the project, Ruth O' Gorman, using the contact details below. If are still concerned, you think your complaint has not been addressed to your satisfaction or you feel that you cannot approach the principal investigator, please contact the departmental Director of Research in the department responsible for this project, [redacted] If you are still not satisfied, please contact the University's Research Governance and Planning Manager, [redacted] (e-mail [redacted]). Please include the IRAS reference which can be found at the foot of this page.

Name of the Researcher/Research Team Members

Ruth O' Gorman Trainee Clinical Psychologist
Email: [redacted]
Telephone: [redacted]

[redacted]
Email: [redacted]

Telephone: [redacted]
Location: [redacted]

[redacted]
Email: [redacted]
Telephone: [redacted]
Location: [redacted]

[redacted]
Email: [redacted]
Telephone: [redacted]
Location: [redacted]

University of Essex

Participant Information Sheet

Project title:

How do gender diverse young people who are accessing the hormone blocker speak about their understanding and experiences of their sexualities?

A narrative analysis of qualitative interviews with young people aged 16+, who are accessing, or have previously accessed, hormone blocking treatment.

Who is carrying out this study?

My name is Ruth O' Gorman and I am a Trainee Clinical Psychologist at the University of Essex. I am inviting you to take part in a research study. This study is being undertaken as part of a Doctoral qualification in Clinical Psychology. Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

What is the study about?

The study aims to allow young people to give their own accounts of the experience of taking the GnRH analogue or 'hormone blocker'.

Research with adults has shown that physical interventions such as gender-affirming hormones can influence their experience of their sexuality. This can be due to numerous factors, such as the influence of hormonal changes, the individual's self-confidence or the response of others to them, among other things.

This study is interested in hearing from young people about their experience of the hormone blocker in relation to sexuality. This includes attraction, behaviour, and identity, and is not unique to those in relationships or those who experience sexual feelings at all. The aim of the study is to hear what it has been like to take the hormone blocker and if it appears to have had any influence on the experience of sexuality. It is hoped that through gathering these stories it will help clarify what this experience is like, as a step towards informing future young people of some of the experiences they might also have as a result.

This study will run until late 2022 when it will be written up and submitted as part of a Doctorate in Clinical Psychology qualification.

Why have I been invited to participate?

You have been invited to take part as you are over 18 years of age and you have previously accessed hormone blocking treatment on its own, for at least 3 months, or more.

Do I have to take part?

Taking part in this research is entirely voluntary. If you wish to take part, you will be asked to provide written consent and you will have the opportunity to ask any questions you wish. If you choose to take part and then later change your mind, you are free to withdraw for whatever reason and without explanation or penalty. You can withdraw your information up to the point of anonymization and write up.

Your decision to participate or not participate will have absolutely no impact on the access, care, and interventions you receive from any service or provider. No individual information will be shared with any professionals involved in your care, with the sole exception of information pertaining to your safety or that of others. If this is necessary, it will be discussed with you in advance.

What will I have to do if I take part?

If you would like more information about the study, or would like to take part, you can contact me and I will arrange a good time with you for a discussion or an interview over video link.

You will be interviewed once for this study. The interview will take no longer than 1.5 hours. It will take place via video link (for instance, zoom) from your own home or wherever is most comfortable and convenient for you. The interview will involve just you and the researcher. It is important that you feel comfortable to speak openly so if you are participating from home, it will be important to find a place where you will not be interrupted by anyone else. If you wish, you can invite someone you trust to join you for the interview. The interview will still be an individual interview, but they can be present with you throughout. If this is something you would like, we can discuss this when setting up the interview.

The interview will be audio-recorded and afterwards, it will be typed up (transcribed) by the researcher. You can choose a pseudonym for your interview and once transcribed, the original audio files will be deleted.

It is unlikely that the interview will be emotionally distressing, but sometimes talking about one's personal experiences can be difficult. If you become distressed or upset in the course of the interview we can think about what might need to happen to support you to feel better. This can include ending the interview, taking a break, agreeing to reschedule, or withdrawing from the research entirely. We can then think together about your support needs beyond the scope of the interview itself. If following the interview, you feel you would like some support, or would benefit from talking about these experiences more, you can contact me and I can signpost you to some resources to support you with this. You can make contact at any point after taking part.

During the interview, you will be asked questions about your experience of taking the hormone blocker in relation to your experience of sexuality. You are under no obligation to answer any particular questions if you do not wish to. The interview will be determined by what *you* feel is relevant to discuss in relation to the topic.

Is what I say in the interview confidential?

Anything you share in the interview is confidential. The exception to this is if you share anything that leads me to have a concern that either you or someone else, is at imminent or extreme risk of harm, either physically or emotionally. I will then have a duty of care to share

the information to help everyone remain safe. If this is the case I will endeavour to speak with you first about the need to pass that information on to your GP as they are your first point of care but this may not always be appropriate or possible.

If you agree to take part in the study your information will be stored on Box, a secure cloud storage system at the University of Essex, which will only be accessible to me as the researcher. This project may be published as a research paper and if quotations from your interview are used, your identity will be anonymised by changing your name and any other identifying features. You will be invited to choose a pseudonym for yourself, or I can assign you one if you prefer.

What are the possible disadvantages and risks of taking part?

The costs of taking part will be your time. It is not expected that taking part will be distressing, however it is possible that the content discussed could be distressing as the topic of sexuality can be emotive. You are free not to answer any questions if you feel uncomfortable. If you do feel upset or distressed at any point we will pause the interview and focus on your needs in that moment before deciding whether to resume the interview or end it as necessary.

What are the possible benefits of taking part?

The benefits of taking part include having a confidential space to talk about your experiences which is entirely independent from, and unrelated to, your support from other services, if receiving any. You will also be directly contributing to the development of our understanding of the experiences of gender diverse young people accessing this intervention and the support that is offered to them. You will also be offered a £15 pound voucher to compensate you for your time.

What information will be collected?

In the interview, you will be asked to provide some information about your experience of taking the hormone blocker, in relation to your experience of sexuality. This information will not be identifiable as yours once it is transcribed from the audio recording. You can choose a pseudonym that you would like to be known as in the write up of the research.

How will my information be used?

We will need to use some personal information from you for this research project.

This information will include your name and your email address. This is so you can be contacted to discuss the research further and to arrange an interview.

I will keep all information about you safe and secure.

Once the study is finished, we will keep some of the data so we can check the results. The write up will be written in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep the information you have shared in the interview if it has already been transcribed and anonymised.

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

You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- by asking me when thinking about participating

by sending an email to the University of Essex Information Assurance Manager ([redacted]), as The Data Controller will be the University of Essex.

Will my information be kept confidential?

Your confidentiality will be safeguarded within legal limitations during and after the study.

After the interview, the audio files will be uploaded from the recorder to a secure NHS computer where they will also be password protected. The audio will not be on the laptop itself but will be held securely on Box, cloud storage provided by the University of Essex, therefore there is no risk of data being compromised in the event the laptop is lost or stolen. The audio file will be deleted from the recorder immediately following its transfer to cloud storage.

The only person with access to your data during the study will be me as the primary investigator. The audio might be transcribed by an external professional transcriber. If this is the case a legally binding non-disclosure agreement will be drawn up as an additional protective measure, and files will be encrypted prior to transfer.

The transcripts will be destroyed after 3 months following the examination of the research.

What is the legal basis for using the data and who is the Data Controller?

The legal basis for processing your data is your consent. Your consent must be freely-given, specific, informed, and unambiguous – given by a statement or a clear affirmative action.

The Data Controller will be the University of Essex and the contact will be University Information Assurance Manager ([redacted]).

What should I do if I want to take part?

If you want to take part you can email me at [redacted] or call/text me on [redacted] and I can answer any questions you might have and arrange the interview at a time that suits you.If reading this online, you can also enter your contact details at the following link to be contacted [redacted]

What will happen to the results of the research study?

The results of the study will be written up as a Doctoral Thesis as part of the requirements of the degree of Doctor of Clinical Psychology. The results may be written up as a conference paper or presentation or as a journal article. Any results will be anonymised, and individual participants will not be identifiable. A copy of the final thesis can be provided to participants if they would like this. If you would prefer, a shorter summary of the research findings can be provided as well.

Who is funding the research?

This research is being undertaken as part of a qualification in clinical psychology and it is unfunded.

Who has reviewed the study?

The study has been reviewed by NHS Health Research Authority North East – Tyne & Wear South Research Ethics Committee.

Concerns and Complaints

If you have any concerns about any aspect of the study or you have a complaint, in the first instance please contact the principal investigator of the project, Ruth O' Gorman, using the contact details below. If are still concerned, you think your complaint has not been addressed to your satisfaction or you feel that you cannot approach the principal investigator, please contact the departmental Director of Research in the department responsible for this project, [redacted] If you are still not satisfied, please contact the University's Research Governance and Planning Manager, [redacted] (e-mail [redacted]). Please include the reference number which can be found at the foot of this page.

Name of the Researcher/Research Team Members

Ruth O' Gorman Trainee Clinical Psychologist
Email: [redacted]
Telephone: [redacted]

[redacted]
Email: [redacted]
Telephone: [redacted]
Location: [redacted]

[redacted]
Email: [redacted]
Telephone: [redacted]
Location: [redacted]

[redacted]
Email: [redacted]
Telephone: [redacted]
Location: [redacted]

Appendix 4e Participant Consent forms 16+ and 18+

University of Essex

Consent Form

Title of the Project: How do gender diverse young people who are accessing the hormone blocker speak about their understanding and experiences of their sexualities?

A narrative analysis of qualitative interviews with young people aged 16+, who are accessing, or have previously accessed, hormone blocking treatment.

Researcher: Ruth O' Gorman (please initial box)

1. I confirm that I have read and understand the Information Sheet dated 08.03.2022 for the above study. I have had an opportunity to consider the information, ask questions and have had these questions answered satisfactorily.	
2. I understand that the interview is confidential and that the exception to this is any information about risk of harm to myself or others as explained in the Participant Information Sheet.	
3. I understand that my participation is voluntary and that I am free to withdraw from the project at any time without giving any reason and without penalty. I understand that I can withdraw my information up to the point of anonymization and write up.	
4. I give my permission for my interview to be audio recorded.	
5. I understand that any identifiable data provided will be securely stored and accessible only to the members of the research team directly involved in the project, and that confidentiality will be maintained.	
6. I understand that my fully anonymised data will be analysed as part of a research thesis which forms part of a Doctorate in Clinical Psychology qualification. This research may be published as a research paper or presented at conferences. My data will be anonymized and if quotations from my interview are used, they will not be identifiable as mine.	
7. I give permission for my direct quotes to be used in publications.	
8. I agree to take part in the above study.	

Participant Name	Date	Participant Signature
_____	_____	_____
Researcher Name	Date	Researcher Signature
_____	_____	_____

University of Essex

Consent Form

Title of the Project: How do gender diverse young people who are accessing the hormone blocker speak about their understanding and experiences of their sexualities?

A narrative analysis of qualitative interviews with young people aged 16+, who are accessing, or have previously accessed, hormone blocking treatment.

Researcher: Ruth O' Gorman (please initial box)

1.	I confirm that I have read and understand the Information Sheet dated 07.06.2022 for the above study. I have had an opportunity to consider the information, ask questions and have had these questions answered satisfactorily.	
2.	I understand that the interview is confidential and that the exception to this is any information about risk of harm to myself or others as explained in the Participant Information Sheet.	
3.	Should the need arise to share information about risk of harm to myself or others (as per the above) I understand that my GP would be informed with my knowledge, I confirm that my GP details are as follows. GP Practice Name: GP Practice Address:	
4.	I understand that my participation is voluntary and that I am free to withdraw from the project at any time without giving any reason and without penalty. I understand that I can withdraw my information up to the point of anonymization and write up.	
5.	I give my permission for my interview to be audio recorded.	
6.	I understand that any identifiable data provided will be securely stored and accessible only to the members of the research team directly involved in the project, and that confidentiality will be maintained.	
7.	I understand that my fully anonymised data will be analysed as part of a research thesis which forms part of a Doctorate in Clinical Psychology qualification. This research may be published as a research paper or presented at conferences. My data will be anonymized and if quotations from my interview are used, they will not be identifiable as mine.	
8.	I give permission for my direct quotes to be used in publications.	
9.	I agree to take part -in the above study.	

Participant Name :	Date :	Participant Signature:
_____	_____	_____
Researcher Name	Date	Researcher Signature
_____	_____	_____

Appendix 5: Interview Guide

Interview guide

Aim: To hear the narratives of gender diverse young people who are accessing the hormone blocker and the impact, or lack thereof, they perceive the blocker as having on their sexuality (drive, attraction etc.)

Introduction

Opening Statement:

"This research aims to learn more from young people like you about the experience of taking the blocker. The blocker stops production of sex hormones, and we are interested in how this may or may not affect different aspects of young people's lives. We are interested to learn from you how you feel it interacts with your experience of sexuality, if at all. This is so that other young people like yourself will be able to know a little bit more about what to expect when they begin to take the blocker, and help inform their consent to the treatment. This interview will focus on your personal experiences. It is confidential, meaning nothing you say will be passed on to your parents, GIDS clinicians, or anyone else. The only exception to this is if I have concerns about your own safety, or the safety of anyone else. If this were the case I would prefer to have a conversation with you first and we can agree who needs to be informed and how to go about this. However, there might be times when this is not possible or appropriate.

You can withdraw from the project at any time. You are under no obligation to take part whatsoever and can withdraw your data after the interview at any point prior to the write-up phase of the research. In the write up no individual information is shared. Your interview data will be stored securely as outlined in the information sheet and destroyed following the examination of the thesis."

Demographic information

Current age ……years……months

How would describe your gender identity?.....

How old were you when you started taking the hormone blocker? ……years……months.

What is the name of the hormone blocker you take?.....

How often do you take it?.....

In what format do you take it?.....

How would you decribe your ethnicity?……

Are you currently in a realtionship or dating? ……..

If yes, how long have you been seeing them (person/people)? ……

How would they decscribe their gender/s?.....

How would you decribe this relationship? E.g. monogomous/exclusive, open, not sure yet, or another way……

Opening Question:

"I would like you to tell me about your experience of taking the hormone blocker and your experiences of this in relation to the way that you experience or think about your sexuality. I would like to hear about all of the aspects of this that are important to you and how your experience and understanding of your sexuality has developed over time.

Sexuality can be a number of things. It can be having consensual sexual or intimate contact with yourself or others, physical drive, attraction, how you identify or your experience of relationships. It can be a lack of desire or drive, identifying as asexual for instance. You may choose to speak about these topics, or other ways you understand your sexuality.

I want to give you time and space to tell your story and what you consider to be important. There is no right way to do this, so please tell me in a way that is comfortable for you. You could start around the time you began to take the blocker, when you first started to think about your sexuality, or at another point in time. You can choose to begin wherever you like"

I will take a few notes as we go along which might guide my later questions.

If at any point you no longer want to continue with the interview please let me know.

……

If the participant struggles: 'A typical story might consist of how you came to understand and experience your sexuality and the role, if any, the blocker has played in that since you began taking it'

Main Area	Prompts	Domains
Meaning of sexuality	What does the word 'sexuality' mean to you? Can you tell me about when you first began to think about your sexuality? Has this changed over time?	The person's historical experience and understanding of their sexuality.
Orientation	'Can you tell me about any times or events that prompted you to think about your sexuality in particular?' 'What words do you use to describe you sexuality? Have	Experience of questioning assumed norms re sexuality.

	these always been the words that describe you best, or have there been other words that have fitted better at different times?' 'How do you make sense of that change?' 'What do you think prompted that change?	Identity labels and their significance, or non significance
Side effects of blocker	'Since taking the hormone blocker, have you noticed any side effects' (e.g. hot flushes, aches, night sweats, nausea and headache, mood swings, weight gain, and fatigue)	Influence of blocker more generally
Drive	'Since taking the hormone blocker, have you noticed any changes to your drive/libido?' 'What have you noticed? (if yes)' 'What kind of impact has this change had on you?' 'How do you make sense of this?'	Sexual drive and desire
Dating + Partnered Sex	'Has the blocker had any impact on your experience of dating or on your romantic or sexual relationship/s?'	Interpersonal relationsips
Non-sexual attraction	'Since taking the hormone blocker have you noticed any changes to the experience of having crushes or fancying people?'	Object of romantic/sexual attraction
Attraction/ Attractiveness	'Since taking the hormone blocker have you noticed any changes in your attraction to others? (If they report feeling attracted to others)' 'How do you make sense of this?'	Attraction as separate from drive/ sexual activity

	'What about your own sense of feeling attractive?' 'Have you noticed any difference in other people finding you attractive?' 'How do you make sense of this?'	Impact of blocker on on sense of feeling/being attractive to others.
Reflections	'Is there anything you have experienced while on the blocker regarding sexuality, that is , romantic and sexual attraction, drive or behaviours, that you were not anticipating or would like to add?' 'Is there anything that you have experienced that you would have liked to learn about in advance?'	

General Probes:

Provide positive feedback and feedback regarding timing 'We are about half-way through and you have been doing a good job of telling me about your experiences' 'We have talked about (areas covered), I wonder did you have any thoughts about the other possible elements of sexuality I mentioned at the start, such as drive, sexual activity, attraction or identity? (delete as appropriate).

CHRONOLOGY: And then…..what happened next…. And after that…

DETAIL: You mentioned ____, [what was that experience like for you/could you tell me about that part of the story in a little more detail? /Can you tell me more about how you felt about….. / Tell me what happened when…..

CLARIIFICATION: I'm a bit unsure about ____, could you tell me more about it / I don't quite understand, could you explain that a little more for me.

EXPLANATION: How come, why's that, how do you make sense of that? Can you say more about x?

<u>Finishing</u>

Is there anything that we haven't spoken about, that you think is important for me to know?

Now that the interview is coming to an end, how did you find the process of talking today?

Do you have any questions for me?

Appendix 6: Notations taken from the Jefferson transcription system as described by Hepburn and Bolden (2017).

Notation	Description	Example
((Double brackets))	Marks transcriber's description of events rather than representing these	((laughs))
[Square Brackets]	Overlapping speech without interrupting the speaker	"…definitely prompted it lot more [R: mmm] but I've again I've always…"
Empty brackets ( )	When something was said but transcriber unable to capture what was said.	"so I have ( )"
{Curly Brackets}	Deliberately omitted text for the purpose of confidentiality	"the best friend of my {sibling} in {their} class"
(word)	Uncertain hearing	"so it's going to be different and like (phased) with …"
(word1/word2)	Two possible hearings	"I've come to an understanding of who I am, (for/through) it, but…"
<u>Underlined</u>	Emphasis through all or part of the word	"it's <u>not</u> the same as before"
Hyphen-	Hyphen indicates unfinished or interrupted word	"and that sounds pr- like, harsh…"
CAPITALS	Words spoken more loudly than others	" It's just like UGH, you know?"

Appendix 7: An extract of notes taken during listening one of the Listening Guide protocol taken from original handwritten notes

Key:  = Indicative of thought or association.

Thought re 62 (line number of transcript): "If that makes sense, I don't really know (laughing)"

YP appealing to me in these moments to legitimize or confirm his narrative re stable attraction to girls as linked w/ maleness? (General maleness and/or his maleness?)

- I responded in the interview with a summary of topics covered + question re first encounters w/ words to describe sexualities (in terms of orientation- as YP mentioned using 'lesbian')

- Prompted story re sex education @ primary school + praise of school mixed w/ acknowledgement that school (72-73) "didn't have anything about transgender until me".

 (My association atm) Possibly difficult exp of being 'the first'? - needing to be the best version of transgender to pave the way so to speak?

Language throughout, "we"- voice of cohort in primary school. (73) "They made a whole PowerPoint on **it*** " ***Interesting use.**  Experienced as whole PowerPoint on YP?

 Perhaps experienced as different, othered, perhaps even freakish?

 Tension b/w glad re school being "good" and possible pressure or embarrassment of being their face of "transgender".

* Use of 'it' re 'Transgender'  Possible indication of framing 'Transgender' as a sort of medical condition, or something outside of himself.

-Contrast w/ use of "they only knew about gays" Identity based language, not speaking of it as 'gay people' or, 'gayness'.

 Might not just be a language convention thing, a lot of people speak about 'Transgender' in the same sort of way they might say 'Religion' or 'Politics', or 'The Weather'- in a sort of disembodied, depeopled way.

They= school "found it all out for me"- narrative feels like YP is almost saying 'I was just a male, school made me transgender'.

 Role of school/places of education in narratives- schools role in this YP's gendered self- "they got me to GIDS".

(76) "It just made life a lot more easier"  Indication that life wasn't totally easy/straightforward before?

YP's account is of learning re things, including his own 'transgender' stuff @ school, rather than seeking this out himself, or speaking with family, parents etc.

"Everyone was really really understanding"

 Indication that this is not always to be expected; this was somehow a pleasant surprise almost.

(84) "They said, you can either be in the classroom or not be in the classroom" -YP awareness + school's framing of idea that it was all about him. 'YP this is your life' sort of thing.

YP decision to be there "it will be a little bit easier" -could answer people's questions.  Position of having to have the information/answers/perhaps even feeling having to justify himself?

Others saying "so what does it kind of mean?"  Reminder to YP of his "weird" status- next statement re sense of "not just a few people, there's a lot of people out there who are very similar"

 YP not claiming membership of this group for himself but perhaps deriving comfort from these "people" being "out there".

-Shift to using "you"- perhaps indicating his previous sense of being less alone by knowing about these other "similar" people "out there".

(91) "Up until now I have never really been open about it"

-Contradiction, indicated earlier in interview he is not open about it + will only tell people "if they ask".

(96) "I didn't know myself up until the last year" (of primary)

 Surprised re others being aware of trans people.

 Association re dual meaning of above statement, not knowing re trans identities until Y6 + also didn't know <u>myself</u>, as in now had a new (possibly unwanted/less valued) way of seeing himself, knowing himself.

(97) " I didn't even know it was a thing, till they said about it."

 Association to saying 'you can't be what you don't see' + (another interviewee) speaking re similar exp. of learning re trans identities by having someone come out in years above him @ school.

Plot so far. I'm just a male, always liked girls like a male, school were really good, they made a whole PowerPoint about it + taught me about it, I didn't even know it was a thing.

Q re- times/events that prompted YP to think about sexuality.

-Again responds with reference to relational aspects of sexuality "I was with someone"

 - 2nd mention of duration (duration redacted). Is this a flex? Showing how desirable he is to others? Trying to remember if it was valued @ school to be in a long relationship, I think it was seen as more 'real'.

Social aspect of sexuality- performance, social currency (104) "A lot of people were getting w/ people" – again sense of romantic/sexual partners, gfs etc. as sort of props.

(105) "saying oh like they've had sex w/ someone"- most salient bit of this characterization of 'people' @ secondary school is the emphasis on the fact that they have had sex, the 'someone' the sex achievement was with seems clearly secondary. YP then specifically mentions "pressure"

"You need a girlfriend" = His internal voice @ this time? – then appears to speak from now as though to younger self "you don't actually need one, it's fine".

 No mention of YP's own sexual feelings here (unlike previous repetition re. "always liking girls") -sense that sex was chiefly social currency? -or embarrassment/privacy on part of YP?