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Exploring well-being, self-harm and suicidality among transgender people

Lisa Ballantyne, BA (Hons), MSc

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DOCTORATE IN CLINICAL PSYCHOLOGY

Chapter 1: Systematic Review

Exploring the nature of gender identity related microaggressions and their relationship with well-being in transgender people:

a systematic narrative review

***Lisa Ballantyne, MSc**

(Keywords: transgender, microaggressions, well-being, implicit bias, systematic review)

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*Address for Correspondence: Academic Unit of Mental Health and Well-being, University of Glasgow, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XY.

E-mail: l.ballantyne.2@research.gla.ac.uk

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Abstract

Microaggressions are described as subtle, implicit communications of prejudice which are experienced by minority group individuals and may adversely affect well-being. Transgender individuals, or individuals whose gender identity is incongruent with their sex assigned at birth, are one minority group who may experience gender identity related microaggressions. The current review aimed to explore the nature of microaggressions toward transgender individuals, and appraise any relationship between microaggressions and well-being within this population. A systematic search of ASSIA, CINHAL, COCHRANE, EMBASE, PBSC, PsycARTICLES, PsycINFO was conducted in June 2020. Grey literature was identified through contacting key researchers and through online database searching of unpublished dissertations/theses. Reference lists of included papers were examined and forward citation completed for key papers. 17 papers were quality assessed and included in the narrative synthesis, encompassing a total of 3432 participants. The findings suggest that transgender individuals experience a range of microaggressive acts, across multiple contexts. A number of additional variables were noted as important when understanding microaggressions within this population; including the individual's gender identity, the perpetrator, the mode of delivery, and frequency. Emerging evidence tentatively suggests a relationship between gender identity related microaggressions and well-being indicators within this population. In particular, negative cognitive, emotional and behavioural responses were noted. Some studies suggested a relationship between microaggressions and negative mental health outcomes, including anxiety, depressive symptoms and suicidality. However, these conclusions should be interpreted with caution, given a number of methodological and conceptual gaps within the literature. Nonetheless, subtle forms of prejudice are an important area for research and clinical consideration within this population.

Introduction

Transgender individuals are those whose gender identity is incongruent with their sex assigned at birth (Vincent, 2018). A spectrum of experiences are generally encompassed by this term including (but not limited to); trans man, trans woman, non-binary, gender fluid, gender non-conforming and genderqueer (Vincent, 2018). Cisgender refers to individuals whose gender identity is congruent with their sex assigned at birth (see Appendix 1.2 for full definitions). Despite growing recognition and moves to de-pathologise trans experiences, cisgenderism and transphobia remain widespread worldwide (Coleman et al., 2011; Bachmann & Gooch, 2018).

Prejudice and Discrimination

The high prevalence of prejudice, discrimination and victimisation towards transgender and gender non-conforming people is well documented (Bachmann & Gooch, 2018; McCann, 2017). Within Britain, a recent report on LGBT lives concluded that 41% of trans people and 31% of non-binary people report past-year experience of at least one hate crime or incident on the basis of their gender identity or expression alone (Bachmann & Gooch, 2018). The Minority Stress Model (Meyer, 2003) has been adapted and applied to capture the stigma-related experiences within the transgender population (Hendricks & Testa, 2012). This framework posits that minority groups (e.g. trans individuals) experience chronic stress resulting from hostile social situations, which has a negative impact on well-being. More specifically, distal (or 'external') stressors (e.g. discrimination, prejudice, victimisation, hate crimes) are highlighted as predisposing minorities to further proximal (or 'internal') stressors (e.g. rumination, expectation of future discrimination/victimisation, hypervigilance, internalised transphobia, concealment) (Meyer, 2003; Hendricks & Testa, 2012).

Transgender individuals are at disproportionate risk of adverse mental health outcomes compared to cisgender individuals including; depression (Borgogna, McDermott, Aita & Kridel, 2019), anxiety (Borgogna, et al., 2019), self-harm (Marshall et al., 2016), suicidality (Marshall et al., 2016; Wolford-Clevenger, Cannon, Flores, Smith & Stuart, 2017), and substance misuse (Glynn & Berg, 2017). The relationship between minority stressors and psychological distress within the trans population has been extensively noted (McCann & Brown, 2017; Clements-Nolle, Marx, & Katz, 2006). Minority stressors such as prejudice, discrimination and perceived lack of social support have also been noted as correlates of both non-suicidal self-injury and suicidality within the trans population (Wolford-Clevenger, Frantell, Smith, Flores & Stuart, 2018). One growing field of research examining how distinct forms of prejudice and discrimination are experienced by minority groups, and their impact on overall well-being, is that which explores microaggressive acts (or microaggressions).

Understanding Microaggressions

Sometimes referred to as 'everyday discriminations'; microaggressions are described as subtle verbal, behavioural or environmental communications which express bias, prejudice or discrimination toward marginalised groups (Sue et al., 2007; Sue 2010). Microaggressions can be either intentional or unintentional, although they are often conceptualised as being distinct from overt forms of discrimination in that the perpetrator is often unaware of the underlying hostile expression or potential for harm (Sue, 2010). Microaggressions are also often subjective, subtle and ambiguous in nature and thus can be challenging to identify (Friedlaender, 2018). Research is yet to explore how microaggressions develop. However,

these acts are generally understood in three categories; microinsults, microinvalidations and microassaults (Sue, 2010).

Microinsults (e.g. “that’s so gay!”) are communications that convey a negative stereotype toward a specific group, whilst microinvalidations (e.g. “all lives matter!”) are described as communications which nullify or dismiss the lived experience of a marginalised group. Microassaults (e.g. displaying a Nazi symbol) are often conscious and explicit communications of a negative attitude or bias toward a marginalised group, and of the three are described as most similar to blatant, overt forms of prejudice and discrimination (Sue, 2010).

Microaggressions and Psychological Well-being

Microaggressions may have a different impact on the well-being of minority groups compared to other forms of discrimination. Perceived discriminations are considered to be more harmful to psychological well-being if they are conceptualised as being pervasive and systemic in nature, as opposed to infrequent or isolated events (Schmitt, Branscombe, Postmes & Garcia, 2014), due to their impact on an individual’s felt sense of control and experience of rejection and social exclusion (Schmitt, et al., 2014; Wirth & Williams, 2009). Microaggressions are one form of perceived discrimination that may be particularly pervasive in nature due to difficulties in both identifying and effectively challenging them (Sue et al., 2007). For example, as microaggressions reinforce social hierarchies, Williams (2020) argues that identified microaggressions often go unchallenged due to the power imbalance between parties. Furthermore, given that microaggressions are predominantly described as

unintentional, this can lead to difficulties in challenging these acts as perpetrators may struggle to engage in meaningful discourse that explores their implicit bias (Nadal et al., 2011; DiAngelo, 2011; Friedlaender, 2018; Williams, 2020). DiAngelo (2011) argues that individuals who challenge racial microaggressions are often met with hostility, defensiveness, and further microaggressions.

The majority of literature exploring microaggressions and their consequences has focused on racial and ethnical microaggressions, and concluded that microaggressions represent a health and mental health risk to racial and ethnic minorities. Racial microaggressions have been found to be significantly correlated with both depressive symptoms and higher negative affect (Nadal, Griffin, Wong, Hamit, Rasmus, 2014), lower self-esteem (Nadal, Wong, Griffin, Davidoff, & Sriken, 2014), and poor psychological well-being (Solorzano, Ceja & Yosso, 2000). Blume, Lovato, Thyken and Denny (2012) highlighted the relationship between microaggressions and both binge drinking and anxiety symptoms among racial and ethnic minority students within predominantly white Colleges.

More recently, a growing body of research has explored microaggressions toward other marginalised groups including; people with disabilities (Keller & Galgay, 2010; Conover, Israel & Nylund-Gibson, 2017), people with ill mental health (Gonzales, Davidoff, Nadal, Yanos, 2015), women (Nadal, Hamit, Lyons, Weinberg & Corman, 2013), marginalised religious groups (Nadal, Griffin, Hamit, Leon, Tobio, Rivera, 2012), people who have been adopted (Garber & Grotevant, 2015), and LGBTQ individuals (Nadal, Whitman, Davis, Erazo & Davidoff, 2016).

Nadal et al., (2016) completed a literature review aimed at providing an overview of existing knowledge of microaggressions towards LGBTQ individuals, and highlighted a wide range of microaggressive acts experienced by this minority group. The authors also noted evidence that transgender individuals experience gender identity related microaggressions, however highlighted that their experiences were often incorporated alongside those of LGBQ individuals within existing literature. Gender identity microaggressions refer to those which express subtle prejudice or discrimination toward transgender individuals due to their gender identity being incongruent with their sex assigned at birth. It is recognised that some transgender individuals may also experience sexual orientation microaggressions, however amalgamating gender identity and sexual orientation minority groups (i.e. LGBTQ) may also limit our ability to draw accurate conclusions regarding trans-specific gender identity related microaggressions.

Review objectives

The current review is the first, to the best of the authors' knowledge, to systematically identify and evaluate the current empirical literature existing around gender identity related microaggressions, well-being, and the transgender population. The review's main aims are to; i) explore the nature of gender identity related microaggressive acts toward transgender people, and ii) explore and determine the evidence of the relationship between these microaggressions and well-being within the transgender population.

Method

The review was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA). The proposed procedures were preregistered with PROSPERO International Prospective Register of Systematic Reviews (CRD42019160392)(Appendix 1.3).

Search Strategy

Scoping searches were completed to determine the feasibility of the research questions. No previous systematic reviews were identified, however key papers that provided an overview of the literature were noted (Nadal et al., 2016; Chang & Chung, 2015). Databases included for electronic searching were chosen based on relevance for the research aims and included: ASSIA, CINHAL, COCHRANE, EMBASE, Psychology & Behavioural Sciences, PsycARTICLES, PsycINFO. The final systematic searches were conducted on 19/06/2020. Searches were limited to papers published in English.

The search strategy was guided by previous reviews which have examined experiences of transgender individuals and/or microaggressions (Wolford-Clevenger, et al., 2018; Lui & Quezada, 2019). Key literature was also searched for alternative key terms (Nadal et al., 2016; Chang & Chung 2015). A subject librarian was consulted on the development of the search strategy. Keywords and indexing terms (MeSH and thesaurus terms) using various combinations included: transgender*, transexual*, female-to-male, male-to-female, androgyn*, TGNC, transmasculine, transman, transmen, transwom*, transfeminine, gender non-conform*, gender minority, gender variant, genderqueer, gender diverse, bigender*, agender*, two-spirit*, genderfluid, gender neutral, non-binary, LGBT*, microaggressi*, microinsult*, microassault*, microinvalidat*, subtle discriminat*, covert discriminat*,

implicit bias, implicit prejudice, subtle prejudice, covert prejudice. See Appendix 1.4–1.10 for full search results.

To improve the sensitivity of the search strategy, forward citation searches of key articles in the area (Nadal et al., 2016; Chang & Chung, 2015) were also examined using Scopus and the reference lists of included studies were hand searched for relevant papers. Grey literature was included to increase the data pool and reduce publication bias. Grey literature was identified through; i) contacting key researchers in the area (via ResearchGate), ii) online database searching of unpublished dissertations/theses (The British Library grey literature for Medical Sciences, ProQuest), and iii) through general search engines (e.g. Google). In instances where a piece of grey literature and a later published piece were both identified, the peer-reviewed article only was included.

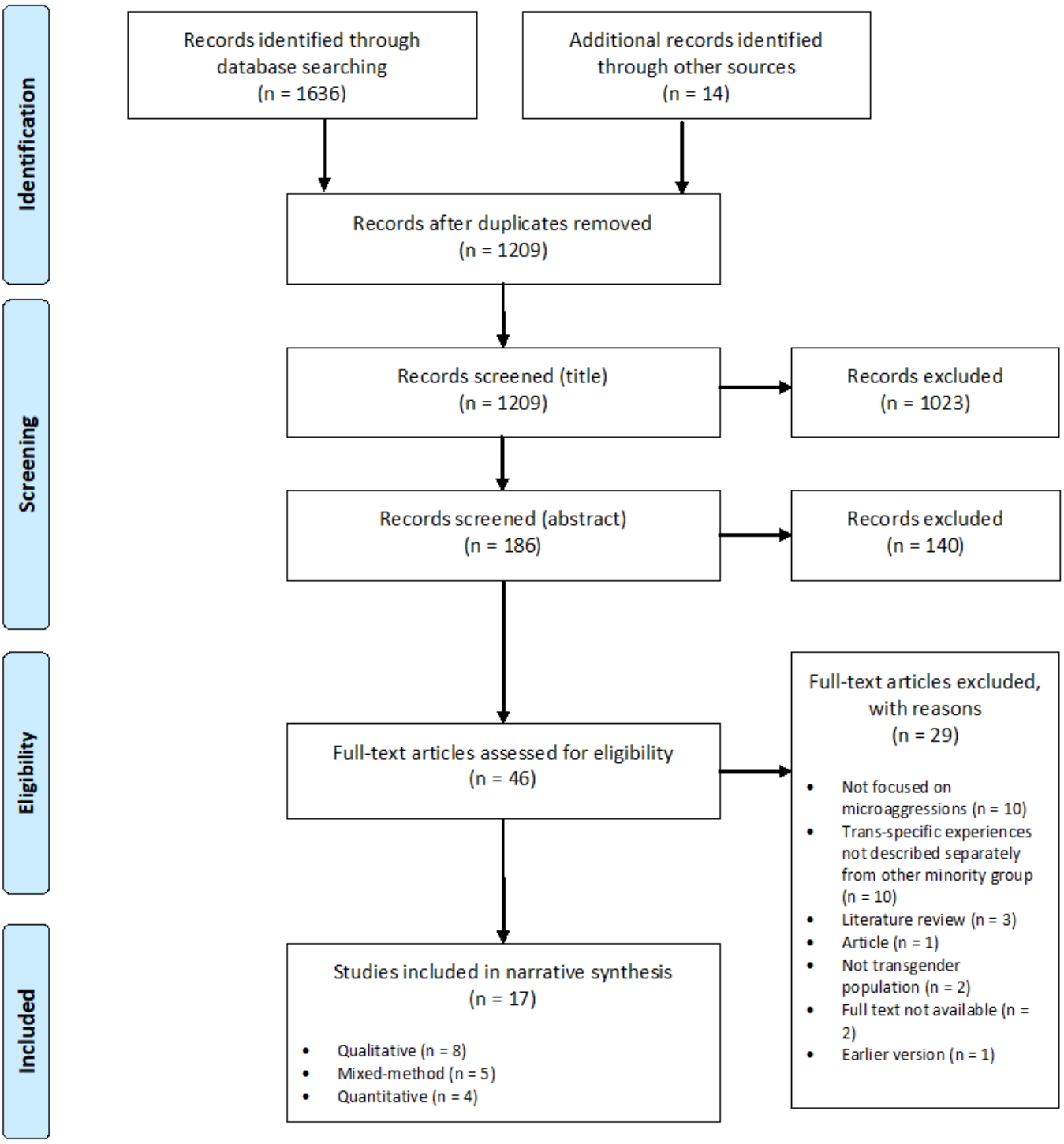
Eligibility Criteria

Studies were included if: i) participants were transgender (defined as people whose gender identity differs from the gender assumed at birth, on the basis of the sex they were assigned), ii) microaggressions (subtle verbal, behavioural or environmental communications which express prejudice or discrimination toward marginalised groups) were the phenomena of interest, iii) the outcome of interest was how microaggressions are experienced by trans people and/or relationship with any well-being indicators, and iv) the study was of qualitative, quantitative or mixed-method design. Studies were excluded if: i) the full-text was not available in English and ii) if trans-specific experiences were not described separately from the overarching LGBT group.

Data Selection

The search yielded 1650 results, of which 441 were duplicates (figure 1). The author screened the titles and abstracts against the inclusion/exclusion criteria, of which 1163 were not relevant to this review. The full-text of 46 studies were reviewed and of these 29 were excluded because they: i) did not focus specifically on microaggressions or looked at prejudice in general (10 studies), ii) did not describe trans-specific experiences separately from LGBT group (10 studies), iii) did not include a transgender sample (2 studies), iv) the full text was not available (2 studies), v) were a review/article (4 studies), or was an earlier version (grey literature) of an included peer-reviewed article (1 study). A total of 17 studies were identified for inclusion.

Figure 1 – PRISMA Flow Diagram



Data Extraction

A data extraction tool (Appendix 1.11) was developed, based on the tool used by Zortea, Gray, & O'Connor (2019), to standardise the process of identifying relevant information from each article.

Quality Assessment

The quality of selected studies was systematically assessed using the Crowe Critical Appraisal Tool (CCAT) (Crowe, 2013) (Appendix 1.12), which allows for appraisal across multiple research designs and has established construct validity (Crowe & Sheppard, 2011). The tool consists of eight categories on reporting and methodological issues including; preliminaries, introduction, design, sampling, data collection, ethical matters, results and discussion. A total score for each category is obtained (6-point scale; 0-5), and a further total score (%) is obtained for each paper. Prior to appraisal, it was determined that for the purpose of quality rating a total score of 0-50% would be considered poor, 51-75% moderate, and 76-100% good. A second researcher independently rated a number of papers (23.5% or n=4) to reduce risk of bias. Inter-rater reliability for the categories was moderate (Cohen's Kappa = 0.5)(McHugh, 2012); all category scores (0-5) were within 1 point. There was no disagreement between any study quality overall (poor/moderate/good). Discussion took place until agreement on ratings was reached.

Data Synthesis

Group-level data were synthesized using an integrative narrative synthesis. This approach was chosen due to the inclusion of diverse study designs/aims and the resulting heterogeneity of data. In line with recommended guidance (Popay et al., 2006), a number of

key principles were adhered to and included: i) a synthesis of included studies, to give a narrative overview of what research exists on microaggressions toward trans people, ii) an exploration of the relationship within and between studies, looking at how microaggressions are experienced by trans people and the nature of the relationship with general well-being and microaggressions within this population, and iii) a critical reflection and assessment of the robustness of the review. For ease of expression, studies are first numbered within the results (see Table 1) and referred to as such throughout the synthesis. Individual authors/author teams are then used within the discussion.

Results

The results of this systematic narrative review represent the key insights and findings from the current literature existing around microaggressions toward transgender populations, as detailed in Table 1.

Quality Appraisal of Studies

The levels of quality were critiqued using the CCAT, with only 17.6% (n=3) of studies rated as 'good' (see Table 2). As per CCAT guidance, the ratings for each of the 8 categories for each paper are reported (see Appendix 1.13). Only one of the 17 studies was rated as having a high quality design (study 5), while the majority had a moderate design (n=13). Almost half of the studies (n=8) were rated as poor in relation to ethical matters. Reported effect sizes, where applicable, are noted in Appendix 1.15.

Study Characteristics

Seventeen articles were eligible for inclusion; eight qualitative (studies 2, 6, 7, 8, 10, 13, 14, and 15), four quantitative (studies 3, 9, 12, and 16), and five mix-method studies (studies 1, 4, 5, 11, 17). All studies were of cross-sectional design. Only one of the studies used a control group (matched, randomised) to compare outcomes in presence/no presence of microaggressions (study 1). Fifteen articles were published in peer-reviewed journals (studies 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, and 17) and two were unpublished grey literature (studies 1 and 5). All included studies were completed in the past decade, with over half (n=9) being completed within the past two years. All studies originated from the USA (n=14) or both the USA and Canada (n=3). Across the studies, microaggressions were loosely defined as subtle, verbal, behavioural or environmental indignities that communicate hostility or discrimination toward trans individuals, in line with Sue (2010) definition of racial microaggressions. Study 7 provided a taxonomy of transgender microaggressions which many of the studies used as frameworks for their interview schedule/survey or to interpret their findings (see Appendix 1.14 for full details of taxonomy).

Sample Characteristics

Two of the mixed-method articles retained the same sample across each study component (studies 1 and 4). Two mixed-method articles from one author team included the same study as their qualitative component (studies 11 and 12) and so these qualitative results and sample are only discussed once. Two articles (studies 7 and 8) used the same sample (n=9) however were included and discussed separately as they focused on different aspects of the findings. Therefore the number of samples across 17 papers was 19 (n=3432 participants).

The mean age was 25.6 years (based on 11/19 samples reporting mean age) and sample age range was 14-82 years (based on 13/19 samples reporting). Samples differed in the gender identities included; eleven included a range of transgender identities that encompassed both binary and non-binary identities (57.9%), three included only binary gender identities (15.8%), one study focused specifically on non-binary and gender non-conforming (5.3%) identities, while one reported only that individuals were transgender (5.3%), three samples included transgender individuals and cisgender/other gender individuals although outcomes were described separately (15.8%).

Table 1. Detail of Studies and Summary of Results

	Author (year), country	**Quality assessment**	**What the study examined**	**Design**	**Methodology**	**Participants** *(self-identified gender)*	**Age (years)**	**Brief Summary of results**
1	AuBuchon (2019) **(†G),** USA	Moderate	Microaggressions (MA) and social exclusion	Mixed-method	Quantitative Basic Needs Satisfaction, Ostracism definition items, Relational evaluation items	Total *n*=32 *(trans male(11), transmasculine(2), male(1), demiboy(1), trans woman(6), female(1), nonbinary(6), genderqueer(2), polygender(1), agender(1))*	18-66 *(M=22.5, SD=4.29)*	Participants reliving MAs reported significantly lower relational value, lower satisfaction of their basic needs being met, and higher rating of ostracism than control group. Experiencing 'macroaggressions' (defined as microassaults) individually, or in conjunction with microaggressions (defined as microassaults and microinsults), both resulted in lower relational value than only microaggressions.
					Qualitative Written recall, grounded theory			Researchers could not reliably identify which specific type of MA individuals were describing due to overarching similarities. Suggested microinvalidations and microinsults grouped as 'microagggressions (covert)' and microassaults grouped as 'macroaggressions (overt)' (76% intercoder reliability)
2	Austin et al., (2019) USA/Canada	Moderate	MA in social work education	Qualitative	Survey responses, grounded theory	Total *n*=97 *(trans men(29), trans women(9), other trans(25), no gender categories(19), man(16))*	19-69 *(†NR).*	Six themes: 1) structural oppression, 2) cisgender and heteronormative privilege, 3) faculty lack of awareness, 4) visible discomfort, 5) pervasive nature of transphobia 6) social exclusion. Impact on well-being including negative emotional responses and impaired learning.
3	Austin et al., (2020) USA/Canada	Moderate	Suicidality in trans youth and role of interpersonal factors	Quantitative	Online survey, Logistic regression	Total *n*=372 *(trans man(332), nonbinary/gender fluid (122) , man(42), trans woman(35), woman(12), demiboy(4), transgender(1), other(3), agender(4), two-spirit(2))*	†NR *(M=15.99), SD=1.23)*	Interpersonal MAs was the only variable (of 9 interpersonal factors) found to significantly contribute to lifetime suicide attempt. Interpersonal MAs and environmental MAs not associated with past 6-month suicidal ideation.
4	Galupo et al., (2014)	Moderate	MA in friendships	Mixed-method	Quantitative Self-report (online	Total *n*=207 *(transfeminine(101), transmasculine(27.5),*	18-65 *M=31.5, SD=12)*	Frequency and impact of MA differ across sexual orientation and gender identity of the friend.

	USA				survey) frequency and severity of MA across friendships.	*gender variant(38), agender (11))*		
					<u>Qualitative</u> Self-report (online survey) open-ended questions targeting MA			Friendship context and identities of the friend (sexual orientation and gender identity) influenced the way MA were received and interpreted by participants.
5	Howe (2019) **(†G)**, USA	Good	Identity-related MA	Mixed-method	<u>Quantitative</u> Online survey, Logistic regression	Total *n*=225 *(Trans woman(137), trans man(88))*	*(†*NR*).*	Increased frequency of identity-related MA associated with higher levels of negative emotions (transgender identity defence-related emotions (TIDE) and suicidality. Media-based has similar or higher distress than real-life MA.
					<u>Qualitative</u> Interviews, grounded theory	Total *n*=66 *(Trans woman(40), trans man(23)), gender queer (3))*	(†NR).	Four themes: 1) self-management of reactions to MA as exhausting 2) MA from media experienced as worse than interpersonal MA 3) denial of existence as taxonomy of MA 4) empathy for own transgender community and resilience
6	Morris et al., (2020) USA	Moderate	MA in therapeutic relationships.	Qualitative	Online survey responses, thematic analysis	Total *n*=91 *(transfeminine/trans woman(32), Transmasculine/trans man(21), genderqueer/fluid(15), man(8), woman(5), agender(5), gender non-conforming(4), bigender (1))*	18-62 *(M=27.9, SD=9.8)*	Four themes: 1) lack of respect for client identity, 2) lack of competency, 3) salience of identity, 4) gatekeeping. Discussed as ethical violations.
7	Nadal et al., (2012), USA	Moderate	Interpersonal and systemic MA	Qualitative	Focus groups, directed content analysis	Total *n*=9 *(trans men(3), trans women(6)).*	21-44 *(M=29.2, SD=6.46)*	Twelve types of MA: 1) use of transphobic and/or incorrectly gendered terminology, 2) assumption of universal transgender experience, 3) exoticization, 4) discomfort/disapproval of transgender experience, 5) endorsement of gendernormative and binary culture/behaviours, 6) denial of transphobia, 7) assumption of sexual pathology/abnormality, 8) physical threat/harassment, 9) denial of individual transphobia, 10) denial of bodily privacy, 11) familial MA, 12) systemic and environmental MA.

8	Nadal et al., (2014), USA	Moderate	Responses to MA.	Qualitative	Focus groups, directed content analysis	Total *n*=9 *(trans man(3), trans women(6))*	21-44 *(M=29.2, SD=6.46)*	A range of emotional (e.g. anger, betrayal, distress, hopelessness), behavioural (e.g. confrontation, passive coping) and cognitive (e.g. rationalising others discrimination, increased beliefs about own resilience) responses are discussed.
9	Nadal et al., (2018) USA	Poor	Piloting of Gender Identity Microaggression Scale (GIMS) (study 3)	Quantitative	Questionnaire, Factor analysis	Total *n*=160 *(trans men(52), trans women(53), genderqueer or non-binary(55))*	18-82 *(M=31.9, SD=10.09)*	The GIMS (Cronbach's alpha of .76) yielded five components: 1) denial of gender identity, 2) misuse of pronouns, 3) invasion of bodily privacy, 4) behavioural discomfort, 5) denial of societal transphobia. Cronbach's alpha across subscales ranged from medium to strong.
10	Pitcher (2017) USA	Poor	Academics experiences of MA.	Qualitative	Semi-structured interviews, thematic analysis	Total *n*=10 *(transgender(10))*	†NR	3 types of MA: (mis)recognition (including misgendering and mispronouning), being an impossible person, and tokenisation. Resisting MAs through refusal as coping strategy.
11	Parr et al. (2019) USA	Good	Heterogeneity of MA and relationship with depressive symptoms and suicidality	Mixed-method	<u>*Qualitative*</u> Focus group, directed content analysis	Total *n*=36 (*transgender(14), other(22))*	14-55 **(**†NR)	43 specific identity nonaffirmation or denial microaggression events. Of the events described, 67% related to public questioning of identity, 44% to denial of transgender identity, 16% to identification by others as psychologically abnormal, and 14% to bodily objectification. Participants described social and emotional withdrawal as a result.
					<u>*Quantitative*</u> Online survey, Logistic regression, self-report social and emotional responses, SBQ-R	Total *n=402* (total N trans was considered 182/only binary trans) (*trans male/man(107), trans female/woman(75), cisgender (128), genderqueer/gender-nonconforming(44), other (48)*	†NR	Increased weekly frequency of non-affirming transgender MAs associated with increased odds (220-240%) of past year depressive symptoms (sadness, hopelessness, withdrawal from social activities), greater odds (150%) of past year suicidal ideation, and greater odds (220%) life-time suicidality (ideation and attempts). These odds are further increased (230-525%) when emotional intensity is incorporated. Increased frequency of MAs which result in weariness or apathy, or those that result in decreased interest in social engagement, are associated with greater odds of past-year depressive symptoms and suicidal ideation.
12	Parr et al. (2020) USA	Good	Factors associated with experience of MA	Mixed-method	<u>Qualitative</u> Included in previous study	See study 11.		
					<u>Quantitative</u> Online survey, Multiple linear	Total *n*=224 *(trans women(136), trans men(88)*	14-65 (†NR)	Lower degree of passing and lower income associated with higher frequency of MA. Older age associated with lower frequency of MA.

					regression			
13	Pulice-Farrow et al. (2017), USA	Moderate	MA in friendships.	Qualitative	Online survey, thematic analysis	Total *n*=221 *(trans feminine(60), trans masculine(100), gender non-conforming(38), agender(13))*	18-65 *(M=31.6, SD=12.6)*	Three themes: 1) authenticity, 2) visibility, and 3) negotiation of identity in social context. Differences were noted in how each of these 3 themes may be experienced based on an individual's gender identity.
14	Pulice-Farrow et al., (2017), USA	Moderate	MA in romantic relationships.	Qualitative	Online survey, Thematic analysis	Total *n*=223 *(trans feminine(21), Trans masculine(64), gender nonconforming 80), agender(65))*	18-60 *(M=23.3, SD= 6.7)*	Four themes: 1) minimizing identity; 2) gendered expectations; 3) public negotiation of transgender identity/relationship, 4) relationship trajectories.
15	Pulice-Farrow et al., (2019), USA	Moderate	MA in romantic relationships.	Qualitative	Online survey, thematic analysis	Total *n*=390 *(gender non-conforming(200), agender(190))*	18-54 *(M=21.1, SD=4.5)*	Three main themes: 1) identity parsing, 2) binary assumptions, 3) transition-dependent.
16	Seelman et al., (2017) USA	Moderate	Victimisation, MAs and psychological distress	Quantitative	Rosenburg Self-Esteem Scale(adapted), Perceived Stress Scale, Generalised Anxiety Scale.	Total *n*=497 *(transgender(72), cisgender(421), unclear(4))*	18-61 *(M=24, SD=†NR)*	MA significantly associated with lower self-esteem, greater stress and anxiety in transgender students.
17	Woodford et al. (2017), Canada/USA	Moderate	MA on college campuses.	Mixed-method	<u>*Quantitative*</u> Various measures of environmental MA, PHQ-9, Self-report past year suicide attempt, and academic performance	Total *n*=152 *(genderqueer, transgender, other identity, two-spirit)**	†NR *(M=23, SD=2.79)*	Sig. positive relationship between environmental MA and developmental challenge. Correlation between suicide attempt and environmental MA (failed to maintain sig when additional variables added). Sig. negative relationship between various environmental MA and positive outcomes (social acceptance, perceived accepting attitudes, academic and intellectual development, satisfaction, and perceived affirming attitudes).
					<u>*Qualitative*</u> Interviews,	Total *n*=18 *(genderqueer(5),*	†NR	3 environmental MA; 1) gender-inclusive bathrooms, 2) gender-binary forms, 3) gender-binary housing.

					analysis †NR	*transgender(6), trans man(3), other(4))*		

†G = Grey literature, †NR = Not reported, * unclear *n* of each identity represented

Main Findings

The key insights relating to the nature of trans-specific microaggressive experiences are summarised below in terms of three broad microaggression elements: their content, the environmental and interpersonal contexts within which they occur, and factors which may impact their frequency or intensity. Findings relating to a relationship between microaggressions and well-being within the trans population are then explored.

Content of Microaggressions

A total of 10 studies specifically aimed to explore and describe the content of gender identity microaggressions experienced by transgender individuals (studies 2, 7, 5, 6, 10, 11, 13, 14, 15, and 17). Three of these 10 studies highlighted that microaggressions experienced may differ in terms of content between different trans identities (studies 7, 13, and 14).

Interpersonal microaggressions included; use of transphobic language (study 7), misgendering or misuse of pronouns (studies 2, 6, 7, 10, and 13), assumption of universal transgender experience (study 7), exoticization/tokenisation (studies 6, 7, 10, and 13), discomfort/disapproval of transgender experience (studies 2, 7, and 15), endorsement of gendernormative and binary expectations/behaviours (studies 2, 7, 14, and 15), denial of existence of transphobia (study 7), assumption of psychopathology or sexual abnormality (studies 7 and 11), physical threat/harassment (study 7), denial of individual transphobia (study 7), denial of bodily privacy (studies 7 and 11), transgender identity-denying or non-affirming communications (i.e. those that question, minimise or dismiss the authenticity of transgender individuals identities) (studies 5, 6, 7, 10, 11, 13, 14, and 15), involuntary gender disclosure/violation of privacy or public questioning of identity (studies 2, 11, and 13),

passive rejection within social contexts based on gender identity or presentation (inc. within relationships were gender identity was accepted in private contexts) (studies 2, 13, 14, and 15), failing to correct transphobia (study 14), and overemphasis on gender identity (study 6).

Systemic and environmental microaggressions found included; non-inclusive binary forms (studies 2 and 17), difficulty accessing of safe and inclusive bathrooms (studies 2, 7, and 17), absence of protocols that allow for the use of gender-inclusive language (study 2), lack of competence/knowledge regarding transgender issues within systems (studies 2 and 6), absence of gender-inclusive housing on campuses (study 17), gatekeeping to health services (study 6), non-affirming policies and practices within systems (i.e. workplaces, healthcare, criminal justice, barriers to changing legal documents) (studies 7 and 10).

One quantitative study (study 9) used qualitative data from a previous study (study 7), to compile and initial pilot a quantitative measure of transgender microaggressions; the Gender Identity Microaggressions Scale-Initial (GIMS-Initial). The validity across five subscales (denial of gender identity, misuse of pronouns, invasion of bodily privacy, behavioural discomfort and denial of societal transphobia) was strong (Cronbach's alpha =.76), however methodological limitations applied.

Context in which Microaggressions Occur

Microaggressions are experienced across various interpersonal and environmental contexts. Nine studies in this review investigated microaggressive experiences in general everyday situations (studies 1, 3, 5, 7, 8, 9, 11, 12, and 16). A total of four studies found

microaggressions are experienced within close interpersonal relationships; including within close friendships (studies 4 and 13) and within romantic relationships (studies 14 and 15). One study found that transgender individuals experience microaggressions within therapeutic relationships (study 6). Three studies found microaggressions occur within education and academic settings (studies 2, 10, and 17), however the scope and aims of these studies varied. Two of these studies described student's experiences; one found that interpersonal and environmental microaggressions were experienced in Social Work programmes (study 2) and one found evidence of environmental microaggressions within Colleges in general (study 17). The third study found that microaggressions are experienced by trans academics in their workplaces (study 10).

Frequency and Intensity of Microaggressions

Microaggressions experienced by trans individuals in general are diverse in both content and context. Similarly, a number of studies also discussed variations in the frequency of trans-specific microaggressions (studies 1, 4, and 12). Two studies investigated factors associated with the frequency by which a transgender individual may experience microaggressions (study 4 and 12). Lower income and lower level of self-reported degree of 'passing' were associated with increased frequency of experienced nonaffirming microaggressions (on average, per week), whilst older age was associated with lower frequency (study 12). Adolescents (aged 14-16) may experience the highest frequency of microaggressions, whilst race/ethnicity was not associated with frequency (study 12). Interpersonal microaggressions are experienced more frequently by trans people within their friendships with cisgender and heterosexual people, followed by cisgender LGBTQ friendships, and lastly (and least frequently) within friendships with other trans individuals

(study 4). Notably, over a third (36%) of a control group of trans individuals who were asked to recall the Wednesday of the previous week (as opposed to experimental group who were asked to recall a microaggression) also described experiencing at least one microaggressive act (study 1).

Five included studies suggested that the intensity of emotional responses to microaggressions may differ based on the perpetrator (studies 4, 13, 14, and 15) and method of delivery (study 11). Interpersonal microaggressions are described as more hurtful when the aggressor was considered a close friend (studies 4 and 13) or a romantic partner (studies 14 and 15). Moreover, self-reported intensity of negative affect is higher in response to interpersonal microaggressions when the friend/aggressor is considered to have a similar gender identity/sexual identity to the victim (study 4). Two studies found that media based non-affirming microaggressions (both traditional and social media) evoke higher emotional responses than interpersonal events (study 5 and 11). Types of microaggressions (microinvalidations and microinsults vs microassaults), although notably hard to categorise, may vary in their impact on feelings of social exclusion (study 1).

Relationship between Microaggressions and Well-being

A number of studies aimed to qualitatively explore and described consequences of experiencing microaggressions. Five studies noted various emotional responses including; betrayal (studies 4 and 8), distress (studies 8 and 17), hopelessness and exhaustion (studies 5, 8 and 11), rejection (study 4), feeling invalidated and misunderstood (studies 4, 8, and 17), disappointment (study 4), feeling uncomfortable (studies 4 and 17), feeling worn

down/apathetic (study 11), empathy for other trans individuals (study 5). Four studies noted behavioural responses including; direct confrontation (study 8), indirect confrontation (studies 8 and 10), passive coping (studies 4, 8 and 11) and adaptive/creative responses (e.g. activism) (study 17). One study noted cognitive responses including; rationalisation, double bind/'balancing act' and, vigilance and self-preservation (study 8). Two studies discussed changes to interpersonal functioning including; withdrawal from social interaction (study 11), and distance within or ending of interpersonal relationships (study 4). Although not specifically investigated, a further five qualitative studies touched on negative emotional (studies 2, 6, 13, 14, and 15), behavioural (study 6), and cognitive (study 15) responses to experiencing microaggressive acts within their participants accounts. Similarly, the ending of interpersonal relationships in response was also noted (studies 13 and 14)

A further 6 studies included quantitative measures of the impact of microaggressive acts on the well-being of trans individuals including; self-esteem (study 16), stress (study 16), anxiety (study 16), depressive symptoms (studies 5, 11 and 17); suicidality (studies 3, 5, 11 and 17) and academic functioning (study 17). Higher levels of microaggressions experienced were associated with lower self-esteem, greater perceived stress and greater anxiety symptoms (study 16). Microaggressions also contributed to feelings of social exclusion (e.g. lower relational value, lower satisfaction of basic needs being met, and higher rating of ostracism)(Study 1). Environmental microaggressions specifically were associated with poorer academic development and lower perceptions of social inclusion, but are not independently associated with depressive symptoms (study 17). Two related mixed-method studies conceptualised transgender identity-related stress (or trans-identity defence related emotions (TIDE)) (studies 5 and 11). Study 5 describes how trans individuals may need to defend the validity of their identity within the context of societal non-acceptance/experiences

of non-affirming microaggressions, which results in subsequent negative affect and emotional compromise.

Increased weekly frequency of non-affirming transgender microaggressions (interpersonal and media based) are associated with increased odds of past year depressive symptoms, past year suicidal ideation, and life-time suicidality (ideation and attempts) (study 11). In particular, increased frequency of microaggressions which result in weariness or apathy are associated with greater odds of past-year depressive symptoms and suicidal ideation (study 11). Trans individuals with higher transgender identity defence-related emotions (TIDE) scores, as a consequence of experiencing non-affirming microaggressions, have higher rates of societal disengagement, emotional withdrawal and engagement in suicide-related behaviours (study 5). Interpersonal microaggressions uniquely contribute to lifetime suicide attempts for trans youth (when compared to other psychosocial risk factors), but are not significantly associated with past 6-month suicidal ideation (study 3). Environmental microaggressions are not associated with suicide attempt (studies 3 and 17), or past 6-month suicidal ideation (study 17).

Discussion

The current review aimed firstly to explore the nature of microaggressive acts toward transgender people. Unsurprisingly, included studies suggest that transgender individuals do experience gender identity related microaggressions across a number of contexts. A second aim was to explore and determine the evidence of the relationship between microaggressions and well-being within the transgender population. Emerging evidence tentatively suggests a

relationship between microaggressions and well-being, with experiencing microaggressive acts as potentially having a negative impact on the well-being of transgender individuals. However, these conclusions should be interpreted with caution, given a number of limitations within the existing literature base.

Nadal et al. (2012) were the first to extend previous literature examining microaggressions toward LGBTQ people to explore trans-specific experiences. Prior to this, our knowledge of transgender individuals' experiences of microaggressions were amalgamated with sexual minority cisgender people's experiences (Nadal, Rivera, Corpus & Sue, 2010) and thus our ability to draw accurate conclusions of trans-specific experiences was significantly limited. For transgender individuals, these subtle, everyday communications of discrimination are diverse in content and can be experienced across multiple contexts including within friendships, intimate relationships, therapeutic relationships, workplaces and academic settings. Despite the current findings, our ability to accurately draw conclusions regarding the nature of gender identity related microaggressions remains limited for a number of reasons, including methodological limitations within existing studies and conceptual gaps within microaggression theory more generally.

Transgender individuals' experiences are not homogenous; they are informed by a number of different factors, such as gender identity, stage of transition, degree of 'passing' (i.e. degree to which they are perceived by others as the gender they identify with) and assigned sex (Chang & Chung, 2015; Levitt and Ippolito, 2014). Chang and Chung (2015) previously cautioned that the complexity of transgender identities may influence how microaggressive acts are experienced by trans individuals. In line with these concerns, the results suggest

qualitative differences in microaggressions experienced by non-binary and gender non-conforming identities when compared to binary identities. Similarly, differences were also highlighted across binary identities (transman/transwoman), and self-reported level of 'passing' was associated with a decreased frequency of microaggressions. Therefore, despite several included studies seeking to identify and describe microaggressions experienced by the transgender population, our current knowledge of gender identity microaggressions may lack depth due to samples often including a diverse range of transgender identities. Similar concerns have been raised in existing racial microaggression literature, which often does not account for differences in racial groups or variations in visibility of minority status (Derthick, David, Saw and Okazaki, 2014). It is recognised that inclusive transgender research which encompasses the range of gendered experiences is imperative; however future studies should also hold in mind the heterogeneity of transgender identities when considering their sampling.

The vast majority of the research literature adding to our understanding of trans microaggressions comes from qualitative methodologies, which facilitate the gathering of rich insights into individuals' lived experiences and how they make sense of particular phenomena (Hammarberg, Kirkman, & Lacey, 2016). Nonetheless, these methods are not without limitations, such as relying on participants self-report and researcher's own interpretations which can both be subject to bias. For example, included studies often first provided participants with definitions of microaggressions before asking for their experiences of such and their emotional reactions, thus automatically confirming the studied phenomenon. Alternatively, researchers interpreted participants' accounts of general lived experiences in line with a definition of microaggressions held in mind. However, this latter approach then relies further on the researchers' own assumptions of what those experiences

entailed for both the individual and the perpetrator. Microaggressions are complex and subjective in nature: what one individual may appraise as a microaggressive act, others may not, thus they may not experience similar reactions or responses. The subjectivity of microaggressions in general may exacerbate these methodological limitations, inherently making it a challenging area of research (Lilienfeld, 2017).

Lilienfeld (2017) cautioned that due to substantial research exploring racial microaggressions and their impact, that subsequent areas of research within minority populations may assume more construct validity than current literature would suggest. One conceptual gap within microaggressions literature in general is discerning microaggressive acts, particularly microassaults, from overt prejudice (Lilienfeld, 2017; Wong et al., 2014). Certainly, at times included studies described microaggressions which could be conveyed as more overt forms of prejudice and discrimination: Pitcher (2017) for example, described trans academics being fired for their trans status within participants accounts. Similarly, Morris et al., (2020) described overt hostility from clinicians and mental health services being unable to meet trans individuals needs as microaggressions. AuBuchon and colleagues (2019) were unable to reliably code participant's accounts of transgender microaggressive experiences into the three distinct types of microaggressions: microassaults, microinvalidations and microinsults (Sue, 2010) due theoretical similarities and common co-occurrence. Included studies tended to focus instead on overarching interpersonal and environmental categories of microaggressions.

With regard to well-being, emerging evidence suggest a relationship between microaggressions and negative well-being outcomes within the transgender population. Negative emotional, behavioural, and cognitive responses to microaggressions were noted

throughout included studies, in addition to negative mental health outcomes including increased anxiety, depressive symptoms and suicidality. Microaggressions may also disrupt social support and academic learning. These findings are in line with existing research exploring the impact of microaggressions within other minority groups (Parr & Howe, 2019; Nadal et al., 2014; Wang et al., 2014; Wong et al., 2014). Some adaptive coping strategies in response were also reported, such as becoming involved in activism. A number of variables were also indicated as important to consider when evaluating the impact of microaggressions on well-being, such as aggressor, frequency, method of delivery (e.g. media vs interpersonal), and type of emotional response (e.g. defence-related stress/emotions). However the aforementioned complexities of defining and measuring microaggressions remain, and again limit our ability to draw definitive conclusions.

Additionally, it remains unclear how transgender microaggressions differ from, or may fit within, other models of discrimination or minority stress. Howe (2019) concluded that microaggressions that deny that trans people exist (gender identity non-affirming microaggressions), described as an emotional trauma, should be considered a specific minority stressor within the minority stress model (Meyer, 2003). However further research is required to support these findings. Similarly, the processes which may mediate any relationship between microaggressions and well-being or mental health outcomes remains largely unknown.

Methodological Limitations and Recommendations for Future Research

The discussion above has pointed to a number of methodological limitations which future research should seek to minimise, including the potential for bias within study designs, the amalgamation of trans identities with samples, and conceptual gaps in how microaggressions are defined and measured. The current review did not identify any validated quantitative measures of microaggressions with the trans population. Nadal et al. (2018) did however pilot a measure (the GIMS), although notably this is based on the findings from a study with a number of methodological limitations (Nadal et al., 2012) and further research is required to fully investigate the reliability and validity of this measure.

All of the studies originated in the USA or Canada and so it unclear how they may generalise worldwide. Similarly, individuals of white ethnicity and those with binary gender identities were over-represented across the studies. Samples were mainly from online LGBT groups, where participants may have had more access to support and resources to understand or cope with microaggressions. There remain important areas yet to be explored, such as microaggressions with family contexts and healthcare settings, or preferred coping mechanisms. Longitudinal studies may help identify the cumulative effects of microaggressions or their impact over time.

Review Limitations

The current review is the first to systematically explore and synthesise the existing literature examining microaggressions within the transgender population, and thus a wide scope of studies with varying experimental designs and aims were included. However this

then presented a challenge of synthesising and describing diverse results from mixed-methods literature. Therefore our ability to describe the results in detail, beyond a narrative, was limited. Similarly, the inclusion of multiple gender identities across the included papers also limits the generalisability of the results and conclusions discussed within the current review.

Microaggressions are a relatively new concept and so there are potentially a number of studies which the search strategy would not have identified due to the authors not defining the explored experiences as subtle prejudice or microaggressions. For example, studies exploring the impact of individuals not using a trans persons chosen name could perhaps be considered, in line with the concept of microaggressions, as describing the impact of a specific non-affirming interpersonal microaggression. It is recognised that individuals can have multiple minority identities, although the current review did not explore intersectional microaggressions that transgender people may experience.

Clinical Implications

Clinicians should be aware of how they themselves may express microaggressions towards transgender individuals and utilise their own supervision structures to explore and reflect on their own implicit biases. Due to the power differences that maintain microaggressions and the negative impact that challenging these may have on minority individuals, clinicians should aim to explore and correct any microaggressive acts/communications they witness. In general, transgender individuals and their needs shouldn't be unfamiliar to those providing care; clinical services should be staffed by individuals who have a clear understanding of the lived experiences of transgender individuals and how forms of prejudice, including microaggressions, can impact on their

well-being and mental health outcomes. Discussing microaggressive experiences during assessment may help to identify important risk factors, particularly given the suggested relationship between microaggressions and suicidality.

Systemic and environmental microaggressions are likely to be encountered within wider healthcare and education systems. Action should be taken at a systemic level to not only reduce these everyday experiences (e.g. use of trans-affirmative and gender-inclusive language within practice (i.e. people who menstruate), removal of gender-binary forms, access to comfortable bathrooms), but actively promote the rights of transgender individuals (e.g. increased access to gender-affirming healthcare, providing trans-inclusive education and training, transgender voices represented throughout healthcare and within decision making roles, funding further clinical research). Wider policy reform that challenges prejudice and discrimination towards trans individuals will help to maintain momentum towards trans-inclusive systems, particularly in the face of cisgender individuals who continue to use their position of privilege and wide reaching platforms to express and 'legitimise' prejudice towards the transgender population.

Conclusions

The current review suggests transgender individuals may experience a wide array of microaggressions, across a number of interpersonal and environmental contexts. Emerging evidence of a relationship between microaggressions and negative consequences for well-being was noted. However, these conclusions should be interpreted with caution, due to limitations within included studies and gaps within existing literature. Despite this, it is

important to continue to draw attention to and investigate subtle, implicit forms of prejudice within psychological research. The relevance of this research within the trans population is clear. In light of increasing visibility of transgender people within society and subsequent 'debate' around transgender individuals' (*human*) rights, this research becomes increasingly imperative. Therefore future studies should seek to address the discussed limitations within existing literature, in order to increase scientific rigour and confidence in the validity of findings. In turn, this will lead to increasingly robust policy and clinical practice recommendations aimed at improved outcomes for trans individuals.

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University of Glasgow

Institute of Health & Wellbeing

DOCTORATE IN CLINICAL PSYCHOLOGY

Chapter 2: Major Research Project

"Why is this not an emergency?": a qualitative exploration of self-harm and suicidality among transgender people

***Lisa Ballantyne, MSc**

(Keywords: transgender, suicide, self-harm, qualitative, lived experience)

Submitted in partial fulfilment of the requirements for the degree of

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*Address for Correspondence: Academic Unit of Mental Health and Well-being, University of Glasgow, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XY.

E-mail: l.ballantyne.2@research.gla.ac.uk

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Plain English Summary

Background: Transgender individuals are those whose gender identity is different from their gender that was assumed at birth. Transgender individuals are at a much higher risk of suicidality and self-harm than the general population. Suicidality refers to thoughts about ending one's life, plans to do so, and actual attempts. Self-harm refers to self-inflicted damage to one's body, which is not related to a desire to end one's own life. For many, self-harm is a means to help cope with difficult emotions.

Aim: This study aimed to explore transgender peoples' experiences of self-harm and suicidality, and how they make sense of these experiences. We sought to uncover factors which may contribute to, or decrease, risk of self-harm and suicidality among transgender people. We also hoped to expand our understanding of how transgender people seek help when experiencing suicidal distress.

Method: A small number of transgender adults (n=4), who report a history of self-harm or suicidality, took part in semi-structured one-on-one interviews. Interviews were recorded, transcribed and then analysed.

Results: Various patterns emerged in participants' accounts of their lives. Participants spoke about early relationships and experiences that increased their self-harm and suicidal distress, and the motives underlying these thoughts and behaviours. Some participants reported that their self-harm and suicidal distress reduced as the strategies that they found helpful to cope, increased. However additional stressors, such as prejudice and discrimination, continued to threaten participants' psychological well-being and may reduce the likelihood that they will seek help when experiencing suicidal distress.

Conclusion: Participants described a range of patterns and experiences across various stages of their lives. These important insights may help inform risk management and clinical interventions.

Abstract

Purpose: Transgender individuals are substantially more likely to report self-harm and suicidality than both cisgender individuals and other LGBT individuals. The psychosocial factors underlying self-harm and suicidality within the trans population, and how they may lead to suicidal ideation or attempts, remain largely under-researched. Protective factors, such as resilience and help-seeking may help to reduce risk of suicide within the trans population, however further research is required to examine these processes. Similarly, exploring trans-specific experiences of help-seeking for suicidal distress is important when considering suicide prevention. Further empirical research, aimed at improving our understanding and prevention of suicide within this population, is imperative.

Method: A qualitative design was used. Semi-structured interviews were conducted with transgender adults (n=4) in Scotland, who reported a history of self-harm and/or suicidality. Interviews were analysed using Interpretative Phenomenological Analysis (IPA).

Results: Four superordinate themes emerged, each with inter-related subordinate themes. 1) "Early Experiences": How individuals made sense of early experiences which increased their self-harm and suicidal distress. 2) "Intent": The motives underlying participants' self-harm and suicidality. 3) "Hope and Resilience": The protective resilience factors that reduced participants' self-harm and suicidal distress. 4) "Threats to Resilience": How participants made sense of additional minority stressors that were relevant to their experiences.

Conclusion: The current study suggests that transgender individuals may experience psychosocial factors related to self-harm and suicidality differently across various stages of their lives. Important insights into the motivations underlying self-harm and suicidality for transgender individuals emerged. Clinical implications are discussed, however further research is required to fully understand self-harm and suicidality within the transgender community.

Introduction

Transgender (or 'trans') people are individuals whose sense of felt gender (i.e. gender identity) differs from the gender assumed at birth, on the basis of the sex they were assigned (Vincent, 2018). The term cisgender (or 'cis') describes individuals whose gender assumed at birth reflects their gender identity (see Appendix 1.2 for full definitions). Research has consistently shown that trans individuals are more at risk of suicide than those from the cisgender population (Adams, Hitomi & Moody, 2017; Clements-Nolle, Marx and Katz, 2006; Haas, Rodgers & Herman, 2014; McNeil, Ellis & Eccles 2017; Peterson, Matthews, Copps-Smith & Conard, 2017). Trans individuals are also more likely to attempt suicide than Lesbian, Gay, and Bisexual individuals (Haas et al., 2014; Mustanski & Liu, 2013).

One UK trans mental health survey (McNeil, Bailey, Ellis, Morton & Regan, 2012) noted that the majority of respondents (84%) indicated current or historical suicidal ideation, with 48% of these individuals having attempted suicide at least once. Similarly, Virupaksha, Muralidhar and Ramakrishna (2016) found lifetime rates of suicide attempts within the trans population to be between 32% and 52% globally. These prevalence rates are substantially higher than the cross-national lifetime prevalence of suicidal ideation (9.2%) and attempts (2.7%) within the general population (Nock et al., 2008). A higher prevalence of self-harm also exists within the trans population (between 19% and 39%), compared to the cis population (Marshall et al., 2016). A history of self-harm, suicidal ideation and suicidal attempts are known risk factors of dying by suicide within the general population (Chan et al., 2016). However, the lifetime prevalence of trans individuals dying by suicide is currently unknown (Wolford-Clevenger, Cannon, Flores, Smith & Stuart, 2017), largely due to challenges in recording trans identities at the time of death (McNeil et al., 2017).

Although research within the transgender population has increased in recent years, this population remains vastly understudied (Wolford-Clevenger et al., 2017). The high rates of self-harm and suicidality among trans people highlights the importance of continued research within this area, aimed at improving our understanding and prevention of suicide within this population.

Correlates of Self-harm and Suicidality

A systematic review by McNeil et al. (2017) summarised the correlates of suicidal ideation and behaviours within the trans population. Environmental factors, specifically those related to minority stressors (e.g. discrimination, victimisation and social stigma), were identified as strongly related to suicidal ideation and attempts. Individual factors, such as co-morbid mental health difficulties and internalised transphobia, were also discussed as risk factors for ideation and attempts. Similar risk factors have been described for self-harm among trans people, including discrimination, perceived lack of social support and interpersonal problems (Marshall et al., 2016). The relationship between self-harm and suicidality within the trans population requires further attention; however research suggests a positive correlation between self-harm and suicide attempt history (Wolford-Clevenger, Frantell, Smith, Flores & Stuart, 2018).

Klonsky & May (2015) proposed the ideation-to-action framework, which provides a theoretical stance for understanding suicidality and suggests that suicidal ideation and attempts have distinct but related pathways. McNeil et al. (2017) did not review correlates of suicidal ideation and attempts separately thus likely limiting our ability to consider clinical implications. Therefore Wolford-Clevenger et al. (2018) systematically reviewed and described separately the correlates of suicidal ideation and attempts within the trans

population. Guided by the ideation-to-action framework (Klonsky & May, 2015), the authors described a number of internal and external minority stress experiences (e.g. prejudice/discrimination, victimisation, expectations of rejection, self-stigma) which, in combination, potentially contribute to psychological pain and thus drive suicidal ideation. In parallel with the general suicide literature, a positive correlation was found between suicide attempt history and fearsome and painful events among trans people. These events include both physical and sexual violence, substance misuse and, as discussed, self-harm. However, in contrast with our understanding that key fearful and physically painful events shift ideation toward attempts, internalised minority stressors were also positively correlated with a move from ideation to action for trans people.

Notably, this review highlighted the poor methodological quality of research within this area, cautioning that any conclusions drawn regarding the correlates of suicidality in trans people should be considered tentatively. The authors noted that further research efforts are needed to understand the factors which may contribute to a shift from suicidal ideation toward action among transgender people, particularly when considering the generalisation of existing suicide theoretical frameworks to this population. The review highlighted that future qualitative research may help to illuminate these factors, which may encompass a range of uniquely trans-specific experiences.

Suicide Prevention

Understanding psychosocial protective factors, including resilience and help-seeking behaviours is important for suicide prevention. Resilience refers to the process whereby an individual is able to adaptively respond to and cope with adversity (Windle, 2011), and recognition has been given to its role in helping individuals 'bounce back' from minority

stressors that threaten their psychological well-being (Meyer, 2015). Literature has highlighted enhanced internal and external resilience strategies that transgender people may develop in response to cumulative adversity, including reframing of challenges, defining one's own gender and collective self-esteem (Grossman, D'Augelli & Frank, 2011; Singh, Meng, & Hansen, 2014; McCann & Brown, 2017). Individual and community resilience factors can reduce risk of suicidality within the trans population (Moody & Smith, 2013; Moody, Fuks, Pelaez & Smith; 2015), although the processes that underlie this reduction remain largely unknown. Edwards, Torre-Barnal, Hanley & Martin (2019) provided some evidence for a process whereby perceived social support first increases an individual's emotional stability, and thus indirectly leads to increased resilience and lower levels of suicide risk.

To date, minimal research has explored help-seeking for self-harm and suicidality specifically within the adult trans population. The current literature discusses experiences of/fear of stigma and discrimination within a healthcare context, fear of social consequences, and a belief that their needs will not be met, as barriers to transgender people fully utilising professional health services in general (Ellis, Bailey & McNeil, 2015; McNair & Bush, 2016; Shipherd, Greene & Abramovitz, 2010; Poteat, German & Kerrigan, 2013). Some limited research has hypothesised that trans people may be more likely to seek help for suicidal distress only when a crisis point is reached (McDermott, Hughes and Rawlings, 2018; Effrig, Bieschke & Locke, 2011), perhaps due to fear of rejection and exploitation (Hunt, Morrow & McGuire, 2019). The existence of group-specific differences (e.g. based on education level, socioeconomic status, culture, race, gender, age)(Niederkrotenthaler et al., 2014), in addition to the substantial impact of attitudes and stigma on help-seeking (Niederkrotenthaler et al., 2014; Calear, Batterham & Christensen, 2014), suggest that further suicide prevention

research is needed to understand the underlying processes of trans-specific help-seeking behaviours.

Lived Experience

Information gained from quantitative research can help to determine a number of risk/protective factors related to self-harm and suicidality. However, a deeper understanding of *how* and *why* these factors may lead to, or reduce, individuals' risk of engaging in harmful behaviours may require a more in-depth examination of accounts of suicidality (Hjelmeland & Loa Knizek, 2010). Qualitative research aimed at exploring the lived experiences of individuals who are directly affected may help to provide rich insights into the context, mechanisms and intent underlying these complex phenomena for individuals, thus helping to inform suicide prevention policy and practice.

Aim

The aim of the research was to explore the lived experience of transgender individuals who report a history of self-harm and/or suicidal thoughts or behaviours.

Research Questions

I. What psychosocial factors are associated with an increased or decreased risk of self-harm and/or suicidality within the trans population?

II. What are trans peoples' experiences of help-seeking in the context of self-harm and/or suicidality?

Method

Design

The study employed a retrospective qualitative design. Semi-structured in-depth interviews were conducted, and analysed using Interpretative Phenomenological Analysis (IPA)(Smith, Flowers & Larkin, 2009).

Ethical Considerations

Approval was gained from the NHS Greater Glasgow and Clyde Research and Development Department (GN19MH431) and the West of Scotland Research Ethics Committee (19-WS-0169)(Appendix 2.1). The confidential nature of participation, and limits thereof, were made explicit. Written informed consent was provided prior to interview (Appendix 2.2). The potentially sensitive and emotive topic was acknowledged, and participants advised that they did not need to answer any questions they did not wish to. A risk screening tool (Appendix 2.7) was used at the start and end of every interview to ascertain imminent risk of suicide specifically. No participant disclosed information suggesting that they may be at imminent risk of suicide. A risk management plan was in place should this have been required, including a field supervisor on site during interviews. Consideration was given to the participants' emotional well-being following interview. Participants described partaking as a cathartic experience, with some expressing a sense of gratification from contributing to research that may help toward improved outcomes for trans people. A list of contacts for further support following interview was provided (Appendix 2.8).

Recruitment

A purposive sample of adult transgender individuals with experience of self-harm and/or suicidality was sought from the Sandyford Gender Identity Service (GIS) within NHS Greater Glasgow and Clyde. The Sandyford GIS is not considered a mental health service; however it is a clinical service that provides support to any person who feels uncomfortable/uncertain about their gender identity. Potential participants who had provided consent to be contacted for research purposes were identified from an internal waiting list, and sent information pertaining to the study (Appendix 2.3). Participants were identified by GIS administration staff who oversee the waiting lists and who were not involved in the research beyond recruitment. Interested individuals provided consent for the researcher to contact them (Appendix 2.4). The researcher then telephoned to arrange a convenient interview date/time.

Participants and Sample Size

IPA embraces smaller sample sizes which allow for a greater, in-depth exploration of participants' accounts (Reid, Flowers & Larkin, 2005). Therefore, the study sought to recruit between 4 and 10 participants, which is the range of sample size recommended for doctoral research (Smith, Flowers & Larkin, 2009). Inclusion criteria indicated that participants should: (i) have a gender identity which is incongruent with sex assigned at birth, (ii) report a history of self-harm and/or suicidal thoughts or behaviours, (iii) be aged 17 or over, and (iv) be fluent in English. The exclusion criteria included those with a known forensic history or who were at imminent risk of suicide

Seven individuals were recruited between February 2020 and March 2020, however, this yielded a final sample size of four participants who were interviewed. One individual did not attend interview (no reason given) and two interviews were cancelled due to Covid-19 restrictions. Recruitment ceased in line with the NHS Greater Glasgow and Clyde suspension of research activities in response to Covid-19 (Appendix 2.5). In light of these circumstances, the data already gathered were discussed between researchers and the decision was made to end recruitment and progress to analysis with the reduced sample size.

Data Collection

Interviews were conducted by the first author (L.B.) at the Sandyford clinic, lasting between 57 minutes and 1 hour 22 minutes. A schedule was used to help structure these interviews (Appendix 2.6) and support participants to reflect on the events, relationships and experiences central to their self-harm and/or suicidality and help-seeking, in line with IPA's inductive stance. The schedule was developed in discussion between researchers and field supervisors, and through exploration of the current literature. Interviews were audio-recorded prior to full verbatim transcription.

Interviews began with open questions, encouraging participants to introduce what they deem important to their first-hand experience of self-harm and/or suicidality. An inductive process of reflection and probing questions was used throughout to facilitate a deeper exploration of participant's accounts (e.g. "what sense do you make of that?", "what was that like?"). The interviews typically followed a chronological story of participants lived experience

preceding, during and proceeding periods of suicidality and/or self-injurious thoughts/behaviours. Accounts of formal and informal help-seeking were intertwined within participant's own understanding and factors related to self-harm and/or suicidality, as opposed to a separate topic of discussion.

Data Analysis

IPA was chosen as its inductive epistemology is concerned with meaning-making, and allows for an, in-depth analysis of expert accounts. Through this analysis, IPA attempts to interpret and present an account of the ways in which people understand and experience subjective, important phenomena in their lives (e.g. self-harm and suicidality). Therefore the researcher first immersed themselves in the data through repeatedly listening to, and re-reading, the interview transcript. As described by Smith et al. (2009), line-by-line analysis was then completed, providing initial exploratory notes on descriptive, linguistic and conceptual content. Secondly, emergent themes were developed by engaging with the initial coded data and interpreting what it might mean for participants to have these concerns, in this context. This analysis and interpretation was done in line with IPA's hermeneutic stance; an inductive process whereby the focus is on interpretation of meaning within the individuals account. Sample coding transcripts and emergent themes were reviewed between researchers to ensure coherence and plausibility of themes. An example analysed transcript is included in Appendix 2.9. Each participant's data were analysed separately, before relationships between emergent themes within the group were considered. Shared higher-order qualities were identified, whilst also accounting for unique idiosyncratic instances. Together, these were further interpreted and developed through an iterative process, whereby recurring key themes were defined. The key themes presented were considered the 'best fit' for participants' narratives and were prevalent within all participants' accounts.

Researcher Reflexivity

The researcher considered how their personal and professional experiences may have influenced how they conducted the research and data analysis. The researcher is a trainee clinical psychologist working within local mental health services, including with individuals expressing suicidality. This experience provided the researcher with valuable knowledge of the psychosocial concepts that participants discussed, although in turn required the researcher to suspend attempts to "formulate" participants' lived experiences, focusing instead on participants' own meaning-making processes. As a heterosexual cisgender woman, the researcher explicitly acknowledged the implicit biases and assumptions that influenced them to undertake research in the field of suicidality in transgender populations. For example, by paying particular attention to the way in which transgender experiences are often portrayed within the existing literature, and how this led to pre-conceived ideas of a 'typical' transgender experience being defined by risk and vulnerabilities. Throughout the process, the researcher embraced an open-mind to participants' experiences, as opposed to searching for solely *challenges* in participants' accounts or interpreting first-hand experiences related the phenomena of interest as being exclusively related to a participant's transgender status. The researcher kept reflective notes to help facilitate this reflective stance and 'bracket-off' beliefs whist engaging in the analysis of data. Given the emotional content on the data, the researcher also considered their own emotional response's during the process, so as to be able to fully engage with the participants' narratives.

Results

The sample characteristics are first discussed, before presenting the findings from the qualitative interviews.

Participant Characteristics

Participants were asked to: (i) describe their gender identity, and (ii) identify the sex they were assigned at birth (Table 2). All participants currently lived in urban Scotland and were aged between 19 and 27 (M=22.25, SD=3.59). All participants expressed a previous desire to kill themselves and planning in response, with one participant having made a number of attempts to do so via overdose. All participants had expressed a desire to injure themselves without intent to die, with three participants having done so multiple times by cutting.

Table 2: Participant Characteristics

Pseudonym	**Sebastien**	**Luke**	**Cameron**	**Eve**
Age (years)	27	19	20	23
Gender Identity	Non-binary	Male	Male	Trans Female
Sex Assigned at Birth	Female	Female	Female	Male
Sexual Identity	Gay/Queer	Bisexual	Bisexual	Queer
Ethnicity	White British	White Irish/Scottish	White Scottish	White Scottish
Religion	Catholic Background	Spiritual	Protestant	No Religion
Suicidal Ideation*	Yes *(5 years)*	Yes *(2 years)*	Yes *(4 years)*	Yes *(2 weeks)*
Suicide Attempt*	No	Yes *(2.5 years)*	No	No
Self-Harm*	Desire *(<2 weeks)*	Yes *(2 years)*	Yes *(5 years)*	Yes *(2 years)*

** (approx. time since last episode)*

Qualitative Interviews

Four superordinate themes and ten subordinate themes emerged from the analysis, as summarised below in Table 3.

Table 3: Superordinate and Subordinate Themes Identified during the Analysis

Superordinate	**Subordinate**
Early Experiences	"**Kicking up a fuss again**": Emotional invalidation "**Everything just keeps pilling up**": Cumulative stressors **"I couldn't understand why I was feeling like this":** Navigating norms
Intent	**"I just wanted someone to notice":** Communicating a need "**It would numb me**": Dealing with dysphoria "**I still had that like survival plan, it was suicide":** Escape from despair
Hope and Resilience	"**I was just being happy that I could finally be me**": I can be me **"I existed as a human being":** Social connectedness
Threats to Resilience	**"More exposed":** Prejudice and discrimination **"Why is this not an emergency?":** Unmet needs

Early Experiences

The first superordinate theme deals with how participants make sense of their journey toward self-harm and/or suicidality. Three interrelated subthemes emerged that may describe risk factors associated with greater risk of self-harm and/or suicidality for trans individuals, and touch on how these risk factors interact with experiences of help-seeking: i) emotional invalidation, ii) cumulative stressors, iii) navigating norms.

Emotional Invalidation

Participants understood their experiences of self-harm and suicidality in the context of early environments and interpersonal relationships that invalidated their internal emotional experiences and contributed to suicidal distress. For Luke, there was a sense throughout his life that persistent rejection of his expressions of emotion by others led to him conceptualising his experiences as abnormal or shameful, resulting in further suicidal distress. He goes on to describe withdrawing from a formal mental health intervention and increasing suicidal behaviours as a result:

> *"my mental health issues were always just brushed off as just me looking for attention and me just needlessly being like wanting to make other people suffer … I just got sick of it all of that and I was just like right if she wants me to stop going, I'll just stop going, and then I think it was like 2 months later was my first suicide attempt". (Luke)*

Similarly, Sebastien described how their family often minimised their distress, "*I was the 'problem child'; the one that always like kicks up a fuss and has a tantrum",* and reflected on reduced seeking of support from caregivers when in distress, as a result. Cameron provided

an explicit account of how these invalidating responses interacted with informal help-seeking to create emotional distance:

> *"When we were in a relationship … I would reach out to them for support [and] it was almost, "well it's not that bad because I've went through *this*"… my problems were squashed and that would just make it worse for me." (Cameron)*

Cameron's use of 'squashed' emphasises how his distress was belittled by those in the position to provide informal support, thus increasing his negative affect whilst reducing his capacity to adaptively cope. It is important to note that for participants, these early experiences were perceived as invalidation and rejection of their emotional experiences at that time and not specifically of their gender identity.

Cumulative Stressors

An accumulation of early adversity and potentially traumatic experiences were highlighted throughout, leading to an increase in hopelessness and increased capacity for self-harm and suicidality, *"everything just keeps pilling up and em- what's the [point]?" (Luke).* Each participant demonstrated a preoccupation with age when conceptualising their life experiences, *"I was so young at that point- and I was going through all my own stuff in school and the thoughts I was having about like [my gender]" (Eve),* portraying a sense of powerlessness in the face of cumulative, overwhelming stressors beyond their capacity to cope with, "*I felt so young but so old" (Luke).* Participants' accounts of how they responded to these accumulating external stressors were dominated by a sense of helplessness and normalisation which reduced their motivation to seek help, *"I was just saying well it's the*

cards that I've been dealt with in life you know, this is just my life, you know this was just my normality" (Cameron).

Participants placed the discovery of their transgender identity within the context of psychological saturation and an already depleted capacity for coping. Below, Sebastien's use of 'upheaval' reflects an anticipatory stress of disclosure; a sense of likely unpredictable or negative consequences and significant disruption to their life. They demonstrate how this minority stress further adds to this accumulation of stressors, which simultaneously reduces their preparedness or readiness to explore their gender identity, thus maintaining and perpetuating distress.

> *"I was not ready to be thinking about- I was like I'd already done the upheaval of coming out as gay, I didn't want to lose that label, I didn't want to be a man, I didn't want to- it was just- I wasn't ready for any of that stuff." (Sebastien)*

Navigating Norms

Participants described challenges in understanding their experiences of gender dysphoria through comparisons with social norms, within the context of cisnormativity. They often described a period prior to the discovery of their transgender identity whereby they struggled to name their dysphoria, leading to heightening suicidal distress and reduced ability to seek help, *"I couldn't understand why I was feeling like this … I was getting really low, I was crying at school, I couldn't really explain it to people" (Cameron).*

Luke describes misinterpreting gender dysphoria as *"a problem with me, rather than something I was struggling with",* leading to self-stigma and further suicidal distress. Below, Luke struggles to describe and quantify the impact of this misinterpretation, instead describing a sense of relief that younger trans youth may have different norms to draw upon and greater clarity of gender-related self-concept. His repetition of 'so so so' further exemplifies this relief, and conversely the impact that the misinterpretation of gender dysphoria had on his distress and coping:

> *"If I had known earlier that gender dysphoria was a thing or that like mental health issues were a thing emm and like, I, I, just things would have been so different … I'm just so so so glad that emm other people emm like there is the, there is the, the opportunity that other people don't have to go through all of that". (Luke)*

Similarly, Eve conveyed increasing negative affect in response to her reattributing her gender experience as 'abnormal' as she entered adolescence; a developmental stage whereby identity development and social norms become increasingly central to our world view:

> *"…when I was in my early teens, before I came out as transgender - I think that's when [self-harm] started … like growing up like I always- I thought it was quite normal to be the way I was … I thought I was female. I thought that was like the norm, and then starting secondary school that's when I was like 'this isny the norm like to be like this'." (Eve)*

Eve goes on to highlight how social norms and stigma negatively influenced others' responses to her help-seeking, thus further reinforcing her negative gender-related self-concept:

> *"…everybody I'd reach out to- I wouldn't feel like I would like get the help or get the like people understanding like what I was going through, they'd just think that like that I was like fucked in the head basically." (Eve)*

Intent

The second superordinate theme deals with how participants make sense of what they gained by acting on their self-harm and suicidality. Three interrelated subthemes emerged that may reflect the intent behind these behaviours for participants: i) communication of need, ii) dealing with dysphoria, and iii) escape from despair.

Communication of need

Self-harm and suicidality were often described as ways to communicate an unmet need; seeking care and emotional validation from others in response to distress. Sebastien conveys a profound sense throughout of being physically present within their family yet alone in their distress, with their emotional needs being overlooked. They reflected on their thoughts of self-injury and suicidality as a means of communicating their pain, *"I just wanted someone to notice that I wasn't very happy" (Sebastien).*

Participants described how self-harm and/or suicidality was often reinforced by responses from others that met their need for validation or care. Eve described connection to an adult within her school that was fostered through these communications of distress, *"it was just nice to hear that somebody cared about you" (Eve).* Cameron placed his self-harm and suicidality within the context of interpersonal conflict, describing a view that his existence was disregarded by his caregivers. He portrays a 'turning-point' in his narrative, born from a compassionate response to his self-harm:

> *"…it's was almost as if [the image] would just flash in my head - just sitting on my mum's couch and having her just come up and hug me, and it was pretty powerful and then almost after a couple of weeks the thoughts of self-harming just would stop … I think it was because I, I've seen her cry before, but because she was crying over something I'd done … I didn't actually expect her to be so upset about it and she embraced me in such a big hug and stuff like that and she was supportive, more supportive than she'd ever been, and that's really what took- it took me so back and it really kind of shocked me and I was like 'fuck', you know?" (Cameron).*

Arguably, Cameron's self-harm reduced in line with a reduction in his urge to communicate his unmet need for care and nurture, highlighting the protective impact that the mental representation of a compassionate caregiver had on his coping.

Dealing with Dysphoria

Participants provided powerful accounts of self-harm as a means of responding to a self that was considered flawed or 'abnormal', within the context of gender dysphoria. Eve recalled the dulling of dysphoria that was achieved through self-harm;

> *"I would look at girls and I'd be like- I want to be like that, that's what I would like. I'd do anything to be like just like that, like so normal and em and I remember I'd like I'd take a knife and I'd press really hard like really like going harder and harder and just to feel the pain and I think it would numb me in a way." (Eve)*

Sebastien described avoiding exploration of self throughout, *"I just didn't feel right as a human being. It was just… everything felt wrong and I would just ignore it",* and consistently conveyed thoughts of self-harm as a means of maladaptive coping/avoidance of distress:

> *"…I would think about hurting myself but then that's also upsetting and making it worse in the long run and it was like "oh my god I'm doing rubbish at this, think about breaking your arms" or whatever to distract from that but then that was also upsetting" (Sebastien)*

Similarly, Luke spoke of seeking clarity and control over his experience of gender dysphoria. In the context of an ambiguous pain that was challenging to name, he described instead expressing this pain through self-harm and suicidality. Luke describes an intense hatred of his self and body which he describes having sought to control through restrictive eating, with self-harm being also framed as punishment:

> *"…partly relief like just expressing mental pain physically and partly em punishment for what I perceived to be bad eating habits" (Luke).*

Escape from despair

A portrayal of a perpetual despair from which there felt no alternative escape was evident throughout. Luke recalls what he hoped to gain from an attempt to end his life:

> *"…seeking relief from all this pain and seeking control over all this pain and emm over life in general. Emm, everything was just so overwhelming, everything was just- I couldn't see an end, I couldn't see any way of this getter better … I just wanted everything, all the pain to stop" (Luke).*

Luke's continual use of 'everything' magnifies his sense of desperation and hopelessness in the face of an emotional pain that defines and controls his life. As a result, his description demonstrates a narrowing of perspective and ability to consider alternative means of alleviating this distress. Eve describes her emotional experience as a monster in her head through which there is little escape. She goes on to place her suicidality as a means to unburden herself from unrelenting conflict, *"I think I'd be better off dead and I'd just… to be at peace" (Eve).*

Similarly, Cameron described a sense of calm and acceptance that occurred after finalising his suicide plans. His use of 'survival plan' below to describe suicidality draws parallels with an 'escape route' and is a striking example of how for some, the knowledge of a possible finality to unbearable distress provides a sense of safety and possible means to cope:

"…I was just like I canny cope with this anymore, I canny cope, and it got to- em, I still had those thoughts of suicide and even though I'd stopped self-harming I still had that like survival plan, it was suicide- like, right if anything happened at school this is what I was going to do." (Cameron)

Hope and Resilience

The third superordinate theme deals with how participants make sense of reducing self-harm and suicidality. Two interrelated subthemes emerge that may reflect internal and external processes which contribute to increasing resiliency: i) I can be me, and ii) social connectedness.

I can be me

Narratives shared a sense of hopefulness for the future that occurred in line with a positive reappraisal of self and further transgender identity development. Eve described a period whereby distress and subsequent self-harm and suicidality were diminished in light of reduced conflict of self following coming out:

"I [came out] and after that I thought like- I didn't have any suicidal thoughts. For the first like two years as being out as trans I was like in my element, I was just being happy that I could finally be me." *(Eve)*

Her use of 'in my element' to describe the impact of being able to live as a trans woman communicates a sense of a flourishing self that feels unstoppable in the face of adversity. Often participants described a social process by which their understanding of their selves in relation to others shifted and precipitated a reduction in harmful behaviours. Sebastien describes a 'life-changing' experience whereby they met people representative of their own gender identity. Their account below references a previous appraisal of a flawed, or 'boring' self, contrasting this with a sense of elation at the realisation that their gender identity, and arguably their self, is both valid and acceptable:

> *"I met people who were non-binary. I didn't- I didn't know- it still gets me a bit sometimes like (funny voice) "ooh.. you're really allowed to be non-binary? Ha! - that's what the crazy Americans do! (laughs) that's not what the more boring people do!" .... Yeah no it.. gave me hope. People had like, lives and careers and families" (Sebastien)*

Moreover, Sebastien demonstrates how this reappraisal of self allowed them to overcome hopelessness and uncertainty for the future, which was maintained by a struggle with a concept of self and gender identity that didn't fit with their understanding of what their future should contain. Luke described a shift in his narrative whereby suicidal ambivalence became evident, *"one little switch that wasn't flipped anymore" (Luke).* When making sense of this experience, he describes increasing hopefulness upon meeting other trans people who were taking steps toward their transition. He conveys how this lead to the ability to define his self as transgender and develop a mental representation of a favourable future:

> *"I think I felt a lot more hopeless emm, especially before I started understanding what I was experiencing was partly gender dysphoria .... that was the one flip, the main*

switch even, it just kind of gave me that little bit of hope …. there was just this little spark of hope that I can "oh like things can be different later on" (Luke)

Social Connectedness

Participants described how the development of positive interpersonal relationships and a sense of belongingness had a profound and positive impact on their psychological well-being and ability to cope with adversity. Cameron explicitly makes reference to a widening social network, encompassing family, friends, a romantic relationship and various social organisations, when reflecting on his current absence of self-harm and suicidality:

"But em so [my support network's] a lot different from what it was now, at the time it was barely non-existent I would say. I'd be quite comfortable saying that – I did not have a support system at that time. And now it's, you know, quite cooshty."(Cameron)

Sebastien described a 'turning-point' in their experience of suicidality, dominated by descriptions of social connectedness. Their quote below highlights their development of a sense of belongingness, leading to an increase in positive affect and self-esteem:

"So everywhere you walk, like someone was happy to see you. Five full days of like-unconditional positive regard. Do you know what I mean? People happy to see you and interested in you …. it gave me an idea that I could- that one I existed as a human being that other people would be interested to hear from" (Sebastien)

Moreover, Sebastian's description of coming to feel that they existed as part of the human race underscores their previous sense of profound isolation.

Threats to Resilience

The fourth superordinate theme deals with how participants make sense of a fragile balance between protective and risk factors. In particular, additional risk factors that increased in line with their transition. Two interrelated subthemes emerge that may reflect additional minority stressors which can threaten resilience and may contribute to risk of self-harm and/or suicidality: i) prejudice and discrimination, and ii) unmet needs.

Prejudice and Discrimination

Participants provided multiple and varying accounts of prejudice and discrimination which lead to a reduced sense of safety and increased negative affect. These experiences were demonstrated through both general social interactions and within close interpersonal relationships. Eve's account was dominated at times by experiences of prejudice and discrimination, including being the victim of hate crimes within the community. She made sense of her increasing suicidality in this context, sharing that these experiences had the power to outweigh resilience factors at times:

> *"I've been… I got spat on once off a guy and I remember that, that night was ho- horrible. I had to go home, I went home crying. I think that's like- that's the point it's like when you go home and then you go back home yourself and like you're dealing with all those thoughts enough" (Eve)*

For Eve, microaggressions within romantic relationships were also conveyed frequently and appeared core to a reduction in resilience for her, "*I would feel like I was a toy or like I'd get used as a fetish, just not as a real human being"*. These subtle communications of prejudice were highlighted throughout Cameron's account of his family's response to him being transgender, such as his family's refusal to use his name or pronouns. For example, he spoke of his brother choosing instead to use the name of a cartoon character, likening his gender identity to a costume:

> *"My brother has been very good, he won't call me [deadname] but he won't call me Cameron, he'll call me [cartoon character] who I dressed up as for Halloween one year." (Cameron)*

There was the sense that Cameron had come to appraise these interpersonal communications as 'acceptable' or 'better than before', despite the negative impact that they have on his sense of self-worth, in order to be able to make use of the social support within these relationships. Participants also reflected on how increasing trans visibility within society can also have negative consequences for the trans community*, "awful people talking about [trans people] now and spreading mis-information" (Luke).* As a result, participants describe negotiating their own visibility within society, in line with awareness of discrimination. Sebastien's example shows a process by which they understand distress on a continuum between being feeling safe/invisible but dysphoric vs being unsafe/visible and comfortable with their gender presentation:

"I think things have changed a lot [in a positive way], but also I think it's, ironically in the last few years it's much more acceptable to be a knobhead .... I worry about my own safety .... I feel a bit more exposed to [prejudice] because [now] people know that there's something to clock and if they're going to be angry about it then they know it's - me. Whereas [4 years ago] they were angry at some concept that they saw on the telly .... I feel more visible, although weirdly I feel less visible now because of the way my body has changed [recently]. Thank god nobody can see me but also can those people not see me, you know can I close my eyes?" (Sebastien)

At times Sebastien describes actively accounting for and balancing these factors, for example by wearing more feminine hairstyles at work so as not to 'rock the boat'.

Unmet needs

Whilst reflecting on their lived experiences, the desire for services that are equipped with the knowledge, skills and capacity to provide care for trans people was described by all participants, including both gender affirming services and mental health services. Participants expressed uncertainty and hopelessness when faced with the task of accessing gender affirming services; *"Like [gender clinic] waiting lists are so long and in that way I felt hopeless" (Luke).* Participants' narratives suggest a belief that trans people's needs are being minimized or ignored. Sebastien questions why stretched gender services and unmet needs aren't prompting an emergency response, perhaps indicating that should another area of health care or group within the population be experiencing similar challenges, then greater efforts would be made to curtail these:

"...it makes me so angry and makes me feel like I'm not important, and that I'm less important than other people. And they're saying, "but we're busy", I understand that you're busy but you're not looking after- like, this is not a system which can look after people so why is this not an emergency? .... it feels like they don't care." (Sebastien)

Participants' accounts, like Sebastien's above, parallel the emotionally invalidating responses to expressions of distress and help-seeking that participants conveyed in their journey towards self-harm and suicidality. Cameron described being deflated by an adult mental health service that was ill-equipped to consider trans specific experiences/stressors when thinking about his psychological well-being. As he conveys below, there was a sense that his needs remained unmet, with his use of 'shot it down' mirroring his previous descriptions of his needs being 'squashed' by others:

*"I'd mentioned [being trans] to them but they shot it down, they were like, "that's not our department, we don't want to deal with it, if you want to do that we can get you contact with the relevant information", I was like, "*sigh* right, ok"" (Cameron)*

Eve described feeling lost between a gender identity service that is perceived as more able to meet her needs, but is not a mental health service, and mental health services which are not trans-specific. Eve described anticipation of stigma or a response similar to that which Cameron received as barriers to engaging:

"I just backed out, but that was more because my anxiety, that was like, cause I wanted to talk to someone that was like- knew about trans and stuff like that ....

[mental health services] would just be- they never knew anything about like, like being trans or anything like that, down that side of it." (Eve)

For Eve, this resulted in her declining timely formal support and later using a crisis help-line in response to increasing suicidal intent. Despite this, anticipated stigma was still present in Eve's account, where she conveys a belief that general services are 'not for trans people':

"I was thinking like oh my god is [Samaritan's worker] going to be like- cause obviously like that's not the- like if they get trans people phoning I was like, 'is she gonny be alright that I'm trans?'"(Eve).

Discussion

The current study explored transgender individuals' lived experience of self-harm and suicidality, and provided the opportunity to understand how trans individuals viewed changes in risk and resilience at various stages in their lives. Following IPA analysis, four superordinate themes emerged: i) early experiences, ii) intent, iii) hope and resilience, and iv) threats to resilience. The main findings and unique contributions are discussed in detail, with reference to existing literature. The methodological strengths and limitations are noted, before discussing implications for clinical practice and research.

Early experiences associated with an increased risk of self-harm and suicidality

Consistent with existing research, the current study highlights the role of perceived family invalidation and perceived peer invalidation in contributing to youth self-harm and

suicidality (Adrian, Berk, Korslund et al., 2018; Yen, Kuehn, Tezanos, et al., 2015). The perceived invalidation or rejection of participants' emotional experiences was described as having compromised their attachment to caregivers and interpersonal connectedness, which may have contributed to thwarted belongingness and consequently suicidal desire, in line with the Interpersonal Theory of Suicide (Van Orden, Witte, Cukrowicz et al., 2010). Early adversity and disrupted attachment experiences have consistently been associated with suicidality (Fergusson, Woodward & Horwood, 2000; Turecki & Brent, 2016), however the current findings suggest these experiences may also complicate the internal and external process of gender identity exploration for trans individuals. Participants reflected on an accumulation of stressful childhood experiences, with transgender identity development positioned as an additional source of distress within this context of elevated vulnerability. Further research is required to understand this interaction, however these environmental and social stressors may compromise an individual's sense of safety and capacity to cope with excess stress associated with minority status, such as anticipated rejection, identity concealment and internalized transphobia (Meyer, 2003; Rood, Reisner, Surace et al., 2016).

Although not directly measured, participants' reported cumulative stressors (including emotional neglect, domestic violence, parental substance misuse and ill-mental health) could also be considered Adverse Childhood Experiences (ACEs), which are significantly associated self-harm and suicide risk within the general population (Choi, Dinitto, Marti & Segal, 2017; Fuller-Thomson, Barid, Dhrodia & Brennenstuhl, 2016). These findings are in line with Austin et al. (2020) who first explored the impact of ACEs on suicidality within the trans population, and found that emotional neglect lead to 2.5 times increased risk of lifetime suicide attempt. Future research may help to further explore the relationship between ACEs, minority stressors and self-harm and/or suicidality within the transgender population.

The analysis illuminated how cisnormativity may contribute to unique risk for trans individuals, with participants describing a lack of gender-related self-concept clarity (i.e. difficulty understanding and verifying own gender identity or expression) and self-concept negativity within this context (i.e. negative cognitions or emotions related to own gender identity or expression). Kuper, Adams and Mustanski (2018) found that gender-related self-concept negativity, but not lack of clarity, is positively associated with suicidal ideation within the trans population. Conversely, the current study suggests a relationship between clarity of gender-related self-concept and risk of self-harm and suicidality, perhaps due to capturing qualitative data from individuals reflecting on various stages of their gender-identity development, or due to including both self-harm and suicidality as phenomena of interest.

These early experiences also shaped participants' help-seeking, whereby participants described difficulties appraising their distress, experiencing internal and external stigma, and a normalisation of their distress as barriers to seeking help. At times, experiences of help-seeking were described negatively (e.g. due to rejection, invalidation, stigma), which both increased distress and reduced their motivation to seek further help. For trans individuals, understanding the components of their distress (e.g. emotional distress due to life experiences in addition gender dysphoria) and stigma may be more prominent, however further qualitative research may help to examine barriers and facilitators to trans individuals seeking formal and informal support when experiencing suicidal distress in greater depth.

The intent behind self-harm and suicidality

Current findings expand existing literature describing the communicative and social function of self-harm and suicidality (Cipriano, Cella & Cotrufo, 2017; Grimmond et al., 2019), whereby participants expressed a desire to communicate their distress, seeking emotional validation and compassion from others. Self-harm as a means to distract from or reduce gender dysphoria was noted, lending support to literature highlighting trans-specific motivations for self-harm (Morris & Galupo, 2019). Further, in-depth qualitative research may help to explore trans-specific motivations for self-harm and/or suicidality. A desire to escape an intolerable psychological pain, or 'psychache' (Shneidman, 1985), in the context of depleted adaptive coping strategies, was key to participants' narratives of the intentions underlying their suicidality in particular. Findings are in line with the integrated motivational-volitional model of suicidal behaviour which documents the role of entrapment in the emergence of suicidal motivation, moderated by deficits in problem solving and coping (O'Connor & Kirtley, 2018).

Protective factors associated with decreased risk of self-harm and suicidality

The ability to conceptualise and self-define your own gender has been suggested as a resilience strategy for trans youth (Singh, Meng, & Hansen, 2014). Moody, Fuks, Pelaez & Smith (2015) described the process of realisation, understanding and acceptance of transgender identity as protective against suicidal ideation for trans individuals. The current study replicates these findings and illuminates how the process of positive group identity development may play a role in cultivating hope and transnormativity. The current study mirrors existing literature suggesting greater perceived social support enhances psychological resilience (Grossman, D'Augelli & Frank, 2011; Singh et al., 2014) and reduces suicide risk

(Moody et al., 2015). However studies have also cautioned that increased social support may not independently reduce risk of suicidality within the trans population (Austin, Craig, D'Souza, McInroy, 2020). Again, further research is required to understand the processes underlying resilience and risk reduction within this population.

Factors which threatened the resilience of participants

Moving on from periods of suicidality and self-harm seemed to coincide with increasing resilience; however, subsequent threats to resilience were also discussed. Prejudice and discrimination are well-recognised risk factors for self-harm and suicidality within the trans population (Marshalle et al., 2016; McNeil et al., 2017). Bockting, Barucco & LeBlanc et al. (2020) recently noted that greater trans visibility within society, although undoubtedly a positive step, unfortunately may also increase trans individuals' experiences of prejudice and discrimination. The current study supports these findings, and provides additional insights into how trans individuals may respond as these minority stressors become increasingly salient. Participants describe feeling 'more exposed' and increasingly worried about their safety in recent years as the wider population, some of whom may hold prejudice and discriminatory beliefs toward the transgender population, become increasingly concerned with trans individuals. As a result, participants described moderating their gender expression or gender-affirming needs to preserve a felt sense of safety, which is particularly noteworthy given that positive self-identity factors (i.e. 'I can be me' theme) were protective for individuals. Similar cognitive and emotional responses to anticipated discrimination for transgender individuals were summarised by Rood, Reisner & Surace (2016), including fear, anxiety, and hypervigilance.

Consistent with the existing literature, challenges in accessing inclusive mental health care and gender-affirming services were, unsurprisingly, described as significant stressors (Ellis, Bailey & McNeil, 2015) as well as being threats to participants' resilience (Singh et al., 2014). Current findings underscore how experiences of/anticipated stigma within a healthcare context is a barrier to receiving appropriate, timely mental health care, including when experiencing suicidal distress. Current findings lend some support to the hypothesis that trans people may be more likely to seek help only when a crisis point is reached (McDermott et al., 2018; Effrig, Bieschke & Locke, 2011). Importantly, the current study demonstrates how health care inequalities contribute to a profound sense of hopelessness, frustration and unmet need for a group of individuals who experience elevated risk of negative outcomes, including self-harm and suicidality (Marshall et al., 2016; McNeil et al., 2017).

Strengths and Limitations

The findings represent the in-depth experiences of a small sample of trans individuals, and so are suggestive as opposed to conclusive. Additionally, the sample includes only young trans adults who have accessed gender-affirming health care. As suggested by Smith, Flowers and Larkin (2009) the themes were contextualised and substantiated by the inclusion of excerpts thereby assisting the reader in determining the transferability of the findings to others. Similarly, non-binary and gender non-conforming individuals are underrepresented within research (Wolford-Clevenger et al., 2018) and so recruitment sought to be as inclusive as possible. However, it is acknowledged that trans experiences are not universal and so the inclusion of multiple gender identities may have decreased the homogeneity of the sample. The current study discusses the experiences of one minority group. Difficulty exists in generalising the current results to other minority groups who may be at greater risk of

suicidality, due to the diversity in their lived experiences and the factors that may increase risk and/or reduce protective factors (e.g. culture, barriers to help-seeking, social norms, access to healthcare, poverty, substance misuse, stigma, and social exclusion).

Similarly, the current study explored first-hand accounts of self-harm and/or suicidality from a non-clinical sample of transgender adults, although the majority of participants had not experienced self-harm or suicidal distress in a number of years. Therefore the results represent individuals who were experiencing, or had experienced, a prolonged period of psychological stability and so the integrity or depth of their accounts may have been reduced given the elapsed time since the acute distress. The current sample, however, allowed for a nuanced, unique perspective of how transgender individuals may experience psychosocial stressors and protective factors differently at various stages in their life.

The chosen qualitative methodology and IPA are considered strengths when exploring lived experiences; however they are not without limitations. As noted, the small sample sizes embraced in IPA may limit the generalisability of the results. The subjectivity of IPA could also be considered a limitation, whereby two researchers may interpret the same account differently. A second researcher therefore reviewed transcripts and emerging codes to increase reliability, and no disagreements were noted. Given the retrospective nature of the qualitative interviews, there is increased likelihood that accounts are subject to recall bias due to additional, subsequent insights. The interview schedule could be improved for future research as the discussions regarding help-seeking naturally occurred throughout accounts of psychosocial protective/risk factors, as opposed to a separate area of discussion.

Clinical Implications

The interviews point to a number of factors which may complicate identity development for trans youth and thus increase distress and risk of self-harm or suicidality. As our understanding of gender continues to advance, educating health professionals, young people, schools and the wider population on gender and transgender identities may help to play a role in reducing cisnormativity and stigma, and in turn help to normalise gender identity development for trans youth. Similarly, mental health services should have the ability meet trans individual needs, regardless of what presenting problems arise. Services should validate transgender individuals' lived experiences and seek to reduce sources of stigma; for example, by withholding making cisnormative assumptions regarding someone's gender identity or expression and maintain a reflective stance regarding their own implicit biases. It is vital that clinicians possess the knowledge and skills required to deliver risk assessments that encompass both trans-specific experiences and general factors known to increase risk of self-harm and/or suicidality. Healthcare providers and professional courses (e.g. Doctorates in Clinical Psychology) should consider learning outcomes that reflect the needs of transgender individuals and other minority groups.

Barriers to help-seeking may be reduced if referrers are able to discuss the enhanced learning practices that local community mental health teams have implemented to ensure they are best able to meet their needs. Culturally inclusive informal support should also be offered, in addition to those that individuals are often directed to (e.g. Samaritans). Engagement in psychological therapy may also be facilitated by addressing gender and power dynamics early within the therapeutic relationships. The current study also highlights the protective role of

increased resilience for participants, and thus psychological therapies aimed at enhancing internal and external resilience strategies may help to prevent suicide within the trans population. Dickey and Budge (2020) provide an overview of how psychological interventions play a key role in supporting trans individuals, highlighting interventions that focus on self-compassion and aim to reduce the impact of proximal minority stressors on psychological well-being.

The socio-political context is also relevant to suicide prevention. Policy reform that protects the rights, dignity and well-being of transgender *people* is imperative. The increasing visibility of trans individuals, which may place them at further risk of prejudice and discrimination, commands these protections urgently. Policies and processes should challenge the social norms that maintain stigma for trans individuals, reduce restrictions to resilience factors for trans individuals (e.g. being able to self-define their own gender (*or* 'I can be me')), and address mental and physical healthcare inequalities. The focus on healthcare inequalities is particularly relevant in the context of Covid-19, whereby healthcare services were halted or vastly reduced, which may exacerbate existing barriers to health care and threats to psychological well-being for trans individuals (van der Miesen, Raaijmakers, & van de Grift, 2020; Wang, Pan & Liu, 2020).

Future Directions

The discussion has highlighted a number of directions for future research, including efforts to better understand: i) the impact that increasing trans visibility may have on the lives of trans individuals, ii) trans-specific motivations for self-harm and suicidality, and iii) the

relationship between Adverse Childhood Experiences (ACEs) and suicidality within the trans population. Future qualitative research may provide rich insights into similarities and divergence between trans individuals who report a history of/life-time suicide attempt and recent attempts.

Conclusion

The current study describes how transgender individuals may experience psychosocial factors related to self-harm and suicidality differently across various stages of their lives. For example, adverse early relationships and experiences may complicate the process of gender identity development and help-seeking, whereas healthcare inequalities and increasing minority stressors may later threaten resilience. Important insights into both the processes underlying the relationship between resilience and suicide risk, and the motivations for self-harm and suicidality within the trans population emerged. There remains a need for further empirical research to fully understand self-harm and suicidality within the transgender population.

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Appendix 1.1: Author submission guidelines for Transgender Health

Review Articles

- Word limit: 5,000 words, excluding title, authors, abstract, keywords, figure legends, tables and table titles and/or footnotes, acknowledgments, disclosure statements, references. Appendices count against the word limit.
- Abstract: Standard abstract 250 word limit, but structured headings not required.
- Details on the study selection and inclusion process and on the participants in each selected study should be included.
- Figures and Tables: Maximum of 10 total figures and/or tables.
- References: Maximum of 150 references.

Manuscript Components

General Formatting and Style

Use of English Language: All submissions must be in English. *Transgender Health* uses American-style English. Appropriate use of the English language is a requirement for review and publication in the Journal.

- **Plagiarism**: All submitted manuscripts will be processed through plagiarism detection software. Plagiarized manuscripts will be rejected immediately.
- **Font**: Times New Roman or Arial in 12-point type
- **Abbreviations**: Expand all abbreviations at first mention in the text
- **Page size**: Letter size (8.5 x 11 inches)
- **Margins**: 1 inch
- **Line and word spacing**: Double-space all manuscript pages, including figure legends.

Full details can be found at:

https://home.liebertpub.com/publications/transgender-health/634/for-authors

Appendix 1.2: Key definitions

Transgender

Transgender (or 'trans') people are individuals whose sense of felt gender (i.e. gender identity) differs from the gender assumed at birth, on the basis of the sex they were assigned (Vincent, 2018). The historical view of gender being wholly binary (e.g. male/female) does not accurately reflect the spectrum of gender expression (Richards et al., 2016). Therefore transgender people may describe a number of different personal experiences of gender; including transmen, transwomen, non-binary, gender diverse and genderqueer identities (Vincent, 2018). Trans people may also have a fluid gender identity and so may identify with more than one term at any given time, or the term they identify with may change over time (McNeil, Ellis & Eccles, 2017). Importantly, sexual orientation and gender identity are distinctly separate.

Cisgender

The term cisgender (or 'cis') describes individuals whose gender assumed at birth reflects their gender identity.

Appendix 1.3: PROSPERO registration

Exploring and understanding the relationship between microaggressive experiences and well-being in transgender people: a systematic review

Lisa Ballantyne, Rory O'Connor

Citation

Lisa Ballantyne, Rory O'Connor. Exploring and understanding the relationship between microaggressive experiences and well-being in transgender people: a systematic review. PROSPERO 2019 CRD42019160392 Available from: https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42019160392

Review question

1) To explore the nature of microaggressive acts toward transgender people.

2) To explore and determine the evidence of the relationship between microaggressions and well-being within the transgender population.

Searches

Sources to be searched will include: PubMed/MEDLINE, the Cochrane Library, EMBASE, CINAHL, PsycINFO, Web of Science, PsycARTICLES, BSCO and ASSIA.

Papers must be available as full-texts in English.

No restrictions will be imposed on publication period.

The search terms will include: (Transgender* OR transsexual OR female-to-male OR male-to-female.....) AND (microaggress* OR microinsult* OR microassault*....)

Types of study to be included

An integrative approach will be taken, and so qualitative, quantitative and mixed-method studies will be included, if available.

Criteria for excluding studies:

Studies not available in English;

Studies in which the outcomes/experiences of transgender people is not described separately to the overarching LBGT cohort;

Studies in which microaggressions are not described separately from other forms of discrimination.

Condition or domain being studied

Transgender people, microaggressive experiences, and general well-being (e.g. social, behavioral, cognitive, psychological, physical health outcomes).

Participants/population

Transgender individuals (people whose sense of felt gender (i.e. gender identity) differs from the gender assumed at birth, on the basis of the sex they were assigned), of any age or nationality.

Intervention(s), exposure(s)

Microaggressions (subtle verbal, behavioural or environmental communications which express bias, prejudice or discrimination toward marginalised groups).

Comparator(s)/control
Not applicable.

Main outcome(s)
The nature of microaggressive acts toward transgender people, and the relationship between these experiences and overall well-being (e.g. social, behavioral, cognitive, psychological, physical health outcomes) in transgender people.

* Measures of effect

Not applicable.

Additional outcome(s)
None.

* Measures of effect

Not applicable.

Data extraction (selection and coding)
Studies identified through the proposed search strategy will be reviewed in accordance with the inclusion and exclusion criteria, following the removal of duplicates.

Papers will then be reviewed by their titles, and those which are identified as not being relevant will be excluded. The remaining papers will then be reviewed by their abstracts. Should the abstract content indicate that the inclusion criteria are met, then the full article will be reviewed, and eligibility determined. From the results of these assessments, a final set of papers meeting the inclusion criteria will be established.

The studies selected for inclusion will then undergo a quality assessment, following which relevant data will be extracted, such as: general study information (e.g. title, year, author, population group, setting and study type) and study-generated data.

Risk of bias (quality) assessment
The Crowe Critical Appraisal Tool (CCAT) will be used to assess the quality of the included studies, and an independent reviewer will rate a number of the included papers to reduce bias. Any discrepancies will be resolved by discussion, and the involvement of a third reviewer, if necessary.

Strategy for data synthesis

Group-level data will be synthesized using an integrative narrative synthesis based on guidance for the conduct of narrative syntheses within systematic reviews (Popay et al., 2006). We will adhere to key principles, and the following will be included:

1) The development of a preliminary synthesis from the different types of evidence, to give a narrative overview on what exists on microaggressions toward trans people;

2) An exploration of the relationship within and between studies, looking at how microaggressions are experienced by trans people and the nature of the relationship with general well-being and microaggressions within this population; and

3) A critical reflection and assessment of the robustness of the review.

Conclusions will then be drawn, and any recommendations made.

Analysis of subgroups or subsets

None planned.

Contact details for further information
Lisa Ballantyne
2356266b@student.gla.ac.uk

Organisational affiliation of the review
University of Glasgow

Review team members and their organisational affiliations
Miss Lisa Ballantyne. University of Glasgow
Professor Rory O'Connor. University of Glasgow

Type and method of review
Epidemiologic, Narrative synthesis, Systematic review

Anticipated or actual start date
21 November 2019

Anticipated completion date
31 July 2020

Funding sources/sponsors
None

Conflicts of interest

Language
English

Country
Scotland

Stage of review
Review Ongoing

Subject index terms status
Subject indexing assigned by CRD

Subject index terms
Aggression; Health Status; Health Status Disparities; Humans; Interpersonal Relations; Mental Health; Prejudice; Quality of Life; Sexual and Gender Minorities; Social Discrimination; Transgender Persons

Date of registration in PROSPERO
16 December 2019

Date of first submission
28 November 2019

Stage of review at time of this submission

Stage	Started	Completed
Preliminary searches	Yes	Yes
Piloting of the study selection process	Yes	Yes
Formal screening of search results against eligibility criteria	Yes	No
Data extraction	No	No
Risk of bias (quality) assessment	No	No
Data analysis	No	No

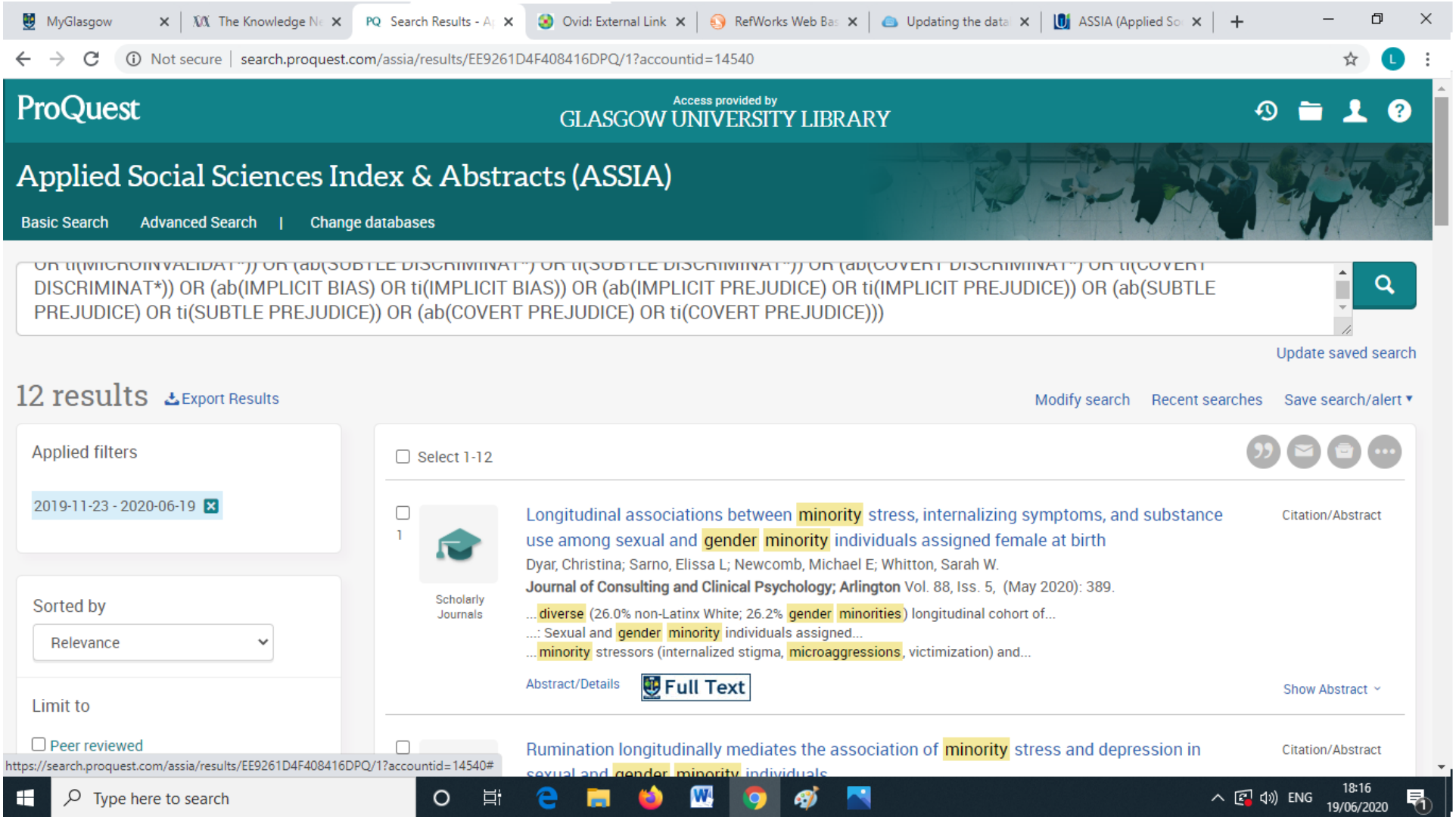
The record owner confirms that the information they have supplied for this submission is accurate and complete and they understand that deliberate provision of inaccurate information or omission of data may be construed as scientific misconduct.

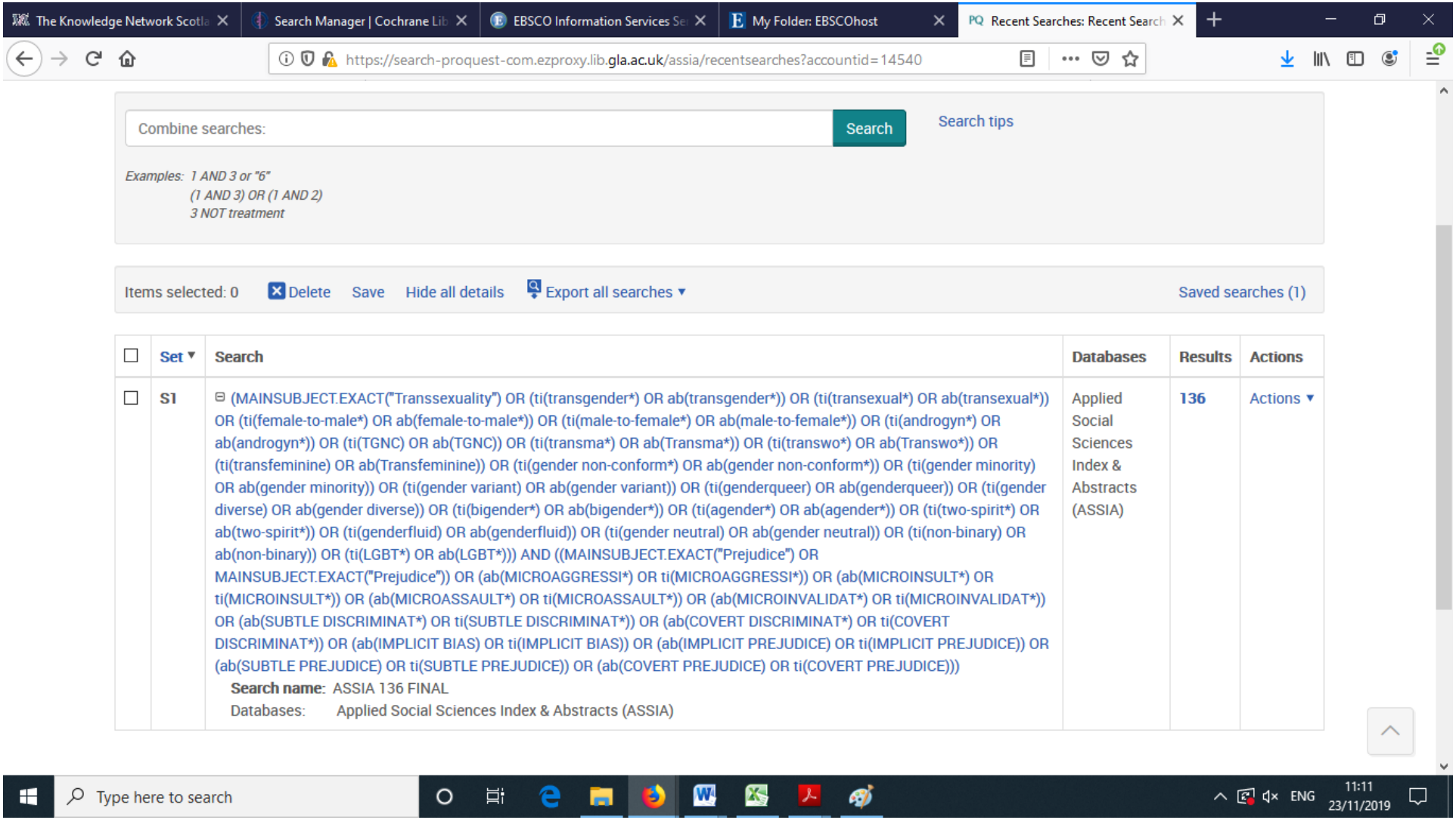
The record owner confirms that they will update the status of the review when it is completed and will add publication details in due course.

Versions

16 December 2019

Appendix 1.4: ASSIA database search

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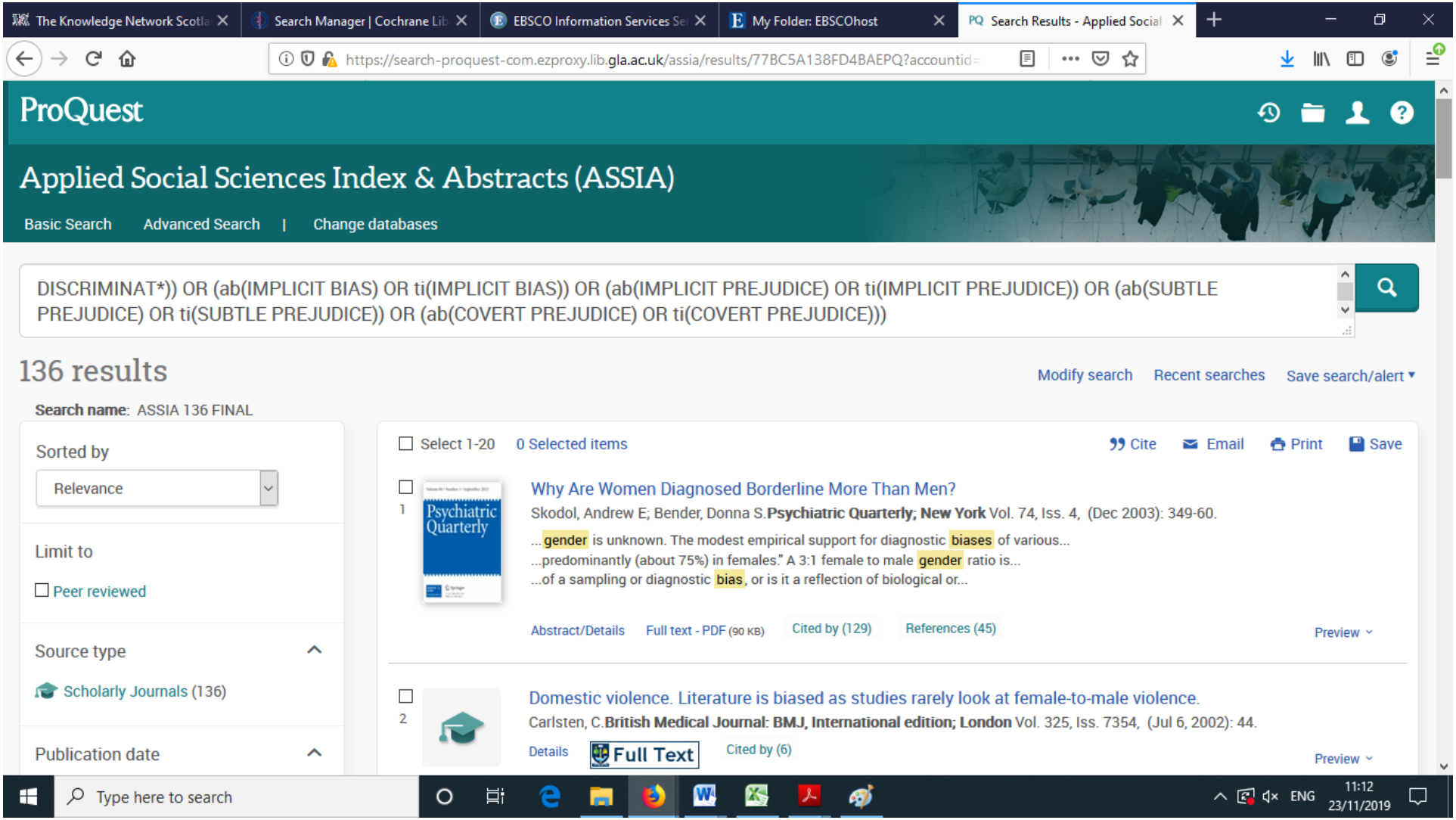
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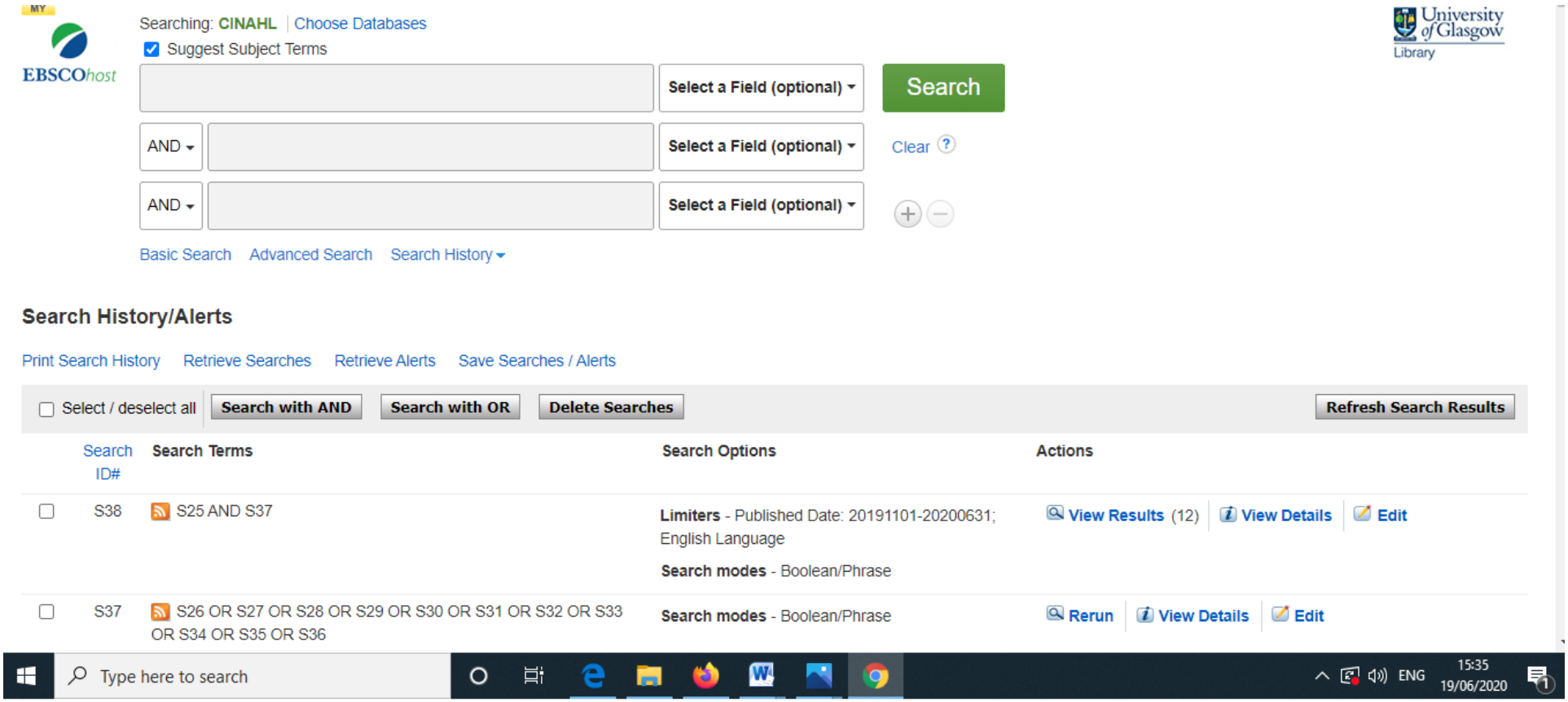
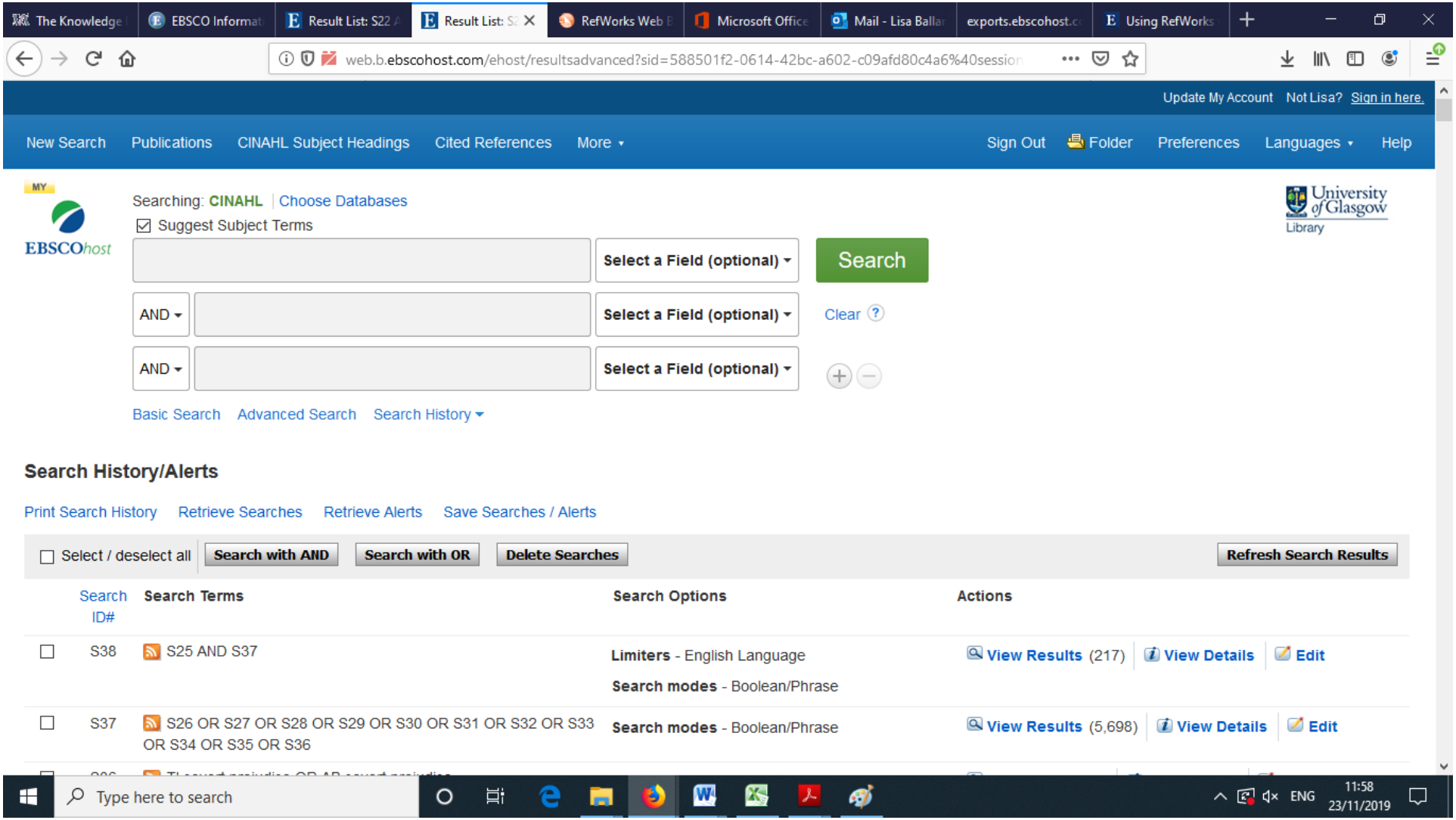
Appendix 1.5: CINHAL database search

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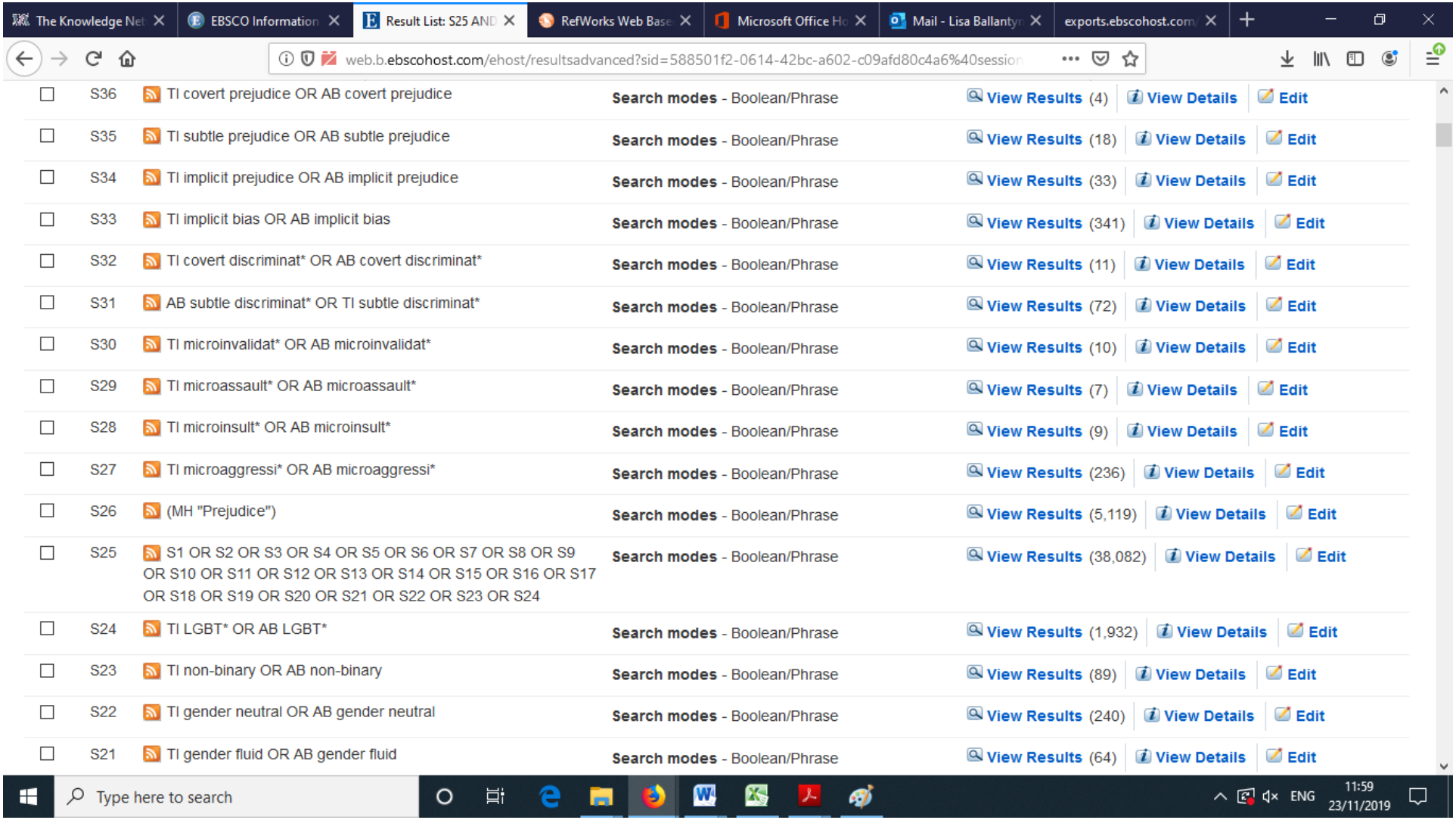
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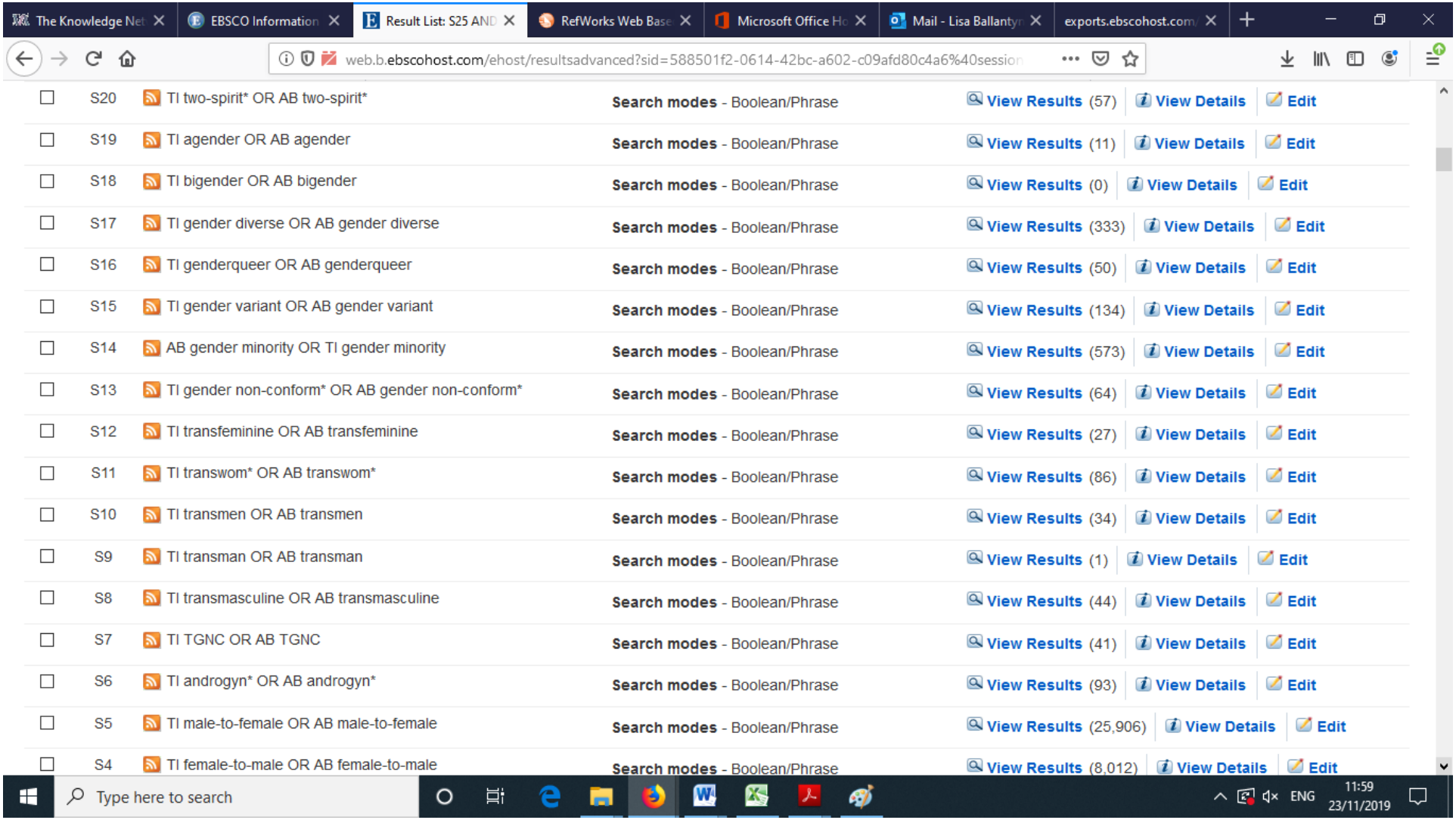
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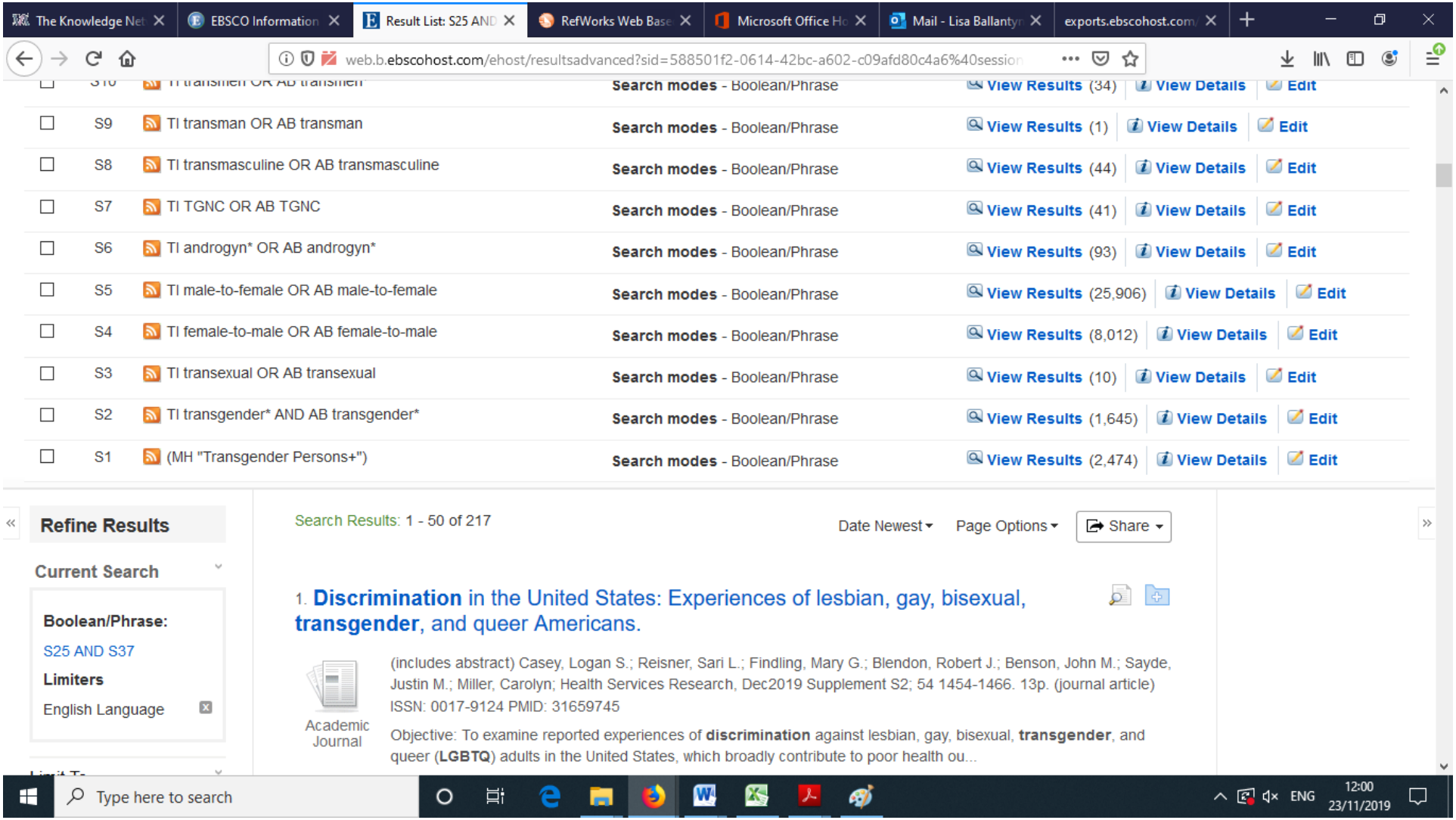
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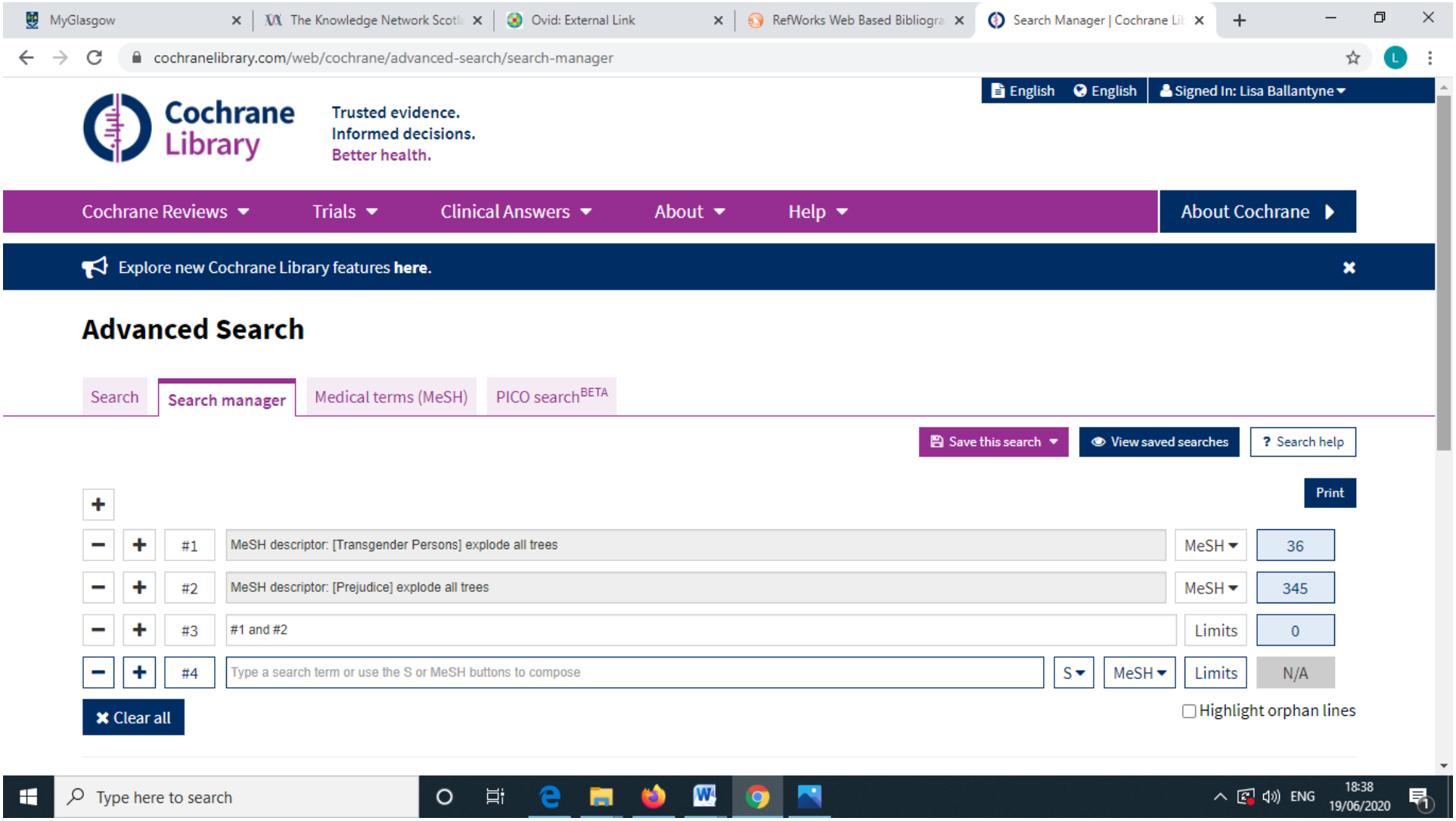
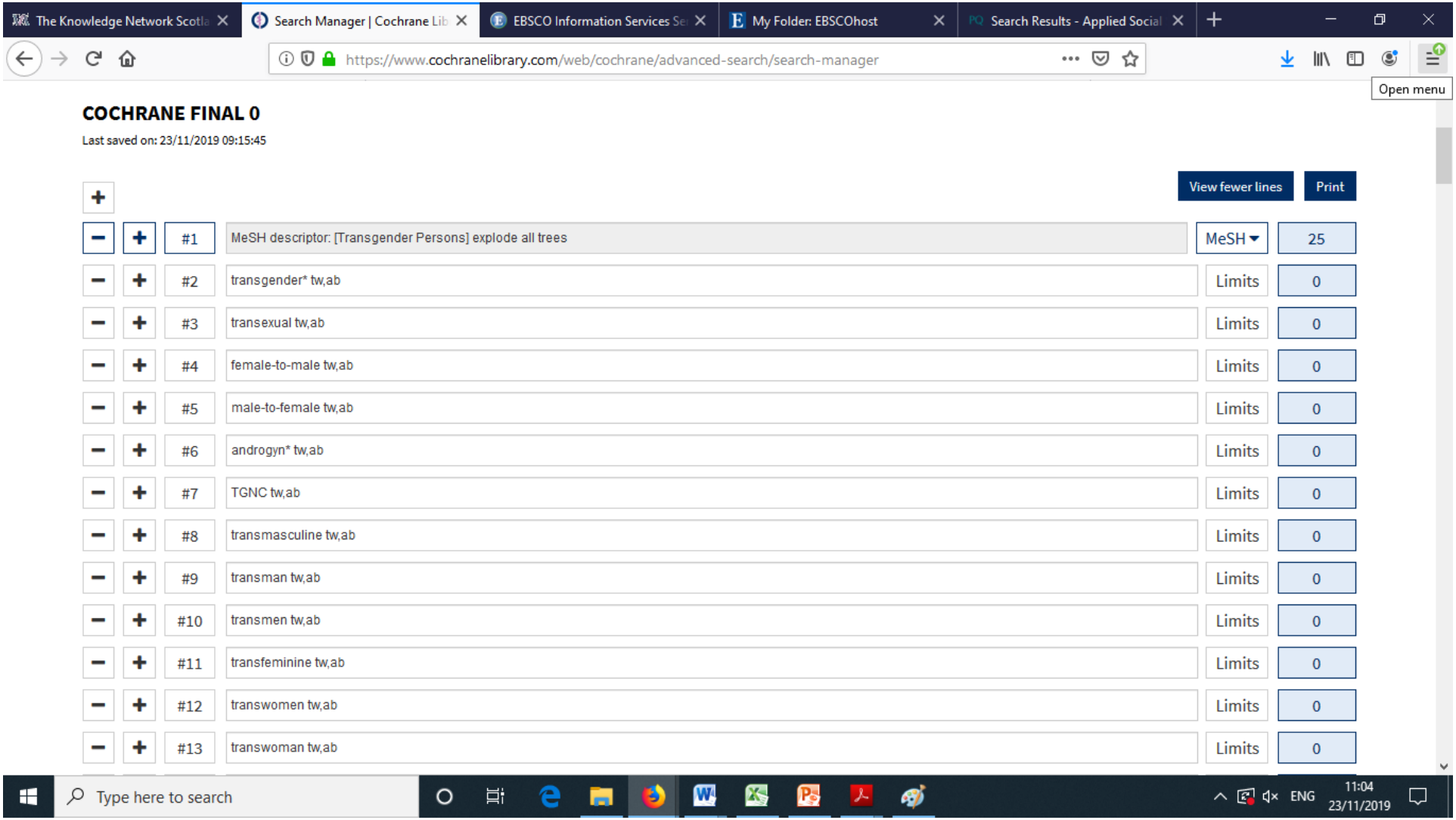
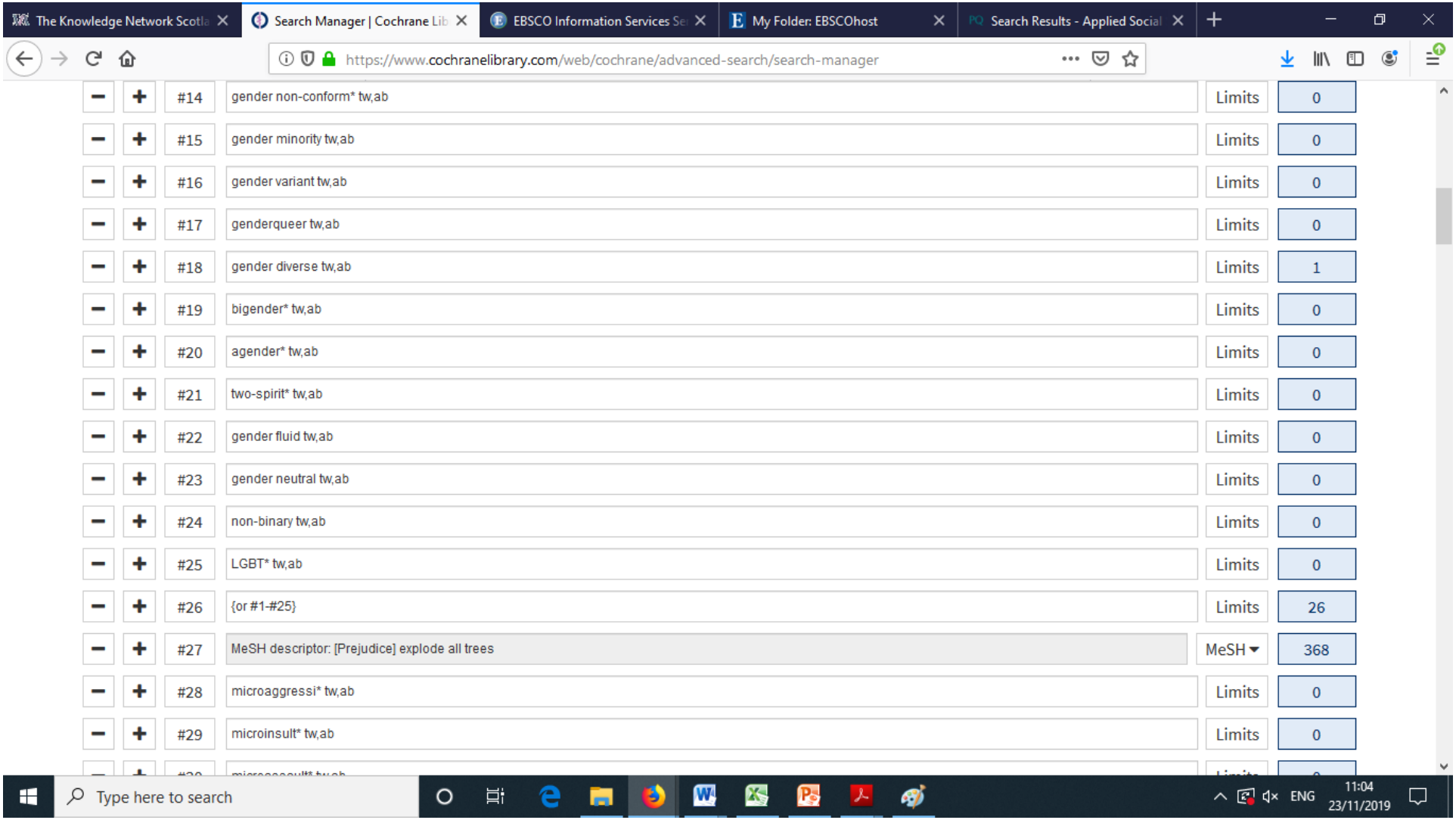
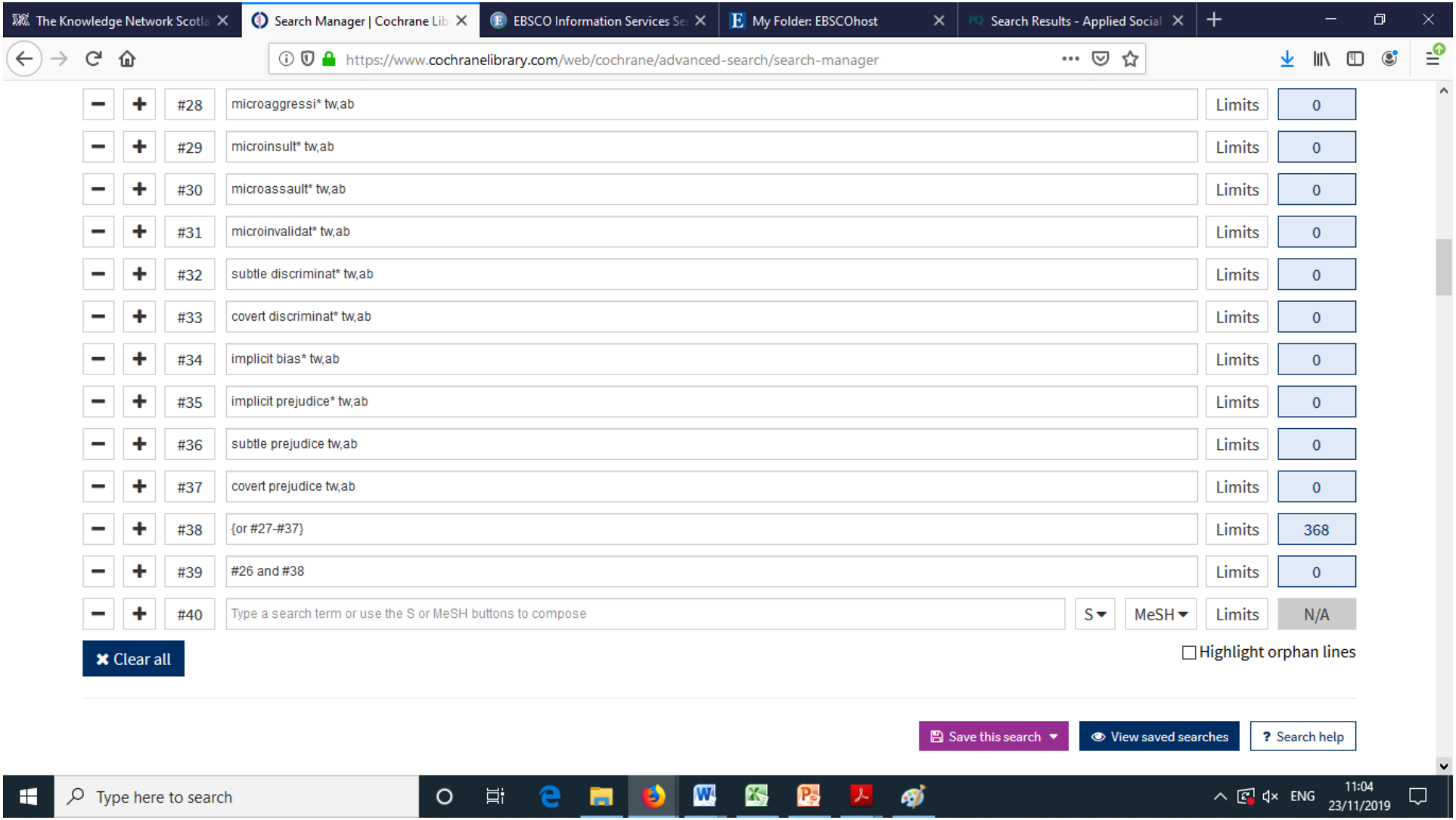
S9 TI transman OR AB transman Search modes - Boolean/Phrase View Results (1) View Details Edit
S8 TI transmasculine OR AB transmasculine Search modes - Boolean/Phrase View Results (44) View Details Edit
S7 TI TGNC OR AB TGNC Search modes - Boolean/Phrase View Results (41) View Details Edit
S6 TI androgyn* OR AB androgyn* Search modes - Boolean/Phrase View Results (93) View Details Edit
S5 TI male-to-female OR AB male-to-female Search modes - Boolean/Phrase View Results (25,906) View Details Edit
S4 TI female-to-male OR AB female-to-male Search modes - Boolean/Phrase View Results (8,012) View Details Edit
S3 TI transexual OR AB transexual Search modes - Boolean/Phrase View Results (10) View Details Edit
S2 TI transgender* AND AB transgender* Search modes - Boolean/Phrase View Results (1,645) View Details Edit
S1 (MH "Transgender Persons+") Search modes - Boolean/Phrase View Results (2,474) View Details Edit
Refine Results
Current Search
Boolean/Phrase:
S25 AND S37
Limiters
English Language
Search Results: 1 - 50 of 217
Date Newest
Page Options
Share
1. Discrimination in the United States: Experiences of lesbian, gay, bisexual, transgender, and queer Americans.
Academic Journal
(includes abstract) Casey, Logan S.; Reisner, Sari L.; Findling, Mary G.; Blendon, Robert J.; Benson, John M.; Sayde, Justin M.; Miller, Carolyn; Health Services Research, Dec2019 Supplement S2; 54 1454-1466. 13p. (journal article)
ISSN: 0017-9124 PMID: 31659745
Objective: To examine reported experiences of discrimination against lesbian, gay, bisexual, transgender, and queer (LGBTQ) adults in the United States, which broadly contribute to poor health ou...
Type here to search
ENG
12:00
23/11/2019

Appendix 1.6: COCHRANE database search

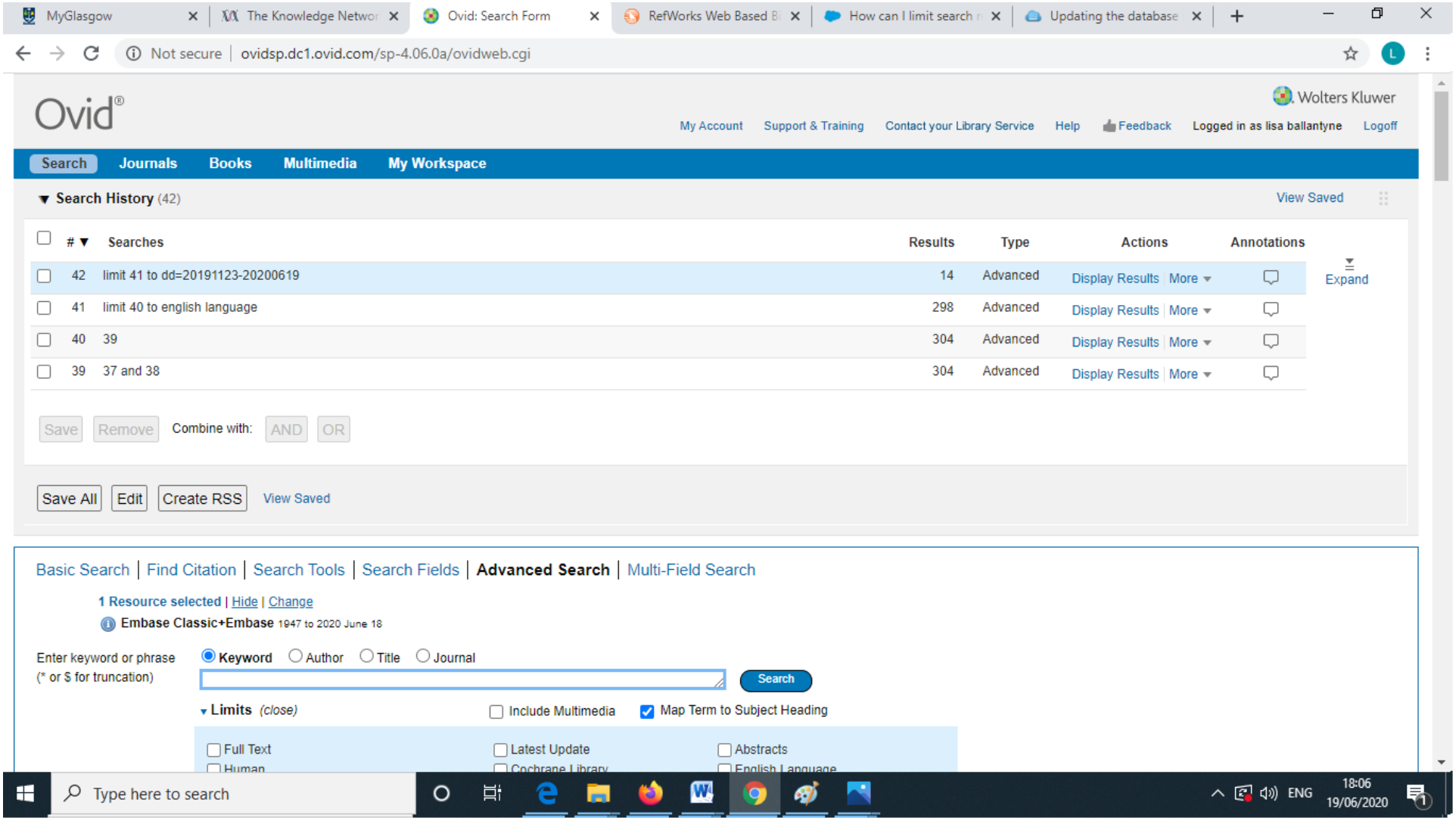


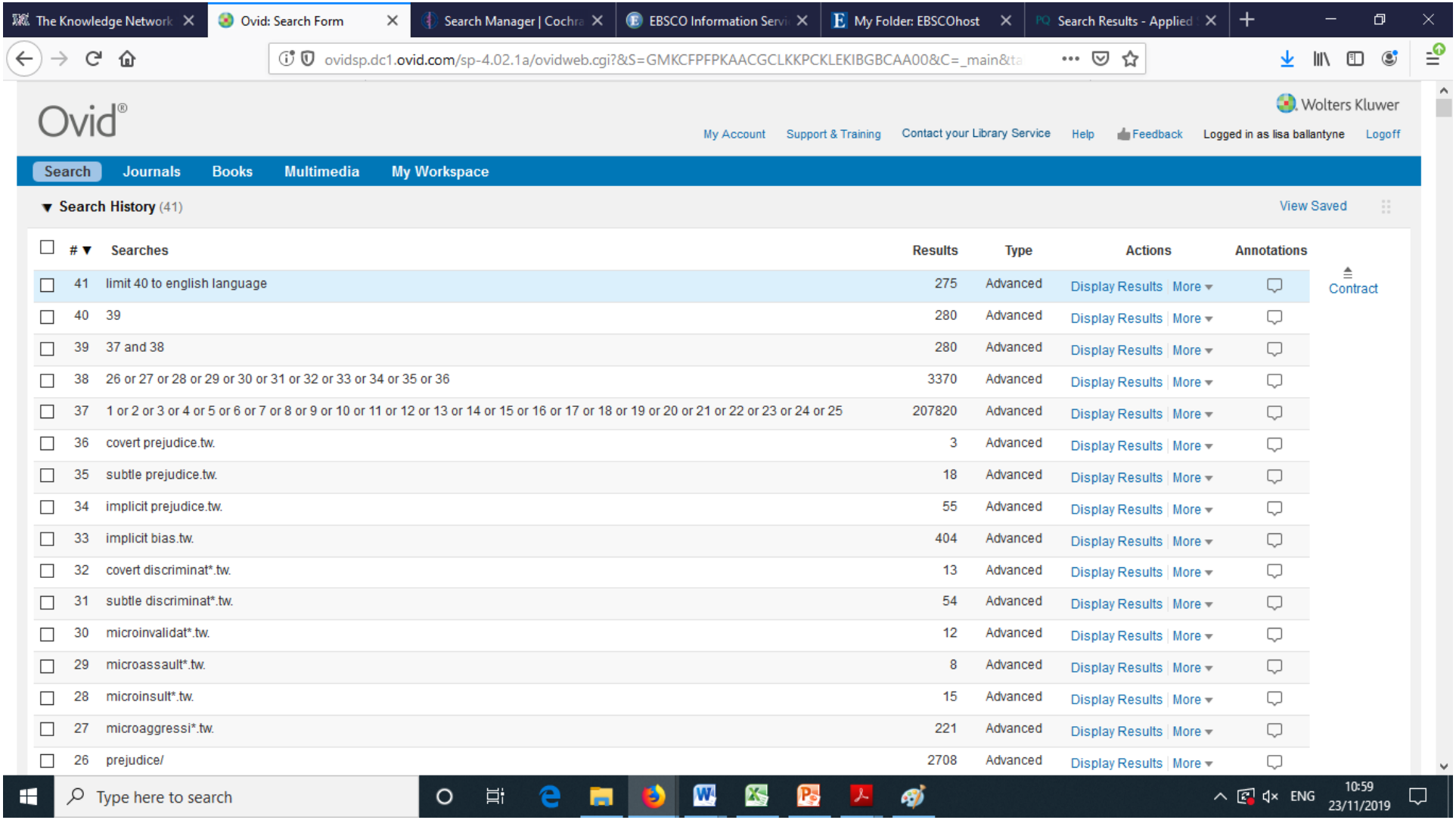

The Knowledge Network Scotla
Search Manager | Cochrane Lib
EBSCO Information Services Se
My Folder: EBSCOhost
Search Results - Applied Social
https://www.cochranelibrary.com/web/cochrane/advanced-search/search-manager
Open menu
COCHRANE FINAL 0
Last saved on: 23/11/2019 09:15:45
View fewer lines
Print
#1 MeSH descriptor: [Transgender Persons] explode all trees MeSH 25
#2 transgender* tw,ab Limits 0
#3 transexual tw,ab Limits 0
#4 female-to-male tw,ab Limits 0
#5 male-to-female tw,ab Limits 0
#6 androgyn* tw,ab Limits 0
#7 TGNC tw,ab Limits 0
#8 transmasculine tw,ab Limits 0
#9 transman tw,ab Limits 0
#10 transmen tw,ab Limits 0
#11 transfeminine tw,ab Limits 0
#12 transwomen tw,ab Limits 0
#13 transwoman tw,ab Limits 0
Type here to search
ENG
11:04
23/11/2019

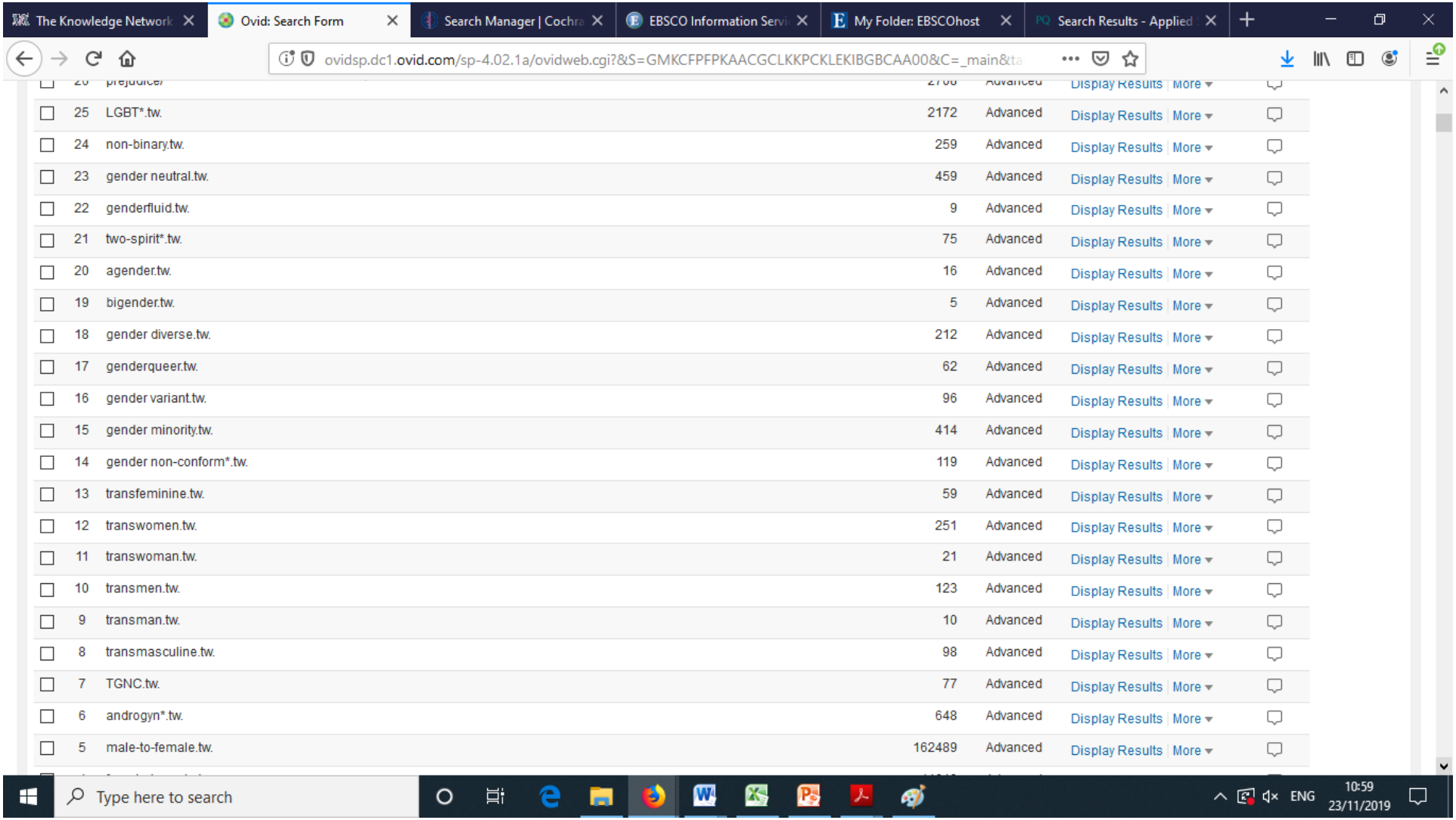

The Knowledge Network Scotla
Search Manager | Cochrane Lib
EBSCO Information Services Se
My Folder: EBSCOhost
Search Results - Applied Social
https://www.cochranelibrary.com/web/cochrane/advanced-search/search-manager
#14 gender non-conform* tw,ab Limits 0
#15 gender minority tw,ab Limits 0
#16 gender variant tw,ab Limits 0
#17 genderqueer tw,ab Limits 0
#18 gender diverse tw,ab Limits 1
#19 bigender* tw,ab Limits 0
#20 agender* tw,ab Limits 0
#21 two-spirit* tw,ab Limits 0
#22 gender fluid tw,ab Limits 0
#23 gender neutral tw,ab Limits 0
#24 non-binary tw,ab Limits 0
#25 LGBT* tw,ab Limits 0
#26 {or #1-#25} Limits 26
#27 MeSH descriptor: [Prejudice] explode all trees MeSH 368
#28 microaggressi* tw,ab Limits 0
#29 microinsult* tw,ab Limits 0
Type here to search
ENG
11:04
23/11/2019

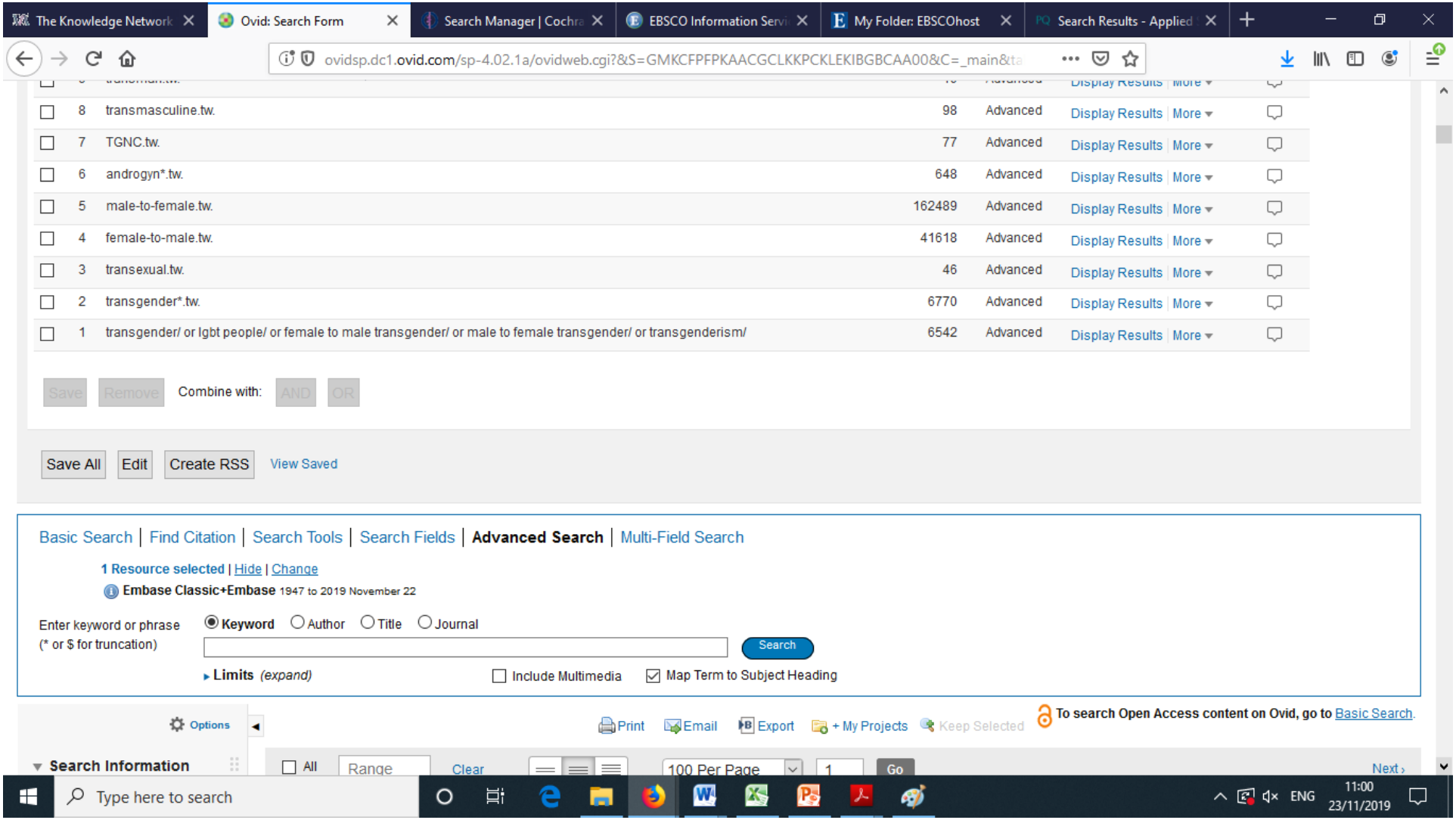

The Knowledge Network Scotla
Search Manager | Cochrane Lib
EBSCO Information Services Se
My Folder: EBSCOhost
Search Results - Applied Social
https://www.cochranelibrary.com/web/cochrane/advanced-search/search-manager
#28 microaggressi* tw,ab Limits 0
#29 microinsult* tw,ab Limits 0
#30 microassault* tw,ab Limits 0
#31 microinvalidat* tw,ab Limits 0
#32 subtle discriminat* tw,ab Limits 0
#33 covert discriminat* tw,ab Limits 0
#34 implicit bias* tw,ab Limits 0
#35 implicit prejudice* tw,ab Limits 0
#36 subtle prejudice tw,ab Limits 0
#37 covert prejudice tw,ab Limits 0
#38 {or #27-#37} Limits 368
#39 #26 and #38 Limits 0
#40 Type a search term or use the S or MeSH buttons to compose S MeSH Limits N/A
Clear all
Highlight orphan lines
Save this search
View saved searches
Search help
Type here to search
ENG
11:04
23/11/2019

Appendix 1.7: EMBASE database search

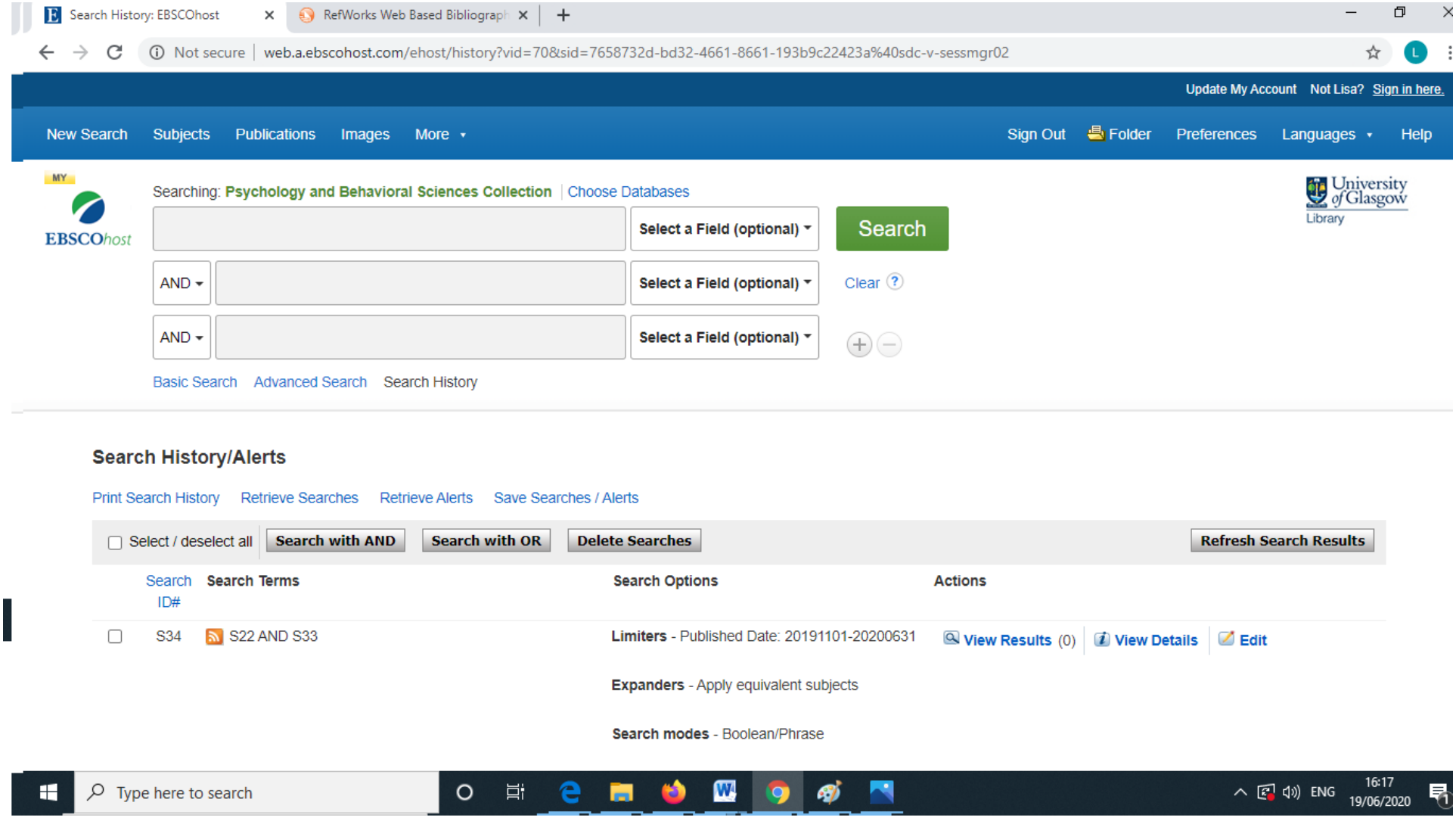


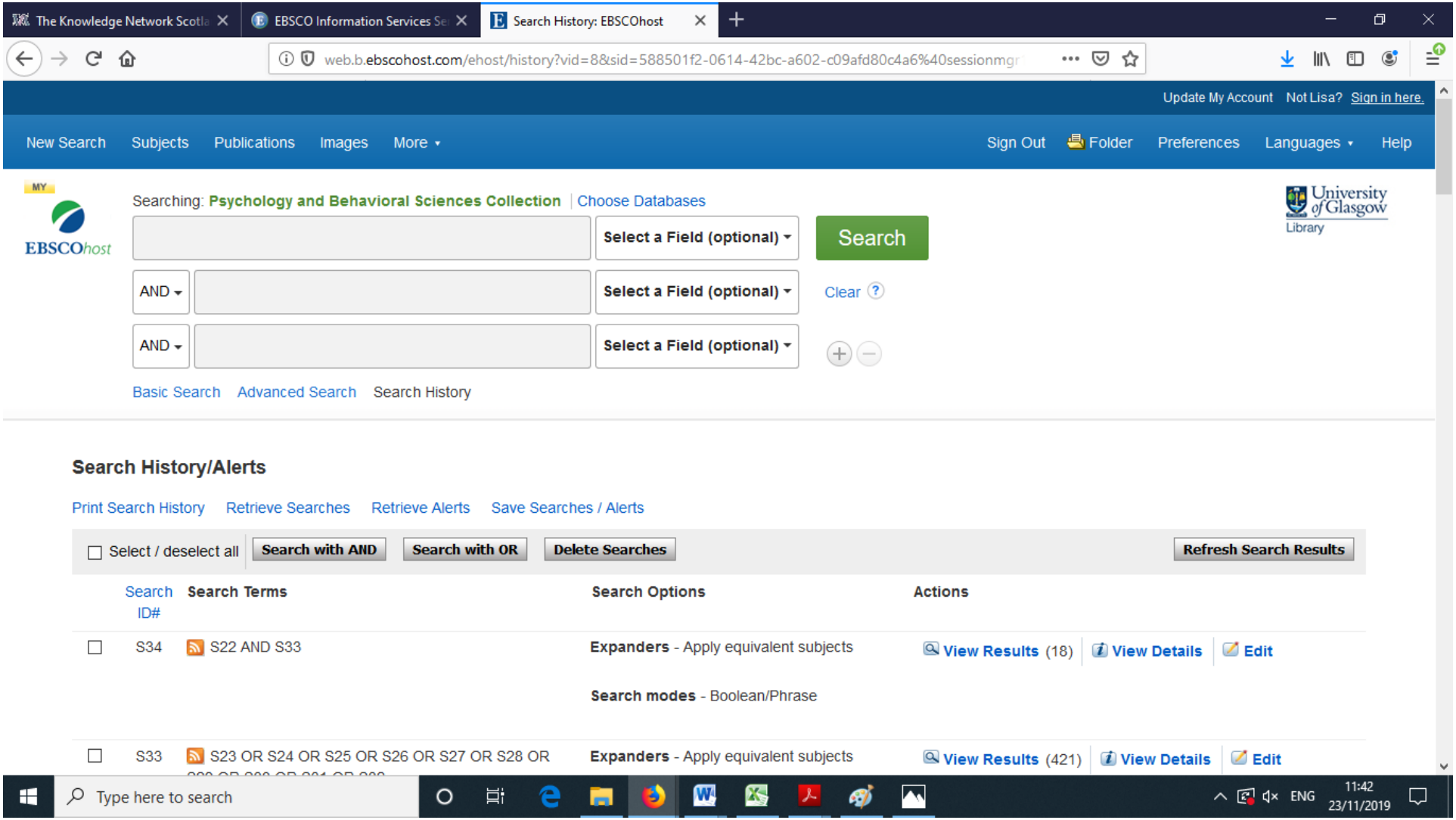

The Knowledge Network
Ovid: Search Form
Search Manager | Cochra
EBSCO Information Servi
My Folder: EBSCOhost
Search Results - Applied
ovidsp.dc1.ovid.com/sp-4.02.1a/ovidweb.cgi?&S=GMKCFPFPKAACGCLKKPCKLEKIBGBCAA00&C=_main&ta
Ovid®
Wolters Kluwer
My Account
Support & Training
Contact your Library Service
Help
Feedback
Logged in as lisa ballantyne
Logoff
Search
Journals
Books
Multimedia
My Workspace
Search History (41)
View Saved
▼
Searches
Results
Type
Actions
Annotations
Contract
41 limit 40 to english language 275 Advanced Display Results | More
40 39 280 Advanced Display Results | More
39 37 and 38 280 Advanced Display Results | More
38 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 3370 Advanced Display Results | More
37 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 207820 Advanced Display Results | More
36 covert prejudice.tw. 3 Advanced Display Results | More
35 subtle prejudice.tw. 18 Advanced Display Results | More
34 implicit prejudice.tw. 55 Advanced Display Results | More
33 implicit bias.tw. 404 Advanced Display Results | More
32 covert discriminat*.tw. 13 Advanced Display Results | More
31 subtle discriminat*.tw. 54 Advanced Display Results | More
30 microinvalidat*.tw. 12 Advanced Display Results | More
29 microassault*.tw. 8 Advanced Display Results | More
28 microinsult*.tw. 15 Advanced Display Results | More
27 microaggressi*.tw. 221 Advanced Display Results | More
26 prejudice/ 2708 Advanced Display Results | More
Type here to search
ENG
10:59
23/11/2019

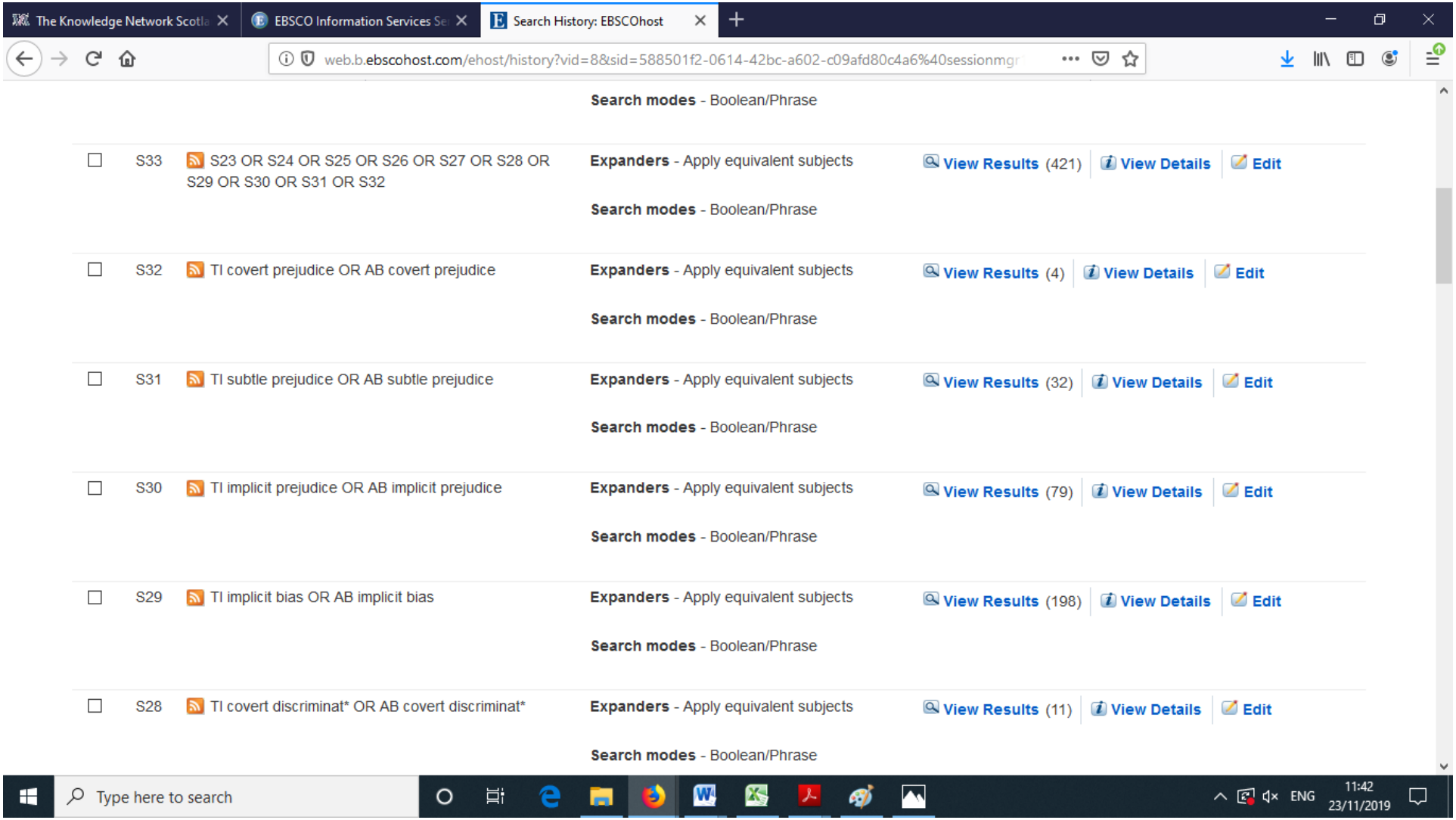

The Knowledge Network
Ovid: Search Form
Search Manager | Cochra
EBSCO Information Servi
My Folder: EBSCOhost
Search Results - Applied
ovidsp.dc1.ovid.com/sp-4.02.1a/ovidweb.cgi?&S=GMKCFPFPKAACGCLKKPCKLEKIBGBCAA00&C=_main&ta
25 LGBT*.tw. 2172 Advanced Display Results | More
24 non-binary.tw. 259 Advanced Display Results | More
23 gender neutral.tw. 459 Advanced Display Results | More
22 genderfluid.tw. 9 Advanced Display Results | More
21 two-spirit*.tw. 75 Advanced Display Results | More
20 agender.tw. 16 Advanced Display Results | More
19 bigender.tw. 5 Advanced Display Results | More
18 gender diverse.tw. 212 Advanced Display Results | More
17 genderqueer.tw. 62 Advanced Display Results | More
16 gender variant.tw. 96 Advanced Display Results | More
15 gender minority.tw. 414 Advanced Display Results | More
14 gender non-conform*.tw. 119 Advanced Display Results | More
13 transfeminine.tw. 59 Advanced Display Results | More
12 transwomen.tw. 251 Advanced Display Results | More
11 transwoman.tw. 21 Advanced Display Results | More
10 transmen.tw. 123 Advanced Display Results | More
9 transman.tw. 10 Advanced Display Results | More
8 transmasculine.tw. 98 Advanced Display Results | More
7 TGNC.tw. 77 Advanced Display Results | More
6 androgyn*.tw. 648 Advanced Display Results | More
5 male-to-female.tw. 162489 Advanced Display Results | More
Type here to search
ENG
10:59
23/11/2019

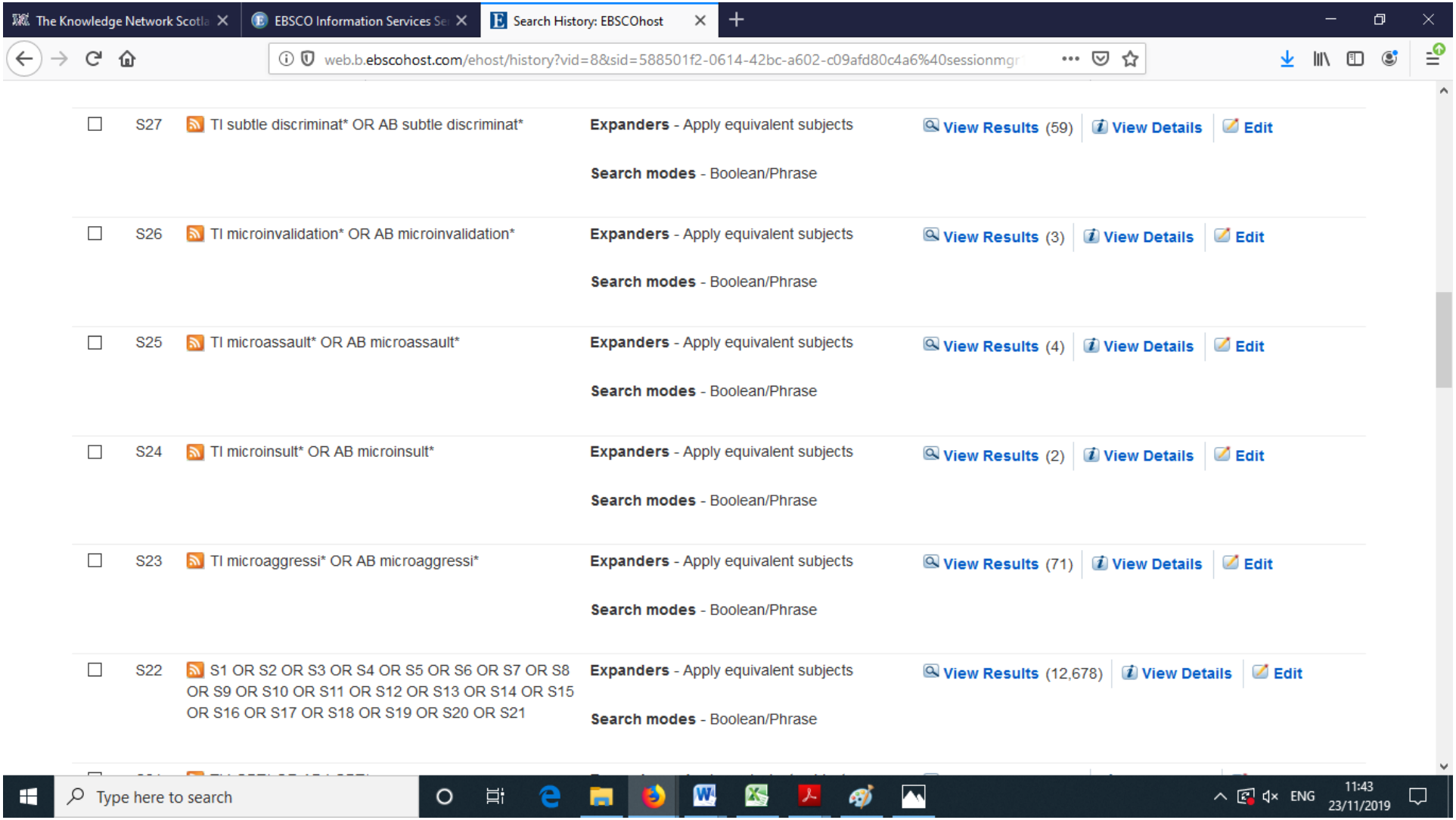

The Knowledge Network
Ovid: Search Form
Search Manager | Cochra
EBSCO Information Servi
My Folder: EBSCOhost
Search Results - Applied
ovidsp.dc1.ovid.com/sp-4.02.1a/ovidweb.cgi?&S=GMKCFPFPKAACGCLKKPCKLEKIBGBCAA00&C=_main&ta
8 transmasculine.tw. 98 Advanced Display Results More
7 TGNC.tw. 77 Advanced Display Results More
6 androgyn*.tw. 648 Advanced Display Results More
5 male-to-female.tw. 162489 Advanced Display Results More
4 female-to-male.tw. 41618 Advanced Display Results More
3 transexual.tw. 46 Advanced Display Results More
2 transgender*.tw. 6770 Advanced Display Results More
1 transgender/ or lgbt people/ or female to male transgender/ or male to female transgender/ or transgenderism/ 6542 Advanced Display Results More
Save
Remove
Combine with:
AND
OR
Save All
Edit
Create RSS
View Saved
Basic Search | Find Citation | Search Tools | Search Fields | Advanced Search | Multi-Field Search
1 Resource selected | Hide | Change
Embase Classic+Embase 1947 to 2019 November 22
Enter keyword or phrase
(* or $ for truncation)
Keyword
Author
Title
Journal
Search
Limits (expand)
Include Multimedia
Map Term to Subject Heading
Options
Print
Email
Export
+ My Projects
Keep Selected
To search Open Access content on Ovid, go to Basic Search.
Search Information
All
Range
Clear
100 Per Page
Go
Next
Type here to search
ENG
11:00
23/11/2019

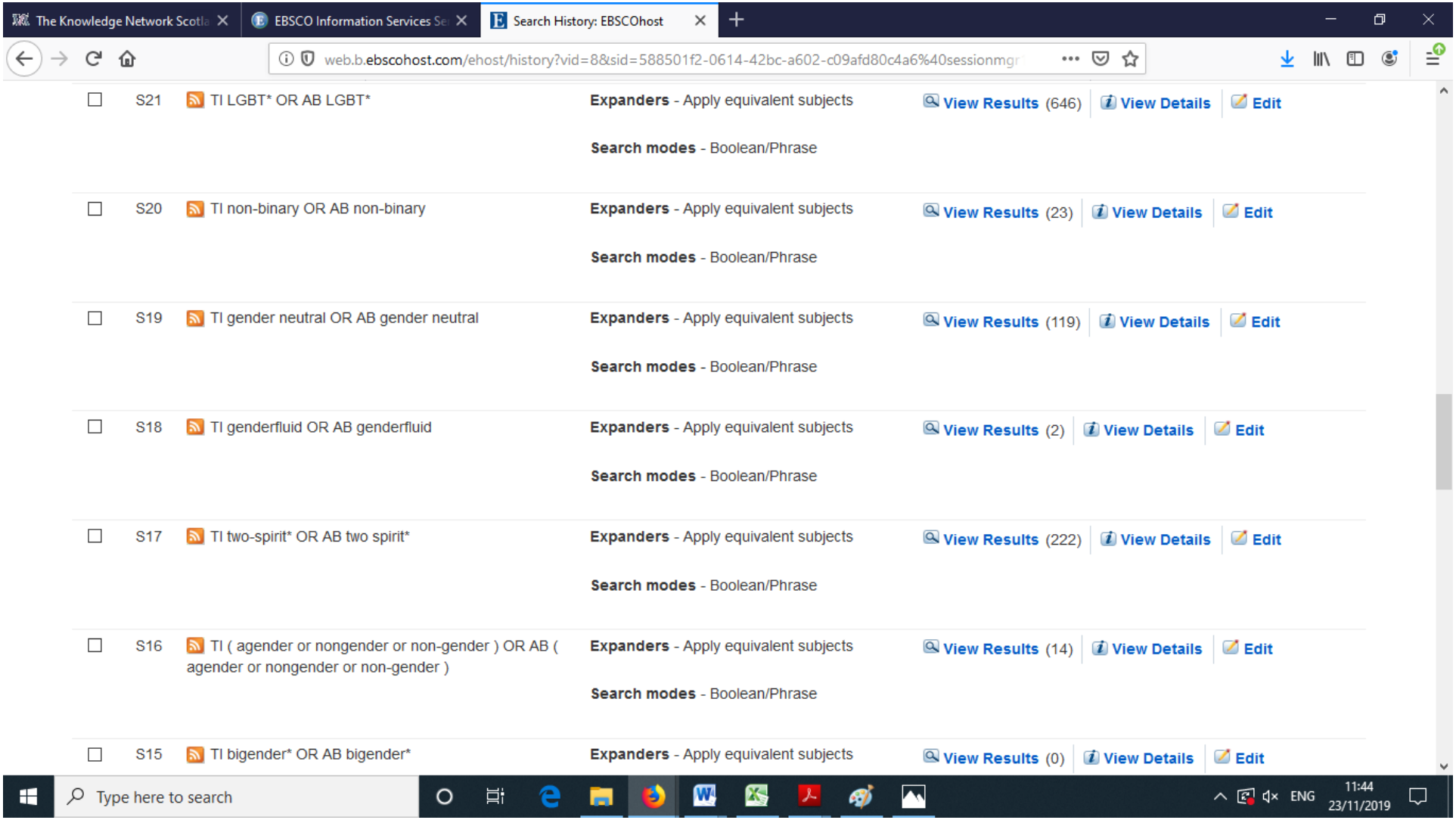
Appendix 1.8: Psychology & Behavioural Sciences database search

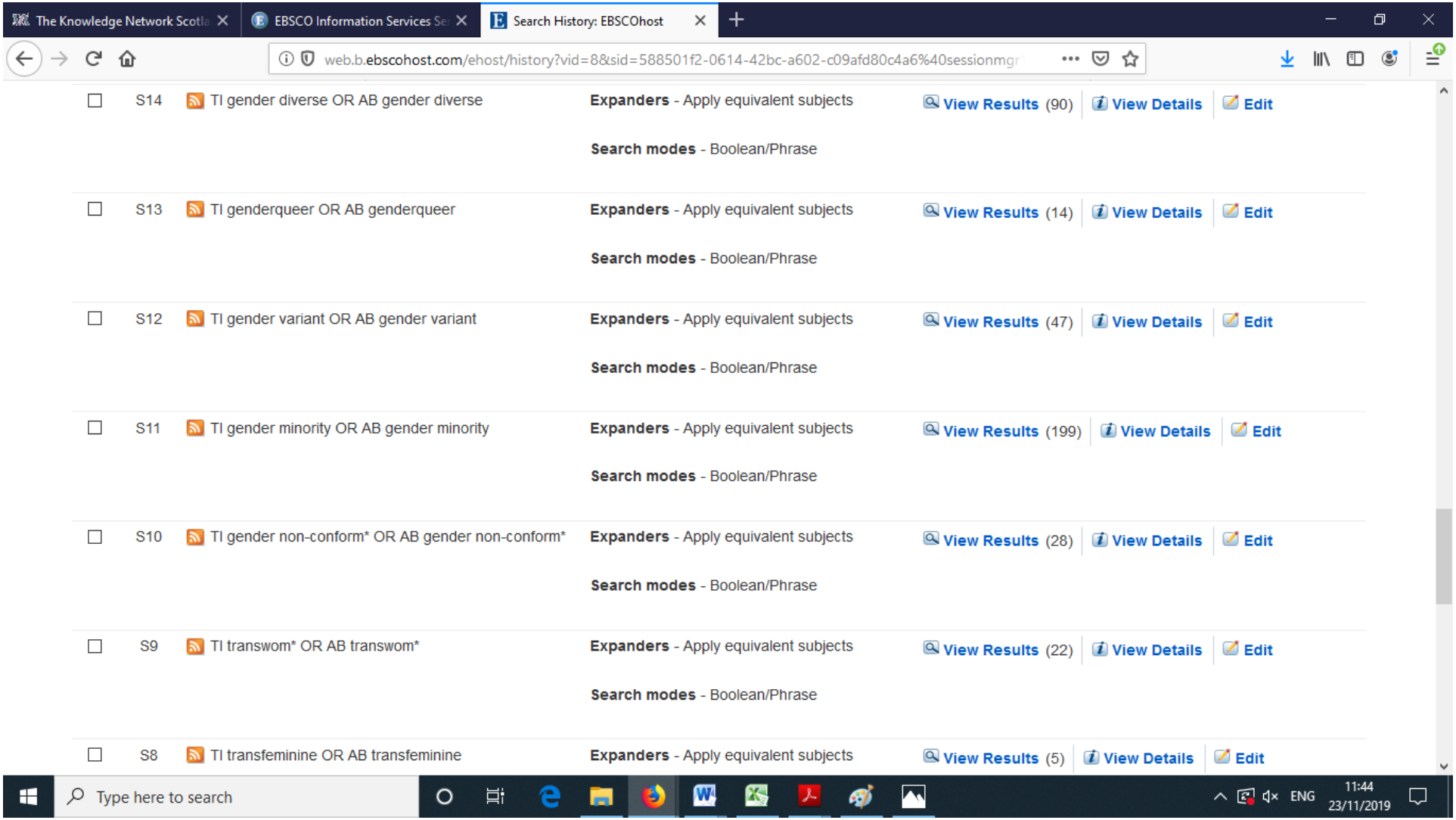


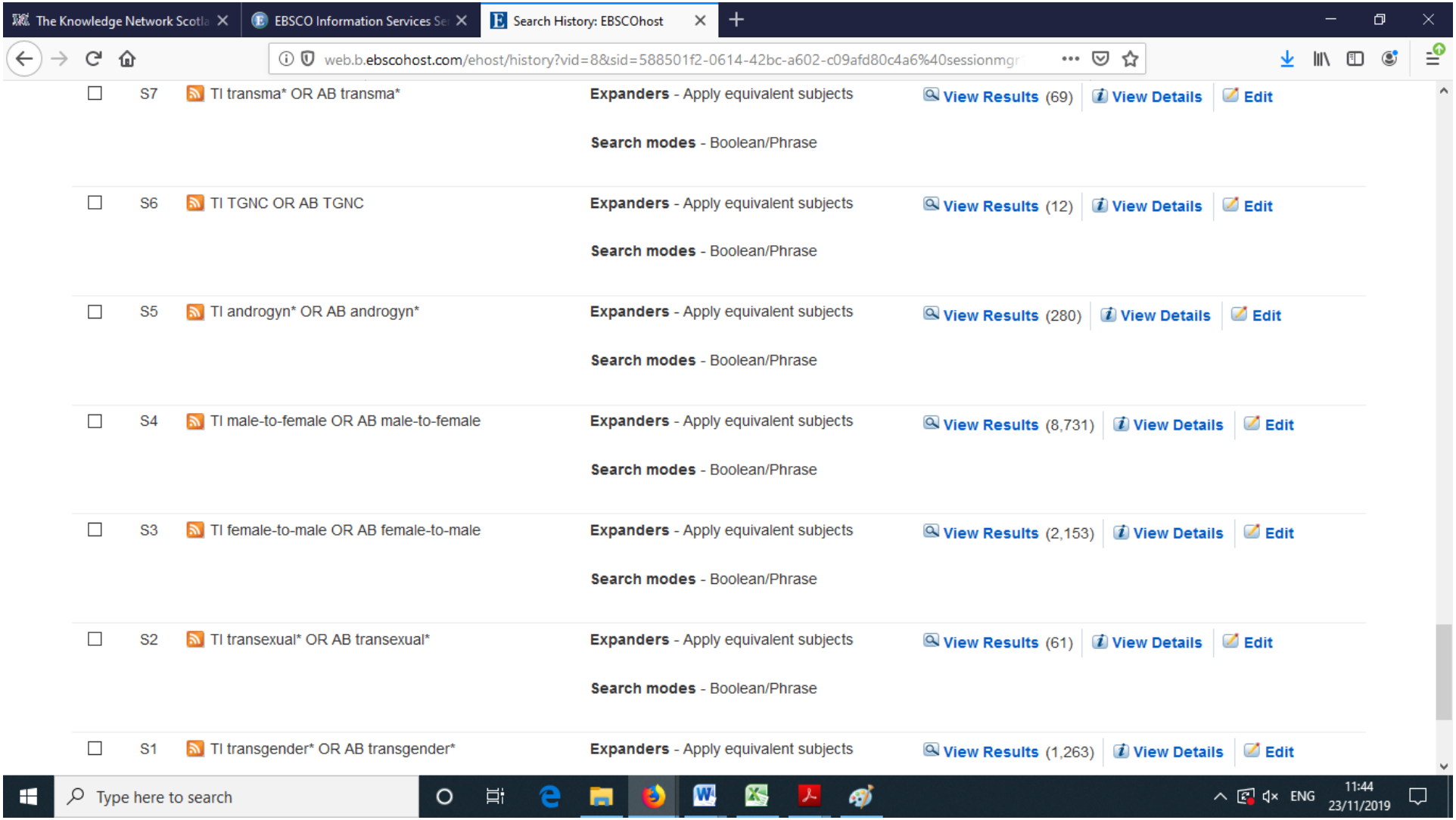

The Knowledge Network Scotla
EBSCO Information Services Se
Search History: EBSCOhost
web.b.ebscohost.com/ehost/history?vid=8&sid=588501f2-0614-42bc-a602-c09afd80c4a6%40sessionmgr
Update My Account
Not Lisa? Sign in here.
New Search
Subjects
Publications
Images
More
Sign Out
Folder
Preferences
Languages
Help
EBSCOhost
Searching: Psychology and Behavioral Sciences Collection
Choose Databases
Select a Field (optional)
Search
AND
Clear
Basic Search
Advanced Search
Search History
University of Glasgow Library
Search History/Alerts
Print Search History
Retrieve Searches
Retrieve Alerts
Save Searches / Alerts
Select / deselect all
Search with AND
Search with OR
Delete Searches
Refresh Search Results
Search ID#
Search Terms
Search Options
Actions
S34
S22 AND S33
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (18)
View Details
Edit
S33
S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR
Expanders - Apply equivalent subjects
View Results (421)
View Details
Edit
Type here to search
ENG
11:42
23/11/2019


The Knowledge Network Scotla
EBSCO Information Services Se
Search History: EBSCOhost
web.b.ebscohost.com/ehost/history?vid=8&sid=588501f2-0614-42bc-a602-c09afd80c4a6%40sessionmgr
Search modes - Boolean/Phrase
S33 S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (421) View Details Edit
S32 TI covert prejudice OR AB covert prejudice
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (4) View Details Edit
S31 TI subtle prejudice OR AB subtle prejudice
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (32) View Details Edit
S30 TI implicit prejudice OR AB implicit prejudice
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (79) View Details Edit
S29 TI implicit bias OR AB implicit bias
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (198) View Details Edit
S28 TI covert discriminat* OR AB covert discriminat*
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (11) View Details Edit
Type here to search
ENG
11:42
23/11/2019

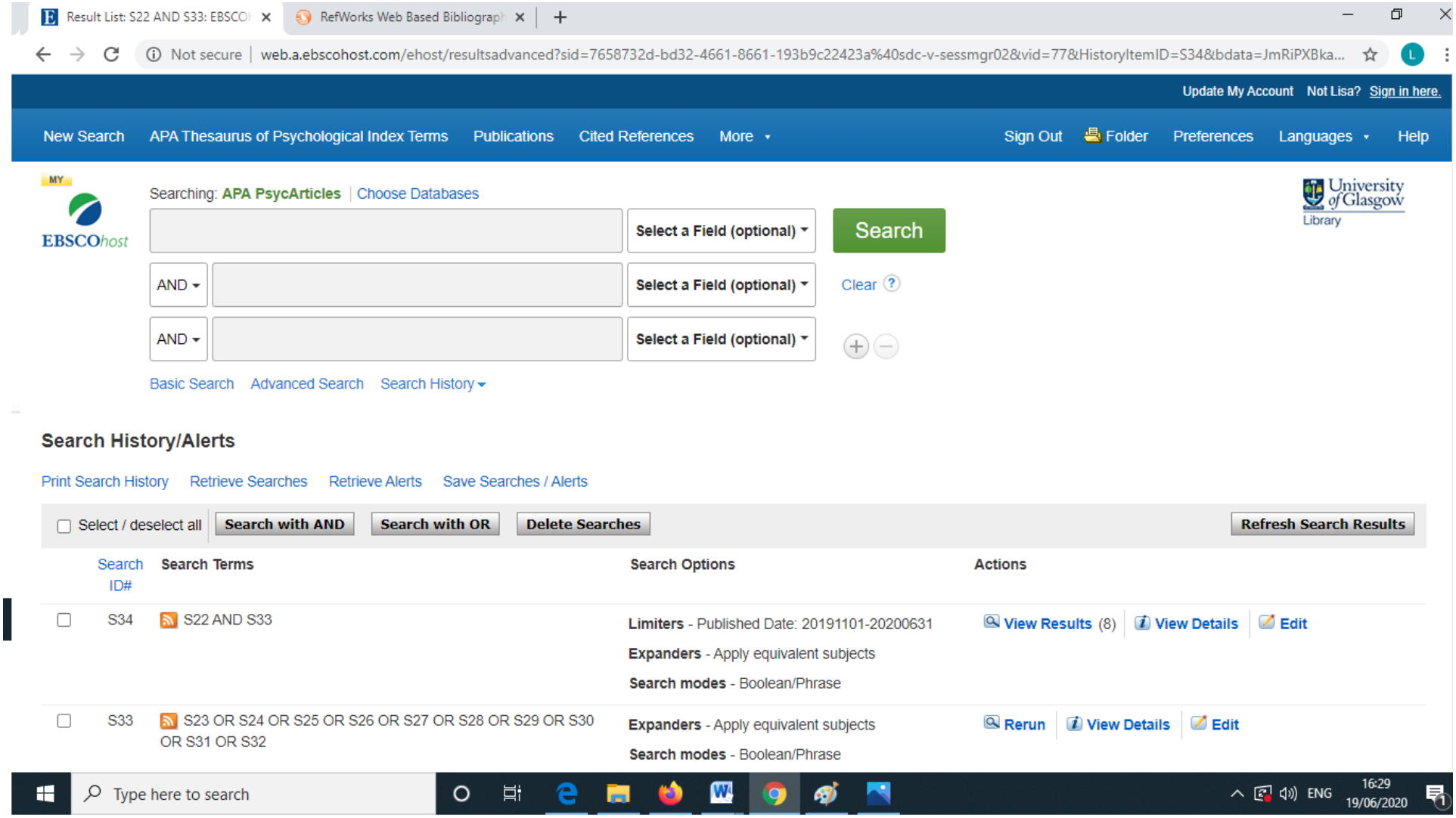

The Knowledge Network Scotla
EBSCO Information Services Se
Search History: EBSCOhost
web.b.ebscohost.com/ehost/history?vid=8&sid=588501f2-0614-42bc-a602-c09afd80c4a6%40sessionmgr
S27 TI subtle discriminat* OR AB subtle discriminat*
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (59) View Details Edit
S26 TI microinvalidation* OR AB microinvalidation*
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (3) View Details Edit
S25 TI microassault* OR AB microassault*
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (4) View Details Edit
S24 TI microinsult* OR AB microinsult*
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (2) View Details Edit
S23 TI microaggressi* OR AB microaggressi*
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (71) View Details Edit
S22 S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (12,678) View Details Edit
Type here to search
ENG
11:43
23/11/2019

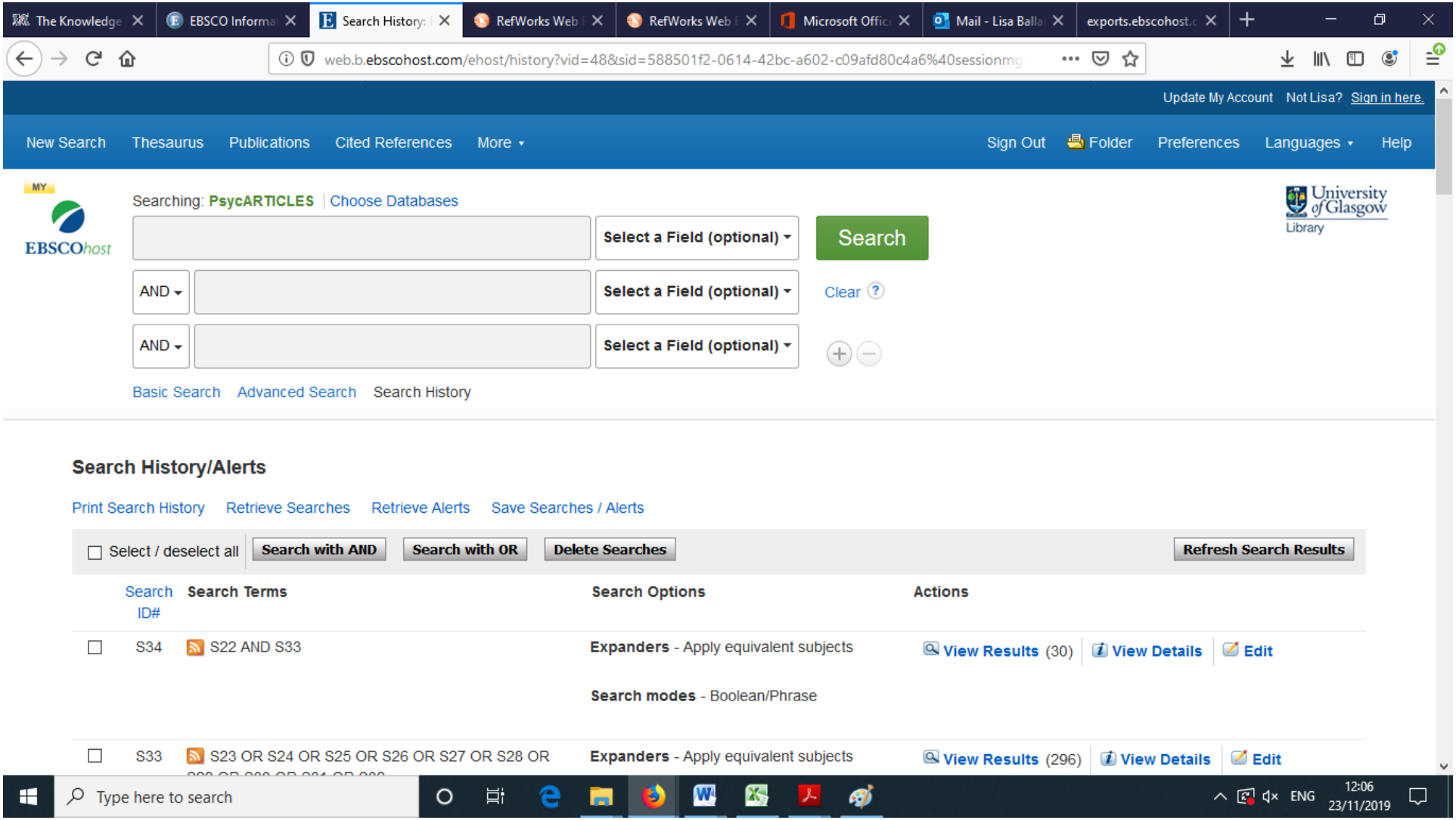

The Knowledge Network Scotla
EBSCO Information Services Se
Search History: EBSCOhost
web.b.ebscohost.com/ehost/history?vid=8&sid=588501f2-0614-42bc-a602-c09afd80c4a6%40sessionmgr
S21 TI LGBT* OR AB LGBT*
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (646) View Details Edit
S20 TI non-binary OR AB non-binary
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (23) View Details Edit
S19 TI gender neutral OR AB gender neutral
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (119) View Details Edit
S18 TI genderfluid OR AB genderfluid
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (2) View Details Edit
S17 TI two-spirit* OR AB two spirit*
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (222) View Details Edit
S16 TI (agender or nongender or non-gender) OR AB (agender or nongender or non-gender)
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (14) View Details Edit
S15 TI bigender* OR AB bigender*
Expanders - Apply equivalent subjects
View Results (0) View Details Edit
Type here to search
ENG
11:44
23/11/2019

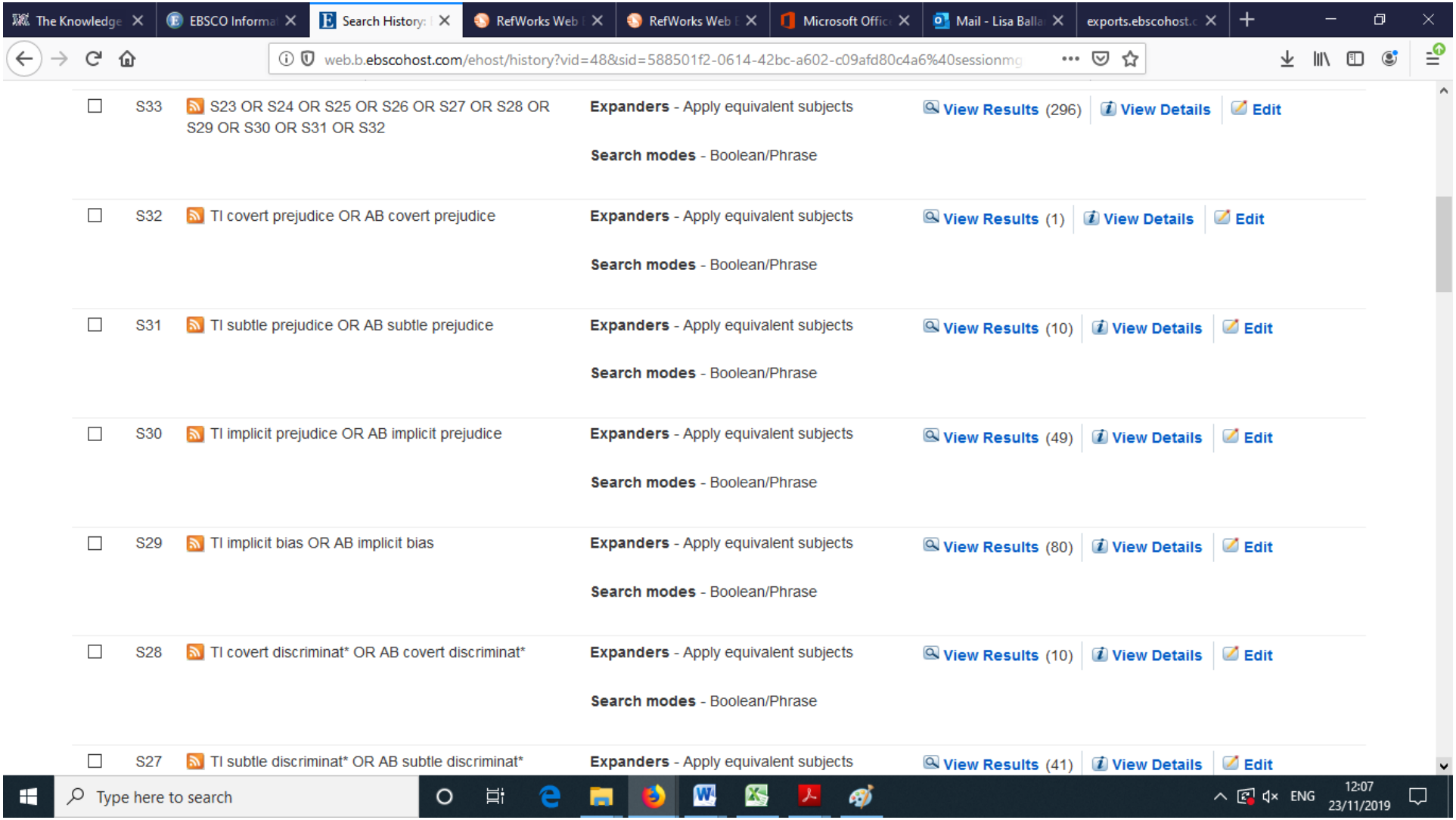

The Knowledge Network Scotla
EBSCO Information Services Se
Search History: EBSCOhost
web.b.ebscohost.com/ehost/history?vid=8&sid=588501f2-0614-42bc-a602-c09afd80c4a6%40sessionmgr
S14 TI gender diverse OR AB gender diverse
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (90)
View Details
Edit
S13 TI genderqueer OR AB genderqueer
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (14)
View Details
Edit
S12 TI gender variant OR AB gender variant
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (47)
View Details
Edit
S11 TI gender minority OR AB gender minority
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (199)
View Details
Edit
S10 TI gender non-conform* OR AB gender non-conform*
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (28)
View Details
Edit
S9 TI transwom* OR AB transwom*
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (22)
View Details
Edit
S8 TI transfeminine OR AB transfeminine
Expanders - Apply equivalent subjects
View Results (5)
View Details
Edit
Type here to search
ENG
11:44
23/11/2019


The Knowledge Network Scotla
EBSCO Information Services Se
Search History: EBSCOhost
web.b.ebscohost.com/ehost/history?vid=8&sid=588501f2-0614-42bc-a602-c09afd80c4a6%40sessionmgr
S7 TI transma* OR AB transma* Expanders - Apply equivalent subjects Search modes - Boolean/Phrase View Results (69) View Details Edit
S6 TI TGNC OR AB TGNC Expanders - Apply equivalent subjects Search modes - Boolean/Phrase View Results (12) View Details Edit
S5 TI androgyn* OR AB androgyn* Expanders - Apply equivalent subjects Search modes - Boolean/Phrase View Results (280) View Details Edit
S4 TI male-to-female OR AB male-to-female Expanders - Apply equivalent subjects Search modes - Boolean/Phrase View Results (8,731) View Details Edit
S3 TI female-to-male OR AB female-to-male Expanders - Apply equivalent subjects Search modes - Boolean/Phrase View Results (2,153) View Details Edit
S2 TI transexual* OR AB transexual* Expanders - Apply equivalent subjects Search modes - Boolean/Phrase View Results (61) View Details Edit
S1 TI transgender* OR AB transgender* Expanders - Apply equivalent subjects View Results (1,263) View Details Edit
Type here to search
ENG
11:44
23/11/2019

Appendix 1.9: PsycARTICLES database search




The Knowledge
EBSCO Informa
Search History:
RefWorks Web
RefWorks Web
Microsoft Offic
Mail - Lisa Balla
exports.ebscohost.c
web.b.ebscohost.com/ehost/history?vid=48&sid=588501f2-0614-42bc-a602-c09afd80c4a6%40sessionmg
Update My Account
Not Lisa? Sign in here.
New Search
Thesaurus
Publications
Cited References
More
Sign Out
Folder
Preferences
Languages
Help
EBSCOhost
Searching: PsycARTICLES
Choose Databases
Select a Field (optional)
Search
AND
Clear
Basic Search
Advanced Search
Search History
University of Glasgow Library
Search History/Alerts
Print Search History
Retrieve Searches
Retrieve Alerts
Save Searches / Alerts
Select / deselect all
Search with AND
Search with OR
Delete Searches
Refresh Search Results
Search ID#
Search Terms
Search Options
Actions
S34
S22 AND S33
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (30)
View Details
Edit
S33
S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR
Expanders - Apply equivalent subjects
View Results (296)
View Details
Edit
Type here to search
ENG
12:06
23/11/2019


The Knowledge
EBSCO Informa
Search History:
RefWorks Web
RefWorks Web
Microsoft Offic
Mail - Lisa Balla
exports.ebscohost.c
web.b.ebscohost.com/ehost/history?vid=48&sid=588501f2-0614-42bc-a602-c09afd80c4a6%40sessionmg
S33 S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (296) View Details Edit
S32 TI covert prejudice OR AB covert prejudice
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (1) View Details Edit
S31 TI subtle prejudice OR AB subtle prejudice
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (10) View Details Edit
S30 TI implicit prejudice OR AB implicit prejudice
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (49) View Details Edit
S29 TI implicit bias OR AB implicit bias
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (80) View Details Edit
S28 TI covert discriminat* OR AB covert discriminat*
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (10) View Details Edit
S27 TI subtle discriminat* OR AB subtle discriminat*
Expanders - Apply equivalent subjects
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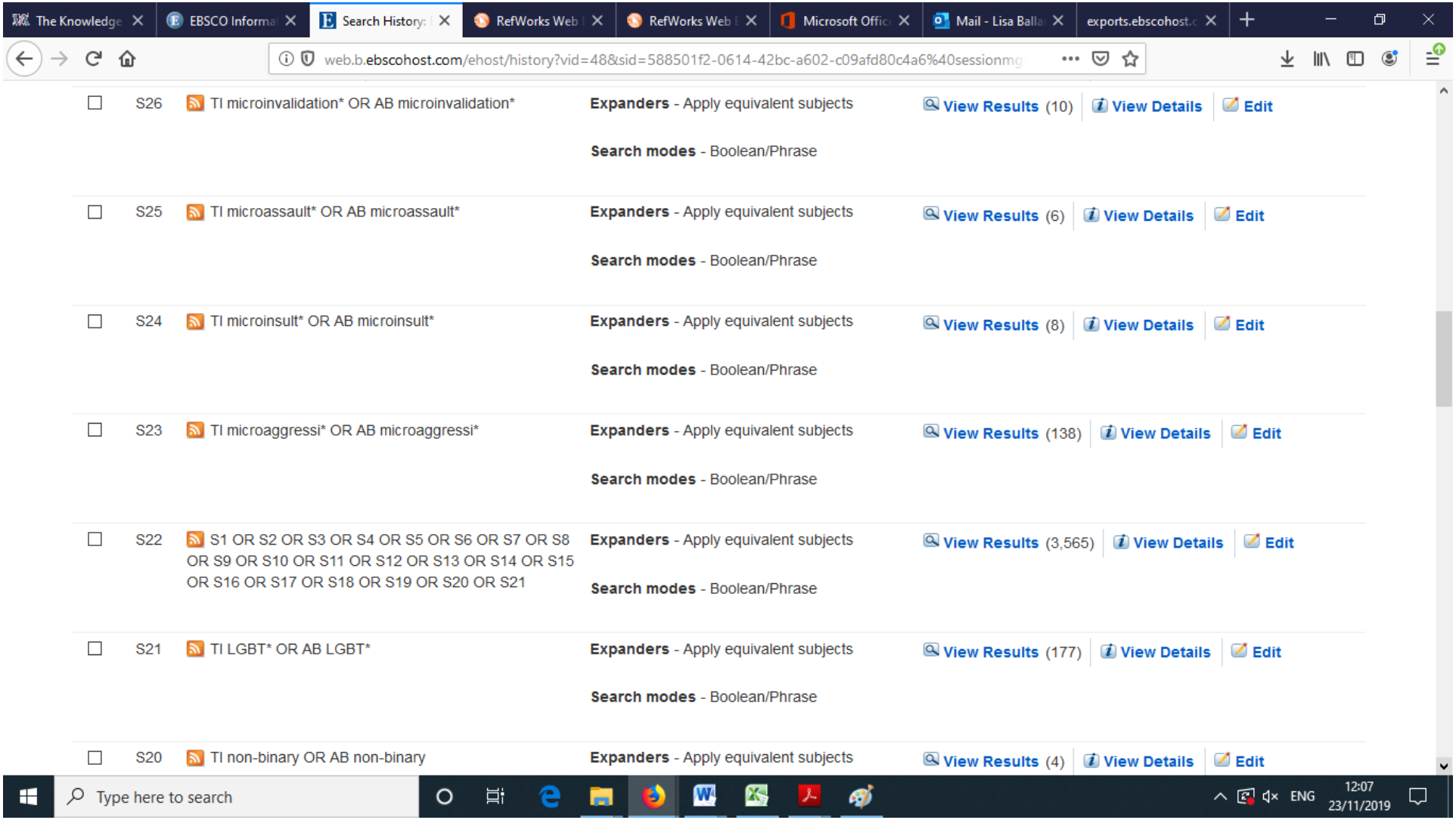
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S26 TI microinvalidation* OR AB microinvalidation* Expanders - Apply equivalent subjects Search modes - Boolean/Phrase View Results (10) View Details Edit
S25 TI microassault* OR AB microassault* Expanders - Apply equivalent subjects Search modes - Boolean/Phrase View Results (6) View Details Edit
S24 TI microinsult* OR AB microinsult* Expanders - Apply equivalent subjects Search modes - Boolean/Phrase View Results (8) View Details Edit
S23 TI microaggressi* OR AB microaggressi* Expanders - Apply equivalent subjects Search modes - Boolean/Phrase View Results (138) View Details Edit
S22 S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 Expanders - Apply equivalent subjects Search modes - Boolean/Phrase View Results (3,565) View Details Edit
S21 TI LGBT* OR AB LGBT* Expanders - Apply equivalent subjects Search modes - Boolean/Phrase View Results (177) View Details Edit
S20 TI non-binary OR AB non-binary Expanders - Apply equivalent subjects View Results (4) View Details Edit
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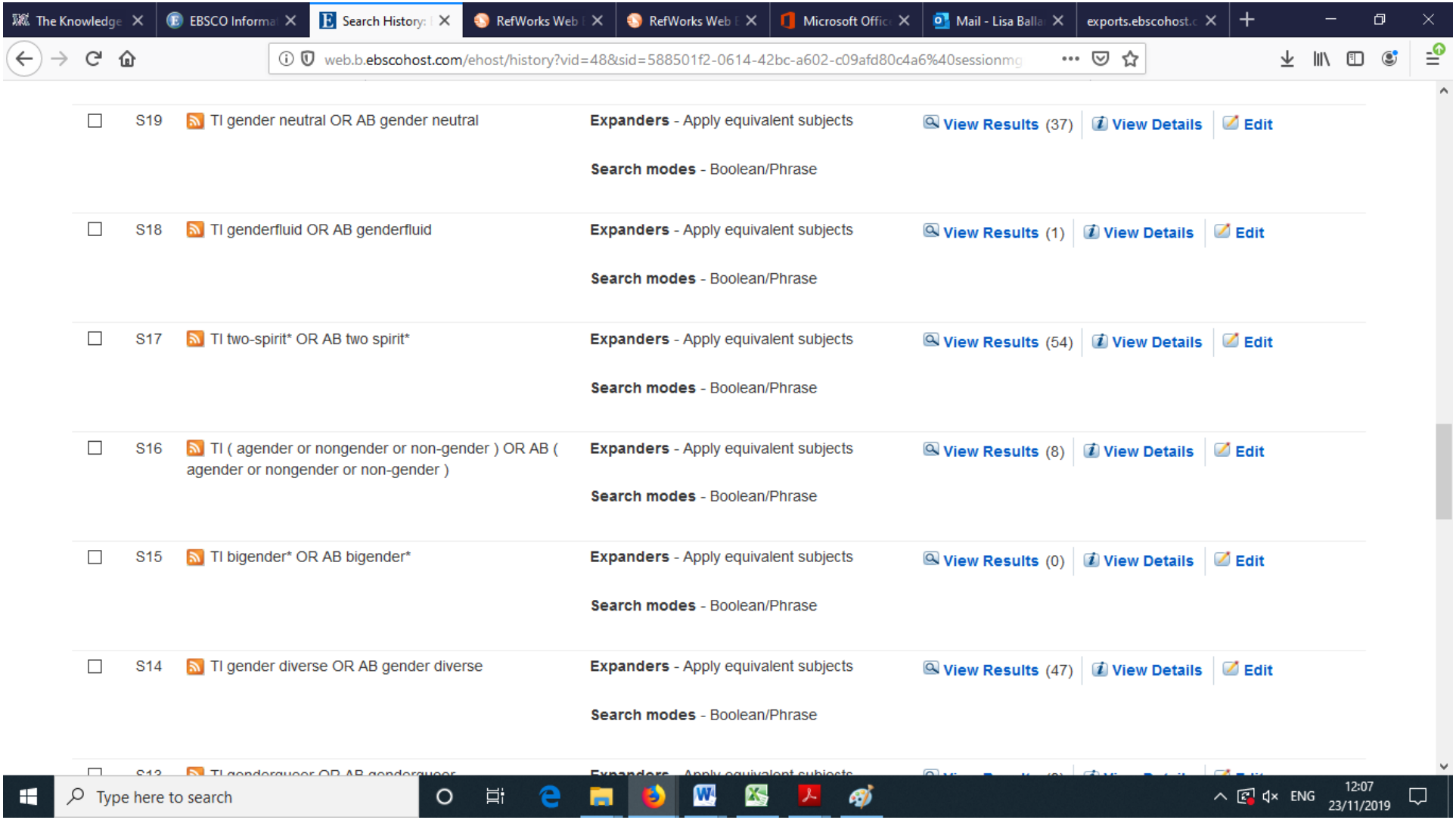
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S19 TI gender neutral OR AB gender neutral
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (37) View Details Edit
S18 TI genderfluid OR AB genderfluid
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (1) View Details Edit
S17 TI two-spirit* OR AB two spirit*
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (54) View Details Edit
S16 TI (agender or nongender or non-gender) OR AB (agender or nongender or non-gender)
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (8) View Details Edit
S15 TI bigender* OR AB bigender*
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (0) View Details Edit
S14 TI gender diverse OR AB gender diverse
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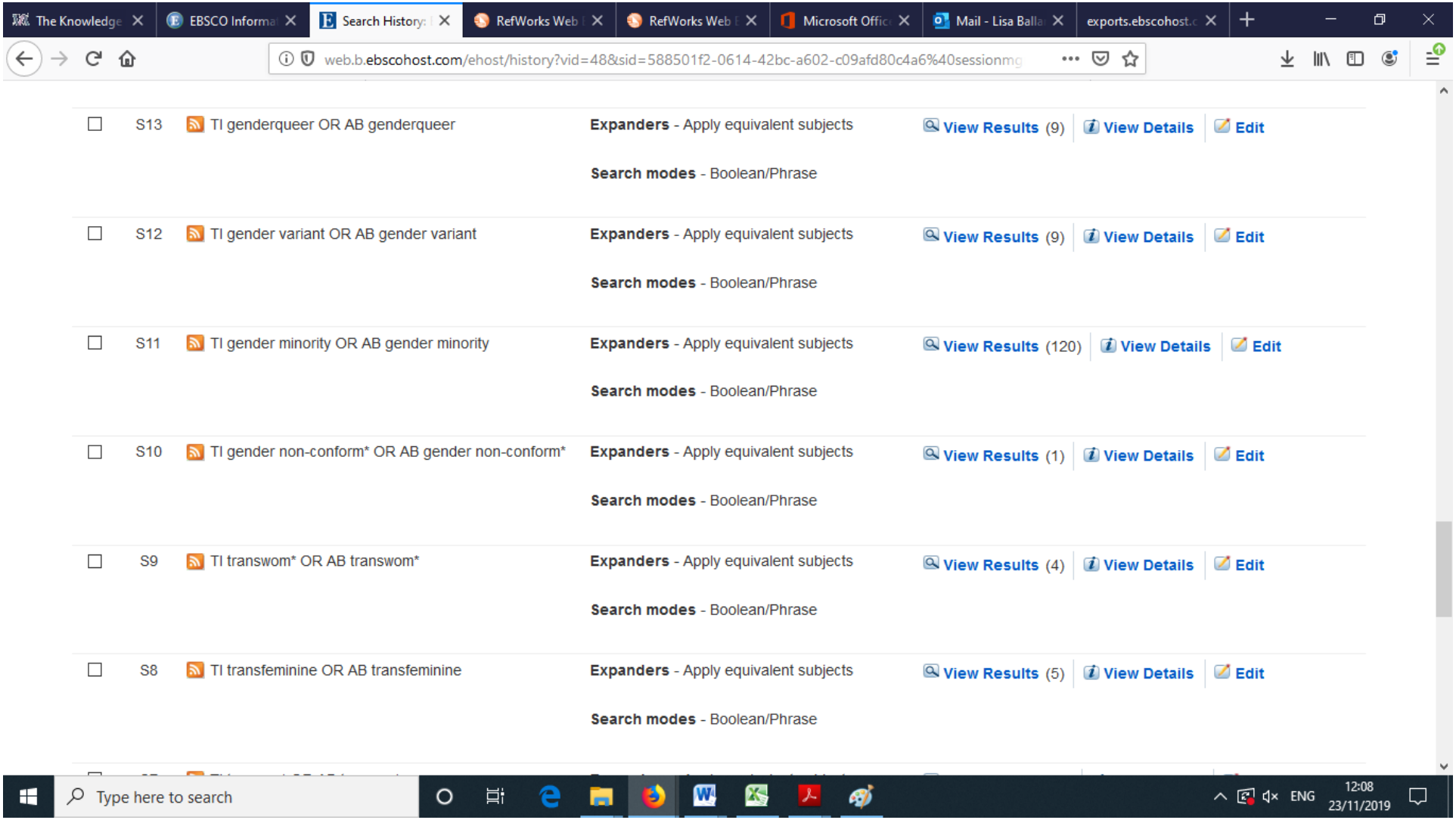
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S13 TI genderqueer OR AB genderqueer
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Search modes - Boolean/Phrase
View Results (9) View Details Edit
S12 TI gender variant OR AB gender variant
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (9) View Details Edit
S11 TI gender minority OR AB gender minority
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (120) View Details Edit
S10 TI gender non-conform* OR AB gender non-conform*
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (1) View Details Edit
S9 TI transwom* OR AB transwom*
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (4) View Details Edit
S8 TI transfeminine OR AB transfeminine
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
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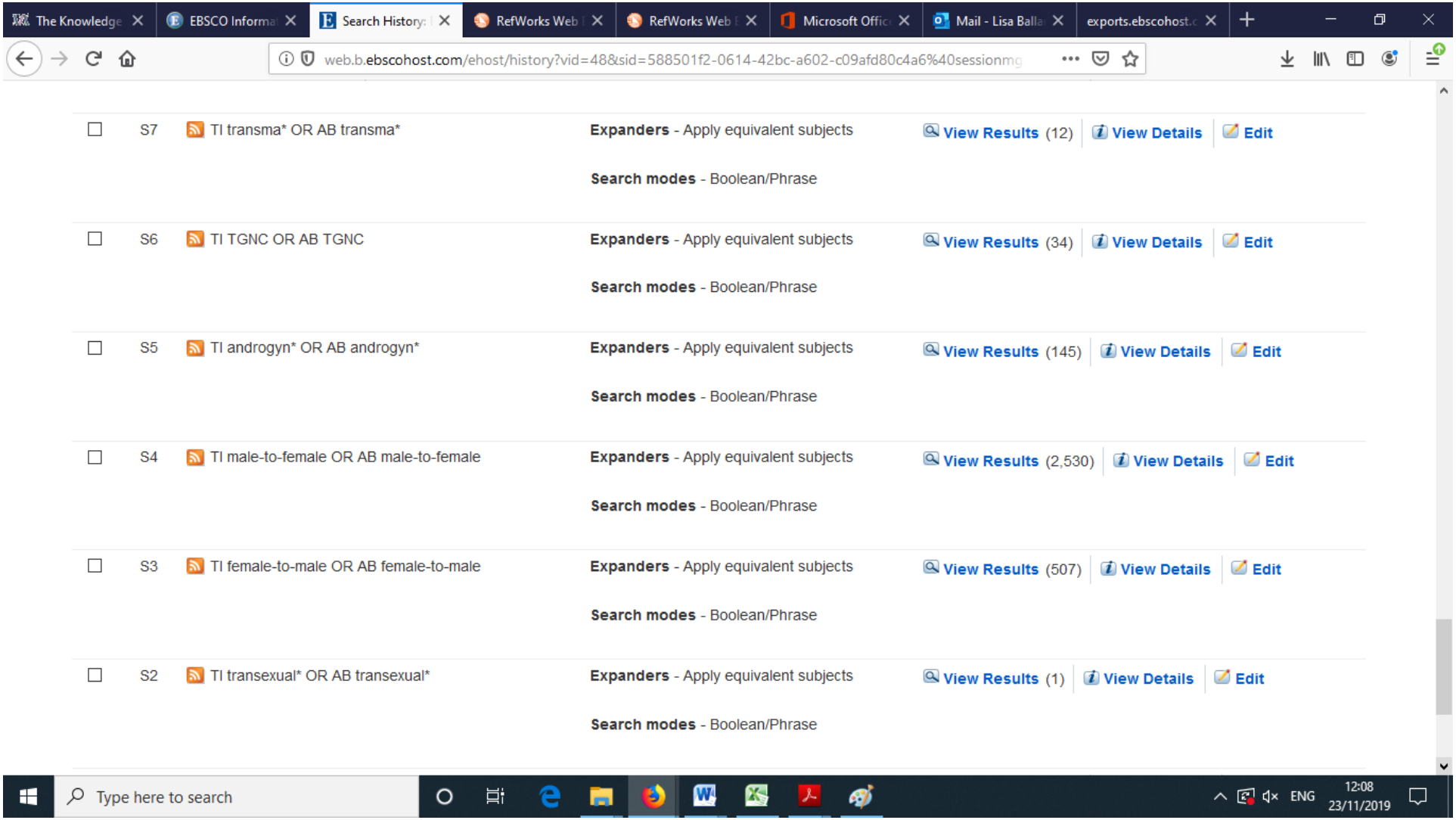
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S7 TI transma* OR AB transma* Expanders - Apply equivalent subjects Search modes - Boolean/Phrase View Results (12) View Details Edit
S6 TI TGNC OR AB TGNC Expanders - Apply equivalent subjects Search modes - Boolean/Phrase View Results (34) View Details Edit
S5 TI androgyn* OR AB androgyn* Expanders - Apply equivalent subjects Search modes - Boolean/Phrase View Results (145) View Details Edit
S4 TI male-to-female OR AB male-to-female Expanders - Apply equivalent subjects Search modes - Boolean/Phrase View Results (2,530) View Details Edit
S3 TI female-to-male OR AB female-to-male Expanders - Apply equivalent subjects Search modes - Boolean/Phrase View Results (507) View Details Edit
S2 TI transexual* OR AB transexual* Expanders - Apply equivalent subjects Search modes - Boolean/Phrase View Results (1) View Details Edit
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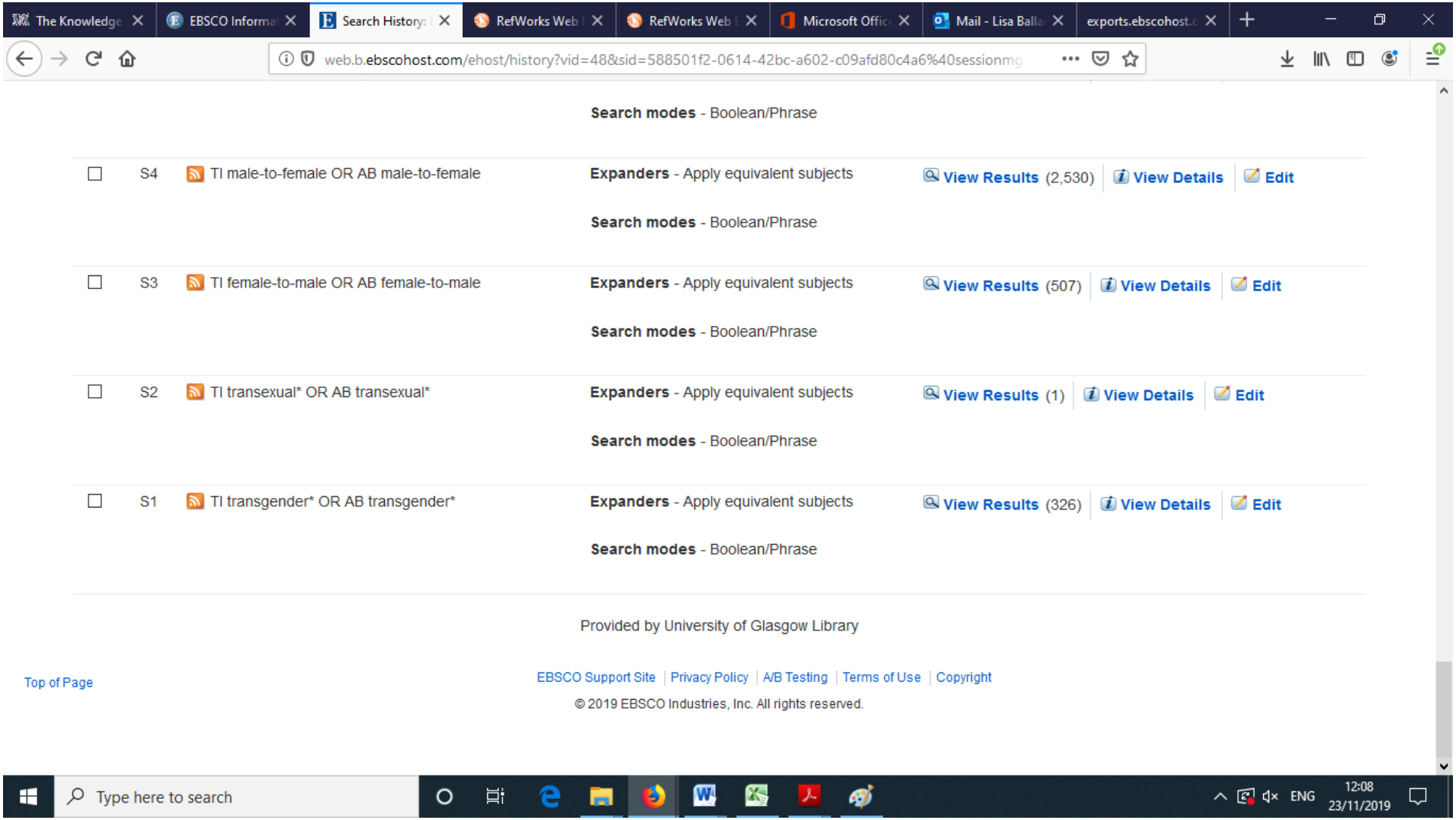
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Search modes - Boolean/Phrase
S4 TI male-to-female OR AB male-to-female
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (2,530)
View Details
Edit
S3 TI female-to-male OR AB female-to-male
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (507)
View Details
Edit
S2 TI transexual* OR AB transexual*
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (1)
View Details
Edit
S1 TI transgender* OR AB transgender*
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
View Results (326)
View Details
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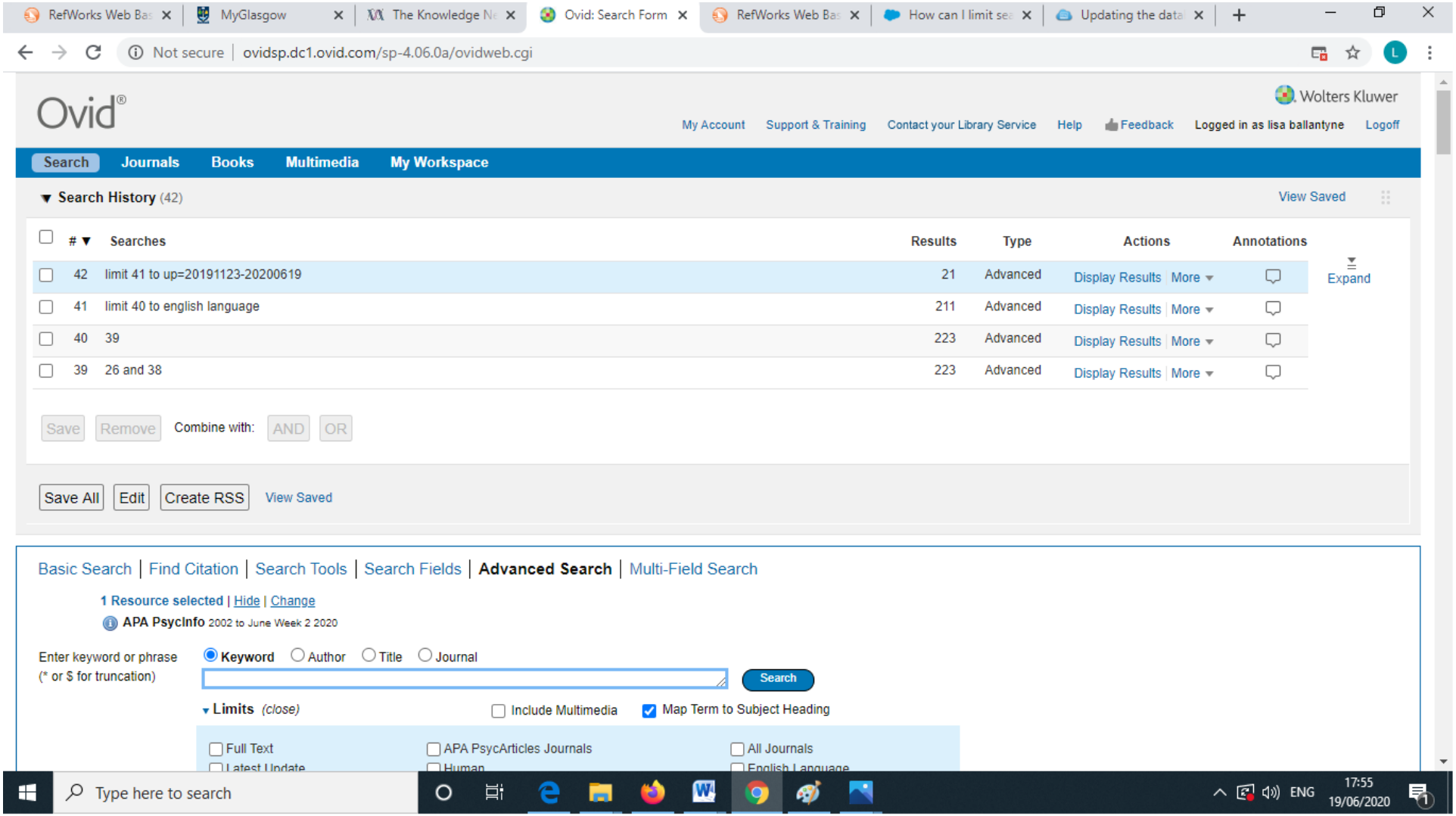
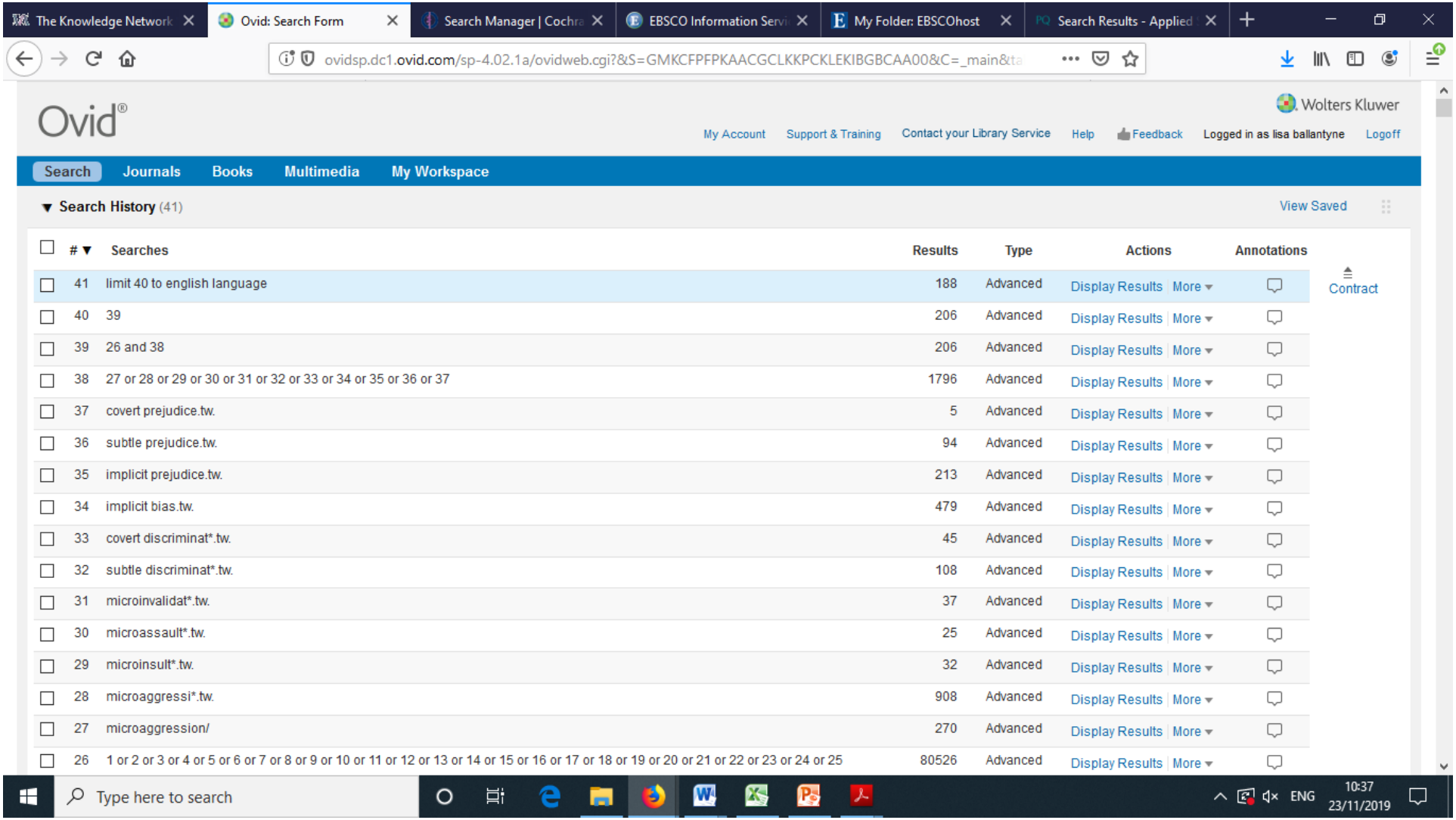
Appendix 1.10: PsycINFO database search

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Ovid®
Wolters Kluwer
My Account
Support & Training
Contact your Library Service
Help
Feedback
Logged in as lisa ballantyne
Logoff
Search
Journals
Books
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Search History (41)
View Saved
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Searches
Results
Type
Actions
Annotations
Contract
41 limit 40 to english language 188 Advanced Display Results | More
40 39 206 Advanced Display Results | More
39 26 and 38 206 Advanced Display Results | More
38 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 1796 Advanced Display Results | More
37 covert prejudice.tw. 5 Advanced Display Results | More
36 subtle prejudice.tw. 94 Advanced Display Results | More
35 implicit prejudice.tw. 213 Advanced Display Results | More
34 implicit bias.tw. 479 Advanced Display Results | More
33 covert discriminat*.tw. 45 Advanced Display Results | More
32 subtle discriminat*.tw. 108 Advanced Display Results | More
31 microinvalidat*.tw. 37 Advanced Display Results | More
30 microassault*.tw. 25 Advanced Display Results | More
29 microinsult*.tw. 32 Advanced Display Results | More
28 microaggressi*.tw. 908 Advanced Display Results | More
27 microaggression/ 270 Advanced Display Results | More
26 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 80526 Advanced Display Results | More
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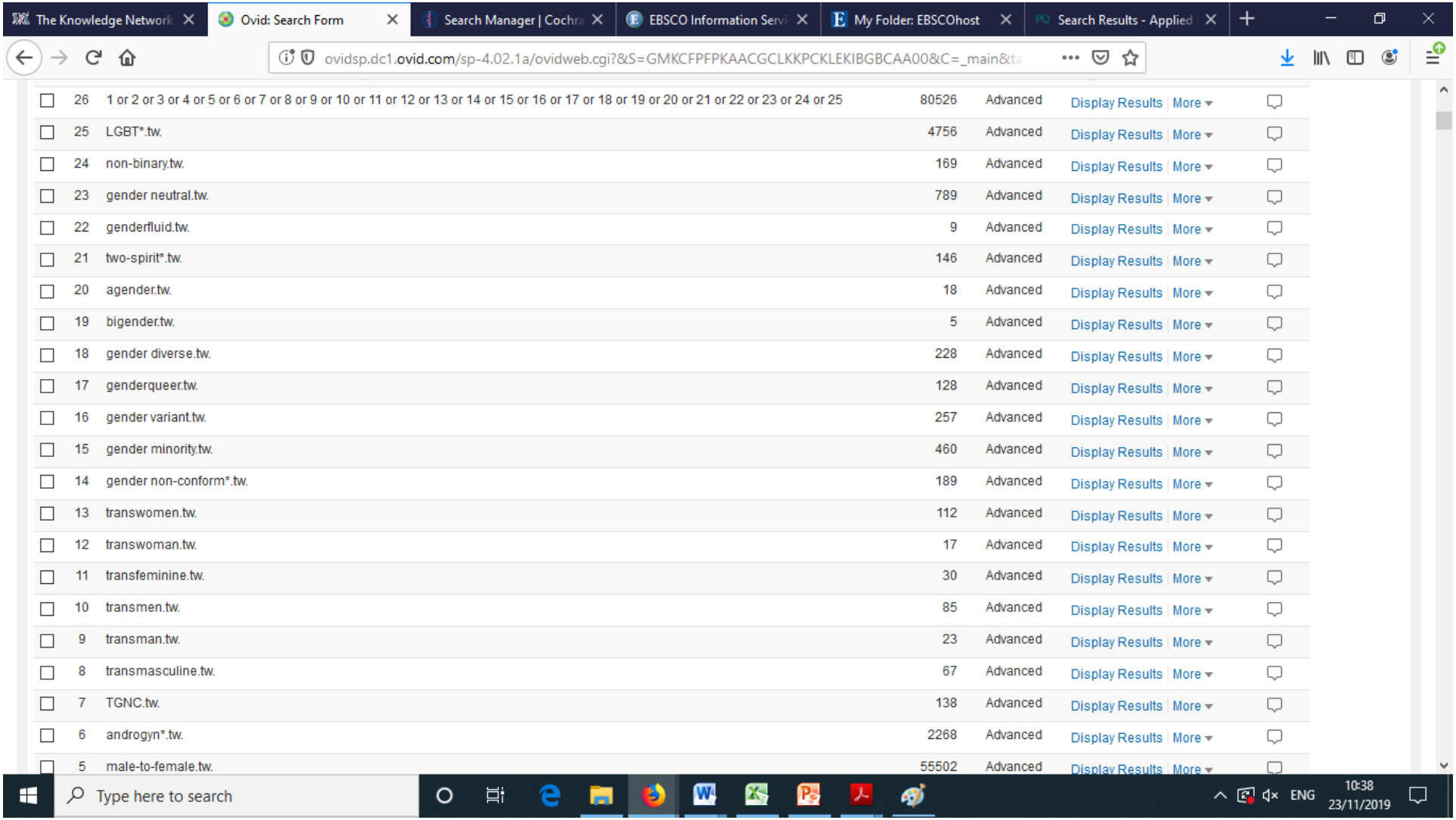
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26 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 80526 Advanced Display Results | More
25 LGBT*.tw. 4756 Advanced Display Results | More
24 non-binary.tw. 169 Advanced Display Results | More
23 gender neutral.tw. 789 Advanced Display Results | More
22 genderfluid.tw. 9 Advanced Display Results | More
21 two-spirit*.tw. 146 Advanced Display Results | More
20 agender.tw. 18 Advanced Display Results | More
19 bigender.tw. 5 Advanced Display Results | More
18 gender diverse.tw. 228 Advanced Display Results | More
17 genderqueer.tw. 128 Advanced Display Results | More
16 gender variant.tw. 257 Advanced Display Results | More
15 gender minority.tw. 460 Advanced Display Results | More
14 gender non-conform*.tw. 189 Advanced Display Results | More
13 transwomen.tw. 112 Advanced Display Results | More
12 transwoman.tw. 17 Advanced Display Results | More
11 transfeminine.tw. 30 Advanced Display Results | More
10 transmen.tw. 85 Advanced Display Results | More
9 transman.tw. 23 Advanced Display Results | More
8 transmasculine.tw. 67 Advanced Display Results | More
7 TGNC.tw. 138 Advanced Display Results | More
6 androgyn*.tw. 2268 Advanced Display Results | More
5 male-to-female.tw. 55502 Advanced Display Results | More
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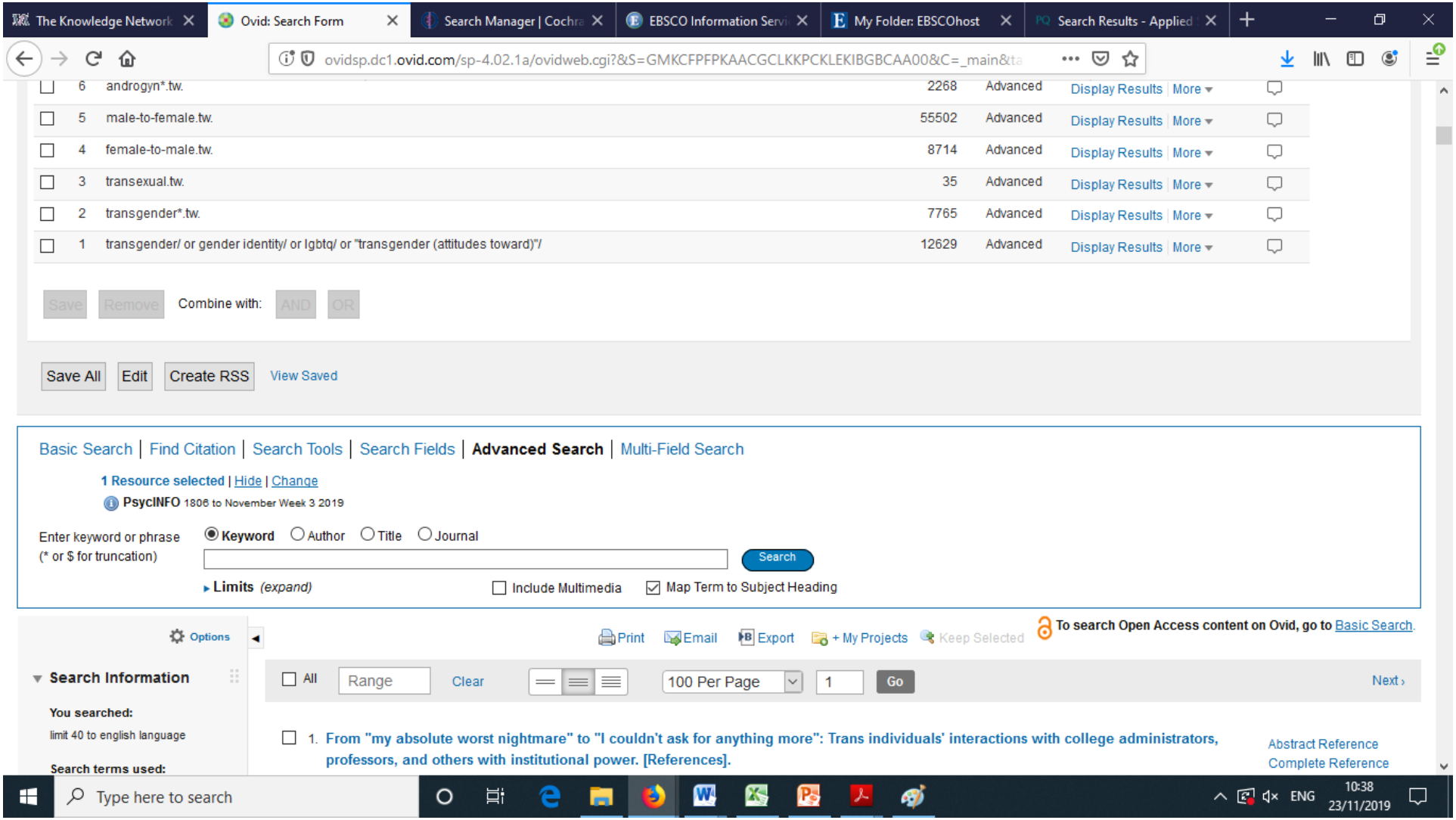
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6 androgyn*.tw. 2268 Advanced Display Results More
5 male-to-female.tw. 55502 Advanced Display Results More
4 female-to-male.tw. 8714 Advanced Display Results More
3 transexual.tw. 35 Advanced Display Results More
2 transgender*.tw. 7765 Advanced Display Results More
1 transgender/ or gender identity/ or lgbtq/ or "transgender (attitudes toward)"/ 12629 Advanced Display Results More
Save Remove Combine with: AND OR
Save All Edit Create RSS View Saved
Basic Search | Find Citation | Search Tools | Search Fields | Advanced Search | Multi-Field Search
1 Resource selected | Hide | Change
PsycINFO 1806 to November Week 3 2019
Enter keyword or phrase
(* or $ for truncation)
Keyword Author Title Journal
Search
Limits (expand)
Include Multimedia
Map Term to Subject Heading
Options
Print Email Export + My Projects Keep Selected
To search Open Access content on Ovid, go to Basic Search.
Search Information
You searched:
limit 40 to english language
Search terms used:
All Range Clear
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1. From "my absolute worst nightmare" to "I couldn't ask for anything more": Trans individuals' interactions with college administrators, professors, and others with institutional power. [References].
Abstract Reference
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Appendix 1.11: Data extraction tool

Data Extraction	**Paper Number**
Citation	
Study Characteristics	
Study Author(s):	
Title:	
Year:	
Location:	
Study purpose/aims:	
Sample Characteristics	
Inclusion/exclusion criteria:	
Gender identities:	
Size:	
Age range:	
Mean age:	
Recruitment:	
Other:	
Data Collection/Analysis	
Design:	
Method:	
Measures used:	
Analysis:	
Findings	
Results:	

Main findings:
Discussion:
Strengths:
Limitations:
Any other notes

Appendix 1.12: Crowe Critical Appraisal Tool (CCAT)

Crowe Critical Appraisal Tool (CCAT) Form (v1.4) Reference Reviewer

This form must be used in conjunction with the CCAT User Guide (v1.4); otherwise validity and reliability may be severely compromised.

Citation	
	Year

Research design (add if not listed)		
❑ Not research	Article | Editorial | Report | Opinion | Guideline | Pamphlet | ...	
❑ Historical	...	
❑ Qualitative	Narrative | Phenomenology | Ethnography | Grounded theory | Narrative case study | ...	
❑ Descriptive, Exploratory, Observational	A. Cross-sectional | Longitudinal | Retrospective | Prospective | Correlational | Predictive | ...	
	B. Cohort | Case-control | Survey | Developmental | Normative | Case study | ...	
Experimental	❑ True experiment	Pre-test/post-test control group | Solomon four-group | Post-test only control group | Randomised two-factor | Placebo controlled trial | ...
	❑ Quasi-experiment	Post-test only | Non-equivalent control group | Counter balanced *(cross-over)* | Multiple time series | Separate sample pre-test post-test [no Control] [Control] | ...
	❑ Single system	One-shot experimental *(case study)* | Simple time series | One group pre-test/post-test | Interactive | Multiple baseline | Within subjects *(Equivalent time, repeated measures, multiple treatment)* | ...
❑ Mixed Methods	Action research | Sequential | Concurrent | Transformative | ...	
❑ Synthesis	Systematic review | Critical review | Thematic synthesis | Meta-ethnography | Narrative synthesis | ...	
❑ Other	...	

Variables and analysis		
Intervention(s), Treatment(s), Exposure(s)	Outcome(s), Output(s), Predictor(s), Measure(s)	Data analysis method(s)

Sampling									
Total size		Group 1		Group 2		Group 3		Group 4		Control	
Population, sample, setting											

Data collection (add if not listed)			
Audit/Review	a) Primary | Secondary | ... b) Authoritative | Partisan | Antagonist | ... c) Literature | Systematic | ...	Interview	a) Formal | Informal | ... b) Structured | Semi-structured | Unstructured | ... c) One-on-one | Group | Multiple | Self-administered | ...
Observation	a) Participant | Non-participant | ... b) Structured | Semi-structured | Unstructured | ... c) Covert | Candid | ...	Testing	a) Standardised | Norm-ref | Criterion-ref | Ipsative | ... b) Objective | Subjective | ... c) One-on-one | Group | Self-administered | ...

Scores										
Preliminaries		Design		Data Collection		Results		Total [/40]	
Introduction		Sampling		Ethical Matters		Discussion		Total [%]	

General notes

Appraise research on the merits of the research design used, not against other research designs.

Category Item	Item descriptors [☑ Present; ☒ Absent; ■ Not applicable]	Description [Important information for each item]	Score [0–5]
1. Preliminaries			
Title	1. Includes study aims ❑ and design ❑		
Abstract (assess last)	1. Key information ❑ 2. Balanced ❑ and informative ❑		
Text (assess last)	1. Sufficient detail others could reproduce ❑ 2. Clear/concise writing ❑, table(s) ❑, diagram(s) ❑, figure(s) ❑		
		Preliminaries [/5]	
2. Introduction			
Background	1. Summary of current knowledge ❑ 2. Specific problem(s) addressed ❑ and reason(s) for addressing ❑		
Objective	1. Primary objective(s), hypothesis(es), or aim(s) ❑ 2. Secondary question(s) ❑		
	Is it worth continuing?	**Introduction [/5]**	
3. Design			
Research design	1. Research design(s) chosen ❑ and why ❑ 2. Suitability of research design(s) ❑		
Intervention, Treatment, Exposure	1. Intervention(s)/treatment(s)/exposure(s) chosen ❑ and why ❑ 2. Precise details of the intervention(s)/treatment(s)/exposure(s) ❑ for each group ❑ 3. Intervention(s)/treatment(s)/exposure(s) valid ❑ and reliable ❑		
Outcome, Output, Predictor, Measure	1. Outcome(s)/output(s)/predictor(s)/measure(s) chosen ❑ and why ❑ 2. Clearly define outcome(s)/output(s)/predictor(s)/measure(s) ❑ 3. Outcome(s)/output(s)/predictor(s)/measure(s) valid ❑ and reliable ❑		
Bias, etc	1. Potential bias ❑, confounding variables ❑, effect modifiers ❑, interactions ❑ 2. Sequence generation ❑, group allocation ❑, group balance ❑, and by whom ❑ 3. Equivalent treatment of participants/cases/groups ❑		
	Is it worth continuing?	**Design [/5]**	
4. Sampling			
Sampling method	1. Sampling method(s) chosen ❑ and why ❑ 2. Suitability of sampling method ❑		
Sample size	1. Sample size ❑, how chosen ❑, and why ❑ 2. Suitability of sample size ❑		
Sampling protocol	1. Target/actual/sample population(s): description ❑ and suitability ❑ 2. Participants/cases/groups: inclusion ❑ and exclusion ❑ criteria 3. Recruitment of participants/cases/groups ❑		
	Is it worth continuing?	**Sampling [/5]**	
5. Data collection			
Collection method	1. Collection method(s) chosen ❑ and why ❑ 2. Suitability of collection method(s) ❑		
Collection protocol	1. Include date(s) ❑, location(s) ❑, setting(s) ❑, personnel ❑, materials ❑, processes ❑ 2. Method(s) to ensure/enhance quality of measurement/instrumentation ❑ 3. Manage non-participation ❑, withdrawal ❑, incomplete/lost data ❑		
	Is it worth continuing?	**Data collection [/5]**	
6. Ethical matters			
Participant ethics	1. Informed consent ❑, equity ❑ 2. Privacy ❑, confidentiality/anonymity ❑		
Researcher ethics	1. Ethical approval ❑, funding ❑, conflict(s) of interest ❑ 2. Subjectivities ❑, relationship(s) with participants/cases ❑		
	Is it worth continuing?	**Ethical matters [/5]**	
7. Results			
Analysis, Integration, Interpretation method	1. A.I.I. method(s) for primary outcome(s)/output(s)/predictor(s) chosen ❑ and why ❑ 2. Additional A.I.I. methods (e.g. subgroup analysis) chosen ❑ and why ❑ 3. Suitability of analysis/integration/interpretation method(s) ❑		
Essential analysis	1. Flow of participants/cases/groups through each stage of research ❑ 2. Demographic and other characteristics of participants/cases/groups ❑ 3. Analyse raw data ❑, response rate ❑, non-participation/withdrawal/incomplete/lost data ❑		
Outcome, Output, Predictor analysis	1. Summary of results ❑ and precision ❑ for each outcome/output/predictor/measure 2. Consideration of benefits/harms ❑, unexpected results ❑, problems/failures ❑ 3. Description of outlying data (e.g. diverse cases, adverse effects, minor themes) ❑		
		Results [/5]	
8. Discussion			
Interpretation	1. Interpretation of results in the context of current evidence ❑ and objectives ❑ 2. Draw inferences consistent with the strength of the data ❑ 3. Consideration of alternative explanations for observed results ❑ 4. Account for bias ❑, confounding/effect modifiers/interactions/imprecision ❑		
Generalisation	1. Consideration of overall practical usefulness of the study ❑ 2. Description of generalisability (external validity) of the study ❑		
Concluding remarks	1. Highlight study's particular strengths ❑ 2. Suggest steps that may improve future results (e.g. limitations) ❑ 3. Suggest further studies ❑		
		Discussion [/5]	
9. Total			
Total score	1. Add all scores for categories 1–8		
		Total [/40]	

Appendix 1.13: Quality appraisal ratings

Author/Year	*Preliminaries*	*Introduction*	*Design*	*Sampling*	*Data Collection*	*Ethical Matters*	*Results*	*Discussion*	Total Score	Descriptive
1. AuBuchon (2019)*	5	5	4	2	3	1	5	4	29(73%)	**Moderate**
2. Austin et al.(2019)	5	4	2	3	3	3	4	4	28(70%)	**Moderate**
3. Austin et al.(2020)	4	5	3	4	3	2	3	4	28(70%)	**Moderate**
4. Galupo et al.(2014)	4	4	3	3	3	1	3	4	25(63%)	**Moderate**
5. Howe (2019)*	4	5	5	5	5	4	5	5	38(95%)	**Good**
6. Morris et al., (in press)	4	4	3	4	4	3	4	4	30(75%)	**Moderate**
7. Nadal et al.(2012)	3	4	3	3	4	4	5	3	29(73%)	**Moderate**
8. Nadal et al.(2014)	4	5	3	2	4	4	4	4	30(75%)	**Moderate**
9. Nadal et al.(2019)	3	3	2	2	2	0	2	2	16(40%)	**Poor**
10. Pitcher (2017)	2	4	1	1	3	2	2	2	17(43%)	**Poor**
11. Parr et al.(2019)	5	4	4	4	4	3	4	4	32(80%)	**Good**
12. Parr et al.(2020)	4	5	3	4	3	4	4	4	31(78%)	**Good**
13. Pulice-Farrow et al.(2017)	5	5	3	4	4	1	4	4	30(75%)	**Moderate**
14. Pulice-Farrow et al.(2017)	5	4	3	4	4	1	4	4	29(73%)	**Moderate**
15. Pulice-Farrow et al.(2019)	5	5	3	3	3	1	4	4	28(70%)	**Moderate**
16. Seelman et al.(2017)	4	5	4	3	3	3	3	4	29(73%)	**Moderate**
17. Woodford et al.(2017)	4	5	3	3	3	3	3	4	28(70%)	**Moderate**

* Grey Literature

Appendix 1.14: Taxonomy of Transgender Microaggressions described by Nadal et al. (2012)

A taxonomy of transgender microaggressions (or 12 themes of transgender microaggressions) was first proposed by Nadal et al. (2012)(*noted at Study 7 within results of review)*, based on findings from qualitative exploration (focus groups) with nine transgender-identified men and women.

1) *use of transphobic and/or incorrectly gendered terminology* includes using incorrect pronouns or derogatory language when addressing trans people.

2) *assumption of universal transgender experience* encompasses when individuals assume that all trans individuals are the same or expect certain gendered roles/stereotypes to be performed.

3) *exoticization,* occurs when trans people are treated as tokens or objects.

4) *discomfort/disapproval of transgender experience*, occurs when an individual receives verbal or non-verbal communications of disgust or discomfort following disclosure of the transgender status.

5) *endorsement of gendernormative and binary culture or behaviours*, reflects communications of gendered stereotypes (e.g. women assumed to be physically weaker than men), particularly when experienced as incongruent to own gender identity (e.g. trans man assumed as weaker than cis man).

6) *denial of existence of transphobia,* manifests when minimise or deny the existence and impacts of transphobia generally

7) *denial of individual transphobia,* occurs when individuals fail to consider their individual role in perpetrating transphobia.

8) *assumption of sexual pathology or abnormality*, refers to assumptions that trans identities are pathological (e.g. occur as result of psychopathology or sexual deviance).

9) *physical threat or harassment* includes reports of being overtly threatened based on gender identity

10) *denial of bodily privacy* occurs for example when trans individuals are asked intimate question regarding their body or when individuals visually assess trans individuals physical characteristics against gendered norms.

11) *Familial microaggressions*

12) *Systemic and Environmental Microaggressions*

Appendix 1.15

Reported effect sizes of significant results for included studies where appropriate.

Study Number	Authors (year)	Effect size/relative risk
1	AuBuchon (2019)	Dependent variable = Relational Value Experience of microaggression (microinsult, microinvalidation) = 0.69* Experience of Macroaggression (microassault) = -0.69*
2	Austin et al., (2019)	N/A
3	Austin et al., (2020)	Dependent variable = lifetime suicide attempt Interpersonal microaggressions - odds ratio [OR] = 1.1
4	Galupo et al., (2014)	For all nine categories, the frequency of microaggressions significantly differed across identity of friend, with effect sizes ranging from medium to large.
5	Howe (2019)	The average number of identity non-affirmation incidents per week increased odds of: - Sadness/hopelessness OR = 3.26, 95% CI = [2.19, 5.11]. - Withdrawal OR = 3.45, 95% CI = [2.21, 5.78] - Past year suicidality OR = 2.21, 95% CI = [1.56, 3.30] - Lifetime suicidality OR = 2.60, 95% CI = [1.47, 5.23] With each increase in the number of identity non-affirmation or denial microaggression incidents that transgender individuals reported as reducing their interest in engaging socially - odds of past-year sadness or hopelessness increased by 1.35 times, OR = 1.35, 95% CI = [1.17, 1.62] - odds of past-year withdrawal from regular activities increased by 1.45 times, OR = 1.45, 95% CI = [1.21, 1.83] - odds of past-year suicide ideation increased by 1.32 times, OR = 1.32, 95% CI = [1.13, 1.60].
6	Morris et al., (2020)	N/A
7	Nadal et al., (2012)	N/A
8	Nadal et al., (2014),	N/A
9	Nadal et al., (2018)	NR
10	Pitcher (2017)	N/A
11	Parr et al. (2019)	In conventional logistic regression analyses, increasing frequency of

		transgender identity nonaffirmation or denial events was significantly associated with 150–240% increases (odds ratio = 2.54–3.41) in odds of past-year sadness or hopelessness, past-year withdrawal, past-year suicide ideation, and lifetime suicide ideation or attempt. Using latent regression analyses that incorporated both frequency and emotional intensity of microaggression events, odds of outcomes were increased by 230–525% (odds ratio = 3.31–6.25).
12	Parr et al. (2020)	Final models explained a moderate amount of variance in the microaggression frequency outcome (multiple-R^2 ¼ .30–.31, adjusted multiple-R^2 =.25–.26)
13	Pulice-Farrow et al. (2017)	N/A
14	Pulice-Farrow et al., (2017)	N/A
15	Pulice-Farrow et al., (2019),	N/A
16	Seelman et al., (2017)	NR
17	Woodford et al. (2017)	NR

N/A = not applicable, NR = not reported, *unclear what measure of effect size used

Appendix 2.1 – Letters of Approval

Administrator: Mrs Elaine O'Neill
Telephone Number: 0141 314 4001
E-Mail: elaine.o'neill2@ggc.scot.nhs.uk
Website: https://www.nhsggc.org.uk/about-us/professional-support-sites/research-development/

Clinical Research & Development
Dykebar Hospital, Ward 11
Grahamston Road
Paisley, PA2 7DE
Scotland, UK

16 January 2020

Ms Lisa Ballantyne
Trainee Clinical Psychologist
Sandyford
6 Sandyford Place
Glasgow G3 7NB

NHS GG&C Board Approval

Dear Ms L Ballantyne,

Study Title:	Non-suicidal self-injury (NSSI) and suicidality among transgender people: understanding correlates and helpseeking
Principal Investigator:	Ms Lisa Ballantyne
GG&C HB site	The Sandyford
Sponsor	NHS Greater Glasgow and Clyde
R&D reference:	GN19MH431
REC reference:	19/WS/0169
Protocol no: (including version and date)	V3; 16/08/19

I am pleased to confirm that Greater Glasgow & Clyde Health Board is now able to grant **Approval** for the above study.

Conditions of Approval

1. **For Clinical Trials** as defined by the Medicines for Human Use Clinical Trial Regulations, 2004

    a. During the life span of the study GGHB requires the following information relating to this site
        i. Notification of any potential serious breaches.
        ii. Notification of any regulatory inspections.

It is your responsibility to ensure that all staff involved in the study at this site have the appropriate GCP training according to the GGHB GCP policy (www.nhsggc.org.uk/content/default.asp?page=s1411), evidence of such training to be filed in the site file.

2. **For all studies** the following information is required during their lifespan.
    a. First study participant should be recruited within 30 days of approval date.

b. Recruitment Numbers on a monthly basis
c. Any change to local research team staff should be notified to R&D team
d. Any amendments – Substantial or Non Substantial
e. Notification of Trial/study end including final recruitment figures
f. Final Report & Copies of Publications/Abstracts

Please add this approval to your study file as this letter may be subject to audit and monitoring.

Your personal information will be held on a secure national web-based NHS database.

I wish you every success with this research study

Yours sincerely,

Mrs Elaine O'Neill
Senior Research Administrator

CC: Emma-Jane Gault (Glasgow University)

WoSRES
West of Scotland Research Ethics Service

NHS
Greater Glasgow and Clyde

Professor Rory O'Connor
College of Medical, Veterinary and Life Sciences,
University of Glasgow, Mental Health & Wellbeing
Academic Centre
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH

West of Scotland REC 3
Research Ethics
Clinical Research and Development
Dykebar Hospital
Grahamston Road
Paisley PA2 7DE

Date 02 December 2019
Direct line 0141 314 0211
E-mail WoSREC3@ggc.scot.nhs.uk

Dear Professor O'Connor

Study title: **Non-suicidal self-injury (NSSI) and suicidality among transgender people: understanding correlates and help-seeking.**
REC reference: **19/WS/0169**
IRAS project ID: **263568**

Thank you for your email of 25 November 2019, responding to the Committee's 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.

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
It is a condition of the REC favourable opinion that **all clinical trials are registered** on a publicly accessible database. For this purpose, 'clinical trials' are defined as the first four project categories in IRAS project filter question 2. Registration is a legal requirement for clinical trials of investigational medicinal products (CTIMPs), except for phase I trials in healthy volunteers (these must still register as a condition of the REC favourable opinion).

Registration should take place as early as possible and within six weeks of recruiting the first research participant at the latest. Failure to register 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/

As set out in the UK Policy Framework, research sponsors are responsible for making information about research publicly available before it starts e.g. by registering the research project on a publicly accessible register. Further guidance on registration is available at: https://www.hra.nhs.uk/planning-and-improving-research/research-planning/transparency-responsibilities/

You should notify the REC of the registration details. We will audit these as part of the annual progress reporting process.

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

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 listed in the application 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*
GP/consultant information sheets or letters [GP Info]	Version 1	16 August 2019
Interview schedules or topic guides for participants [Interview]	Version 1	18 August 2019
IRAS Application Form [IRAS_Form_11102019]		11 October 2019
Letters of invitation to participant [Invitation]	Version 2	16 August 2019
Non-validated questionnaire [Risk assessment tool]	Version 1	16 August 2019
Organisation Information Document [GGC OID]	Version 1	25 September 2019
Organisation Information Document [Lothain OID]	Version 2	25 September 2019
Other [Response to Prov Op]		25 November 2019
Participant consent form [Consent form]	version 4	25 November 2019
Participant information sheet (PIS) [Support services - Contact info for participants]	Version 1	16 August 2019
Participant information sheet (PIS) [PIS]	version 4	07 November 2019
Research protocol or project proposal [Proposal]	Version 3	16 August 2019
Summary CV for Chief Investigator (CI) [CI CV]	V1	25 September 2019
Summary CV for student [CV Student]	V1	25 September 2019
Summary CV for supervisor (student research) [CV Supervisor]	Version 1	25 September 2019
Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only) [Insurance]	1	24 July 2019

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/

19/WS/0169	**Please quote this number on all correspondence**

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

Yours sincerely

Ben Parkinson
Vice Chair

Enclosures: "After ethical review – guidance for researchers"

Copy to: Ms Emma Jane Gault

Appendix 2.2 – Consent Form

Centre Number: _____

Project Number: _____

Participant Identification Number: _____

Title of Project:
Self-harm and suicide among transgender people: an explorative study.

Name of Researcher:
Lisa Ballantyne, Trainee Clinical Psychologist

CONSENT FORM

		Please initial each box if you agree
1.	I confirm that I have read and understood the Participant Information Sheet version (4) dated (07/11/2019).	
2.	I have had the opportunity to think about the information and ask any questions I have, and understand any answers I have been given.	
3.	I confirm that I agree to the way my data will be collected and processed. Personal data will stored for up to 3 years. Anonymised data generated through interviews will be stored for up to 10 years in the University of Glasgow archiving facilities in accordance with relevant Data Protection policies and regulations.	
4.	I understand that all data and information I provide will be kept confidential and will be seen only by study researchers and regulators whose job it is to check the work of researchers.	
5.	I agree to my interview being audio-recorded	
6.	I understand that the recorded interview will be anonymised and transcribed word by word and the transcription stored for up to 10 years in University archiving facilities in accordance with Data Protection policies and regulations.	
7.	I understand that my information and things that I say in an interview may be quoted in	

reports and articles that are published about the study, but my name or anything that could tell people who I am will not be revealed. ☐

8. I agree that researchers can tell my GP that I am taking part in this study. ☐

9. I understand the researcher will undertake a short risk assessment prior to, and after, my taking part in the study. This risk assessment is used to determine if there are any current risks to myself or others. ☐

10. I agree that should I disclose information which causes the researcher concern, such as reason to believe I may harm myself or others, then the researcher will have a duty to report this. The researcher will try to discuss this before doing so. ☐

11. I agree to take part in this study. ☐

_____	_____	_____
Name of participant	**Date**	**Signature**
_____	_____	_____
Name of researcher	**Date**	**Signature**

Appendix 2.3 – Information Sheet

Researcher Contact Information
Lisa Ballantyne, Trainee Clinical Psychologist
Email: l.ballantyne.2@research.gla.ac.uk

Institute of Mental Health & Well-being
Administration Building, 1st Floor
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH

Participant Information Sheet
Self-harm and suicide among transgender people: an explorative study.

We would like to invite you to take part in a research study. Before you decide, you need to understand why the research is being done and what participation would involve. Please read the following information carefully. Talk to others about the study if you wish, and please ask if there is anything that is unclear or if you would like more information.

Who is conducting the research?
The research is being carried out by Lisa Ballantyne, Trainee Clinical Psychologist, from the University of Glasgow. It is being supervised by Professor Rory O'Connor from the University of Glasgow and Dr Katie Smith from the Sandyford Gender Identity Clinic.

What is the purpose of the study?
The study is being carried out as part of the requirements of the Doctorate in Clinical Psychology training course at the University of Glasgow. The purpose of the study is to try to better understand transgender individuals' experiences of self-harm and/or suicidal thoughts or behaviours. The study will involve speaking to people whose gender identity is different from the sex they were assigned at birth, who have had thoughts of self-harm or suicide. The study aims to understand more about factors which may contribute to thoughts of self-harm or suicide, and what factors influence how they may seek help when feeling distressed. A better understanding of these factors may help people who are vulnerable to suicide.

Why have I been invited?
We are looking to recruit between 4 and 10 people who have self-referred or are currently attending a Scottish Gender Identity Clinic. Participants should be aged over 17 years old, whose gender identity is different from their sex assigned at birth. To take part, participants should also have a history of self-harm and/or suicidal thoughts or behaviour.

What does taking part involve?
If you think that you fit the criteria and are interested in taking part, you can return the slip attached to your invitation letter or email your interest to Lisa Ballantyne, the lead researcher

(l.ballantyne.2@research.ac.uk). Lisa will then telephone you to tell you more about the study, answer any questions you have, and, if you decide to take part, make an appointment for you to take part in an interview. The interviews will take place at Sandyford Central (Glasgow) or Chalmers Centre (Edinburgh) and will last around 1 hour. This will feel like an informal discussion with the researcher about your experiences of self-harm and/or suicidal thoughts or behaviour. You do not have to answer any questions that you don't want to and you can have breaks during the interview if you wish.

You will be asked to complete a short risk assessment both before and after the interview. This will involve answering a number of questions which are asked by the researcher to help identify if there are any current risks to yourself or others that would need to be considered. The personal data generated by this will be held for up to 3 years in accordance with relevant Data Protection policies and regulations; this is discussed in detail below.

If you disclose anything during the interview or risk assessment that causes the researcher concern, such as being a risk to yourself or others, the researcher will have a duty to report this but will try to discuss this with you before doing so.

With your permission, the interview will be audio recorded so that the researcher can listen back to the conversation and identify the key points that you made. Some quotes from your interview may be included in the research paper, however all information will be anonymised.

We will write to your GP to tell them that you have taken part in this study.

Do I have to take part?

No. It is up to you to decide if you want to take part in the study or not. If you agree to take part, you will be asked to sign a consent form at the time of the interview to show that you have agreed to take part in the study. You are free to withdraw from the study at any time until the research is written up, without giving a reason. Withdrawing from the study would not affect the standard of care you receive or your future treatment in any way.

What happens to the information?

Your information will be held at the University of Glasgow. Your identity and personal information will be completely confidential and held in accordance with the General Data Protection Regulation (GDPR; 2018), which means that we keep it safely and cannot reveal it to other people without your permission. NHS GG&C is the sponsor for this study based in the United Kingdom. We will be using information from you and/or your medical records in order to undertake this study and will act as the data controller for this study. We will store your personal data for up to 3 years. Anonymised data generated through interviews will be stored for up to 10 years in the University of Glasgow archiving facilities in accordance with relevant Data Protection policies and regulations.

The results of this study may be published in academic journals, conference proceedings and as a piece of work for a doctoral qualification in Clinical Psychology. A summary of results will be made available to participants who would like feedback about the research once completed. Some direct quotes from your interview may be included in these reports/publications, however all information will be anonymised with pseudonyms and it will not be possible to personally identify you from this information.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the

study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information at -
https://www.nhsggc.org.uk/media/249727/gdpr-publish.pdf

What are the possible benefits of taking part?
Whilst your taking part will not have any direct impact on your own care, it is hoped that it will allow us to improve our understanding of people with similar problems. You will contribute to research in this area which may help people who are at risk of self-harm or suicide. If, for any reason, you experience distress during or after the interview, we will ensure that you are able to access appropriate sources of support, where these are required.

Who has reviewed the study?
The study has been reviewed by the West of Scotland research ethics committee 3, the NHS Greater Glasgow and Clyde Research & Development Department, NHS Lothian Quality Improvement Team and the NHS GGC Sandyford Research Governance Group (RGG).

If you have any further questions:
We will give you a copy of the information sheet and signed consent form to keep. If you would like more information and would like to speak to someone who is not closely involved in the study, then you can contact:

Dr Karen McKeown (Research Tutor)
Institute of Health & Well-being, University of Glasgow
Administration Building, 1st Floor
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH
Email: Karen.mckeown@glasgow.ac.uk
Tel: 0141 211 3920

Researcher(s) Contact Detail(s):	
Lisa Ballantyne, Trainee Clinical Psychologist Institute of Mental Health & Well-being Administration Building 1st Floor Gartnavel Royal Hospital 1055 Great Western Road Glasgow G12 0XH **Email:** l.ballantyne.2@research.gla.ac.uk	**Professor Rory O'Connor** Institute of Mental Health & Well-being Administration Building 1st Floor Gartnavel Royal Hospital 1055 Great Western Road Glasgow G12 0XH **Email:** rory.oconnor@glasgow.ac.uk **Tel:** 0141 211 3920

What if you have a complaint about any aspect of the study?
If you are unhappy about any aspect of the study and wish to make a complaint, please contact the researcher in the first instance but the normal NHS complaint mechanism is also available to you.

Thank you for taking the time to read this information sheet.

Appendix 2.4 – Cover Letter/Consent to Contact

Researcher Contact Information
Lisa Ballantyne, Trainee Clinical Psychologist
Email: l.ballantyne.2@research.gla.ac.uk

Institute of Mental Health & Well-being
Administration Building, 1st Floor
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH

[PARTICIPANTS ADDRESS]

Dear X,

I am writing to invite you to take part in a research study called: S*elf-harm and suicide among transgender people: an explorative study.*

The research is being completed by a final year Trainee Clinical Psychologist, Lisa Ballantyne. Lisa works in NHS Greater Glasgow and Clyde, and is completing the research as part of her doctoral degree at the University of Glasgow. I am inviting you to take part in this study as you have been referred to/are attending a Scottish Gender Identity Clinic and so may meet eligibility criteria.

Please find enclosed an information sheet which contains all of the details pertaining to the research study. Please take the time to read this and consider whether you may be interested in taking part. The study involves taking part in a one-off interview with Lisa, the researcher, at a time that is convenient for you. The interviews will last around 1 hour and will take place at the Gender Identity Clinic which you are in contact with; either Sandyford Central (Glasgow) or the Chalmers Centre (Edinburgh).

If you are interested in taking part in the study, please complete and return the slip attached below, providing consent for Lisa to contact you. A freepost envelope is also included for your use. Alternatively, you can also email written consent for Lisa to contact you (l.ballantyne.2@research.gla.ac.uk). Please be sure to include a contact number.

Yours sincerely,
<Involved clinician/admin team>, <Contact number>

Self-harm and suicide among transgender people: an explorative study.
Please complete and return this slip if you would be happy to be contacted by the researcher.

- I consent to being contacted by the researcher, Lisa Ballantyne, to discuss the research study.

Name: _____ Date: _____

Contact number: _____

Can we leave a voice message on this number if you are unavailable to answer? ____ Yes ____ No

Email: ____

Signature: ____

Appendix 2.5 – Covid-19 Suspension of Recruitment

Professor Julie Brittenden

Clinical Research, Development & Innovation, NHS Greater Glasgow & Clyde

Ward 11, Dykebar Hospital,

Grahamston Road,

Paisley PA2 7DE

Tel 0141 211 2872

Julie.Brittenden@ggc.scot.nhs.uk

13th March, 2020

Dear Principal Investigator

Suspension of recruitment to all hosted clinical trials/studies in NHS GG&C

In order to address the current and potential implications of the COVID-19 outbreak on our patient population we have taken the difficult decision to ***suspend recruitment*** into all clinical research studies hosted within NHS GG&C. As from Monday 16th March, please do not approach any new patient regarding imminent clinical study participation. Patients who have already signed informed consent should continue to screen and register for the trial where the investigator considers it safe and in the patient's best interests to do so. Patients may still be approached about observational studies or pre-screening studies where this participation requires no additional hospital attendance by the patient and where the sponsor permits.

Please inform us immediately if you are involved in studies which are categorised as providing "essential clinical care". Please send any exemption requests to RandDRecruitment@ggc.scot.nhs.uk with details of the study (PI, IRAS number, Title) along with a justification, and plan for ongoing recruitment including the availability of study specific staff.

At this stage we will ***continue with planned follow up visits***, in accordance with the study protocol.

In order to mitigate the impact of COVID-19 we will,

1) Work with sponsors to be permitted to carry out follow-up visits remotely

2) Postpone any external monitoring visits unless there is a subject safety issue which cannot be addressed remotely. Where possible please make arrangements to participate in remote monitoring

3) Postpone any site initiation visits unless they involve studies related to COVID-19

4) Protocol deviations - The MHRA expect there to be an increase in protocol deviations but have requested that these are documented in the normal manner. For studies sponsored by NHS GG&C the research governance office should be contacted directly RandD.MonitoringGroup@ggc.scot.nhs.uk.

5) IMP supplies for our hosted CTIMPs have been monitored and Sponsors contacted for reassurances or additional supplies where appropriate. We have slightly less control when we have to supply IMP from NHS stock and NHS are not permitted to stockpile. Please contact the trial pharmacist at the participating GGC site and Samantha Carmichael (samantha.carmichael@ggc.scot.nhs.uk) if patients are not travelling to the site for study visits and need resupply of IMP.

MHRA advice is available at https://mhrainspectorate.blog.gov.uk/2020/03/12/advice-for-management-of-clinical-trials-in-relation-to-coronavirus/

HRA advice is available at https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/covid-19-guidance-sponsors-sites-and-research

Please forward this letter to the sponsor and chief investigators. Separate correspondence will follow in relation to our sponsored studies. Ongoing contingency planning is underway and further correspondence will follow should the situation change.

Should have any queries please direct them to myself or Chloe Cowan at the Glasgow CRF Chloe.Cowan@ggc.scot.nhs.uk/Ruth Orr at the Beatson CRF ruth.orr@glasgow.ac.uk (as applicable).

Yours sincerely,

Professor Julie Brittenden

Director of Research and Development, Vascular Surgeon, Queen Elizabeth University Hospital,
Professor of Vascular Surgery, College of Medical, Veterinary and Life Sciences University of
Glasgow

Appendix 2.6 – Interview Schedule

Thank you for agreeing to participate in the research study and taking the time to meet with me. As you will now be aware, the research that we are doing involves asking between 4 and 10 people to take part in this one-off interview. So today I will be asking you some questions which relate to your experiences of self-harm and/or suicidal thoughts and behaviours. There are no right or wrong answers; I am interested in your own personal experience. If at any time there are questions which you don't want to answer, that is okay; you don't have to. Alternatively, if there is anything you feel is important and would like to talk about, please feel free to just bring these up. It is also fine if you would like to take a break at any point. If you want to stop the interview at any time, please just let me know.

Experience of self-harm and or suicidal thoughts and behaviours

- I am interested to know more about your experiences of self-harm or suicidal thoughts and behaviours. Can you tell me about the first time you began to experience thoughts of suicide and/or self-harm?
    - Probe: Can you describe those thoughts to me? What do you remember about those thoughts?
    - Probe: What was going on in your life at this time? Who was in your life at this time? What sense do you make of your experience of thoughts of suicide and/or self-harm?
    - Do the thoughts change over time? If so, how do they change? Why do you think this happens?

- What (if anything) limits the frequency/duration/severity of these thoughts?
    - Probe: Have there been times when you have not acted on these thoughts?

- Can you tell me what factors (if any) reduce the likelihood of you acting on these thoughts?
    - Probe: What sense do you make of this?

- *If acted on thoughts..* How did you come to act on these thoughts?
    - *Probe:* Can you talk me through that process?
    - *Probe:* Can you tell me what factors you think led to you acting on these thoughts

- What do you gain by acting on these thoughts?
    - What sense do you make of your experience of acting on these thoughts?

Help-seeking in the context of self-harm and or suicidal thoughts and behaviours

- I am also interested in the different ways that people respond when they have these experiences. Can you tell me if you sought support from anybody/anywhere?

- *If yes..* Can you talk me through that process?
    - *Probe:* What did this support look like? Why did you choose this approach?
    - *Probe:* From your experience, what factors influenced you seeking this support?

- *If no/explore other forms..* From your experience, were there any factors that hindered you seeking support (informal/formal/any)?
    - *Probe:* What (if anything) do you think would have encouraged you to seek this type of support?

- How did you feel during this experience (seeking/not seeking)?
    - Probe: How do you feel about your course of action now?

Is there anything that you would like to add before we finish the interview?

Appendix 2.7 – History Taking/Risk Screening Tool

History of Suicidality/NSSI **Participant No.**

[Suicide Ideation]
Have you ever had thoughts about actually killing yourself?
If so, when was the last time?
And what did you find yourself thinking [timeframe] ago? (e.g., if you had to put your thoughts into words?) **[If actual desire to kill self (vs. not exist, not live), qualifies as suicidal]**
[If yes, provide details]

[Suicide Attempt]
Have you ever actually attempted to kill yourself? If so, when was the last time?
[If they have attempted suicide in the past then a Risk Assessment must be completed GO TO PART E]

[Self-harm]
Have you ever hurt yourself without wanting to die (i.e. self-harm)? [If yes, when was the last time and what did you do to harm yourself?]

[Current Suicidality]
Currently, how would you rate your desire to live, with "10" being you really want to be alive and "0" being you very much want to be dead? **[If answered 3 or less, read small paragraph below, and then go on to risk assessment PART E]**

Do you have any plan or intent to kill yourself at this time? **[If yes, read small paragraph below, and then go on to risk assessment PART E]**

IF DESIRE TO LIVE 3 OR LESS OR INTENT/PLAN TO KILL ONESELF: *I am concerned to hear that you are currently having these thoughts. In our study, we are going to ask you about some things that may be difficult to talk about. Given you are currently feeling like you want to die, what I would like to do is first make sure you have someone to talk to about getting help, and we can talk more about the study later on.*

Suicide Risk Assessment Protocol

Risk factors for suicide *(Interviewer complete known sections on own)*

- ❒ Male gender (females more attempts, males more completions)
- ❒ Ethnicity (white attempt & complete more than others)
- ❒ Age ≥16 years?
- ❒ Current psychiatric disorder?
    - ❒ Current mood disorder (MDD, Bipolar)
    - ❒ Current substance use disorder (alcohol, drugs)
    - ❒ Current psychotic disorder
    - ❒ Current personality disorder (esp. BPD or ASPD)
- ❒ Suicide history
    - ❒ Previous suicide attempt (yes/no)
    - ❒ Family history of suicide attempts/completions (yes/no)?
    - ❒ Current suicidal ideation (0-10 scale)?
    - ❒ Current plan (yes/no)?
        - Access to lethal means (firearm, drugs, etc)?
    - ❒ Current intent (On scale 0 – 10, what is your current intent to kill yourself ? ___)
- ❒ Other risk factors
    - ❒ Recent loss, separation/divorce/break-up?
    - ❒ Impulsiveness?
    - ❒ Hopelessness about the future?
    - ❒ Current distress, irritability, agitation or other "abnormal" mental state
    - ❒ Depressed mood (On scale 0 – 10 [0 = neg, 10 = pos] how would you rate your current mood? ___)

NOTES :

Protective factors & Safety plan:

- ❒ In treatment? If so, is clinician aware of risk? _____
- ❒ Family/roommate/friends aware of risk? _____
- ❒ [IF YES TO ACCESS] Means restriction (firearms, drugs, family/social support/monitoring)? _____
- ❒ Presence of children in the home, spouse/partner, or other positive relationships?
- ❒ Steps taken to increase subject safety (check all that apply):

LOW RISK == No past attempt or current SITB:

- ❒ Validated subject's feelings
- ❒ Encourage S to contact clinician if distressed or in need of help in future
- ❒ Provide referrals as needed

MODERATE RISK == Past attempt, but intent ≤6

- ❒ (check all completed above)
- ❒ S articulated own safety plan (i.e., what to do if thoughts/urges increase)
- ❒ Provided S with emergency contact numbers (999, find # of own clinician, Samaritans, Breathing Space and from list of referrals)

HIGH RISK == Current SI present, and intent 7-8, but no plan or access to lethal means

- ❒ (check all completed above)
- ❒ Encourage S to immediately contact support(s) and clinician(s)/psychiatric emergency services to inform of risk
- ❒ Call Rory O'Connor/ GIC clinician ***(must do)***

IMMINENT RISK == Current suicidal intent (7-8 with specific plan/access or 9-10 regardless of plan)

- ❒ (check all completed above)
- ❒ Call Rory O'Connor / GIC clinician ***(must do)***
- ❒ S tells/calls clinician and/or people in support network to inform them of level of risk and enlist their assistance in getting subject to a clinician ***(preferable)***
- ❒ If in lab: S should not leave alone. They can leave with family member/friend, experimenter should accompany S to Hospital Emergency Department ***(must do)***
- ❒ If on the phone: Subject should not remain at home alone. Experimenter tells/calls clinician and/or people in support network to inform them of level of risk and enlist their assistance in getting the S to a clinician ***(must do)***
- ❒ If an ambulance is being sent, stay on the phone with the S until the ambulance arrives.
- ❒ If S refuses to do the above: call 999 and inform of subject's location and risk level.

NOTES:

Appendix 2.8 – Contact Services

Support Services

Most of us will feel down, depressed or blue at some time in our lives. If you are feeling down, or are worried about something and would like to speak to someone, please see the list of organisations below.

You may also wish to contact your GP or another healthcare professional.

If you think your life or someone's life is in danger you should visit an emergency department or call an ambulance by dialling 999.

Scotland:

NHS 24; Health Information and Self Care Advice for Scotland

NHS 24 provides comprehensive up-to-date health information and self-care advice for people in Scotland. If your GP surgery is closed and you can't wait until it opens, you can call NHS 24. They will direct you to the right care for you or the person you are calling for. This may be to your local Health Board's out of hours services, Accident and Emergency department, or the Scottish Ambulance Service. If appropriate, they may recommend some steps you can take to look after yourself at home.

Website: www.nhs24.com **Telephone:** 111 **Available:** 24-hours every day

Breathing Space

Breathing Space is a free and confidential phone line service for any individual, who is experiencing low mood or depression, or who is unusually worried and in need of someone to talk to.

Website: www.breathingspacescotland.co.uk **Tel:** 0800 83 85 87

Available: Evenings (6pm-2pm) Monday to Thursday, 24-hours from Friday 6pm –Monday 6am

Emergency Department

The Emergency Department prioritise people who have a serious injury or accident or who have a sudden serious illness or medical condition. If you think that a life is at risk you should call emergency services right away.

Tel: 999 **Available:** 24-hours every day

Scottish Association for Mental Health (SAMH)

SAMH is a Scottish mental health charity which operates an information service from Monday to Friday between the hours of 2pm and 4pm. Information service staff and volunteers can answer general mental health enquiries, advise you on your rights and signpost you to your local services.

Website: www.samh.org.uk **Tel**: 0800 917 3466 **Available:** Monday-Friday: 2pm-4pm

LGBT Youth Scotland

LGBT Youth Scotland is Scotland's national charity for LGBTI young people, working with 13–25 year olds across the country. Their website links to local youth groups and a wide range of information should you wish to get LGBT advice. Their trained staff also offer digital support through LiveChat sessions every Monday, Wednesday and Thursday evening from 6-8pm.

Website: www.lgbtyouth.org.uk **Text:** 07786 202 370 **Available:** Monday-Friday

If You Are In Other Parts Of The United Kingdom (also available in Scotland):

Samaritans

Samaritans is available 24 hours a day to provide confidential emotional support for people who are experiencing feelings of distress or despair, including those which may lead to suicide.

Website: www.samaritans.org.uk **Tel:** 116 123

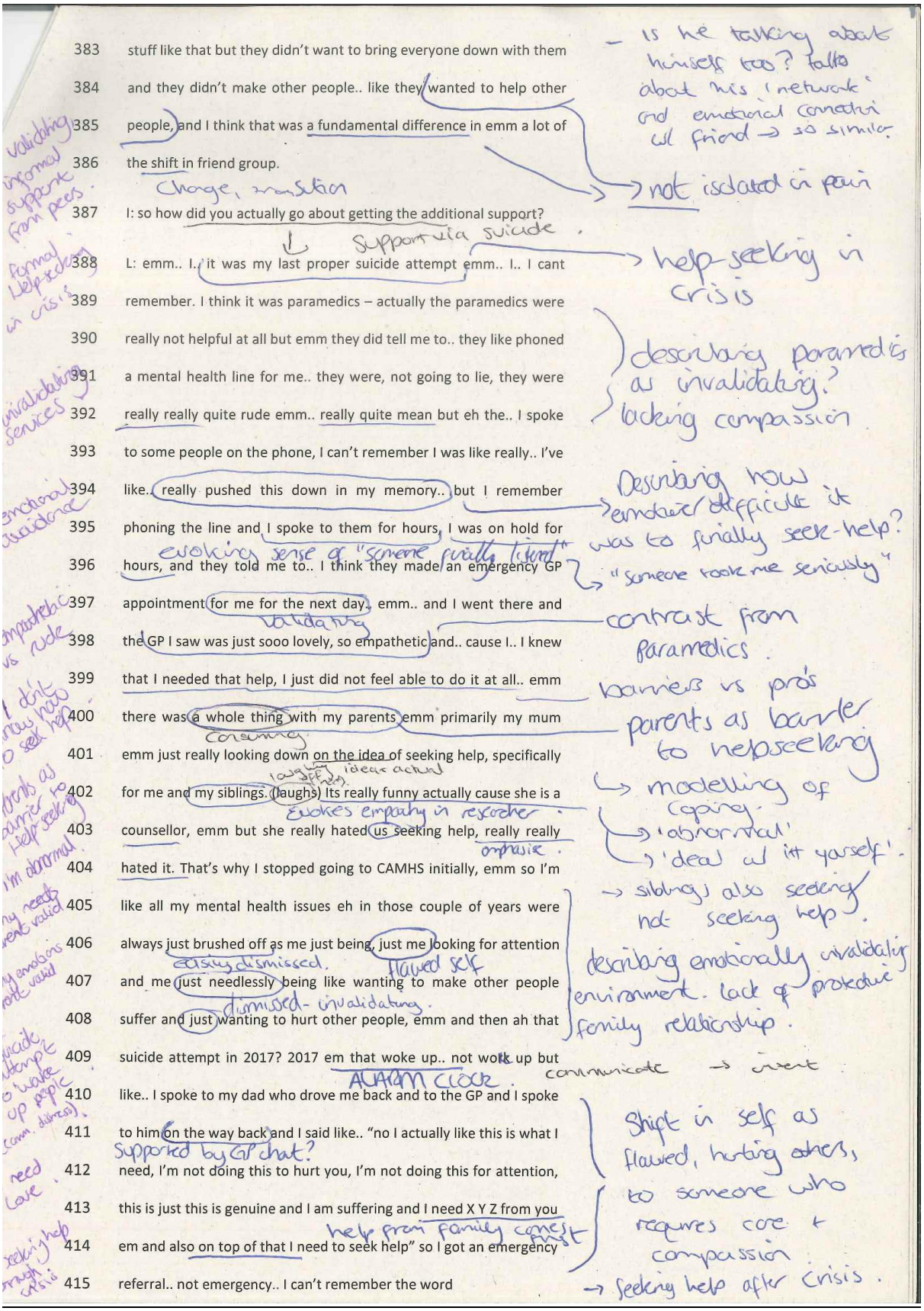
Safe Space

Safe Space is Switchboard's new, UK-wide awareness campaign launched at Pride in London 2019. They offer a confidential and non-judgemental space – a safe space – to talk and feel supported. All their volunteers self-identify as LGBT+.

Website: https://switchboard.lgbt **Tel:** 0300 330 0630 **Available:** 10am-10pm everyday

Email: chris@switchboard.lgbt (typically replies within 72 hours)

Appendix 2.9 – Analysis Example



383 stuff like that but they didn't want to bring everyone down with them
384 and they didn't make other people.. like they wanted to help other
385 people, and I think that was a fundamental difference in emm a lot of
386 the shift in friend group.
387 I: so how did you actually go about getting the additional support?
388 L: emm.. I.. it was my last proper suicide attempt emm.. I.. I cant
389 remember. I think it was paramedics – actually the paramedics were
390 really not helpful at all but emm they did tell me to.. they like phoned
391 a mental health line for me.. they were, not going to lie, they were
392 really really quite rude emm.. really quite mean but eh the.. I spoke
393 to some people on the phone, I can't remember I was like really.. I've
394 like.. really pushed this down in my memory.. but I remember
395 phoning the line and I spoke to them for hours, I was on hold for
396 hours, and they told me to.. I think they made an emergency GP
397 appointment for me for the next day, emm.. and I went there and
398 the GP I saw was just sooo lovely, so empathetic and.. cause I.. I knew
399 that I needed that help, I just did not feel able to do it at all.. emm
400 there was a whole thing with my parents emm primarily my mum
401 emm just really looking down on the idea of seeking help, specifically
402 for me and my siblings. (laughs) Its really funny actually cause she is a
403 counsellor, emm but she really hated us seeking help, really really
404 hated it. That's why I stopped going to CAMHS initially, emm so I'm
405 like all my mental health issues eh in those couple of years were
406 always just brushed off as me just being, just me looking for attention
407 and me just needlessly being like wanting to make other people
408 suffer and just wanting to hurt other people, emm and then ah that
409 suicide attempt in 2017? 2017 em that woke up.. not work up but
410 like.. I spoke to my dad who drove me back and to the GP and I spoke
411 to him on the way back and I said like.. "no I actually like this is what I
412 need, I'm not doing this to hurt you, I'm not doing this for attention,
413 this is just this is genuine and I am suffering and I need X Y Z from you
414 em and also on top of that I need to seek help" so I got an emergency
415 referral.. not emergency.. I can't remember the word

Appendix 2.10 – MRP Proposal

University of Glasgow

Institute of Health & Wellbeing

DOCTORATE IN CLINICAL PSYCHOLOGY

"Non-suicidal self-injury (NSSI) and suicidality among transgender people: understanding correlates and help-seeking."

Study Proposal

Version: 3

Date: 16/08/2019

Abstract

Background: Transgender people are at high risk of non-suicidal self-injury (NSSI) and suicide Research has consistently shown that transgender people are substantially more likely to report suicidal ideation and behaviours than both cisgender people and other minority groups. Correlates of NSSI and suicidality within the trans-population are largely unknown due to limited high-quality research within this area. Furthermore, no research has explored trans-specific experiences of help-seeking for NSSI and suicidality to date. Help-seeking is an important factor in suicide prevention.

Aims: To explore transgender individuals' experiences of NSSI and suicidality, and how they make sense of these phenomena. Through this exploration, we hope to uncover factors which may contribute to these experiences of NSSI and suicidality within this population. We also hope to further our understanding of transgender individuals' perspectives on help-seeking.

Method: A qualitative design will be used. Semi-structured interviews will be conducted with a small sample of transgender adults who report a history of NSSI and/or suicidality. Interview transcripts will then be analysed using Interpretative Phenomenological Analysis (IPA).

Applications: Identification of factors which influence NSSI, suicidality and help-seeking in the transgender population will aid risk management and clinical interventions.

Non-suicidal self-injury (NSSI) and suicidality among transgender people: understanding correlates and help-seeking.

1. Introduction

Transgender (or 'trans') people are individuals whose sense of felt gender (i.e. gender identity) differs from the gender assumed at birth, on the basis of the sex they were assigned (Vincent, 2018). The term cisgender (or 'cis') describes individuals whose gender assumed at birth reflects their gender identity. The historical view of gender being wholly binary (e.g. male/female) does not accurately reflect the spectrum of gender expression (Richards et al., 2016). Therefore transgender people may describe a number of different personal experiences of gender; including transmen, transwomen, non-binary, gender diverse and genderqueer identities (Vincent, 2018). Trans people may also have a fluid gender identity and so may identify with more than one term at any given time, or the term they identify with may change over time (McNeil, Ellis & Eccles, 2017). Importantly, sexual orientation and gender identity are distinctly separate.

1.1 Non-suicidal self-injury and suicidality

Research has consistently shown that trans individuals are more at risk of suicide than the cisgender population (Adams, Hitomi & Moody, 2017; Clements-Nolle, Marx and Katz, 2006; Haas, Rodgers & Herman, 2014; McNeil et al., 2017; Peterson, Matthews, Copps-Smith & Conard, 2017; Resiner et al., 2014). This disparity is also true when compared to other marginalised groups. For example, within the Lesbian, Gay, Bisexual and Transgender (LGBT) group, trans individuals are more likely to attempt suicide than the LGB population (Haas et al., 2014; Mustanski & Liu, 2013). One UK trans mental health survey (McNeil, Bailey, Ellis, Regan, & Morton, 2012) noted that the majority of respondents (84%) indicated current or historical suicidal ideation, with 48% of these individuals having attempted suicide at least once. A total of 51% and 11% of transgender adults report past year suicide ideation and attempts, respectively, across the USA and Canada (Adams et al., 2017). Similarly, Viripukasha, Muralidhar and Ramakrishna (2016) found lifetime rates of suicide attempts within the trans population to be between 32% and 52% globally. These prevalence rates are substantially higher than the cross-national lifetime prevalence of suicidal ideation (9.2%) and attempts (2.7%) within the general population (Nock et al., 2008).

A higher prevalence of non-suicidal self-injury (NSSI) also exists within the trans population (between 19% and 39%), compared to the cis population (Marshall et al., 2016). NSSI, or self-harm, refers to intention self-inflicted damage one's own body tissue without suicidal ideation, and not consistent with cultural norms. Methods of NSSI include cutting, burning, scratching, and hitting oneself, which have been found to serve a variety of functions including affect regulation, self-punishment and social functions (Cipriano, Cella & Cotrufo, 2017).

A history of self-harm, suicidal ideation and suicidal attempts are known risk factors of dying by suicide within the general population (Chan et al., 2017). However, despite the high prevalence rates of NSSI and suicidal behaviour within the trans population, the lifetime prevalence of trans individuals dying by suicide is currently unknown (Wolford-Clevenger, Cannon, Flores, Smith & Stuart, 2017). The lack of data in this area may reflect challenges in recording trans identities at time of death (McNeil et al., 2017). Although research within the transgender population has increased over recent years, this population is still vastly understudied. The high rates of NSSI and suicidality among trans people highlights the importance of continued research within this area, aimed at improving our understanding and prevention of suicide within this population.

1.2 Correlates of NSSI and Suicidality

A recent systematic review by McNeil et al. (2017) summarised the correlates of suicidal ideation and behaviours within the trans population. Environmental factors, specifically those related to minority stressors (e.g. discrimination, victimisation and social stigma), were identified as strongly related to suicidal ideation and attempts. Individual factors, such as co-morbid mental health difficulties and internalised transphobia, were also discussed as risk factors for ideation and attempts. Conversely, positive social interactions and timely access to interventions were noted as protective. Notably, trans individuals are not biologically predisposed to psychopathology, nor do they experience mental health difficulties differently from the cis population (Robles et al., 2016). Olsen et al., (2016) found that normative levels of mental health difficulties can be observed if individuals (in this case trans youth) are socially supported in their chosen gender identity, suggesting that psychopathology is not inherently part of a trans identity and again highlighting the protective nature of positive social interactions.

Similar risk factors have been described for NSSI among trans people, including discrimination, perceived lack of social support and interpersonal problems (Marshalle et al., 2016). Literature suggests that transmen (female-to-male) are particularly at risk of NSSI (Holt, Skagerburg & Dunsford, 2016; Peterson et al., 2017). One hypothesis is that being born phenotypically female may increase an individual's risk of NSSI, as ciswomen are more at risk of self-harm than cismen (Marshalle et al., 2016). Further research is required to explore the relationship between specific gender identities and NSSI. The relationship between NSSI and suicidality within the trans population requires further attention; however recent research suggests a positive correlation between NSSI and suicide attempt history (Wolford-Clevenger, Smith, Flores & Stuart, 2018).

Wolford-Clevenger et al. (2018) systematically reviewed the literature from January 1991 to July 2017, to describe separately the correlates of ideation and attempts. Guided by an ideation-to-action framework (Klonsky & May, 2014), the authors described a number of internal and external minority stress experiences (e.g. prejudice/discrimination, victimisation, expectations of rejection, self-stigma) which, in combination, potentially contribute to psychological pain and thus drive suicidal ideation. In parallel with the general suicide literature, a positive correlation was found between suicide attempt history and fearsome and painful events among trans people. These events include both physical and sexual violence, substance misuse and, as discussed, NSSI. However, in contrast with our understanding that key fearful and physically painful events shift ideation toward attempts, internalised minority stressors were also positively correlated with a move from ideation to action for trans people. Further research efforts are needed to understand the factors which may contribute to a trans person's capacity for suicide, particularly when considering the generalisation of existing suicide frameworks to a population which encompasses a range of uniquely trans-specific experiences.

Notably, this review highlighted the poor methodological quality of research within this area, with only 15% of the 45 included studies rated as good quality. Methodology was often limited by dichotomous measuring (e.g. lifetime prevalence vs absence) of both ideation (58% of studies) and attempts (80% of studies). Furthermore, of the studies which reported correlates of suicide attempts, none defined the key aspect of 'intent to die' (Freedenthal, 2007) when measuring attempted suicides. Thus the authors noted that any conclusions drawn regarding the correlates of suicidality in trans people should be considered tentatively, again highlighting the need for further empirical research in this area. Further qualitative research may help to provide context to the mechanisms underlying NSSI and suicidality risk for trans people.

1.3 Help-seeking behaviours

To date, no research has explored help-seeking for NSSI and suicidality specifically within the adult trans population. Help-seeking is an important factor in suicide prevention. Within the general

population, research has sought to understand the formal (medical professionals and mental health services) and informal (self-help, social) help-seeking behaviours of individuals experiencing NSSI or suicidal distress (Hom, Stanley & Joiner, 2015; Rowe et al., 2014). Individual demographic factors (e.g. education level, socioeconomic status, culture, race, gender, age) influence the likelihood that a person will seek help when experiencing suicidal distress (Niederkrotenthaler et al., 2014). The existence of these group-specific differences, in addition to the substantial impact of attitudes and stigma on help-seeking (Calear, Batterham & Christensen, 2014), suggest that further suicide prevention research is needed to understand the underlying processes of trans-specific help-seeking behaviours.

Whilst exploring help-seeking in LGBT women who report general mental health difficulties, McNair and Bush (2016) found that transwomen reported barriers to seeking help including; fear of/prior experience of prejudice and/or discrimination (71%), concerns that providers will not be well informed/trans-sensitive (38%), and lack of readiness (45%). These findings appear in line with literature exploring both physical and mental health care use by trans people. The literature discusses experiences of/fear of stigma and discrimination within a healthcare context, fear of social consequences, and a belief that their needs will not be met, as barriers to transgender people fully utilising professional health services (Shipherd, Greene & Abramovitz, 2010; Poteat, German & Kerrigan, 2013).

A study by Effrig, Bieschke & Locke (2011) compared reported levels of psychological distress between treatment seeking and non-treatment seeking trans college students. They concluded that there was no significant difference in levels of psychological distress between groups, however, higher levels of suicidal ideation within the treatment-seeking group was observed. The authors hypothesised that trans people may be more likely to seek help only when a crisis point is reached. Methodological limitations however, including inclusion/exclusion criteria for each group, suggest interpretation of these results should be tentative. However, a recent study by McDermott, Hughes and Rawlings (2017) may lend some support for this hypothesis.

McDermott et al., (2017) explored LGBT youth suicidality, self-harm and help-seeking (formal and informal). Like much of the transgender research, trans people were amalgamated within the LGBT category, thus significantly limiting our ability to draw informed conclusions on trans-specific experiences. Additionally, this study focused on youth LGBT (mean age 18) and so results were likely influenced by age-related variables. Nevertheless, this mixed-methods study serves as an initial starting point in exploring the process of help-seeking in trans people who experience suicidal distress. Qualitative interviews (41% of respondents were 'trans or other') identified three main themes that pose a challenge to help-seeking; negotiating norms (managing a heteronormative[1] environment and fear of stigma), inability to discuss emotions (lack of trust/confidence speaking about difficulties, negotiating disclosure of LGBT status), and self-reliance (viewing help-seeking as a weakness, maladaptive strategies viewed as positive coping).

Similar to Effric et al., (2011), the authors concluded that LGBT individuals often normalise their psychological distress and so are more likely to seek help only when at a crisis point. Interestingly, McDermott et al., (2017) also reported being transgender, planned/attempted suicide, NSSI, and experience of abuse related to gender identity/sexual orientation as significant predictors of help-seeking for suicidality. However, they did not control for the possibility that trans individuals may experience these additional predictors at a higher frequency than cisgender individuals, which may in turn mediate the increased likelihood that trans people will seek support.

[1] Heteronormativity refers to the assumption that a binary gender identity (in line with sex assigned at birth) and heterosexuality are the norm. This often leads to the "othering" of people who do not conform to these assumed norms.

2. Aims

The principal aim of the proposed research is to explore the lived experience of transgender individuals who report a history of non-suicidal self-injury (NSSI) and/or suicidal thoughts or behaviours, in order to better understand their experiences. The researcher will be guided by the participants in terms of themes for discussion, however the proposed research will explore the following topics; i) transgender individuals' experiences of any psychosocial factors which may increase or decrease the likelihood that NSSI and/or suicidality will occur, and ii) their experiences of help-seeking in the context of experiencing NSSI and/or suicidality.

3. Plan

3.1 Design

The proposed study will be of qualitative design. Semi-structured in-depth interviews will be conducted, and analysed using an Interpretative Phenomenological Analysis (IPA) framework.

3.2 Participants

Participants will be recruited from the both the NHS GGC and NHS Lothian Gender Identity Clinic's. Participants will be asked to (1) describe their gender identity and (2) identify the sex they were assigned at birth. The study will also collect socio-demographic data (e.g. age, race, religion, sexuality, postcode) to help account for intersectional experiences.

3.3 Inclusion/Exclusion Criteria

Inclusion criteria: (i) gender identity which is incongruent with sex assigned at birth (ii) report a history of NSSI and/or suicidal thoughts or behaviours (iii) aged 17 or over (iv) fluent in English. Exclusion criteria: (i) known forensic history or (ii) at imminent risk of suicide (assessed before participation).

3.4 Justification of Sample Size

Interpretative Phenomenological Analysis (IPA) embraces a "less is more" stance, suggesting that it is more desirable to explore themes from smaller sample sizes in great depth, as opposed to recruiting a larger sample which may provide broader, shallower, more descriptive themes (Reid, Flowers & Larkin, 2005). Therefore, studies employing IPA generally recruit between one and ten participants (Starks & Trinidad 2007). The proposed study seeks to recruit between 4 and 10 participants, which is the recommend total of participants for doctoral research (Smith, Flowers & Larkin, 2009).

The sample size is considered feasible as the NHS Gender Identity Clinic's accept a large number of referrals onto their waiting list each year. Additionally, given the high prevalence of a history NSSI and suicidality within the trans population (McNeil et al., 2017), it is not anticipated that application of the inclusion criteria will significantly limit the number of potential participants. There are currently 531 individuals on the waiting list for GGC Sandyford (as of 18/01/2019) and the service accepts approximately 30 new adult referrals each month. The proposed sample size represents only 0.75% to 1.88% of the potential participant pool prior to inclusion/exclusion criteria.

3.5 Recruitment Procedures

Participants will be recruited from two Gender Identity Clinics within NHS Scotland; the Sandyford Centre (NHS Greater Glasgow and Clyde; GGC) and the Chalmers Centre (NHS Lothian). Potential participants will be identified from the adult service at these clinics during a number of points of contact; initial waiting list, initial assessment, and internal waiting list for medical review. Gender Identity Clinics are not considered mental health services; however they provide support to any person who feels uncomfortable or uncertain about their gender identity or expression of their gender. Their primary role is to assist transgender people to facilitate social, medical and surgical

treatments that enable greater comfort in the face of gender non-conformity. Both clinics accept referrals from other health professionals (e.g. GP), whilst GGC Sandyford centre also self-referrals. Prior consent to be contacted for research purposes is sought at the point of self-referral and at initial appointment. Anyone who has not provided consent to be contacted for research purposes (at initial appointment or at time of self-referral) will be omitted from any invites.

The clinics provide a national service to any individuals registered with a GP in Scotland. Individuals on the waiting list for initial partnership appointment are not considered GGC/Lothian patients unless they are registered at a GP within these health board areas. Once individuals are open to the gender identity clinic following initial contact, they are then considered NHS GGC/Lothian patients (dependent on location).

A number of recruitment strategies will be employed to increase the likelihood that the required number of participants will be recruited. These are summarised below

Recruitment strategy one: Following initial assessment, individuals are then placed on an internal waiting list for medical review. Individuals who are on the waiting list for medical review and have provided consent to be contacted for research purposes will be sent information pertaining to the study (e.g. inclusion criteria, purpose of study), and invited to participate.

Recruitment strategy two: Clinical staff will be provided with information regarding the study, including inclusion/exclusion criteria. Clinical staff conducting initial assessments will be asked to introduce the study and provide study information packs to individuals who have indicated that they would like to be contacted for research purposes and who may meet inclusion criteria for the study.

Recruitment strategy three: Individuals who have self-referred and have provided consent to be contacted for research purposes will be sent information pertaining to the study (e.g. inclusion criteria, purpose of study), and invited to participate. NHS Lothian does not accept self-referrals and so recruitment strategy three will only be employed at NHS GG&C Sandyford Centre. Only individuals who are registered with GP in Greater Glasgow and Clyde Health Board Area will be identified from the partnership waiting list.

After receiving an information pack, potential participants will be asked to provide consent for the researcher to contact them should they wish to take part, either by returning the enclosed consent form or by emailing written consent to the researcher. They will then be contacted directly by telephone by the researcher (following a period of at least 24 hours) who will provide any further information that is required and arrange a time for interview at the convenience of participants. A formal assessment of suicidal risk will be administered by the researcher prior to/following each interview. This standardised risk screening protocol is extensively used by the Suicidal Research Behaviour Laboratory (see Appendix 1). Additionally, the researcher (Lisa Ballantyne) is a final year Trainee Clinical Psychologist with experience in conducting formal risk assessments, including suicide risk, within clinical mental health settings. The research has also undertaken a number of additional training courses aimed at suicide awareness, risk assessment, and prevention (e.g. ASSIST Training, STORM training, FACE CARAS). Any individual identified as at imminent risk of suicide at any stage of the interview will be referred immediately to the appropriate Crisis Service.

3.6 Setting and Equipment

All interviews will be conducted in a clinical setting within Sandyford Central (Glasgow) or Chalmers Centre (Edinburgh). A recorder, transcription kit, and laptop will be borrowed from The University of Glasgow

3.7 Methodology

Interviews will be audio-recorded and transcribed before being analysed using Interpretative Phenomenological Analysis (IPA) guided by Smith, Flowers and Larkin (2009). IPA is a qualitative approach which explores the processes whereby individuals make sense of their subjective lived experiences. IPA relies on an inductive approach which invites individuals, viewed as experts of their own experiences, to share their accounts of a given phenomenon. Participants are afforded the opportunity to reflect on their own experiences and express their ideas, whilst sharing their detailed first-hand stories with the researcher during interview (Smith et al. 2009).

3.8 Qualitative Interviews

One-on-one semi-structured interviews, lasting approximately one hour, will be conducted by the primary researcher. An interview schedule will be used to help structure these interviews, although this will be a limited guide and will not be followed rigidly. Instead, this guide will support participants to reflect on the experiences which they deem central to the given topic, in line with IPA's inductive stance.

3.9 Data Analysis

Each participant's data (e.g. claims, concerns and understandings) will be analysed line by line through transcription and coding. Emergent themes will then be identified, focusing convergence and divergence, commonality and nuance. This interpretation will be a dialogue between the researcher, the coded data, and their knowledge, when considering what it might mean for participants to have these concerns, in this context. A structure will then be developed to demonstrate the relationships between themes, before then forming a more cohesive narrative. The coherence and plausibility of themes will be tested through the use of supervision.

3.10 Data Management Plan

Personal data will be recorded on consent forms which will be stored in a locked filing cabinet at the University of Glasgow. Each consent form (with personal identifiable information) will be given a unique code. Each interview will audio recording will be stored on an encrypted USB stick provided by the University of Glasgow. Only the researcher (Lisa Ballantyne) will have access to these audio files. Recordings will be backed up on a password protected part of the University network and will be destroyed at the end of the study. Each recording will be transcribed verbatim and all identifiable information will be removed to preserve the anonymity of participants and pseudonyms will be applied. A unique code for each participant will be noted on the anonymised data, which will link to identifiable information held separately. Recordings and transcripts will be treated in accordance with the General Data Protection Regulations (2018) and NHS Confidentiality Code of Practice on Protecting Patient Confidentiality (2002). The University of Glasgow will retain personal data for between 12 months and 3 years due to the typical time required for publication exceeding 12 months. Research data generated by the study will be stored for 10 years. The research data will be stored in a locked filing cabinet at the premises of the Institute of Health & Well-being at Gartnavel Royal Hospital.

4. Health and Safety

The researcher will receive regular supervision by the local clinical supervisor. All interviews will take place on NHS clinical grounds and the appropriate local health and safety guidelines will be followed, thus reducing the risk to both researcher and participants. Participant safety issues are discussed in further detail below in section 5 (ethical issues).

5. Ethics

Prior to commencing research, ethical approval will be requested from the West of Scotland Research Committee and the *Sandyford Research* Governance Group (RGG).

5.1 Informed Consent

The voluntary and confidential nature of participation will be made explicit. Participants will be assured that they can withdraw their participation at any time. Written consent will be obtained prior to interview.

5.2 Risk of Coercion

Information provided (information sheet/verbal discussions) will stress that participation is voluntary and the decision to participate or not will not affect their care.

5.3 Data Protection and Confidentiality

Participants will also be assured that their data will be anonymised and will remain confidential and limits of confidentiality will be explained. Pseudonyms will be used for the duration of the interview and during analysis.

5.4 Potential Distress

The potentially sensitive topic will be acknowledged and participants will be advised that they are not required to answer any questions they do not wish to. In the unlikely event that a participant does become distressed, they will be encouraged to discuss any issues with their GP. A field supervisor will available while the interviews are taking place should immediate support be required. Participants will be provided with a list of contacts for further local/ culturally inclusive support. As noted, a risk screening tool will be used at the start and end of every interview to ascertain risk of suicide specifically. An action plan will be in place should any participant disclose information suggesting that they may be at imminent risk.

5.5 Transgender Health Research

Adams, Pearce, Veale et al. (2017) highlighted further ethical considerations needed for transgender health research, including the potential for distressed caused by misgendering individuals or by using stigmatising language. The language and procedures used will be guided by collaboration with local trans groups (e.g. Scottish Trans Alliance).

6. Finance

The University of Glasgow will fund the costs involved in printing, photocopying, and posting of the research information packs.

7. Proposed Timetable

January 2019:	Proposal submission
April-October 2019:	Ethics
November-January 2019:	Data collection
February 2019:	Review point
February-March 2020:	Data Coding/analysis
April-July 2020:	Write-up/Submission

8. Practical Applications

Identification of factors which increase or decrease NSSI and suicidality for transgender people will in turn aid risk management and inform clinical interventions. Given the importance of help-seeking behaviours in preventing suicide, identification of factors which influence these behaviours within

the transgender population may provide important considerations for both policy and service development.

The results of this study will be submitted as a piece of work for a doctoral qualification in Clinical Psychology. The results may also be published in academic journals, conference proceedings and a summary of results will be made available to participants who would like feedback about the research once completed.

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